KPMG

Health Agency Review Final Report

San Luis Obispo County

—

Updated June 4, 2025

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Executive Summary

Executive Summary

Scope of Services

In January 2025, the County of San Luis Obispo contracted with KPMG LLP to conduct an operational and performance review of its Health Agency. The purpose of this review is to provide a high-level assessment of agency strengths, weaknesses, opportunities, and threats and identify opportunities to enhance cost efficiency and operational efficiency, effectiveness, and service delivery.

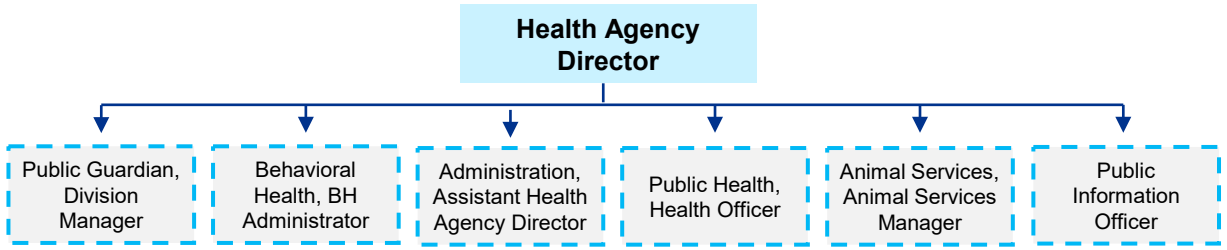
Description

- The Health Agency consists of the Behavioral Health Department, the Public Health Department, the Animal Services Division, and the Office of the Public Guardian. Currently with 485.5 employees, 95.5 vacancies, and an annual operating budget of $168.12 million, it is the only agency within the San Luis Obispo County Government.
- Health Agency Mission: To provide a broad array of services essential to the health and well-being of those living in and visiting San Luis Obispo County.
- Health Agency Vision: That our residents and visitors are healthy and have access to services essential to maintain optimal health.

Methodology: Over a 9-week period, the KPMG Team conducted the following activities

1. ***77 interviews*** *with Agency leadership and staff to understand the organizational structure, roles and responsibilities, operations, and processes of the Agency and each of its divisions and programs.*
2. ***14 interviews*** *with key stakeholders to understand the Health Agency's strength and areas for opportunity. Stakeholders consisted of Law enforcement, Courts/Judges, Fire Services, Hospitals, Schools, and Community Providers*
3. *Analysis of available data and policy documents comprised of* ***over 500 files*** *to understand the demands upon and the operations of each departments and its divisions*
4. *A* ***benchmarking and leading practice review*** *was also conducted across the* ***five benchmark counties*** *at the request of the Agency Leadership.*
5. *An* ***Interim Workshop*** *followed by* ***1:1 meetings*** *and a* ***final workshop*** *with department leadership to review each opportunity for consideration and reach consensus. List of opportunities are outlined on slides 5-13.*

Organization Structure



FY 24-25	
Operating Expenses	$168.12 million
Revenue (including federal, state, and grant funding)	$130.77 million
General Fund Contribution	$37.34 million
Total FTEs*	581

*The total FTE count (including vacancies) and FTE numbers for each division were pulled from an export from SAP as of April 11, 2025.

Overview of Key Opportunities

Overarching

Division	Key Opportunities	*Est. Efficiency $
Overarching	• **1.1 a-b:** Implement a Contract Management System, standardize processes, establish clarified roles and responsibilities, review portfolio, and consider the adoption of AI to improve the contract management process • **1.2a-b:** Streamline the Grant/Allocation and capital expenditure (e.g., equipment) request process through a redesigned request and approval workflow, enhanced monitoring, and a dashboard for improved transparency, spend analytics, and risk mitigation. • **1.2c:** Assess equipment life cycle costs when considering the acceptance of grant funding or allocation of funds related to equipment to support more informed grant/allocation of funding decisions. • **1.3:** Implement a standardized financial reporting process to bridge the gap between clinical, operational, and financial management. • **1.4:** Consolidate the Fiscal and Billing departments into a single cohesive unit, and evaluate the usage of AI for Billing function to improve financial processes and enhance decision-making • **1.5:** Partner with Auditor Controller Treasurer Tax Collector (ACTTC) to align Revenue Recognition with GASB 62 and account for COLA increases for Accurate Financial Reporting and Improved Decision-Making • **1.6:** Develop a marketing strategy for Health Agencies services to increase awareness of services offered among diverse community members. • **1.7:** Implement AI solutions to support documentation practices across the agency by reducing time spent by clinicians and psychiatrists. • **1.8:** Adjust the model of care for clients with a high rate of No-Show/Cancellation while implementing operational efficiency practices. • **1.9:** Improve productivity through verification of staff activities and billing eligibility. • **1.10:** Resolve data quality challenges, standardize data collection and management to enhance data analytic capabilities and support data-driven decision-making	*These opportunities will further support the Health Agency to achieve greater Non-Net County Cost (NCC) through collaboration and communication. However, do not have specific Non-NCC figures associated with each opportunity.*

**Est. Efficiency figures are estimates based on the previous financials, caseload data, and other resources shared by the Health Agency.*

Overview of Key Opportunities

Behavioral Health

Division	Key Opportunities	*Est. Efficiency $
Mental Health Division	• **2.1a:** Optimize staffing across all Mental Health Adult Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach. • **2.1b:** Optimize staffing across all Mental Health Youth Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach. • **2.1c:** Improve utilization for LPT, Nursing, Nurse Practitioners, and Psychiatrists across Services through enhanced scheduling practices and shift model of care to a multidisciplinary team approach, while right sizing staffing to meet community needs and volume demand.	**$304,000 - $387,000**
Drug and Alcohol Services	• **2.2:** Optimize current staffing by implementing direct client engagement targets across all positions, evaluate hours of operations, model of care and engage key stakeholders through educating them on the services offered by Drug and Alcohol Services.	*This opportunity will further support Drug and Alcohol Services to achieve greater Non-NCC through collaboration and communication.*
Prevention and Outreach	• **2.3:** Realign Services from Prevention and Outreach to programs more aligned with service offering to develop synergies across similar services and achieve economies of scale among staff and management.	**TBD****
Access & Crisis (Contracts)	• **2.4:** Redesign Mobile Crisis and Dispatch Services to align with community need, volume demand, while being financially sustainable. • **2.5:** Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability. • **2.6:** Transition Youth and Transitional-Age Youth (TAY) Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.	**$1,480,000** **$1,800,000 - $2,350,000** **$500,000 - $800,000**

**All Cost Efficiency figures are estimates based on the previous financials, caseload data, and other resources shared by the Health Agency. Cost efficiency estimates are not exclusively to General Funds.*
***The Estimated Cost Efficiency for the opportunity is dependent on the Span of Control upon transitioning of services detailed on page 58.*

Overview of Key Opportunities

Behavioral Health

Division	Key Opportunities	*Est. Efficiency $
Access & Crisis (Contracts)	• **2.7:** Transition Homeless Outreach Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability. • **2.8:** Consider reducing contracts for duplication of services that are funded by the State, the County and Federally.	**$1,000,000 - $2,000,000** • **Central Coastal Hotline: $318,000** • **Iris Telehealth Medical Group: $45,000 – $300,000**
Justice Services	• **2.9:** Realign resources across Justice Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach. • **2.10:** Meet BH Connect requirements for Forensic Assertive Community Teams by enhancing current team structure and aligning model of care with FACT requirements. Consideration to be given to merge ACT and FACT teams to meet model.	*Pending integrating ACT and FACT into one team and pending absorbing Veterans Justice Treatment.*

**All Cost Efficiency figures are estimates based on the previous financials, caseload data, and other resources shared by the Health Agency. Cost efficiency estimates are not exclusively to General Funds..*

Overview of Key Opportunities

Public Health

Division	Key Opportunities	*Est. Efficiency $
Clinical and Communicable Disease	• **3.1:** Enhance reporting and analysis through development of an Acuity Model and Power BI Dashboard to better understand staff workload, productivity, caseload allocation, and overall divisional performance.	**$88,000**
	• **3.2:** Reevaluate staffing levels at the Reproductive Health Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.	*While not yielding immediate calculable Cost Efficiencies, this opportunity will staff to increase efficiency and effectiveness.*
	• **3.3:** Reevaluate staffing levels at the Immunization Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.	*It is not possible to calculate Potential estimated cost efficiencies for this opportunity given data on staff utilization across program is unavailable*
	• **3.4:** Engage Divisions in developing EHR business requirements and enhance pre-clinic communication processes to improve efficiency and Patient experience.	*While not yielding immediate calculable Cost Efficiencies, this opportunity will staff to increase efficiency and effectiveness.*
EMSA	• **3.5:** Increase EMT certification fees to achieve better Non-NCC for providing these services.	**$40,000 - $67,000**
	• **3.6:** Adjust response time requirements to match industry standards and realign penalties accordingly for non-compliance.	*The Potential for Cost Efficiencies will be dependent on agreements with existing ambulance providers on response times and penalties*
	• **3.7:** Establish contract oversight fees for Air Ambulance oversight helping ensure that the charges reflect the actual costs incurred for providing the service.	**$25,000**
	• **3.8:** Adopt dispatch protocols to expand use of an “ambulance alone” response to most efficiently respond to low-urgency medical calls.	*An accurate dollar value saving is difficult to develop without data on the number of calls that may be considered ambulance alone in the future which is unavailable*

**All Cost Efficiency figures are estimates based on the previous financials, caseload data, and other resources shared by the Health Agency.*

Overview of Key Opportunities

Public Health

Division	Key Opportunities	*Est. Efficiency $
Environmental Health	• **3.9:** Re-evaluate fees for Water Systems and Land Use program fees to support full Non-NCC and reduce reliance on the General Fund.	**$280,000 - $435,000**
	• **3.10:** Consider incorporating the cost of Emergency Response into regular fees to improve Non-NCC for this service.	**$120,000 - $175,000**
	• **3.11:** Collaborate with other county departments such as Public Works to consider adoption of surveillance cameras in illegal dumping hotpots.	*As data on the number of violations is not available, it is not possible to calculate the cost efficiencies that can be achieved*
	• **3.12:** Update the fee schedule after finalizing the budget to better align fees with departmental costs in collaboration with County leadership.	*This opportunity will further support the Division to achieve greater Non-NCC; however, will not be in addition to the Cost Efficiencies already identified*
	• **3.13:** Implement credit card convenience fees for payments made via credit card to cover transaction costs and enhance Non-NCC.	**$25,000 - $30,000**
Healthcare Access	• **3.14:** Adopt a Community Approach aligned with leading practices for the development of a Community Information Exchange (CIE) to improve data sharing and coordinated care system.	*This program does not utilize general fund and this opportunity will not result in Potential estimated cost efficiencies, but support the Division to align to leading practices in considered the development of a CIE*
	• **3.15:** Collaborate with key partners to consider the adoption of artificial intelligence to support the Oral Health program.	*This program does not utilize general fund and this opportunity will not result in Potential estimated cost efficiencies; however, it may support the Program to service more schools across the County.*

**All Cost Efficiency figures are estimates based on the previous financials, caseload data, and other resources shared by the Health Agency. Cost efficiency estimates are not exclusively to General Funds.*

Overview of Key Opportunities

Public Health

Division	Key Opportunities	*Est. Efficiency $
Healthcare Promotion	• **3.16:** Implement processes for tracking staff utilization within the WIC Clinic and setting utilization targets to enhance program service delivery and cost efficiency.	*This opportunity will not result in immediate Cost Efficiencies but will support operational efficiency which may result in future Cost Efficiencies once implemented*
	• **3.17:** Consider transitioning to mobile clinics in low-volume locations, implementing telehealth to reduce costs and enhance client accessibility, and commencing the tracking of key financial metrics across clinics to optimize resource allocation and increase cost efficiency.	*As the Division does not track cost per clinic, it is not possible to calculate the cost efficiencies that can be achieved.*
	• **3.18:** Conduct a cost-benefit analysis to explore the feasibility of relocating the WIC clinic in Paso Robles to a more cost-effective facility, considering both County-owned and alternative rental properties.	**$101,000**
	• **3.19:** Based on funding availability, engage with interested schools to explore collaborative funding opportunities for expanding community wellness services. (Based on uncertainty of Federal Funding this opportunity may not be started until 2026)	*This will not result in cost efficiencies; however, it will result in an increase in service provision for no net new cost.*
	• **3.20:** Collaborate with the Social Services Department and other key health services departments to adopt leading practices for enhancing CalFresh enrollment across the County, to increase CalFresh Healthy Living grant funding for the Division.	*This will not result in cost efficiencies; however, it will result in an increase in revenues based on percentage increase in CalFresh enrollment*
Maternal Child and Adolescent Health	• **3.21:** Reevaluate staffing levels within the Home Visiting Program to better match demand and reallocate full-time equivalents (FTEs) to areas with greater need and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.	**$1,200,000**
	• **3.22:** Reevaluate staffing levels at Martha's Place to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.	**$20,000 - $50,000**
	• **3.23:** Implement processes to decrease no-show rates in the Medical Therapy Program to increase staff utilization and reduce wait times and cost of service.	*Since total number of visit data is unavailable, an estimate for Potential estimated cost efficiencies cannot be determined.*

**All Cost Efficiency figures are estimates based on the previous financials, caseload data, and other resources shared by the Health Agency. Cost efficiency estimates are not exclusively to General Funds.*

Overview of Key Opportunities

Public Health

Division	Key Opportunities	*Est. Efficiency $
Public Lab	• **3.24:** Explore three key options for the Laboratory's future operations to enhance Non-NCC and decrease reliance on the general fund	**$0 - $750k**
	• **3.25:** Optimize staffing to test ratios to better align with demand for service and support greater Non-NCC	**$295,000**

Animal Services

Division	Key Opportunities	*Est. Efficiency $
Animal Services	• **4.1:** Consider the feasibility of establishing to a 501(c)(3) organization to collect donations for animal services and increase cost efficiency, similar to the approach taken by Ventura County • **4.2:** Consider the benefits of a coordinated governance model with the cities to increase collaboration and enhance the shared decision-making process	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency*

Public Guardian

Division	Key Opportunities	*Est. Efficiency $
Public Guardian	• **5.1:** Transition to an alternative technology solution to reduce manual efforts and administrative burden and support future data-driven decision-making on	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency and more accurately alignment of workload to demand*

**All Cost Efficiency figures are estimates based on the previous financials, caseload data, and other resources shared by the Health Agency. Cost efficiency estimates are not exclusively to General Funds.*

Behavioral Health: Potential Cost Efficiency Summary

Outlined below is a breakdown of all cost efficiency opportunities plus vacancies across the Health Agency.

- Behavioral Health: There are 2 positions (LPT/Nursing) in Youth Services proposed for reduction. The remaining positions may be transitioned or eliminated once the County can evaluate utilization against established targets upon data verification. The remaining cost efficiencies is in Contracts.
- While there is opportunities for cost efficiencies in the Span of Control, County Administration will need to accept the opportunities and undergo the 'bumping' process before determining the true financial opportunity.
- *Cost efficiency estimates are not exclusively to General Funds.*

Behavioral Health			
Opportunities for Consideration		**Minimum Total Cost Efficiency**	**Maximum Total Cost Efficiency**
Subtotal		**$ 3,644,000**	**$ 6,835,000**
Division	**Vacancies**	**Minimum Total Cost Efficiency**	**Maximum Total Cost Efficiency**
Mental Health	12.75	$ 1,834,679	$ 3,314,896
Drug & Alcohol	24.00	$ 1,421,802	$ 4,016,337
Prevention & Outreach	12.50	$ 1,080,284	$ 2,309,260
Access and Crisis Services Division	5.00	$ 681,217	$ 786,370
Justice Services	7.00	$ 965,104	$ 1,159,683
Subtotal	**61.25**	**$ 5,983,086**	**$ 11,586,546**
Estimate Cost Efficiency		**$ 9,627,086**	**$ 18,421,546**

It is understood that some of these positions may have been eliminated by the County during the process of KPMGs review, however, the analysis above does not account for the changes that took place during the same time period.

Public Health: Potential Cost Efficiency Summary

Outlined below is a breakdown of all potential cost efficiency opportunities plus vacancies across the Health Agency.

- Public Health: There has already been elimination of positions in both Laboratory Services and Maternal Child Services by the department, therefore we believe that these efficiencies are already listed under vacancies.
- While there is opportunities for cost efficiencies in the Span of Control, County Administration will need to accept the opportunities and undergo the 'bumping' process before determining the true financial opportunity.
- *Cost efficiency estimates are not exclusively to General Funds.*

Public Health			
Opportunities for Consideration		**Minimum Total Cost Efficiency**	**Maximum Total Cost Efficiency**
Subtotal		**$ 1,174,000**	**$ 1,671,000**
Division	**Vacancies**	**Minimum Total Cost Efficiency**	**Maximum Total Cost Efficiency**
Children's Med Services	5.00	$ 452,482	$ 612,370
Environmental Health	2.00	$ 213,402	$ 292,219
Healthcare Access	1.00	$ 190,071	$ 190,071
Healthcare Promotion	1.00	$ 110,879	$ 158,743
Maternal Child Adolescent Health	10.75	$ 1,460,304	$ 1,657,962
Public Health Admin	1.00	$ 157,720	$ 185,322
PH EMSA	1.00	$ 114,474	$ 150,561
PH Nursing	2.00	$ 430,147	$ 449,594
WIC Program	1.00	$ 134,174	$ 151,331
Subtotal	**24.75**	**$ 3,263,654**	**$ 3,848,173**
Estimate Cost Efficiency		**$ 4,437,554**	**$ 5,518,823**

Estimated total cost efficiency across the Health Agency ranges from $14,064,640 to $23,940,369.

It is understood that some of these positions may have been eliminated by the County during the process of KPMGs review, however, the analysis above does not account for the changes that took place during the same time period.

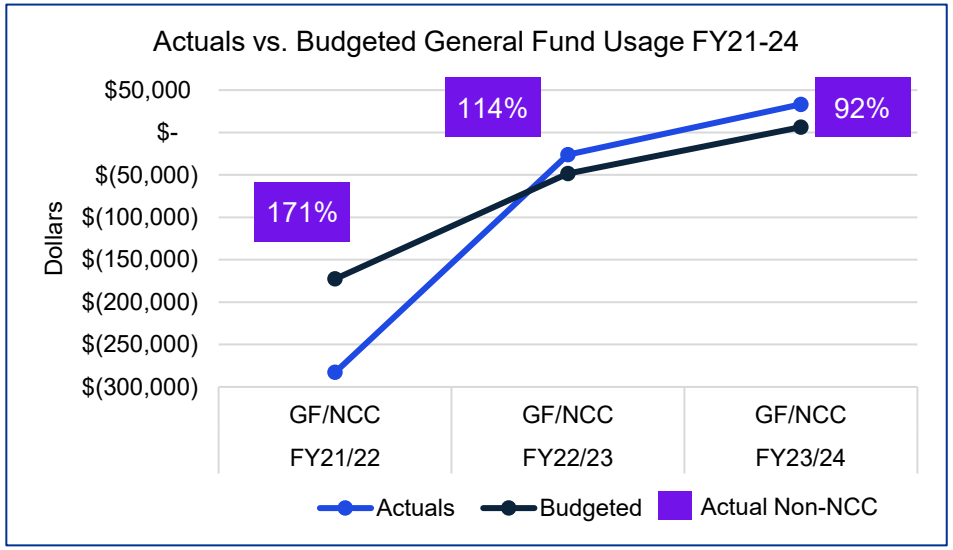
Health Agency Administration

Health Agency Administration Overview

Division Overview

- The Health Agency Administration supports Animal Services, Behavioral Health, Public Guardian, and Public Health in delivering essential health and well-being services.
- The Health Agency Administration delivers a broad range of services including fiscal and budget management, compliance and privacy oversight, IT support, health applications, contract management, facility maintenance, and safety.
- The team plays a crucial role in supporting the promotion of health equity, reducing health disparities, and helping ensure access to quality healthcare services for all individuals in the community.

70.50 *Total FTE*	**$258k** *Total Budget FY24-25*
130% *Budgeted FY24-25 Non-NCC*	**0%** *Budgeted FY24-25 General Fund*
92% *Actual FY23-24 Non-NCC*	**8%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

County	Population	Total Funding	Charges For Service %	General Fund Use	Intergov. Revenue	FTEs
SLO*	281,639	$257,653	*N/A*	($76,647)	*N/A*	70.50
Santa Barbara*	441,257	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Monterey	430,723	$1,986,419	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	65.50
Santa Cruz	261,547	$29,583,606	10%	*Not Publicly Reported*	$23,927,441	56.00
Sonoma**	481,812	$137,576,700	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	179.00
Ventura***	829,590	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*

**The Health Agency within San Luis Obispo County allocates administrative expenses across divisions, whereas the comparison counties separate administrative costs.*

***Santa Barbara County does not provide a separate breakdown of their Health Administration unit.*

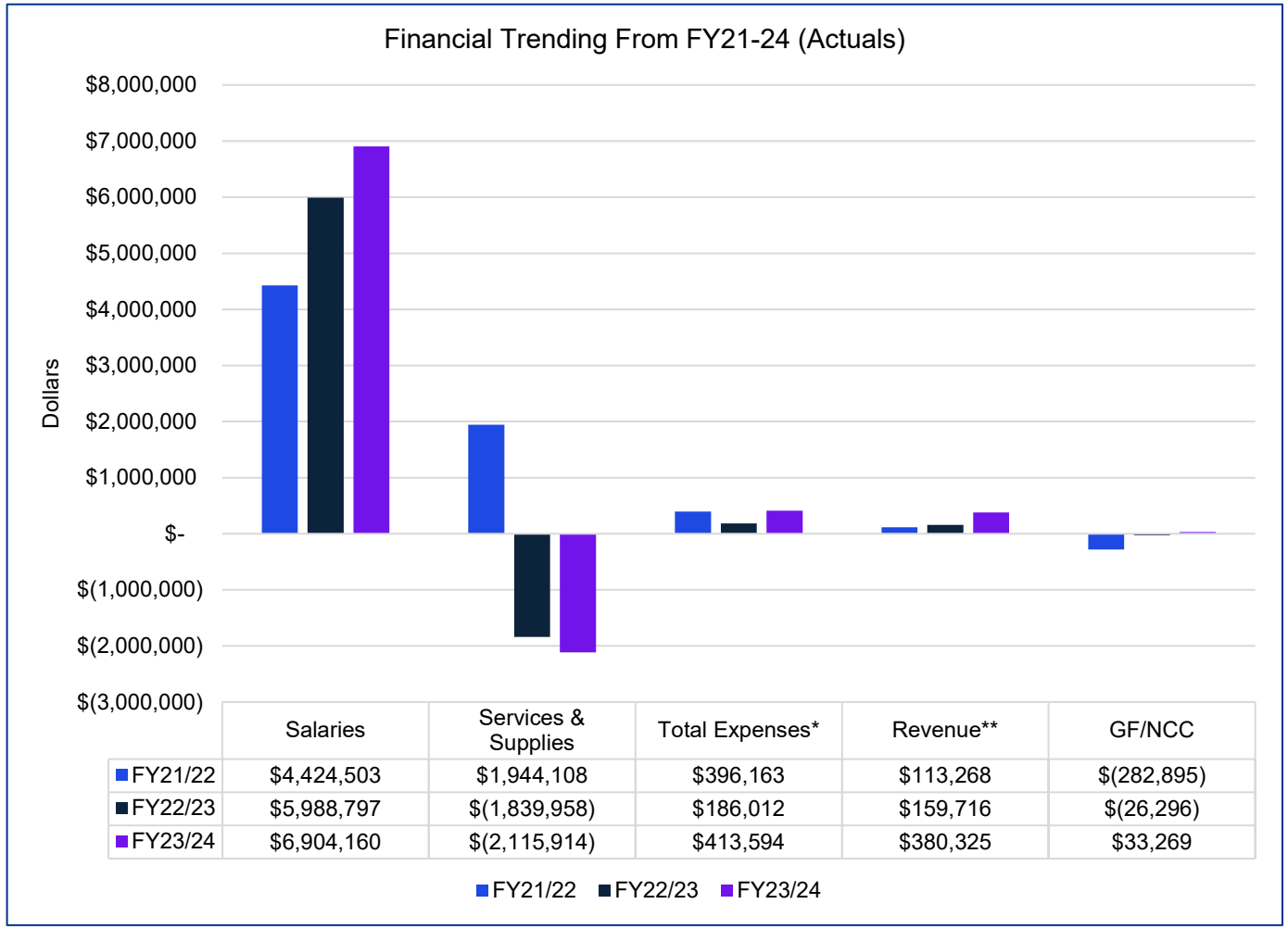
****Sonoma County does not separate its health administration budget into specific component programs, and therefore, detailed financial information on Health Agency Administration not is available. The numbers provided come from their Department of Health Services' "Executive Management & Administration" unit. This unit includes all leadership positions including IT, HR, Health Data and Epidemiology.*

*****Ventura County does not provide a separate breakdown of their Health Administration unit.*

Health Agency Administration – Trend Analysis

Between FY 21-22 and FY 23-24, Health Agency Administration achieved a combined average Non-NCC rate of 126% because the Division did not require general fund in FY21-22 and FY22-23. However, in FY 23-24, Health Agency Administration required $33,269 General Fund use.

- Salaries have increased by 56% over the past three fiscal years from $4.42M to $6.90M. This can be attributed to the need for additional positions given the Health Agency Administrations workload.
- Services & Supplies expenses have actually been offset for the Health Agency Administration. In FY 21-22, Services & Supplies cost the Division $1.94M, but in FY 23-24, Services & Supplies offset total expenses by $2.12M. This is due to the Division receiving a $2.98M Public Health Allocation in FY 22-23.
- Total Expenses have fluctuated between fiscal years dropping 53% between FY 21-22 and FY 22-23. Then increasing 1.2x in FY 23-24. This is due to the Public Health Allocation introduced in FY 21-22 being $3.39M, which was 9% lower than budgeted for FY 23-24. Salaries and the offset for Services & Supplies surplus both increased by 15%.
- Revenue (including grant funding) has more than doubled between FY 21-22 and FY 23-24 from $113,268 to $380,325. This is due to the doubling of funds received from an IFR Health Bill.



	Salaries	Services & Supplies	Total Expenses*	Revenue**	GF/NCC
FY21/22	$4,424,503	$1,944,108	$396,163	$113,268	$(282,895)
FY22/23	$5,988,797	$(1,839,958)	$186,012	$159,716	$(26,296)
FY23/24	$6,904,160	$(2,115,914)	$413,594	$380,325	$33,269

**Total Expenses do not equal the total of the sum of Salaries and Services & Supplies because Health Agency Administration receives an Intrafund balance each fiscal year that further offsets total expenses.*
**Revenue includes charges for service, grant funding, and realignment*

Health Agency Administration – SWOT Analysis

Strengths	Weaknesses
• **Dedicated to the Agency's Mission:** Administration staff is committed to promoting and protecting the health and well-being of the community they serve. • **Prioritize Service Delivery to the Community:** Administration staff finds alternative solutions to deliver high-quality services despite administrative constraints. • **Adaptable and Responsive to Change:** Administration can quickly adjust service delivery models in response to COVID-19, Prop 1, and other changes to prioritize public health needs. • **Stakeholder Feedback:** The Department has consistently received positive feedback across all stakeholders engaged in regard to their collaboration.	• **Fragmented Grant/Allocation Management:** Each division tracks and manages grants and allocations independently with support from Health Agency Administration. This process is not standardized and can cause miscommunication across Fiscal, Billing, and Division/Program Managers. • **Large Number of Contracts:** With 459 contracts, 120 for Behavioral Health and 255 for Public Health, in 2024/25, and managed by only 5 FTEs, it may be difficult to maintain thorough and accurate contract assessments to track outcomes and confirm vendor compliance. • **Unclear Procurement Processes:** Lack of standardized purchasing processes can lead to complex escalations that utilize resources without substantial benefits. • **Organizational Silos:** Fragmentation and miscommunication across Health Agency departments may lead to organizational silos, operational inefficiencies, and hindered collaboration. • **Delayed Revenue Recognition:** Delayed revenue recognition practices in certain programs (e.g., Land Use) may hinder timely and accurate financial reporting and decision-making.
Opportunities	**Threats**
• **Implement Contract Management System:** Introduce system to mitigate manual process, manage the extensive number of contracts, and analyze performance. • **Standardize Grant/Allocation Approval Workflows:** Establish clear and consistent purchasing workflows with an escalation protocol to help minimize resource misallocation. • **Enhance Grant Management Process:** Utilize dashboard with spend analytics to manage grants/allocations and monitor funding use across programs. • **Consolidate Fiscal and Billing:** Combine Fiscal and Billing Departments to address fragmentation and communication challenges. • **Align Revenue Recognition Across Agency:** Confirm revenue is being recognized by Divisions and Programs in compliance with GASB 62. • **Redefine Roles and Responsibilities:** Develop clear roles, responsibilities, and processes to foster coordination among departments and enhance operations.	• **Role Ambiguity:** Current fragmentation over role responsibilities for budget setting, scope definition, and vendor oversight may lead to operational inefficiencies and departmental misalignment. • **High Volume of Contracts in Public Health:** Considerable manual oversight to meet contract demands and can impact the efficiency of contract renewals or new implementation. • **Resistance to Change:** Potential resistance to change and the need for extensive training and communication to support execution of new policies and procedures. • **Potential Regulatory Changes:** External changes in federal or state regulations may adjust service delivery, financial management, and reporting practices.

Overarching – Key Opportunities

Opportunity 1.1a - b	Implement a Contract Management System, standardize processes, establish clarified roles and responsibilities, review the current contract portfolio, and consider the adoption of AI to improve the contract management process.

Current State

- The Health Agency currently manages 459 contracts with a team of 5 FTEs resulting in significant manual workload in managing these contracts. The number of contracts managed for Public Health is double that of Behavioral Health, i.e., 255 vs. 120.
- Additionally, there is a lack of clear processes and procedures for purchasing, leading to multiple non-value-add escalation processes that strain resources. This includes roles, responsibilities, and processes related to contract management which are fragmented, with inconsistencies in defining budgets, scope, contract requirements, and oversight.
- This makes it challenging to accurately assess each contractor's performance to validate if contract requirements are in compliance with outcome measures.

Key Opportunity

(a) Review, standardize and consider automating the contract management process to address these issues and mitigate risks such as inconsistent oversight, miscommunication, and inefficient resource use.

Key Opportunity Action Steps

- **Develop and Implement Standardized Purchasing Processes:** Engage key stakeholders in developing a standardized workflow and escalation protocol for purchasing. Test the new process over a 3-month period, gather feedback, and make necessary adjustments. Formally roll out the new process and establish an annual review cycle.
- **Assess and Select a Contract Management System:** Evaluate the County's contract management requirements and assess potential systems that can meet those needs. Select a system that can handle the volume of contracts, provide accurate performance analysis, and support Requests for Information (RFIT) in line with the newly defined process. Dedicate Health Agency personal to the ERP implementation to verify the system meets ongoing contract management and grant oversight requirements. *The County is currently conducting ERP selection.*
- **Redefine Roles, Responsibilities, and Processes:** Facilitate workshops with key personnel across departments to develop future state roles, responsibilities, and processes. Maintain clarity in scope development, vendor performance management, and oversight responsibilities.
- **Review and Optimize Public Health and Behavioral Health Contracts:** Establish a joint task force with Contracts and Public Health/ Behavioral Health to review the existing 255 contracts and 120 contracts. Identify opportunities for consolidation, and potential elimination, while assessing the impact on the Contracts Department's workload and personnel requirements.

Benefit

- **Increased Efficiency:** Standardized purchasing processes and clear escalation protocols will reduce non-value-add activities and improve resource utilization.
- **Improved Contract Performance:** A Contract Management System will enable more accurate analysis of contractor performance, leading to better-informed decision-making and improved outcomes.
- **Enhanced Collaboration:** Engaging key personnel across divisions in redefining roles, responsibilities, and processes will foster collaboration and support a cohesive approach to contract management.
- **Organized Contract Portfolio:** Reviewing and consolidating contracts will streamline the contract portfolio, reduce manual workload, and support resource allocation.

This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.

Overarching – Key Opportunities

Opportunity 1.1a - b	Implement a Contract Management System, standardize processes, establish clarified roles and responsibilities, review the current contract portfolio, and consider the adoption of AI to improve the contract management process.

Key Opportunity

In the future, the County should consider implementing an **AI-driven solution** to enhance the development and management of Request for Proposals (RFPs) and contracts. Such a solution could automatically generate RFPs and other procurement documents by referencing prior documents within the County. AI could also tailor these documents based on the specific requirements of any new procurement, so that they are current and compliant with sector-specific standards. Additionally, AI could assist in streamlining contract management by automating routine tasks such as monitoring contract performance, flagging compliance issues, and recommending amendments.

Key Opportunity Action Steps	Benefit	
• **Conduct a Needs Assessment:** Assess current processes and gather stakeholder input to identify improvement areas. • **Research and Select an AI Solution:** Evaluate potential AI solutions through a procurement process. • **Pilot the AI Solution:** Implement a pilot program to test the AI solution's functionality and gather feedback. • **Monitor and Optimize:** Continuously track the system's performance, making adjustments as needed. • **Establish Governance:** Develop a governance framework and define roles for managing the AI-driven processes. • **Right Size Contract Team**: Upon implementation of an AI solution, evaluate roles and responsibilities of current team to determine the right size of the team based on enhancement of AI solution. Oversight of contract performance based on established KPIs as detailed in their contracts should be realigned to Program management and when required Quality reporting.	• **Enhanced Efficiency:** AI can automatically generate RFPs and other procurement documents, reducing the need for manual drafting. This allows staff to focus on higher-value tasks and accelerates the procurement process. • **Cost Efficiencies:** By increasing efficiency and reducing manual workload, AI can lower administrative costs associated with the drafting and management of RFPs and contracts. This can result in Cost Efficiencies for the County in the long run.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

Overarching – Key Opportunities

Opportunity 1.2a-b	Streamline the Grant/Allocation process through a redesigned request and approval workflow, enhanced monitoring, and a dashboard for improved transparency, spend analytics, and risk mitigation.

Current State

- All Departments and Divisions within the Health Agency must submit grant and/or allocation requests through an approval process with the County. After conducting interviews with both the Department and the County Administrative Office, gaps with the current Grant and Allocation Request/Approval process were identified. For example, time is spent researching grants and determining how to meet requirements, but often inefficiencies in the approval process result in missing submission deadlines.
- The process involves completing an internal e-form and then, if possible multiple Board of Supervisors (BOS) approvals, including when applying for a grant, accepting the grant, and posting for staffing to accommodate grant requirements. This also includes requests for additional information prior to approving a grant or allocation because the current e-form does not adequately capture the specific requirements and potential costs associated with each type of funding.
- Additionally, once a grant is approved, it is documented in a spreadsheet to track the commencement date, end/renewal date, total award amount, and funding type for both Behavioral (34 total grants/allocations for FY 23-24) and Public Health (54 total grants for FY 23-24). However, both departments track grants independently using their own administrative staff in conjunction with the contracts and grants team within Health Agency Administration. Public Health also tracks grant utilization and spend in this spreadsheet, but there is a lack of standardization making the spreadsheet difficult to track or comprehend (e.g., “N/A” in cells that are being used for calculations resulting in errors). In fact, in FY 23-24, the tracker for Public Health showed a total $2.31M remaining across current year accounts for all grants (including outstanding invoices). Behavioral Health tracks total funding amount but not spend in their grant and allocation tracker.

Key Opportunity

(a) Streamline the Allocation and Grant Request and Approval Process including enhancing the current e-form being used for better information collection.

Key Action Steps

- **Engage Stakeholders:** Involve key stakeholders including leadership and staff from Health Agency Administration, IT, Fiscal, Billing, Division and Program Leadership, and staff from the County Administrator’s office in the design of the new form, development, and testing of the new process.
- **Redesign Approval Process:** Work with the Administrative Office and other relevant parties to streamline the approval process, reducing the number of BOS approvals required by creating a clear inclusionary and exclusionary criteria of what can be applied for and collapse approval for acceptance and staff posting into one process, therefore taking the 3 step process down to 1 step.

Benefit

- **Increased Efficiency:** Streamlining the approval process by reducing the number of BOS approvals required will save time and resources.
- **Enhanced Clarity:** Clear inclusionary and exclusionary criteria for program applications will reduce confusion and helping ensure appropriate requests are submitted.

This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.

Overarching – Key Opportunities

Opportunity 1.2a-b	Streamline the Grant/Allocation process through a redesigned request and approval workflow, enhanced monitoring, and a dashboard for improved transparency, spend analytics, and risk mitigation.

Key Action Steps (Continued)	Benefit (Continued)	
• **Implement Accountability Measures:** Incorporate formal sign-off requirements into the redesigned Allocation and Grant forms and establish a monthly review process and assign responsibilities for monitoring and escalation. All Departments (e.g., Fiscal, IT, Billing, etc.) that will be affected by the grant / allocation change should provide formal sign-off. • **Evaluate e-form:** Evaluate separate e-forms for Allocation and Grant requests, incorporating the specific requirements and frequent information that is currently requested from the County Administrator. • **Communicate and Train:** Inform all relevant parties of the new process and provide training to promote effective implementation.	• **Better Alignment with County Priorities:** Identifying if Allocations and Grants offset General Funds and specifying the duration will support alignment with County's financial priorities. • **Proactive Planning:** Including information on the notification period for when Allocations and Grants are no longer available will allow for proactive planning and resource management.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

Key Opportunity

(b) Enhance the Management and Monitoring of Allocations and Grants by considering moving away from excel sheets and utilizing a grant/allocation management dashboard.

Key Action Steps	Benefit	
• **Review the Grant Management Process:** Perform a review of the grant management process identifying areas of improvement and in need of increased standardization across the Health Agency. • **Establish Clear Roles and Responsibilities:** Outline the responsibilities of all staff and leadership involved in managing grants. Consider creating a monthly meeting between Division leaders and Contract / Grant Management staff. • **Design Dashboard:** Collaborate with IT to develop a Grants and Allocation Dashboard that provides real-time data, spend analytics, and risk identification for overspend or upcoming renewals for grants. This dashboard should be accessible to both Health Agency Leadership and Division and Program Managers. • **Communicate and Train:** Inform all relevant parties of the new grant management and monitoring processes and provide training as necessary.	• **Improved Transparency:** A real-time view of the financial and in-kind impact of Allocations and Grants on the County. • **Risk Mitigation:** Regular monitoring and review of Allocations and Grants to identify and address discrepancies or potential overspend promptly. • **Enhanced Accountability:** Formal sign-off requirements and regular review cycles to help ensure adherence to original grant submissions. • **Better Decision Making:** More informed decision-making based on accurate and timely data provided by the Grants and Allocation Dashboard.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

Stretch Goal: Consider establishing a centralized grant/allocation management office for the entire County to manage all grant/allocation requests

Overarching – Key Opportunities

Opportunity 1.2c	Assess equipment life cycle costs when considering the acceptance of grant funding or allocation of funds related to equipment to support more informed grant/allocation of funding decisions.

Current State

- During interviews, staff reported that while grants and allocation of funds often cover the initial cost of equipment, they can encounter high maintenance and consumables expenses associated with that equipment, which are not covered by the funding. As a result, they must often rely on the general fund to cover these additional costs that are not initially budgeted for which can lead to budgetary strain in maintaining the equipment. For example, the Public Lab received grant funding as a result of COVID-19 to purchase specialist testing equipment (Capital Expenditure of $407,800 in FY21-22), which has increased maintenance contract costs by 1.3x between FY 21-22 and FY 23-24 (from $62,464 to $143,362). However, the current cost of maintaining the equipment can be high and was not budgeted for, increasing general fund reliance. In addition, these purchases can increase contracts, contract oversight, billing and reporting, which all need to be taken into account as new equipment is considered.

Key Opportunity

In the future, as part of the process for obtaining grant and allocation funding approval from the Board of Supervisors, the County should assess the life cycle costs of any equipment for which the funds will cover, including contract, contract oversight, maintenance, operation, related consumable expenses, billing and reporting. This assessment will allow all associated costs to be appropriately budgeted for at the outset, allowing the Health Agency leadership and Board of Supervisors to make informed decisions regarding the use of grant/allocation funds and evaluating the long-term helps benefit and costs.

Key Action Steps	Benefit	
• **Develop Assessment Guidelines:** Create clear guidelines for evaluating the life cycle costs of equipment, including contract, contract oversight, maintenance, operation, consumable expenses, billing and reporting. • **Implement Review Process:** Establish a standardized review process to help ensure life cycle cost assessments are included in all grant/allocation applications related to equipment. • **Train Staff:** Develop and provide standardized training to staff engaged in this process in how to conduct impact assessments. • **Include Cost Analysis in Proposals:** Require that all grant/allocation proposals related to equipment submitted to Health Agency leadership and Board of Supervisors include a detailed life cycle cost analysis.	• **Enhanced Budget Accuracy:** By assessing life cycle costs, the County can help ensure that all associated expenses are accounted for from the outset, leading to more accurate budgeting. • **Informed Decision-Making:** Providing detailed life cycle cost analyses in proposals allows the Health Agency leadership and Board of Supervisors to make more informed decisions about the allocation of funds, weighing the full costs and helps benefit of each equipment purchase. • **Optimal Resource Allocation:** Understanding the long-term financial implications of equipment investments helps the County allocate resources more effectively, reducing the risk of unexpected expenses and supporting financial sustainability.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

Overarching – Key Opportunities

Opportunity 1.3	Implement a standardized financial reporting process to bridge the gap between clinical, operational, and financial management.

Current State

- Interviewees reported a disconnect between clinical, operational, and financial management in the Health Agency, which may be contributing to the financial challenges currently faced by the Agency.
- Currently, fiscal staff prepare quarterly reports in collaboration with department heads. These reports are sent to the County Administrative Office. If variances or issues arise, the Department usually addresses them by reallocating funds, mainly from staff vacancy savings. The County Administrative Office then analyzes the reports from all departments and consolidates the information into a detailed quarterly financial report for the Board, presenting a County-wide financial perspective.
- Independently, Public Health accountants hold monthly budget and contract meetings to check in with each of their associated division and program managers. Behavioral Health accountants do not follow the same process due to their workload. The Health Agency's various levels of management including Fiscal, the Division Manager, Program Managers, and Accountants are not collaboratively engaged in reviewing and understanding the department's financials in an organized and standardized manner, leading to a lack of financial oversight and control.
- Interviewees also report the current SAP system has various limitations including the lack of customized reporting. As a result, each Accountant has to extract data from SAP and then align it using various Excel sheets to complete workpapers, budget reporting, and generate reports needed by Division Managers.

Key Opportunity

To address the disconnect between clinical, operational, and financial management, and to enhance management's understanding of the department's financials, a standardized financial reporting process should be implemented, involving the development of a detailed variance report, clear roles and responsibilities, monthly reporting, and an escalation process for unresolved issues. Involve Health Agency personal in the new ERP design and implementation to influence processes based on the uniqueness of the Health Agency financial reporting and billing needs.

Key Action Steps

- **Standardize Accounting Practices:** Consider augmenting the current SAP system to allow for customized reporting. In the short term, develop a standardized template for accounting across Public and Behavioral Health. The template should incorporate fields necessary for workpapers and budget reporting.
- **Design Variance Report:** Collaborate with relevant stakeholders to design a variance report template that includes budget versus actuals, projected revenue, and other key financial metrics at both the division and clinic level (example pg.25).
- **Establish Reporting Roles and Responsibilities:** Clearly define the roles and responsibilities of the Division Manager, Billing, Accountant, Contracts and Grants/Allocation lead, Deputy Director, and Department Director in the financial reporting process.

Benefit

- **Enhanced Financial Oversight:** Improved engagement of management in reviewing and understanding the department's financials, will lead to better financial control and decision-making.
- **Improved Communication:** By having fiscal, billing, contracts and grants, and program staff in the meetings, all parties will be aware of the financial health of their divisions.
- **Timely Issue Resolution:** Regular reporting and action plans will enable the timely identification and resolution of financial issues and variances, mitigating escalation.

This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.

Overarching – Key Opportunities

Opportunity 1.3	Implement a standardized financial reporting process to bridge the gap between clinical, operational, and financial management.	
Key Action Steps	**Benefit**	
• **Implement Monthly Reporting**: Set up a monthly reporting schedule across all divisions and clinics within the Health Agency and require that the designated team members adhere to the reporting frequency and requirements. • **Develop Dashboard:** Work with IT and finance teams to develop a user-friendly dashboard that allows for easy month-over-month analysis of financials and service volumes. • **Communicate and Train:** Communicate the new financial reporting process to all relevant stakeholders and provide training to support effective implementation. • **Monitor and Refine:** Continuously monitor the effectiveness of the financial reporting process and make necessary refinements based on feedback and lessons learned.	• **Increased Accountability:** Clear roles and responsibilities in the reporting process will foster a culture of accountability and ownership among management. • **Data-Driven Decision Making:** The dashboard view will allow for data-driven decision-making by providing a detailed overview of financial performance and trends.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

Overarching – Key Opportunities

The template below is a potential structure that can be used to conduct the monthly variance meetings outlined in Opportunity 3.10. This template can also be used to track next steps and outcomes providing all stakeholders with a way to track progress and hold each other accountable.

- **Division:** The specific division being reported on.
- **Program:** The specific program being reported on.
- **Budget:** The allocated budget for the program or department.
- **Actual:** The actual expenses incurred for the reporting period.
- **Variance:** The difference between the budgeted and actual expenses.
- **% Variance:** The variance expressed as a percentage of the budget.
- **Projected Revenue:** The expected revenue for the program or department.
- **Actual Revenue:** The actual revenue generated for the reporting period.
- **Revenue Variance:** The difference between the projected and actual revenue.
- **% Revenue Variance:** The revenue variance expressed as a percentage of the projected revenue.
- **Services Provided:** The number of clients served or services provided such as client visits, permits approved, licenses provided, and.
- **Action Plan:** The steps to be taken to address any significant variances or issues identified.
- **Responsible Party:** The individual or team responsible for implementing the action plan.
- **Timeline:** The expected completion date for the action plan.
- **Attendees:** The participants in the monthly meeting to track attendance and hold stakeholders accountable.

Division Managers should be responsible for developing the Action Plans based on the variances seen and present the Action Plan to the Deputy Director, ultimately being responsible for implementing and actioning all plans.

Division	Program	Budget	Actual	Variance	% Variance	Projected Revenue	Actual Variance	Revenue Variance	% Revenue Variance	Services Provided	Action Plan	Responsible Party	Timeline	Attendees

Overarching – Key Opportunities

Opportunity 1.4	Consolidate the Fiscal and Billing departments into a single cohesive unit, and evaluate the usage of AI for Billing function to improve financial processes and enhance decision-making.

Current State

- Currently, the Fiscal and Billing Divisions are separate functions within the Health Agency Administration. In addition, Behavioral Health and Public Health both have independent quality support or administrative teams responsible for policy, supporting grant management, provider education, and other administrative duties. Interviewees reported that this structure increases fragmentation and creates a disconnect between the different functions. For example, it was shared that when services are billed differently, perhaps due to a new grant or based on needs of a client, this is not communicated to the Fiscal Division and causes confusion during financial reporting.
- These challenges are compounded with varying processes and the lack of standardization across Accounting, Fiscal, and Billing due to the current SAP system. For instance, grants and certain expenses such as IT for each Division are being managed through various internal orders instead of the projects capability. Internal order codes track costs for internal activities but lack the comprehensive planning, control, and financial visibility features that projects provide for managing complex initiatives. Additionally, the limited functionality of the system has created a reliance on independent spreadsheets structured and managed differently across accounting staff, with no noted automation in any of the processes. This fragmentation across divisions and lack of automation will continue to affect the Health Agency operations, and efficiency.

Key Opportunity

Combining the Billing and Fiscal Departments into one to help reduce fragmentation and improve communication. Consider implementing Opportunity 1.3 on page 23 in conjunction with this consolidation to further enhance communication and financial reporting within the Health Agency.

Implement automation for billing function that support effective, compliant and secure submissions, which will address bottlenecks, errors and inefficiencies. Involve Health Agency personal in the new ERP design and implementation to influence processes based on the uniqueness of the Health Agency financial reporting and billing needs.

Key Action Steps

Consolidate Team:

- **Assess Current Processes and Structures:** Conduct a thorough analysis of the current processes, workflows, and organizational structures of the Fiscal and Billing departments. Identify areas of duplication, inefficiencies, and potential standardization between the two divisions.
- **Develop a Consolidation Plan:** Create a detailed plan for consolidating the Fiscal and Billing departments including timelines, structure, and milestones.
- **Integrate Policies, Procedures, and Systems:** Review and update policies, procedures, and workflows to reflect the consolidated department structure. Identify and implement necessary changes to financial systems and tools to support the integrated processes.

Benefit

- **Improved Efficiency:** Consolidating the Fiscal and Billing departments will streamline processes, reduce duplication of efforts, and enhance overall efficiency.
- **Better Communication and Collaboration:** Bringing fiscal and billing staff together under one department will foster better communication, knowledge sharing, and collaboration.
- **Consolidated Financial View:** Consolidating financial data and reporting will provide a more detailed view of the organization's financial health, enabling better decision-making.

This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.

Overarching – Key Opportunities

Opportunity 1.4	Consolidate the Fiscal and Billing departments into a single cohesive unit, and evaluate the usage of AI for Billing function to improve financial processes and enhance decision-making.

Current State

Key Action Steps	Benefit	
Consolidate Team Continued: • **Communicate and Train:** Develop a communication plan to inform all relevant stakeholders about the consolidation and its benefits. Provide training to staff on the new policies, procedures, and workflows to help ensure a successful transition. • **Monitor and Gather Feedback:** Regularly gather feedback from stakeholders to assess the effectiveness of the consolidation and make necessary adjustments. **Automation Technology**: • **Automation Technology**: Examine and select automation software and tools, through RFP/RFI processes that specialize in Medicaid claims. Consider features like Electronic Data Interchange (EDI) support for claim submission, integration with existing systems, and data security. • **Plan for the integration** of the automation system with existing Electronic Health Records (EHRs), Billing Systems, and any other relevant IT infrastructure. Evaluate compatibility and smooth data transfer between systems. • Post **data migration** and data cleansing from current system, configure the system to handle **various aspects of Medicaid billing**, such as **eligibility verification, claim submission, reimbursement tracking, reconciliation, and denial management.** • Testing, training, monitoring, evaluation and continuous quality improvement will need to be part of the new consolidates teams objectives. **Right Sizing the new consolidated team**: Once roles, responsibilities and automation of billing has been established, a review of the FTE count should be considered. It is anticipated that once manually processes are automated, a decrease in FTE count can be achieved.	• **Automation of Billing Function:** Will reduce processing time, help minimize errors, improve compliance for federal and state Medicaid regulations. • **Right Sizing Team:** Potentially decreasing operational cost post implementation of automation for eligibility verification, claim submission, reimbursement tracking and denial management.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

Overarching – Key Opportunities

Opportunity 1.5	Partner with ACTTC Office to align Revenue Recognition with GASB 62 and account for COLA increases for Accurate Financial Reporting and Improved Decision-Making.

Current State

- Currently, lack of standardization in revenue recognition practices across different departments and programs within the Health Agency may lead to high variance between actuals and budgeted revenue.
- Within the Environmental Health Division, specifically the Land Use program, revenue is recognized in the period in which it is received (cash receipts) rather than in the period in which it was earned which is not in line with the principles outlined in GASB Statement No. 62. The current approach may lead to fluctuations in revenue which does not reflect the true financial position of the Land Use program at any given point in time. This makes it challenging to make data-driven and representative decisions on program Cost Efficiency and fees.
- Additionally, when forecasting, the Health Agency has difficulty accounting for known future salary and benefits and changes in Cost of Living Adjustments (COLA) due to County practice. Compounded this challenge with delaying revenue recognition until the end of an agreement may also hinder effective decision-making for resource needs.

Key Opportunity

Align the Health Agency's revenue recognition practices with GASB Statement No. 62 and account for COLA increases in financial forecasting to improve accuracy.

Key Action Steps

- **Assess Current Revenue Recognition Practices:** Conduct a review of the Health Agency's current revenue recognition practices across all divisions and programs. Identify areas of inconsistency with GASB Statement No. 62. (e.g., Environmental Health – Land Use Program).
- **Deploy Revenue Recognition Policy:** Clearly define the principles, criteria, and procedures for recognizing revenue in different scenarios.
- **Train Current Staff and Update Fiscal Recruiting:** Partner with ACTTC to provide training to current staff on the new revenue recognition policy and its application. Additionally, when recruiting and hiring new fiscal staff, prioritize candidates with detailed understanding of accounting standards.
- **Implement and Monitor:** Implement the new revenue recognition policy across all departments and programs within the Health Agency. Regularly monitor compliance with the policy and address any deviations or challenges promptly.
- **Recurring Reviews:** Periodically review the revenue recognition policy to support ongoing compliance with GASB standards and any updates or revisions.

Benefit

- **Improved Financial Reporting:** Consistent application of revenue recognition principles will enhance the accuracy and reliability of financial statements.
- **Better Decision-Making:** Accurate and consistent financial information will enable better resource allocation and strategic planning decisions.
- **Enhanced Comparability:** Compliance with GASB standards will facilitate comparisons of financial performance across periods and with other similar agencies.
- **Increased Transparency and Accountability:** Demonstrating consistency with GASB standards will enhance the Health Agency's financial transparency and accountability to stakeholders.

This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.

Overarching – Key Opportunities

Opportunity 1.6	Develop a marketing strategy for Health Agencies services to increase awareness of services offered among diverse community members.

Current State

The Health Agency offers a wide range of services to address the behavioral health and public health needs of infants, children, and adults, including a 24/7 access line for mental health and insurance assistance. However, a staff utilization analysis included in this report indicates low utilization rates in certain programs, suggesting an opportunity to increase capacity within these services. One reason for this low utilization may be a lack of community awareness about the available programs, which became apparent during stakeholder engagement with law enforcement, Fire Services, the Courts, and Schools to name a few. Additionally, with 24% of the county's population being Spanish-speaking, it is crucial to provide public information in their language to support services accessibility.

Key Opportunity

There is an opportunity for the Agency to develop a marketing strategy to effectively communicate its key service offerings and related helps benefit in multiple languages. This strategy should be shared with key stakeholders such as law enforcement, fire departments, schools, and other local organizations, as well as the broader community. Additionally, the Department's Access Line, which provides crucial 24/7 services, should also be a central focus of the marketing strategy to increase awareness of this service for individuals in need of behavioral health services.

Key Action Steps

- **Assess Community Needs:** Evaluate current awareness and demographic/language requirements to support targeted marketing.
- **Craft Key Messages:** Collaborate with the Public Information Officer to develop clear, compelling, and multilingual messages about the Agency's key services and the 24/7 Access Line.
- **Engage Stakeholders:** Partner with local law enforcement, fire departments, schools, and community organizations to disseminate information on key service offerings including front line front-line to inform their public engagement.
- **Utilize Communication Channels:** Enhance leveraging of social media, local media, and public announcements to reach a broad audience.
- **Host Outreach Events:** Attend community events such as health fairs and informational sessions to directly engage with residents**.**
- **Annual Engagement Plan:** Help ensure a detailed marketing/engagement plan is developed annually, implemented and evaluated. Regular education of front-line staff/ officers/ school personal should be conducted at least on a quarterly basis with open lines of communication fostered.

Benefit

- **Increased Service Utilization:** Targeted marketing and multilingual messaging will help more residents to be aware of key service offerings increasing enhancement of services, staff utilization and billable services.
- **Strengthened Community Partnerships:** Collaborations with local stakeholders will extend the reach of the information, building stronger community networks and support systems.
- **Enhanced Community Engagement:** Direct interactions at outreach events foster trust and relationships, making community members more likely to utilize services and seek help when needed.

This opportunity may not yield immediate tangible cost efficiencies, but it will lead to a future increase in service volumes and staff utilization.

Overarching – Key Opportunities

Opportunity 1.7	Implement AI solutions to support documentation practices across the agency by reducing time spent by clinicians and psychiatrists.

Current State

In the current state, some staff across the agency spent significant time on documentation. For example, the Behavioral Health Department employs a scribe to assist certain psychiatrists with documentation tasks. In other cases, staff time spent on documentation is almost equivalent to the time spent on direct client services, creating a 1:1 time ratio. This significant amount of time dedicated to documentation reduces the time available for providing direct client services and essential care. Moreover, the extensive focus on documentation lowers staff productivity, as this task is not considered part of direct client services and for front line staff is not a billable service.

Key Opportunity

There is an opportunity for the Agency to better leverage artificial intelligence (AI) to improve documentation efficiency for psychiatrists and clinicians. There are currently several HIPAA approved AI tools available to support documentation*:

- **DeepScribe:** Transcribes provider/client conversations into clinical notes and integrates efficiently with various EHR systems, helping ensure ease of use across diverse healthcare settings. When implemented at Ochsner Health, it achieved a 78% clinician adoption rate, reduced documentation time by 75%, and increased patient satisfaction from 89% to 96% by allowing healthcare providers to spend more time on client-related services during patient visits.
- **Suki AI:** Streamlines clinical documentation through note generation, dictation, coding recommendations, and real-time answers to clinical questions. Integration with Amwell's Converge platform allowed Suki Assistant to reduce clinician documentation time by 72%, achieving a 9X ROI and significantly enhancing telehealth service efficiency.
- **Abridge AI Tool:** Leverages speech recognition technology to generate clinical documentation in real time. At University of Vermont Health Network (UVM Health Network), Abridge decreased after-hours documentation by 60%, and increased professional fulfillment by 53%

Key Action Steps	Benefit	
• **Evaluate AI Tools**: Identify and select the most suitable HIPAA-compliant AI documentation tools that integrate well with the Agency's existing EHR systems, if applicable. • **Conduct a Pilot Program:** Implement a small-scale pilot to test the chosen AI tool with select clinicians and monitor its impact on documentation efficiency. • **Provide Training:** Offer training sessions to support staff to use the AI tool effectively. • **Gather Feedback and Measure Success:** Continuously collect feedback from users and track KPIs such as time saved, adoption rates, and patient satisfaction. • **Scale Up Implementation:** Roll out the AI tool across the entire Agency based on the pilot's success and adjust to improve performance and user satisfaction.	• **Increased Clinician Efficiency:** Reducing the time clinicians spend on documentation will allow them to focus more on direct patient care, enhancing service delivery. • **Improved Data Accuracy:** AI-driven documentation tools can help minimize human error, leading to more accurate and consistent clinical notes. • **Higher Patient Satisfaction:** With more time dedicated to patient interactions, the overall quality of care will improve, leading to higher patient satisfaction rates.	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency.*

*https://www.deepscribe.ai/resources/deepscore-measuring-the-performance-of-ambient-ai-clinical-documentation, https://www.suki.ai/suki-platform/ , and https://www.abridge.com/product

Overarching – Key Opportunities

Opportunity 1.8	Adjust the model of care for clients with a high rate of No-Show/Cancellation while implementing operational efficiency practices.

Current State

Typically, there is a percentage of clients who are served by behavioral and public health that have a higher-than-average no-show/cancellation rate due to the nature of their illness, life circumstances and where they are in the recovery.

2023/24. Cancellation and No-Show Rates

Youth Services	
Location	**Average of No Show / Cancellation Rate**
Martha's Place	24%
South County Youth MH	23%
North County Youth	21%
Atascadero Youth	19%
SAFE	18%
San Luis Obispo Youth MH	18%
Prevention & Outreach	13%
Contractor	6%
Juvenile Hall	5%
Managed Care	0%

Adult Services	
Location	**Average of No Show / Cancellation Rate**
San Luis Obispo Adult MH	23%
South County Adult MH	22%
Paso Robles Adult MH	21%
Atascadero Adult MH	19%
Grover Beach DAS	17%
San Luis Obispo DAS	17%
Atascadero DAS	14%
Prevention & Outreach	12%
Justice Services	9%
Paso Robles DAS	3%*
Contractor	3%

- For clients with high no-show and cancellation rates, a review of the model of care should be considered to align with the clientele needs. For example, if clients have been unable to attend office-based visits, is there an opportunity to consider field base visits or consider virtual visits to support ongoing engagement. Another option is to consider a 'drop-in' clinic to allow clients to attend when they are able. Among these clients, a late afternoon 'drop-in' service has shown enhancement of human resources.
- *further examination of the no show rate for Paso Robles DAS should be explored as this is significantly lower than what is typically seen especially among this population. It may be that staff are not coding no show rates or that services are based on a drop services.

Overarching – Key Opportunities

Opportunity 1.8	Adjust the model of care for clients with a high rate of No-Show/Cancellation while implementing operational efficiency practices.

Current State

- Establishing several key staff who are able to develop rapport with this group of clientele, supports engagement between appointment/drop-in sessions. Other creative means of engaging clients in care, is to establish a healthy cooking class, which allows them to engage in a meaningful activity, and also have a healthy meal while they are awaiting services. These groups are often run by Peer Support Specialists and Case Managers. Clinicians or Prescribers can then pull from this group for their 1.1 session helping to optimize staff while meaningfully engaging clients. The cancellation and no-show rates are higher than typically seen for outpatient services.
- Even if Clinicians and Prescribers schedule 80% of their days, the current no-show and cancellation rates would have them potentially reach an average of 60% utilization rate. As a result, it is strongly encouraged that the following five opportunities be considered and implemented.

Key Opportunity

1. Help ensure reminder calls and texts are conducted for all clients. Recognizing that there is deficits in the SmartCare process for reminder notification, the Department should consider other means to improve no show rates, such as volunteers supporting the reminder call process.
2. Schedule Clinicians and Prescribers schedules for 80% direct client care.
3. Decrease length of appointment times, i.e., instead of 30-minute medication follow up, consider 20-minute medication follow up appointments; instead of 60 minutes therapy appointments, consider 45-minute appointments.
4. Stagger appointment times specially for clients that have 2 or more no shows.
5. Develop community-based models of care to accommodate client needs versus office-based services.

Key Action Steps	Benefit	
• **Scheduling Practices:** Advise all staff to book their schedule in 80% direct client care. • **Establish Reminder Calls:** (1) Administer SmartCare reminder call process. (2) have administrative staff conduct reminder calls. (3) have peer support specialists conduct reminder calls. • **Volunteer Support:** If the above is not feasible, utilize volunteers to conduct reminder calls. • **Review Current Clientele:** Determine which clients would be best serviced (1) in the community or (2) via drop-in service.	• **Increased Clinician Efficiency:** Reducing the time clinicians spend on documentation allows them to focus more on direct patient care, which will enhance service delivery. • **Higher Patient Satisfaction:** With more time dedicated to patient interactions, the overall quality of care improves, leading to higher patient satisfaction rates.	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency and ultimately increase billable services.*

Overarching – Key Opportunities

Opportunity 1.9	Improve productivity through setting clear expectations and verification of staff activities and billing eligibility.

Current State

Setting Expectations: Department Health Care Services (DHCS) productivity standards, state "*DHCS assumed that each full-time equivalent (FTE) provider can work a maximum of 2,080 hours... per year (assumptions: 52 weeks × 40 hours per week). DHCS assumed a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive … [time] per state FY for each FTE SMHS provider. The 60% productivity rate was established after convening internal and external stakeholder meetings which confirmed that, on average, most providers spend about 60% of their time providing treatment services directly, while the remaining 40% is spent on administrative or other non-service-related professional activities (e.g., participation in meetings, professional events and conferences, etc.).*"

Based on the no-show and cancellation rate of approximate 20%, this will require staff to schedule 80% of their calendar in direct client contact in order to achieve the 60% target as set by DHCS.

Utilization Targets vs. Breakeven Analysis: The County should consider differentiating between a break-even analysis (43.5%) and enhancement of front-line staff.

- Why the difference? By setting a target of 43.5%, it does not consider departmental overhead cost and secondly, staff who aim to schedule 43% of their day have not accounted for 'no show or cancellation' rates, which averages 20% among the larger clinics and the majority of the staff's time is currently unaccounted for time.

Undertaking Training: During stakeholder engagement, it was confirmed by the Quality Support Services Team that each clinical team has been trained in how to help maximize their billable activity to support the staff in reaching their 43.5% target for Behavioral Health. While this training was conducted, the Quality Support Services Team indicated that they did not conduct a pre and post quantitative evaluation to determine the impact of the training, which should always be considered when training is provided.

Verifying Staff Activities: Based on the utilization data, and management feedback that the data is inaccurate, some managers conduct monthly analysis of staff productivity.

Key Opportunity

Improve staff utilization and billable activity in Behavioral Health by implementing a weekly review and analysis process that includes scheduling optimization, eligibility verification, AI-supported documentation, performance tracking, and action planning to help staff consistently meet their targets.

Undertaking Training: The Quality Support Services Team should re-conduct the training and apply pre and post quantitative evaluation to determine the impact of the training. If there is no improvement, sample evaluation should be conducted to determine if there truly is no additional improvement that can be made.

Verifying Staff Activities: Based on the utilization data, and management feedback that the data is inaccurate, verification analysis should be conducted on a weekly basis with week over week analysis on each staff productivity.

While there is no utilization target for clinical teams in Public Health, the same methodology should be applied.

Consensus Reached with Division Managers: During the on-site visit on March 18th- 19th, 2025, each Division Manager agreed to the aforementioned process below noting the biggest risk of not meeting this opportunity is receiving an accurate weekly analysis of staff productivity.

Behavioral Health Information Notice 23-068: Updates to Documentation Requirements for all Specialty Mental Health (SMH), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
Behavioral Health Information Notice 23-04. 2023 Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMCODS) Plans

Overarching – Key Opportunities

Opportunity 1.9	Improve productivity through verification of staff activities and billing eligibility.	
Key Action Steps	**Benefit**	
• **Differentiating between a breakeven analysis vs. productivity targets:** The County needs to differentiate between a break-even analysis from effective utilization of front line staff, which should be the target set for staff. • **Re conduct training:** Quality Division to support and training clinical staff in understanding how to accurately capture billable services. Pre and post measures should be applied to determine if training has achieved its desire outcome**.** • **Implement Scheduling and Review Process:** Direct staff to allocate 80% of their time to direct client services (billable and other) and assign Administrative Service Officers and supervisors to review compliance weekly. • **Establish Billing/Service Eligibility, Verification, and Variance *Reporting (Behavioral Health Specific)*** Train ASOs to verify billing eligibility through Medi-Cal – Meds light and Ability insurance screener for all clients and develop a process for ASO to confirm all visits are accounted for weekly and report variances to supervisors. • **Introduce AI for Documentation Support:** Consider implementing AI technology to support documentation and help staff focus on direct client care activities (refer to opportunity 1.7). • **Develop Utilization Tracking and Action Planning:** Assign a member of Health Agency IT or Division staff to pull and present weekly staff activity data in a dashboard format and schedule weekly meetings for supervisors and managers to review utilization and develop action plans for staff and prescribers not meeting targets. • **Conduct Regular Staff Utilization Reviews and Reporting:** Hold weekly meetings with staff and prescribers until they demonstrate consistent improvement over a 3-month period, establish bi-weekly departmental-level analysis, and conduct monthly agency-level reviews for corrective actions.	• **Potentially increased revenue generation:** By having staff schedule 80% of their time in direct client billable services and verifying eligibility for Medi-Cal and other insurance billing, the organization may increase revenue from client services • **Improved staff performance management:** Weekly review of staff schedules and activities, along with the development of action plans for those not meeting targets, allows supervisors to provide targeted support and accountability to drive improved productivity and utilization of staff time	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency and ultimately increase billable services.*

Overarching – Key Opportunities

Opportunity 1.10	Resolve data quality challenges, standardize data collection and management to enhance data analytic capabilities and support data-driven decision-making.

Current State

- The Health Agency currently faces challenges in data management and analytics due to the absence of a centralized data management system, leading to data silos across various divisions and programs. This decentralized approach results in each division, across both Public and Behavioral Health, conducting their own independent analyses to support data-driven decision making, such as Clinic Supervisors and Managers performing staff utilization analysis and divisions across Public Health tracking caseloads separately.
- As part of this review, the KPMG team conducted in-depth data analysis across programs within Behavioral Health and Public Health. This included evaluating staff utilization across clinics, analyzing readmission rates at the County's Psychiatric Health Facility (PHF), assessing vacancy rates per program, and performing a span of control analysis. This analysis required the review of several key files sourced from each department's EHR system as well as the County's HR system. While conducting this analysis, KPMG faced significant challenges stemming from data quality issues and technological limitations within each department. An outline of the key challenges faced across each department are outlined below and should be taken into account when evaluating the analysis included within this report.
- **Behavioral Health Data Challenges:**
  - The Behavioral Health Department has developed a dashboard to evaluate staff utilization based on a report pulled from Smartcare, the Department's EHR system. The raw data used to develop this dashboard is known as the "Green Report" and was provided to KPMG as the basis for the utilization analysis included within this report and within the Power BI dashboard develop by the KPMG team. Based on a review of this raw data, the following challenges were identified:
    - The raw data file lacked key fields such as staff position and clinic assignment, making it challenging to conduct analysis at these levels. This information is essential for evaluating the performance of specific positions and clinics and making data-driven decisions for future strategies. To address this issue, KPMG manually mapped 1,000+ fields into the dataset using additional data files provided by the Department to support this analysis.
    - The file provided did not include FTE numbers for each staff member to support an accurate analysis of utilization; therefore, KPMG obtained this data from the Department in a separate file and mapped this data to each position within the file.
    - The KPMG team independently recalculated the utilization percentages within the Department's Green Report and 4% of the utilization figures reported by the Department did not match those independently calculated by KPMG, despite KPMG validating the Department's utilization calculation on two separate occasions.
    - During the validation process, KPMG found it challenging to accurately analyze data by staff member at the clinic level because staff often work across multiple clinics, and the number of hours each staff member spent at each clinic was unavailable. Consequently, evaluating each individual's utilization for a specific clinic resulted in inaccurately low utilization rates. Therefore, analysis could only be completed at the overall position level or at the employee level.
    - Finally, the organization chart provided by the County did not align with the data provided within the Green Report. For example, the organization chart indicated that Justice Services had 3 LPT/LV Nurse FTEs; however, the Green Report shows only 2 LPT/LV Nurse FTEs coding time to Justice Services. This discrepancy further complicated the analysis.
    - Finally, across the review process, varying files were provided to KPMG which required an update to analysis on four separate occasions.

Overarching – Key Opportunities

Opportunity 1.10	Resolve data quality challenges, standardize data collection and management to enhance data analytic capabilities and support data-driven decision-making.

Current State

- **Public Health Data Challenges:**
  - The Public Health Department tracks utilization differently from the Behavioral Health Department and standard industry practices. Instead of measuring the percentage of time providers spend on direct client services, they focus on caseloads, the number of clients served, and service impacts. For example:
    - **Nurse Visiting Program:** This program does not track the length of time each nurse spends with clients, making staff utilization monitoring challenging.
    - **Clinic and Communicable Disease Program:** Nurses work across the immunization clinic and communicable disease investigation without tracking the time spent on each area, hindering accurate utilization analysis.
    - **Reproductive Health and Martha's Place Clinics:** These clinics do not track the length of time spent on direct client services but do track the number of appointments. Average appointment lengths by type were provided and mapped to calculate utilization.
    - **WIC Clinic:** This clinic tracks staff time using a time system, but only for one week each month. This data was extrapolated to estimate annual utilization.
  - Additionally, the department's EHR system is outdated, making it difficult for the department to extract data in the format requested by KPMG.
- The lack of standardized data collection, storage, and reporting processes across the Agency creates inconsistencies and inefficiencies in data management, compounded by the need for several divisions to meet varying grant reporting requirements, necessitating the regular tracking of different metrics and outcomes. Consequently, the Health Agency's ability to derive meaningful insights from available data and make data-driven decisions is hindered by limited data analytics capabilities and a lack of real-time data access and reporting, which negatively impacts decision-making, resource allocation, and the ability to respond quickly to changing needs.

Key Opportunity

Implement a centralized data management system and enhance data analytics capabilities to improve data quality, accessibility, and decision-making across the Health Agency.

Key Action Steps	Benefit	
• **Evaluate Data Quality:** Conduct an analysis of key data quality challenges highlighted in this report and commence tracking key data fields are within critical data outputs, including staff positions and clinic assignments. This will enable more accurate and comprehensive analysis of staff utilization and performance metrics. • **Assess Current Data Management Practices:** Conduct an assessment of the Health Agency's current data management practices, identifying data silos, inconsistencies, and inefficiencies across departments and programs.	• **Improved Data Quality and Consistency:** A centralized data management system will help with data consistency and accuracy across the Health Agency. • **Enhanced Decision-Making:** Access to real-time, reliable data and advanced analytics capabilities will enable the Health Agency to make informed, data-driven decisions and allocate resources more efficiently.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

Overarching – Key Opportunities

Opportunity 1.10	Resolve data quality challenges, standardize data collection and management to enhance data analytic capabilities and support data-driven decision-making.

Key Action Steps	Benefit	
• **Develop a Data Management Strategy:** Create a data management strategy that outlines the goals, objectives, and key initiatives for improving data management and analytics within the Health Agency. • **Implement a Centralized Data Management System:** Select and implement a centralized data management system that integrates data from various sources, helps ensure data consistency, and enables easy access to information across the Health Agency. Consider establishing a data management committee involving IT, Division Managers, and Contracts / Grants Management. • **Establish Data Governance Policies:** Develop and implement data governance policies and procedures to promote data quality, security, and compliance. • **Enhance Data Analytics Capabilities:** Invest in data analytics tools and training to enable staff to derive meaningful insights from the available data.	• **Increased Operational Efficiency:** Streamlined data management processes and improved data accessibility will help reduce manual efforts, eliminate redundancies, and increase operational efficiency. • **Better Collaboration and Information Sharing:** A centralized data management system will facilitate collaboration and information sharing across departments and programs.	*This opportunity will further support the Health Agency to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.*

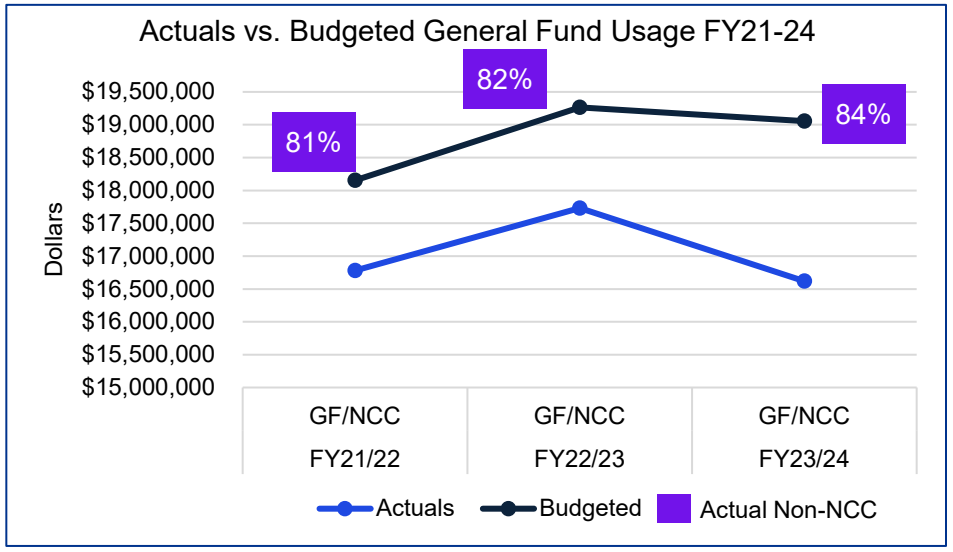
Behavioral Health

Behavioral Health Department Overview

Division Overview

- The Behavioral Health Department, a department within the San Luis Obispo County Health Agency, is focused on delivering compassionate behavioral health services which empower, embrace, and promote healing and recovery.
- These services are categorized in 6+ divisions including access and crisis services, drug and alcohol, justice, adult and youth mental health services, prevention and outreach, and quality support. Additionally, the department provides specialty mental health services for individuals meeting medical necessity criteria including medication support and Drug Medi-Cal Organized Delivery System services.
- The Department works in partnership with school sites, clinic sites, residential providers, and contract providers to deliver a continuum of care encompassing prevention and wellness, intensive outpatient, crisis, intensive residential, and community services.

318.25 *Total FTE*	**$120.26M** *Total Budget FY24-25*
83% *Budgeted FY24-25 Non-NCC*	**17%** *Budgeted FY24-25 General Fund*
84% *Actual FY23-24 Non-NCC*	**16%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

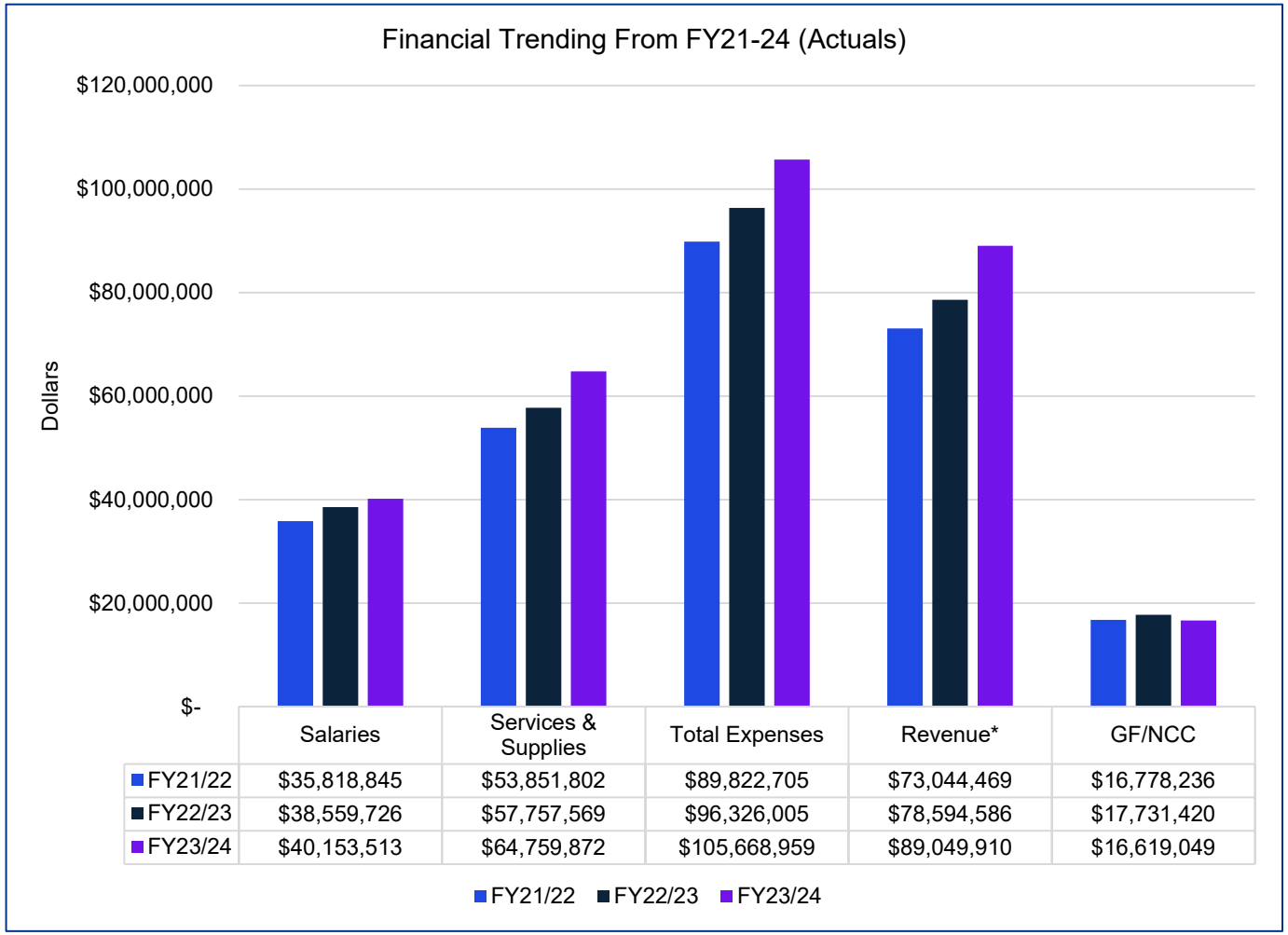
County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$120,257,431	0.5%	$20,638,922	$95,876,615	318.25***
Santa Barbara	441,257	$205,718,400	46%	$6,122,400	$99,146,000	469.08
Monterey*	430,723	$212,598,143	*Not Publicly Reported*	*Not Publicly Reported*	$156,692,495	*Not Publicly Reported*
Santa Cruz	261,547	$182,275,995	5.4%	$16,369,953	$155,655,890	296.30
Sonoma**	481,812	$275,958,737	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	288.31
Ventura	829,590	$124,113,219	37%	$18,501,745	$57,169,711	330.50

**Monterey County does not provide a consolidated number of FTEs at the department level.*
***Sonoma County consolidates the General Fund Contribution at the agency level including Executive Management & Administration, Behavioral Health, Homelessness, and Public Health which totals to $10,975,336.*
****Reflected Allocated FTEs from the Position Allocation list shared on April 11, 2025 (vacant and filled but total authorized by Board) as opposed to just filled positions.*

Behavioral Health Department - Trend Analysis

Between FY 21-22 and FY 23-24, the Behavioral Health Department has achieved a combined average Non-NCC rate of 82%. In FY 21-22, the Department required $16.78M general fund and this increased by 6% in FY 22-23. In FY 23-24, General Fund use decreased by 6% to $16.6M.

- Salaries for the Department have increased steadily over the past three fiscal years. Between **FY 21-22 and FY 23-24**, **Salaries have increased a total of 12%.**
- Expenses related to Services & Supplies have also increased steadily over the past three fiscal years. Between FY 21-22 and FY 23-24, Services & Supplies have increased by a total of 20%. This is largely due to a 28% increase in “Professional and Special Service” costs and a 19% increase in “Other Professional and Special Service” costs.
- As a result of increasing expenses related to Salaries and Services & Supplies, Total Expenses have also increased by 18% between FY 21-22 and FY 23-24.
- Revenue (including grant funding and realignment) has also increased steadily over the past three fiscal years. Between FY 21-22 and FY 23-24, increased by 22%. This can be attributed to a 37% increase in funding through realignment and changes that result from recent payment reform. It is also important to note that MHSA funding increased by 14% in the same period.

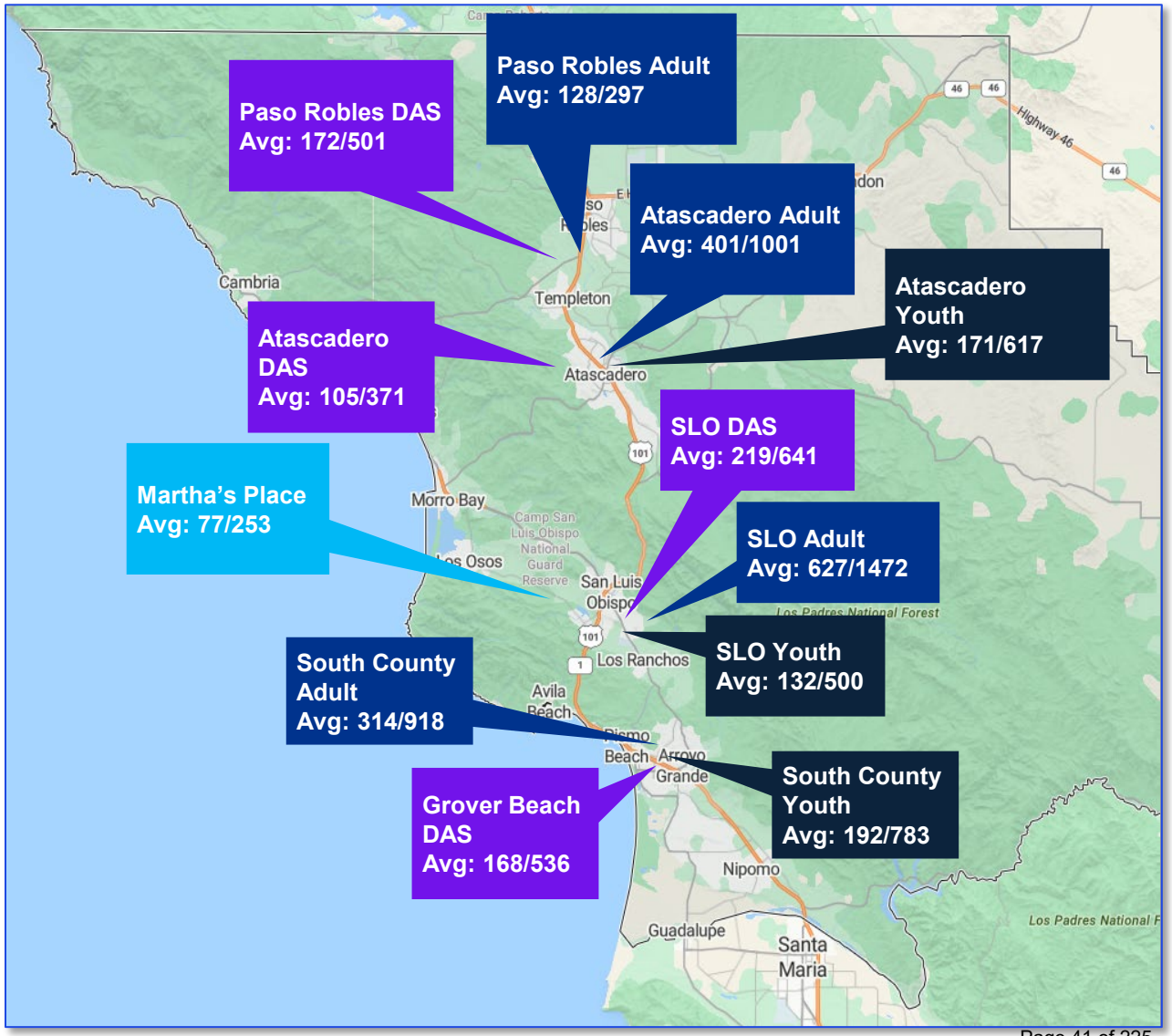


	Salaries	Services & Supplies	Total Expenses	Revenue*	GF/NCC
FY21/22	$35,818,845	$53,851,802	$89,822,705	$73,044,469	$16,778,236
FY22/23	$38,559,726	$57,757,569	$96,326,005	$78,594,586	$17,731,420
FY23/24	$40,153,513	$64,759,872	$105,668,959	$89,049,910	$16,619,049

**Revenue includes charges for service, grant funding, and realignment.*

Behavioral Health: Average Monthly Clients, Visits, and Staff by Clinic

Below is a summary of all Behavioral Health clinics by location, with the average monthly clients seen, and average monthly visits against the average staff in a month.



Clinic	Average Monthly Clients Seen	Average Number of Monthly Visits	Average Staff in a Month
Atascadero Adult	401	1001	19
Atascadero DAS	105	371	15
Atascadero Youth	171	617	18
Grover Beach DAS	168	536	18
Martha's Place	77	253	7
Paso Robles Adult	128	297	10
Paso Robles DAS	172	501	18
SLO Adult	627	1472	24
SLO DAS	219	641	21
SLO Youth	132	500	17
South County Adult	314	918	27
South County Youth	192	783	25
Min	**77**	**253**	**7**
Max	**627**	**1472**	**27**
Average	**226**	**658**	**18**

Key	
	Youth
	Adult
	Drug and Alcohol Services (DAS)
	Other (Martha's Place)

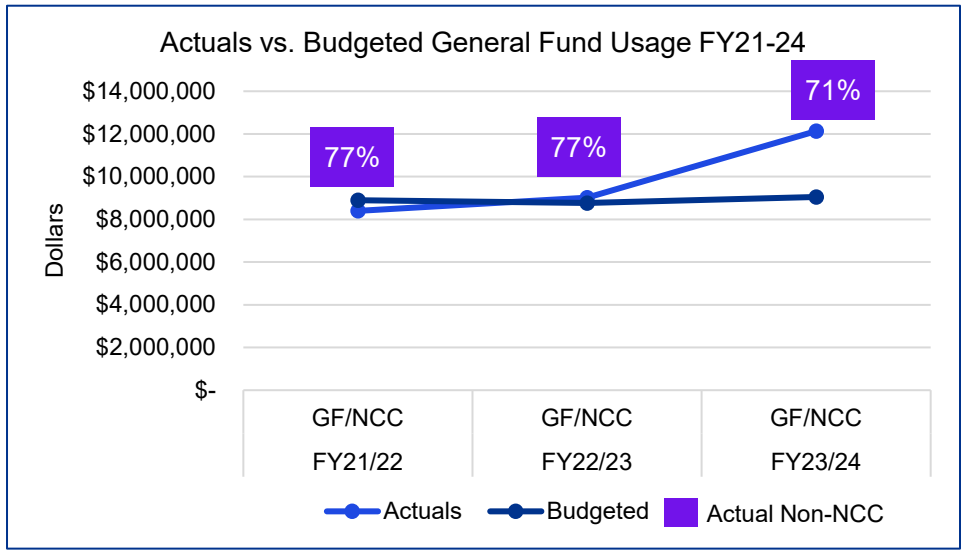
***Sources**: EHR Data.*

Mental Health Division Overview

Division Overview

- The Mental Health Division, a division within the San Luis Obispo County Health Agency's Behavioral Health Department provides a wide range of mental health and substance abuse services to individuals and families in the community.
- Adult Mental Health Services encompass outpatient treatment across three sites and contracts out for mobile crisis intervention, Adult and Older Adult Full-Service Partnership (FSP), Homelessness Outreach FSP, Dispatch services Residential Programs, and inpatient psychiatric facilities.
- Youth Mental Health Services encompass outpatient treatment across three sites and offer 20+ services either offered by the County or through contracted providers, which include Abused Children's Treatment Services (ACTS) for abuse recovery, Intensive Day Treatment Services, and Transitional Aged Youth (TAY) Full-Service Partnership for young adults transitioning out of foster care.

107.25 *Total FTE*	**$47.68M** *Total Budget FY24-25*
73% *Budgeted FY24-25 Non-NCC*	**27%** *Budgeted FY24-25 General Fund*
71% *Actual FY23-24 Non-NCC*	**29%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)*

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$47,676,844	0.3%	$12,803,830	$33,356,264	107.25
Santa Barbara	441,257	$123,765,900	41%	$898,100	$65,424,800	275.40
Monterey**	430,723	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Santa Cruz	261,547	$48,547,813	*Not Publicly Reported*	*Not Publicly Reported*	$332,784	114.80
Sonoma***	481,812	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Ventura	829,590	$80,236,431	41%	$80,769	$45,148,558	192

**The benchmark data included in this table excludes administrative costs, with the exception of San Luis Obispo, as the counties listed them separately.*

***Monterey County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the Mental Health Program is not available.*

****Sonoma County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the Mental Health Program not is available.*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Mental Health Division - SWOT Analysis - Adult Services

Strengths	Weaknesses
• **Strong Referral Network:** Referral system includes self-referral, family referral, step-downs from psychiatric health facilities, justice services, and other community partners. • **Dedicated Management team:** A well trained and skilled group of supervisors and Manager who have extensive knowledge of the population served and community partners. • **Accessible Services:** Adult services are well established across three sites.	• **Reliance on Contracted Peer Support:** Absence of county-employed peer support workers, relying instead on contractors whose support has been inconsistent. • **Overburdened Medical Staff:** Prescribers have heavy caseloads, impacting access to care. • **High Appointment No-Show Rates:** High no-show rates for appointments, particularly for assessor clinicians with long time blocks, leading to inefficiencies. • **High Turnover Among Staff:** High turnover rates among staff creates relational and operational instability. • **Billing and Documentation Uncertainties:** Staff uncertainties around billing and documentation practices, necessitating continuous training to maximize billables.
Opportunities	**Threats**
• **Workflow Enhancement:** Opportunities to streamline workflows, such as helping to optimize appointment scheduling, reducing unused blocks of time, and better documenting billable services. • **Enhanced Collaborations with Community Partners:** Strengthening collaborations with community partners (like CenCal) and Federally Qualified Health Centers (FQHCs) to support smoother transitions for clients and reduce duplication of efforts. • **Expansion of Integrated Services:** Further co-locating clinics and offering more integrated services to enhance whole person care. • **Telehealth Expansion:** Expanding telehealth options to better serve remote and underserved populations. • **Staff Training Enhancements:** Enhancing training programs and support for staff to better understand and implement CalAIM requirements and billing practices. • **Alternative Care Models**: Explore alternative models of care to better engage and support consumers transitioning from jail or psychiatric health facilities (PHF), supporting smoother reintegration and continuity of care.	• **Rising Cases of Dual Diagnosis Clients:** Increasing number of clients with severe mental illness and medical needs, with few facilities equipped to handle both conditions. • **Administrative Burden on Clinical Staff:** Burden of administrative tasks on clinical staff, along with managing new systems and reforms, affecting their ability to focus on client care. • **Legal and EHR Integration Barriers:** Navigating complex legal and electronic health record (EHR) barriers to fully integrate services, along with the limitations of SmartCare reporting capabilities. • **Service Tracking Challenges for Homeless Clients:** Challenges in tracking and providing consistent services to clients who are homeless or do not have phone access.

Mental Health Division - Adult Services Key Opportunities

Opportunity 2.1a	Optimize staffing across all Mental Health Adult Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach.

Current State

With an average staff count of 41.63 FTE*, utilization varies greatly across all positions. Utilization ranges and averages by position are outlined in the table below with improvement seen year over year across 7 of the 10 position categories, while 2 of the 10 position categories declining in utilization. Currently, 1 of the 10 position categories meet the County's breakeven target of 43.5%, while the other 9 position categories are well below industry average and DHCS targets.

Position	BH Clinician I	BH Clinician II	BH Clinician III	Specialist I	Specialist II	Specialist III
2023-24 Range	15% – 35%	2% – 58%	0.56% – 56%	N/A**	0.19% – 42%	2% – 23%
Average Utilization	27%	25%	26%	N/A**	17%	12%
2024-YTD Range	15% – 23%	0.73% – 66%	0.17% – 59%	N/A**	32%	4% – 48%
Average Utilization	19%	23%	27%	N/A**	32%	22%

Position	BH LPTI	BH LPT II	BH LPT III	BH LPT/ RN Manager	MH Nurse II & III	Nurse Practitioner	Psychiatrist
2023-24 Range	30%	N/A**	0.57% – 41%	0.57% – 41%	N/A**	0.11% – 44%	0.01% – 66%
Average Utilization	30%	N/A**	20%	23%	N/A**	21%	31%
2024 YTD Range	46%	N/A**	2% – 48%	0.50% – 48%	N/A**	0.50% – 45%	0.04% – 50%
Average Utilization	46%	N/A**	31%	29%	N/A**	29%	31%

*This FTE number is based on the FY25-26 Program Inventory as a detailed breakdown for the cost center was not available in the Position Allocation List exported as of April 11, 2025.

**Data was not available for the specific position, program, or year as the position does not exist within the service.

Mental Health Division - Adult Services Key Opportunities

Opportunity 2.1a	Optimize staffing across all Mental Health Adult Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach.

Current State

- **Adult Services Utilization:** As employees go across clinics and services, it is difficult to determine overall clinic utilization, therefore it was agreed that management will examine employee utilization and work with each employee on a weekly basis to optimize resources. The previous slide outlines the range per position with an average across the period of evaluation. The dashboard provides utilization by employee, positions, clinics and divisions
- To account for the **no-show and cancellation rates**, management should direct office-based staff to schedule 80% of their day and 60% of community-based staff in direct client contact. Accounting for no-show and cancellation rates, which for 2024 averaged in the 20% range, the projection billable services would be 60% for office-based services, where the majority of services are offered.
- **Model of Care Redesign**: Averaging a 20% no show and a 13%, 30-day readmission rate for the PHF may suggest that the current model of care offered in the outpatient setting is not meeting client needs. Consideration for redesigning OPS to include services such Intensive Case Management (ICM) or a Partial Day Hospital (PDH), may be more effective use of personal. Through appropriate approval processes, both ICM and PDH can be achieved by the same staffing and physical locations where the adult Outpatient Services (OPS) are currently located.
- **Wait Time:** There is currently a wait list for therapy services across the four adult clinics. Based on the underutilization of staff, and in discussion with the Division Manager, it was agreed that by May 2025 all clients on the wait list will be picked up for service.
- **Stakeholder Feedback:** Stakeholders consistently reported challenges in accessing prescribers in a timely manner. Optimization of these highly skilled resources should be a priority over the next 3 months. Based on the consistent feedback received by stakeholders regarding significant difficulties in accessing appointments for medications, and that these positions are fully scheduled with as many as 11-14 clients per day, changes in scheduling practice may be warranted in order to address the high no-show and cancellation rates. Both Nurse Practitioners and Psychiatrists are well below expected targets. Please refer to Opportunity 2.1c that discusses optimization of nursing and prescriber resources through a multidisciplinary approach.

Key Opportunities for Consideration*

- **Utilization Enhancement:** Require staff to schedule to 80% of their day for office-based services and 60% for community-based staff to account for no-shows, supporting better staff utilization and reduced wait times by May 2025.
- **Prescriber Access:** Optimize prescriber schedules by reducing appointment times from 30 to 20 minutes to optimize resources, decrease wait times to access service.
- **Model Redesign**: Exploring Intensive Case Management (ICM) and/ or Partial Day Hospital model of care and redirecting current outpatient services (OPS) resources to these models to better meet client needs, upon receiving appropriate authority.
- **Wait Time:** Managers and Leadership should evaluate wait times against capacity on a weekly basis and help ensure effective access to care is conducted especially when there is clear capacity within the services.

** Please refer to page 50 for the action steps and benefits related to these opportunities given they mirror those to be completed for the Youth Services opportunities*

Mental Health Division - SWOT Analysis - Youth Services

Strengths	Weaknesses
• **Comprehensive Services for Youth:** Comprehensive program and services primarily serving Medi-Cal beneficiaries aged birth to 20 years. • **Widespread Regional Clinics and Specialized Services:** Presence of multiple regional clinics and specialized services, including the birth-to-5 clinic and community-based therapy. • **Multi-Agency Collaboration:** Collaboration with various agencies like probation departments, public health services, and education offices. • **Diverse Community Programs and Partnerships:** Programs and partnerships addressing a variety of community needs, including the Latino Outreach Program and Katie A. • **Strong Integration with Justice and Educational Systems:** Demonstrates a strong integrated approach involving justice and educational systems.	• **Retention Challenges for Spanish-speaking Clinicians:** Struggle to retain Spanish-speaking clinicians, resulting in a service gap. • **Electronic Health Record Inefficiencies:** Issues with the new electronic health record and documentation requirements under CalAim, leading to inefficiencies. • **Financial and Operational Challenges with Fee-for-Service:** The transition from cost-based reimbursement to fee-for-service created financial/operational difficulties. • **High Staff Turnover:** High turnover of staff, particularly among those who become licensed and leave for better opportunities. • **Shortage of Experienced Clinical Supervisors:** Lack of experienced clinical supervisors to provide support, compounded by education and supervision needs. • **Productivity Hindered by Logistical Challenges:** Challenges with productivity standards due to factors like significant travel times and limited hours available for appointments due to school schedules. • **Barriers to Telehealth Adoption:** Inability to fully adopt telehealth due to privacy concerns and limited internet access in some regions.
Opportunities	**Threats**
• **School Partnerships for In-School Therapy:** Potential partnerships with schools to provide in-school therapy services utilizing CYBHI funds to help address the scheduling and accessibility issues for children and youth. • **Expansion of Telehealth Services:** Expanding the use of telehealth, particularly by leveraging spaces like the wellness center at Shandon School. • **Flexible Work Schedules for Staff Retention:** Address flexibility in work schedules to improve staff retention and potentially attract new hires. • **Enhanced Contract Management:** Enhancement of contract management with external providers to support continuous and effective service delivery.	• **Impact of Administrative and Policy Changes:** The impact of changes in Federal administration and policy, leading to reluctance to access services. • **Financial Constraints vs. Clinical Needs:** Financial constraints and the need to balance service delivery with meeting billing requirements. • **Productivity Standards and Staff Burnout:** Ongoing challenges with maintaining and meeting productivity standards, which may lead to increased staff burnout. • **Uncertainty from Changes in Documentation and Billing:** Uncertainty caused by changes in documentation and billing practices under the CalAIM initiative. • **Implementation of California Youth Behavioral Health Initiative (CYBHI):** Each district will have its own approach. Some may bring behavioral health services in house, others will contract with community providers while others will contract with the County. Regardless of approach, the County's volumes will be impacted.

Mental Health Division - Youth Services Key Opportunities

Opportunity 2.1b	Optimize staffing across all Mental Health Youth Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach.

Current State

With an average staff count of 41.07 FTE*, utilization varies greatly across all positions. Utilization ranges and averages by position are outlined in the table below with improvement seen year over year across 5 of the 7 position categories, while 1 of the 7 position categories saw a decline in utilization. Currently, *none* of the 7 position categories meet the County's breakeven target of 43.5%, and are significantly below industry average and DHCS targets.

Position	BH Clinician I	BH Clinician II	BH Clinician III	Specialist I	Specialist II	Specialist III
2023-24 Range	6%-9%	6%-44%	1%-44%	N/A	0%-1%	11%-23%
Average Utilization	8%	26%	23%	N/A	0.4%	17%
2024-YTD Range	5%	2%-43%	1%-42%	N/A	0.7%	8%-26%
Average Utilization	5%	29%	27%	N/A	0.7%	18%

Position	BH LPTI	BH LPT II	BH LPT III	BH LPT/ RN Manager	MH Nurse II & III	Nurse Practitioner	Psychiatrist
2023-24 Range	N/A**	N/A**	0.1%-0.3%	0.1%-24%	N/A**	N/A**	0.4%-84%
Average Utilization	N/A**	N/A**	0.2%	9.5%	N/A**	N/A**	39%
2024 YTD Range	N/A**	N/A**	N/A**	9%-27%	N/A**	N/A**	0.3%-81%
Average Utilization	N/A**	N/A**	N/A**	17%	N/A**	N/A**	39%

*This FTE number is based on the FY25-26 Program Inventory as a detailed breakdown for the cost center was not available in the Position Allocation List exported as of April 11, 2025.

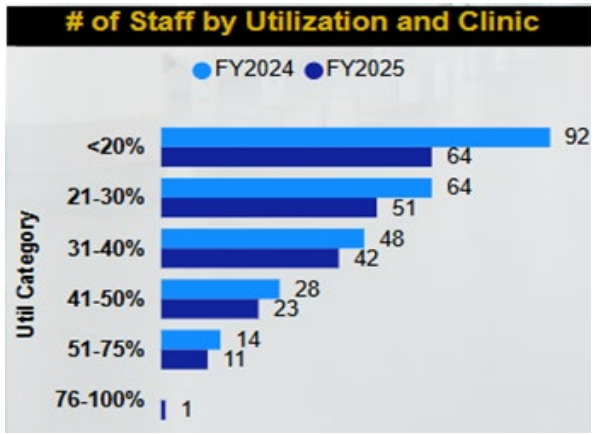
**Data was not available for the specific position, program, or year as the position does not exist within the service.

Mental Health Division - Youth Services Key Opportunities

Opportunity 2.1b	Optimize staffing across all Mental Health Youth Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach.

Current State

- **Youth Services Utilization:** As employees go across clinics and services, it is difficult to determine overall clinic utilization, therefore it was agreed that management will examine employee utilization and work with each employee on a weekly basis to optimize resources. The previous slide outlines the range per position with an average across the period of evaluation. The dashboard provides utilization by employee, positions, clinics and divisions. The majority of the staff fall below 20% utilization and between 71 and 78% as unaccounted for time.
- The County **Psychiatrists utilization** has noticeably higher than the Contractor and the County Psychiatrist has availability due to the recent decline in volume across Youth Services. Consideration of eliminating this contract should be made based on the availability of the County Psychiatrist. Please see Opportunity 2.8 for details.
- Based on the **high no show rates**, it is recommended that the county consider three options to improve optimization of human resources. 1) consider a drop in/walk in clinic for clients who have a no-show rate of 2 or more visits, or (2) consider staggering appointment times for clients who have a history of no-show rates and/or (3) decrease appointment times from 30 to 20 minutes. With the decrease of appointment time and the change to multidisciplinary approach to engage clients, reminder calls should be part of regular processes and check ins between appointments.



- **Wait Time:** There is currently a wait list for therapy services across the youth clinics. While there is underutilization, the wait is for Spanish speaking clinicians or for Neurofeedback treatment. Clients on the waitlist for Neurofeedback Therapy are also engaged in other treatment modalities.
- **Impact on Market Share:** According to the Division Manager, based on CalAIM eligibility screening changes, the screening process has impacted client volumes, specifically for those 0-5 years of age, as a high volume of the population now aligns with CenCal mandate.
- **Future Impact on Market Share:** Based on stakeholder engagement, there will most likely be a mix of schools bringing in funding and services in house as a result of CYBHI while some will contract with the County or Community Agencies to embed services within the schools. This may cause further reduction in future volumes.
  - Based on the 2024, YTD 2025 utilization analysis, the youth clinics are over staffed. Elimination of all vacant positions could be considered to right size staffing levels with program and community needs. In addition, based on consistent low volumes, the following positions under Key Opportunities for Consideration may also be considered through attrition or transition to other vacancy needs.
  - Of importance, a push is required to market County Services, which include professionals and the larger community. The proposed FTE count accounts for the potential increase one hopes to see once the County becomes more aggressive in their marketing strategies.
  - Based on the monthly analysis and reporting cadence, the County can determine if future alignment is required based on the upcoming changes for CYBH

* *Please refer to page 50 for the action steps and benefits related to these opportunities.*

Mental Health Division - Youth Services Key Opportunities

Opportunity 2.1c	Improve utilization for LPT, Nursing, Nurse Practitioners, and Psychiatrists across Services through enhanced scheduling practices and shift model of care to a multidisciplinary team approach, while right sizing staffing to meet community needs and volume demand.

Current State

- **Opportunity to Improve Low Utilization of Nursing and LPT Staff**
  - In discussion with the division managers, while occurring in some clinics, there is an opportunity to align nursing/LPT with the prescribers' activities, where nursing/LPT conduct initial client engagement by completing vitals, brief medical, mini mental status and then conduct handover to the prescriber prior to each appointment. This approach allows an additional member of the team to foster a therapeutic relationship with the client versus the one prescriber, supporting the client in their recovery journey.
  - As there are limited number of prescribers, it allows for a multidisciplinary care model and aligning activities with the most suitable skill set versus conducting activities that a lower level of skilled staff can conduct. This should be a standard process across all clinics.
  - The benefits of a **multidisciplinary care approach** is joint planning and responsibility for the client care needs while improving quality and continuity of care through delineating roles and responsibilities among the multidisciplinary team. This is accomplished by developing structured management plans, having clear communication among team members, external stakeholders, the client, and having multiple team members review and update the clients care plans in collaboration with the client.
  - This approach would be a substantial model shift as it is reported that 60% of all adult clients seek medication only services, while 40% are medication and therapy. Division managers indicated that Prescriber(s) see 10-14 clients a day. LPT(s) have a caseload of 110 to 140 clients while Therapist(s) have a caseload of 30-35 clients. In 2024, adult services served 4,527 unique clients. 60% totals 2,829 clients being served primarily by a few prescribers, while 1,698 clients are served by the rest of the larger team. While the LPT have reported high caseloads, this does not translate into high utilization.
    - **Youth Services**: Based on the low utilization seen across LPTs and Nurse Managers, that ranges from 0.3% to 28% with an average of 13% across the 4 positions and the projected further decline in services due to CYBHI, there is an opportunity to decrease the number of positions currently allocated to Youth Services.
    - **Adult Services**: Based on the 2024-25 YTD utilization, only 3 of the 15 LPT and Nurse Managers met or exceed the County target of 43.5%. While there is an opportunity to decrease the number of LPTs and Nurse Managers, a closer look at utilization once the multidisciplinary approach is taken needs to be considered.

Key Opportunity for Consideration*

- Based on the 2024 and 2025 analysis, there is an opportunity for the County to right size LPT and RN staff in Youth Services from 4.0 FTE to 2.0 FTE and this allows for the increase that should occur with the multidisciplinary approach. The County should consider hiring part time positions to account for PTO and backfill.
- ***Consideration: Decrease Youth Services LPT Nurse Manager and MH Nurse II & III Staffing from 4.0 FTE to 2.0 FTE.***

** Please refer to page 50 for the action steps and benefits related to these opportunities.*
*** This is an estimate based on the minimum and maximum total costs for the LPT, RN, Mental Health Nurse and Nurse Manager positions.*

Mental Health Division - Key Opportunities

Opportunity 2.1a – 2.1c	The below outlines the key action steps and benefits for Opportunities 2.1a – 2.1d related to Adult and Youth Services

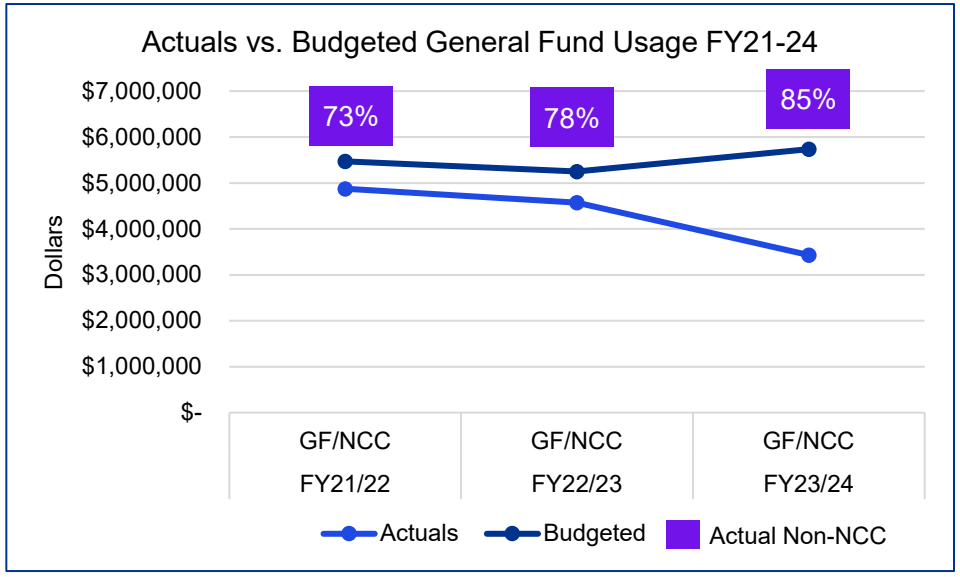
Key Action Steps	Benefit	
• **Conduct Formal Engagement with Key Stakeholders:** Engage and educate key stakeholders in the services offered by the County, which includes front line responders, schools, colleges, faith and culture-based organizations and community centers. • **Redesign Model of Care:** Consider redesigning services to meet consumers within the community vs. office-based services for the hard-to-reach population and for Adult Services consider Intensive Case Management and/or Partial Day Hospital. • **Enhance Scheduling Practices:** o Staff to be directed to schedule 80% of their day in direct client contact. o Appointments should either decrease in time or be staggered to accommodate the high no show and cancellation rates. o Decrease medication follow-up appointments from 30 to 20 minutes while introducing a multidisciplinary team approach. o For clients with a high no-show and cancellation rates, consideration should be given to a 'drop in' clinic in addition to a wrap around model of care to support clients in the recovery journey. • **Implement Verification Process and Improvement of Staff Optimization.** o Weekly analysis on utilization by Division Managers and Medical Director should incorporate 1.1 meeting with each staff member with strategies on how to improve rapid access to care. o If significant progress is not achieved in a 3-month period, the matter should be further escalated as the issue may be the individual versus the process. • **Right Size the Services:** • *Transition LPT Nurse Manager and MH Nurse II & III Staffing from 4.0 to 2.0 FTE.* • *Eliminate contract with Iris Telehealth Services for Clinician and Child Psychiatrist.* • Remain on a hiring freeze until overall productivity improves across the service and by position. Through attrition, this process will right size the clinics.	• **Financial Viability:** Optimizes current staffing while reducing overall cost in order to be financially viable. • **Community Alignment:** Right sizing the service based on community need and volume demand. • **Strengthen Engagement:** Meeting clients in the community vs. office-based services for those with high no show rates. • **Strengthen Accountability:** Establishing clear accountability through a transparent process.	**$304,000 – $387,000** *Potential Annual Cost Efficiencies for LPT/Nursing. Specific Cost Efficiencies related to Contracts are under Opportunity 2.5.*

Drug and Alcohol Services Division Overview

Division Overview

- The Drug & Alcohol Services Division provides a variety of programs and services to address problems related to substance use through public walk-in clinics, outpatient treatment, and court-mandated programs. These services are offered at several locations including Grover Beach, SLO, Paso Robles, and Atascadero.
- They provide over 20+ comprehensive services encompassing opioid safety, youth and veterans' treatment, and justice system programs. Their offerings include detox, medication-assisted treatment, residential and outpatient care, and recovery support. Additionally, services like behavioral health bridge housing and on-site pharmacy access, deliver support for various stages of recovery.
- Their mission is to promote safe, healthy, responsible, and informed choices concerning alcohol and other drugs through responsive community programming.

99.25 *Total FTE*	**$25.84M** *Total Budget FY24-25*
79% *Budgeted FY24-25 Non-NCC*	**21%** *Budgeted FY24-25 General Fund*
85% *Actual FY23-24 Non-NCC*	**15%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)*

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$25,836,174	3%	$5,483,427	$18,585,514	99.25
Santa Barbara	441,257	$29,967,500	59%	$(248,600)	$12,521,400	30
Monterey**	430,723	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Santa Cruz	261,547	$44,486,031	8%	$5,337,509	$35,400,892	30
Sonoma***	481,812	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Ventura	829,590	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*

**The benchmark data included in this table excludes administrative costs, with the exception of San Luis Obispo, as the counties listed administrative costs separately.*

***Monterey County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the Drug and Alcohol Program is not available.*

****Sonoma County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the Drug and Alcohol Program is not available.*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Drug and Alcohol Services Division - SWOT Analysis

Strengths	Weaknesses
• **Broad Integration and Collaboration:** Integration with residential service providers within and outside of the County (e.g., Sun street Center, Bryan's House) and collaboration with other supportive housing environments (Gryphon Society, Restorative Partners, Discipleship, Next Step). • **Strong Partnerships with Key Stakeholders:** Effective partnerships with probation, social services, Child Welfare Services (CWS), and local sober living environments that support streamlined client support and oversight. • **Diverse Treatment Programs:** Offers diverse treatment programs such as Moral Reconation Therapy (MRT), trauma-based programs like Seeking Safety, and specialized groups for women and men, including well-defined perinatal programs with positive outcomes. • **Outcome Tracking by Quality Services:** The Quality Services division tracks treatment outcomes including completion, graduation, retention, and recidivism rates.	• **Documentation Process Hindering Productivity:** Staff struggles with productivity due to the documentation process, which hinders meeting the 43.5% productivity requirement—staff cite issues with detailed documentation despite having adequate clientele. • **Inadequate Data Management Systems:** The system lacks an efficient daily data management solution, impacting tracking and reporting capabilities. • **Reliance on Unstable Funding for Substance Use Programs:** Unlike the mental health program, the substance use disorder program heavily relies on grants to sustain operational aspects like jail integration services, which can be unpredictable and unsustainable long-term. • **Lack of Onsite Detox Services:** The absence of onsite detox services requires collaboration with external entities like sobering centers, which may be at capacity.
Opportunities	**Threats**
• **Advanced Data Tracking System Implementation:** Implementation of an advanced data tracking system to enable real-time data reporting, streamline documentation processes, and enhance overall operational efficiency. • **Enhanced Outreach and Integration:** Enhancing outreach and integration with the transitional age youth population currently managed by the prevention and outreach division. • **Expanded Bilingual Services:** To better serve non-English speaking communities. • **Continuous Staff Training:** Facilitating continuous training for staff on productivity, case management, and documentation practices to improve efficiency and service delivery. • **Engage and Education Community Partners and Key Stakeholders on services offered:** There is a gap in what the Drug and Alcohol program offers and what is known about the services offered across key community partners.	• **Financial Instability Due to Dependency on Grants:** Limited financial resources and a dependency on grants create a risk of program instability if funds are discontinued or reduced. • **Resource Strain from High Client Volumes:** High client volumes sometimes necessitate out-of-county placements, which could strain resources and affect continuity of care. • **Staff Challenges Due to Documentation and Productivity Demands:** The demanding nature of the documentation process and productivity requirements could lead to staff burnout, turnover, and recruitment challenges. • **Compliance with Evolving State Regulations:** Continuously meeting evolving state regulations for licensure and accreditation (e.g., C-Cap certification) to maintain contracts and funding. • **System Impact:** Proposition 36 is expected to significantly affect the Courts and Drug and Alcohol Services.

Drug and Alcohol Services - Key Opportunities

Opportunity 2.2	Optimize current staffing by implementing direct client engagement targets across all positions, evaluate hours of operations, model of care and engage key stakeholders through educating them on the services offered by Drug and Alcohol Services.

Current State

With an average staff count of 48.25*, utilization varies greatly across all positions. Utilization ranges and averages by position are outlined in the table below with improvement seen year over year in 6 of the 11 position categories, with a decline in utilization seen in 3 of the 11 position categories. Currently, 1 of the 10 position categories meet the County's breakeven target of 43.5%, while the other 9 position categories are well below industry average and DHCS targets.

Position	BH Clinician I	BH Clinician II	BH Clinician III	Specialist I	Specialist II	Specialist III
2023-24 Range	30% – 40%	0.17% – 38%	0.22% – 46%	1% – 33%	0.37% – 35%	8% – 38%
Average Utilization	35%	12%	22%	15%	18%	21%
2024-YTD Range	31%	0.36% – 45%	38% – 54%	1% – 26%	0.21% – 44%	8% – 48%
Average Utilization	31%	15%	44%	15%	19%	33%

Position	BH LPTI	BH LPT II	BH LPT III	BH LPT/RN Manager	MH Nurse II & III	Nurse Practitioner	Psychiatrist
2023-24 Range	N/A**	N/A**	3% – 8%	3% – 26%	19% – 26%	4% – 16%	4%
Average Utilization	N/A**	N/A**	6%	11%	23%	3% – 22%	4%
2024 YTD Range	N/A**	N/A**	5%	5% – 26%	24% – 26%	N/A*	1%
Average Utilization	N/A**	N/A**	5%	19%	25%	N/A*	1%

*This FTE number is based on a Position Allocation List exported as of April 11, 2025.
**Data was not available for the specific position, program, or year.

Drug and Alcohol Services - Key Opportunities

Opportunity 2.2	Optimize current staffing by implementing direct client engagement targets across all positions, evaluate hours of operations, model of care and engage key stakeholders through educating them on the services offered by Drug and Alcohol Services.

Current State

- **Utilization – 2023-24 and 2025 YTD:** As employees go across clinics and services, it is difficult to determine overall clinic utilization, therefore it was agreed that management will examine employee utilization and work with each employee on a weekly basis to optimize resources. The previous slide outlines the range per position with an average across the period of evaluation. The dashboard provides utilization by employee, positions, clinics and divisions. Across the majority of staff, utilization is below targets. There is a high ratio seen in direct client care to documentation with one employee almost reaching 1.1.
- **Wait Time to Access Care:** Currently there is no wait list for clients to access care across any of the programs.

Drug and Alcohol Services	
Outpatient	No clients on waitlist
Intensive Outpatient	No clients on waitlist
Medication for Addiction Treatment	No clients on waitlist
Residential Treatment	No clients on waitlist

- **Stakeholder Feedback:** Based on stakeholder engagement among Law Enforcement, and Fire Services, it was noted that access, working with and navigation of the drug and alcohol services is challenging.
- **Access to Care:** With regards to access, there are mix messages with regards to evening appointments offered. In addition, working with a highly acute homeless population, while 14 days to access care is within the State standard, this population requires a more rapid access to engagement, assessment and treatment. Client follow-through is noted to be poor due to the current structure of how services are offered, 14 days to assessment and office-based care.
  - When engaging with the Division Manager and supervisors, it was noted that all clinics have walk-in services and evening appointments. There appears to be a gap in knowledge of services offered by the program.
- **Collaboration with Key Stakeholders:** When asked for specifics, Law Enforcement indicated that information shared with services is not taken into consideration when the client undergoes assessment and treatment planning. For example, an individual who has been arrested 10 times for drug related charges helps minimize their circumstances during the assessment and can be deemed not requiring the level of care offered. Collaboration with those that interact with consumers in their communities should be part of the assessment and care planning in order to support clients in the meaningful way.
  - When engaging with the Division Manager and supervisors, it was noted that they check the Criminal Justice Information Services (CJIS) system to review client arrests/charges during assessment and collaborate with Probation/Law Enforcement on clients with justice involvement. There appears to be a miscommunication between the Department and stakeholders.
- **Alternative Destination/Bypass Protocol:** The other opportunity to streamline access to the right care, is allowing Fire and Law Enforcement to bring clients to Detox or Sobering Centers vs. Emergency Departments. Other Counties have a bi-pass protocol to permit process. This will decrease clients attending the Emergency Department for medical clearance when there is no indication that one is required. There is an opportunity to develop protocol that aligns with other Counties as a pilot.

Drug and Alcohol Services - Key Opportunities

Opportunity 2.2	Optimize current staffing by implementing direct client engagement targets across all positions, evaluate hours of operations, model of care and engage key stakeholders through educating them on the services offered by Drug and Alcohol Services.

Key Opportunities for Consideration

- **Enhance Marketing Strategy:** Boost marketing efforts to increased awareness of walk-in services and evening appointments.
- **Stakeholder Collaboration:** Enhance collaboration with Law Enforcement/Fire by incorporating their insights into client care planning and develop bypass protocol.
- **Alternative Destination and Bypass Protocol Consideration**

Key Action Steps

- **Conduct Formal Engagement with Key Stakeholders:** Engage and educate key stakeholders in the services offered by the County, which includes front line responders, schools, colleges, faith and cultural based organizations and community centers.
- **Redesign Model of Care:** Consider redesigning services to meet consumers within the community vs. office-based services for the hard-to-reach population.
- Determine the feasibility of **Bypass Protocol**
- **Enhance Scheduling Practices:**
  - Staff to be directed to schedule 80% of their day in direct client contact.
  - Appointments should either decrease in time or be staggered to accommodate the high no show/cancellation rates.
  - Decrease medication follow-up appointments from 30 to 20 minutes while introducing a multidisciplinary team approach.
  - For clients with a high no-show and cancellation rates, considering should be given to a ‘drop in’ clinic in addition to a wrap around model of care to support clients in the recovery journey.
- **Implement Verification Process and Improvement of Staff Optimization**
  - Weekly analysis on utilization by Division Managers and Medical Director should incorporate 1.1 meeting with each staff member with strategies on how to improve rapid access to care.
  - If significant progress is not achieved in a 3-month period, the matter should be further escalated as the issue may be the individual versus the process.
- **Right Size the Services:** Consider remaining on a hiring freeze until overall productivity improves across the service and by position. Exceptions to this should be standardized and approved by County Administration. Through attrition, this process will right size the clinics by position.

Benefit

- **Financial Viability**: Optimizes current staffing while reducing overall cost in order to be financially viable.
- **Responsive Services**: Right sizing the service based on community need and volume demand.
- **Strengthen Client Engagement**: Meeting clients in the community vs. office-based services for those with high no show rates.
- **Strengthen Accountability:** Establishing clear accountability through a transparent process.

This opportunity will further support Drug and Alcohol Services to achieve greater Non-NCC through collaboration and communication. However, it does not have specific Non-NCC figures associated with it.

Prevention and Outreach (MHSA) Overview

Division Overview

- Prevention and Outreach employs universal, targeted, and specific prevention and early intervention methods to deliver culturally and linguistically appropriate mental health and substance abuse especially within youth and special populations in alignment with the Mental Health Services Act (MHSA).
- They offer 17+ services including college prevention and wellness, mental health first aid, middle school comprehensive student assistance, opioid safety, naloxone access and education, student support counseling, veterans outreach, and first episode psychosis early intervention.
- With the use of MHSA, the program aims to address a continuum of prevention, early intervention, and service needs, while also providing funding for the infrastructure, technology, and training necessary to sustain the community mental health system.

63.75
Total FTE

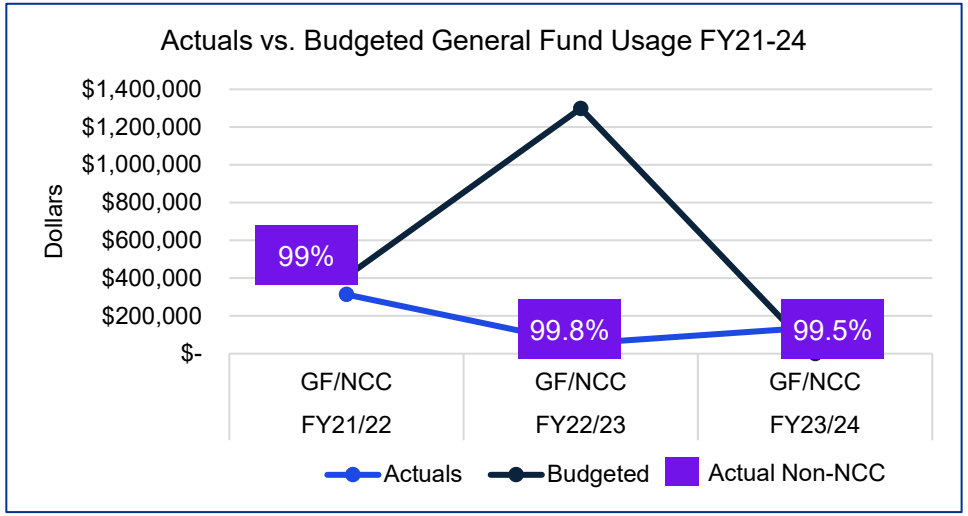
$34.51M
Total Budget FY24-25

101%
Budgeted FY24-25 Non-NCC

-1%
Budgeted FY24-25 General Fund

99.5%
Actual FY23-24 Non-NCC

.05%
Actual FY23-24 General Fund



Benchmark Counties Budget and FTEs (FY24-25)*

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$35,512,297	0%	$(347,187)	*N/A*	63.75
Santa Barbara**	441,257	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Monterey***	430,723	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Santa Cruz****	261,547	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Sonoma*****	481,812	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Ventura	829,590	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*

**The benchmark data included in this table excludes administrative costs, with the exception of San Luis Obispo, as the counties list out administrative costs separately.*
***In Santa Barbara County, Prevention and Outreach forms part of the Mental Health Outpatient & Community Services programs and Alcohol and Drug Program Budget; however, a separate breakdown for this service in not available.*
****Monterey County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the MHSA Program is not available.*
*****In Santa Cruz County, Prevention and Outreach forms part of the Adult Mental Health Division and program level budget data is unavailable.*
******Sonoma County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the MSHA Program is not available.*
*******Ventura County provides a breakdown of its Substance Use Prevention Program; however, a breakdown of the County Mental Health Prevention Program is unavailable and therefore, has been excluded.*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Prevention and Outreach (MHSA) - SWOT Analysis

Strengths

- **Training and Outreach:** The training and outreach team are trusted sources for media and public education.
- **Effective Multilingual Outreach:** Effective outreach to the Spanish-speaking and Mixteco populations.
- **Proactive Naloxone Training and Public Awareness:** Proactive in naloxone training and public awareness through school-based training, online resources, and onsite naloxone boxes.
- **Strong Community Relationships:** Strong relationships with local community-based organizations, consumers, and family members.
- **Strategic Role Alignment for Funding:** Strategic role alignment with long-term funding prospects.
- **Cost Reduction through Attrition:** Reducing costs through attrition instead of drastic measures.
- **Program Expansion - Support for Students:** Initially focused on drug and alcohol issues, the program now also addresses mental health and emotional wellness.
- **School Implementation:** The program is implemented in all secondary schools within the district, including two middle schools and three high schools (one of which is a continuation high school).

Weaknesses

- **Significant Funding Gap:** Significant funding gap that has not been fully closed, impacting program continuity and resources.
- **Lack of State Guidance:** Lack of state guidance leading to financial instability and inefficient spending.
- **Poor Program Integration:** Lack of integration between different programs and services, such as the integration with quality support services and other treatment programs (e.g., drug and alcohol services).
- **Service Gaps - Support for Students:** Potential service gaps during school breaks, with the reliance on county-based services that require Medi-Cal eligibility and parental involvement, which may be difficult for some students.
- **Data and Metrics:** Accountability-based data to demonstrate program value for student base services.

Opportunities

- **Program Integration for Efficiency:** Align and merge integrated programs, e.g.,
  - Veterans' treatment court with justice services,
  - School based services with youth services,
  - Public Education with Public Health,
  - MHSA reporting with the Quality Division.
- By aligning programs, better synergy and efficiency can be achieved.
- **Enhancing Revenue Maximization:** Streamlining revenue maximization strategies and improving Medi-Cal revenue collection.

Threats

- **Risk of Drastic Measures for Deficit Closure:** Potential for more drastic measures to close the deficit if attrition and internal adjustments are insufficient.
- **Impact of BHSA Changes:** BHSA changes impacting established community planning processes and program development.
- **CYBHI Changes:** CYBHI will impact current service offering school-based services.
- **Budget and Funding - Preventative Drug, Alcohol, Mental Health, and Social-Emotional Wellness Support for Students:** Facing budget contractions and operational deficits. Contracts are currently under review for future affordability.

Prevention and Outreach (MHSA) - Key Opportunities

Opportunity 2.3	Realign Services from Prevention and Outreach to programs more aligned with service offering to develop synergies across similar services and achieve economies of scale among staff and management.

Current State

- **Utilization of Adult Services:**
  - **2025 YTD:** Utilization across employees coded to this service ranges from 19% to 40%. **2024.** Utilization across employees coded to this service ranges from 10% to 45%.
- **Utilization of Youth Services:**
  - **2025 YTD:** Utilization is not captured based on the way the program operates.
  - Services are funded via MHSA Funds. It is anticipated that school-based services, will be sunset in 2026. In addition, the changes anticipated based on CYBHI would further impact this initiative. Based on the change anticipated in both funding and CYBHI, the span of control will require consideration. The Program Manager is also responsible for Veterans Treatment Services, which would be better aligned with Justice Services.
- **Waitlist to Access Care:** There are currently 19 clients awaiting services for Youth Substance Abuse Treatment. Based on 2025 utilization for youth services, the highest utilization among BH Clinicians and Specialists is 34%, indicating staff's availability to clear the waitlist. If the majority of the under-utilized staff are school based providers, consideration should be given to transitioning staff from youth clinics or Drug and Alcohol Services to address the wait list.

Prevention & Outreach (MHSA)	
Veterans Treatment Services	No clients on waitlist
Student Support Counselling	No clients on waitlist
Middle School Comprehensive Program	No clients on waitlist
Youth Substance Abuse Treatment	19 clients on waitlist for services

- In discussing this opportunity with both Division Managers, Youth Services will need to upskill their current staff to treat youth seeking substance abuse treatment and Drug and Alcohol services as they have indicated that based on the recent number of resignations, they would not be able to assist.
- **Realigning services with other established services across the Health Agency:** This program offers a mix of services that may be better aligned and has stronger synergies with other programs across the Health Agency, such as Youth Services, Justice Services, Health Promotion and the Quality Team.

Key Opportunities for Consideration

- **Youth Services Optimization:** Transition Youth Substance Abuse Treatment to Youth Services.
- **Veterans Justice Services:** Transition Veterans Justice Services to the Justice Services portfolio.
- **MHSA and Quality Reporting:** Transition MHSA and Quality Reporting under the Quality Division.
- **Behavioral Health Promotion:** Transfer Behavioral Health Promotion to the Public Health Promotion team.

Prevention and Outreach (MHSA) - Key Opportunities

Opportunity 2.3	Realign Services from Prevention and Outreach to programs more aligned with service offering to develop synergies across similar services and achieve economies of scale among staff and management.

Key Action Steps	Benefit	

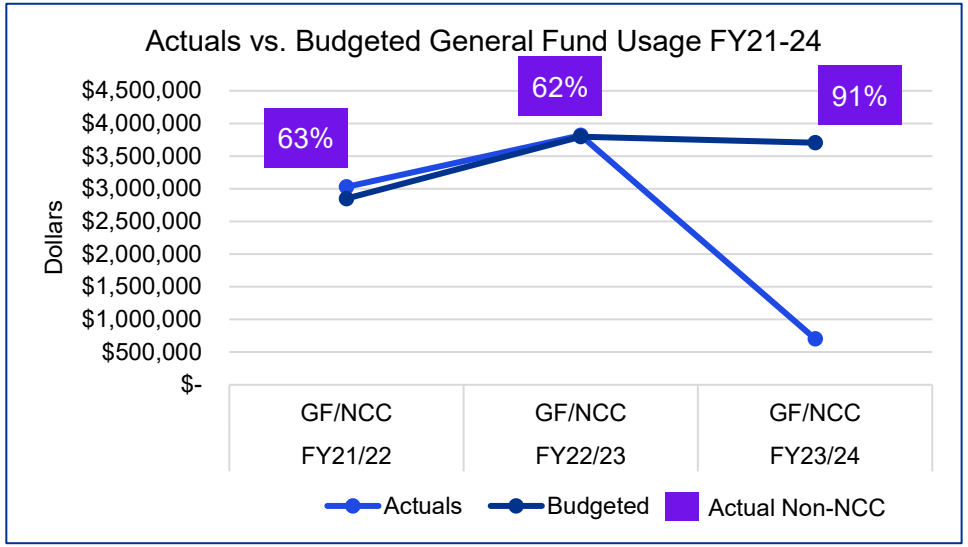
• **Youth Services:** Sunset School Based Services as planned for 2026. Determine transition plan for the employees under service, as transitioning to youth services is not viable due to the high underutilization across all clinics.
  ○ As school-based services will be sunsetting and there will be an impact to overall youth mental health services in California, no recommendations are noted.
  ○ Transition Youth Substance Abuse Treatment to Youth Services to improve access to care, optimize clinic staff and span of control while consolidating all youth services under the same portfolio.
  ○ In discussing this opportunity with both Division Managers, Youth Services will need to upskill their current staff to treat youth seeking substance abuse treatment and Drug and Alcohol services as they have indicated that based on the recent number of resignations, they would not be able to assist.
• **Veterans Justice Service:** Transition Veterans Justice Services to Justice Services portfolio to allow all Justice Services to be under the same service, optimize Justice Staff and management span of control.
• **MHSA and Quality Reporting**: Transfer MHSA and Quality Reporting under the Quality Division.
• **Behavioral Health Promotion:** Transfer Behavioral Health Promotion to the Public Health Promotion team.
	• **Enhance Staffing and Alignment:** It may optimize current county staffing while creating synergize by having all Justice services and youth services under the same programs.
	• **Simplify Oversight:** Decreasing the number of contracts requiring oversight.
	• **Community Alignment:** It aligns models to community need and volume demand.
	• **Support Accountability**: Establishing monthly reporting to help ensure model fidelity and contractual obligations are being met.
		TBD
		Potential Annual Cost Efficiencies will materialize in the Span of Control upon transitioning of services

Access and Crisis (including PHF) Division Overview

Division Overview

- The Access and Crisis Services Division works with local hospitals and crisis centers to deliver transitional and intensive care through outpatient clinics, managing crisis care programs and facilities operating 24/7 throughout the year to deliver constant support.
- The division contracts out 6+ services including sobering centers, behavioral health community action team, crisis stabilization services, mobile crisis services, dispatch services, psychiatric health facilities (inpatient), and suicide prevention.
- The Division's efforts aim to streamline the coordination of crisis services and enhance the overall efficiency and effectiveness of behavioral health crisis care. This is reflected through their centralized contract management and oversight.

21.00 *Total FTE*	**$8.64M** *Total Budget FY24-25*
79% *Budgeted FY24-25 Non-NCC*	**21%** *Budgeted FY24-25 General Fund*
91% *Actual FY23-24 Non-NCC*	**9%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)*

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$8,637,677	2%	$1,855,737	$8,312,483	21
Santa Barbara	441,257	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Monterey**	430,723	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Santa Cruz	261,547	*$8,137,014*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	38
Sonoma***	481,812	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Ventura****	829,590	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*

**The benchmark data included in this table excludes administrative costs, with the exception of San Luis Obispo, as the counties listed them separately.*
***In Santa Barbara County, Access and Crisis forms part of the Mental Health Outpatient & Community Services programs and Alcohol and Drug Program Budget; however, a separate breakdown for this service in not available.*
***Monterey County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the Access and Crisis Program is not available.*
****Sonoma County does not separate its behavioral health budget into specific component programs, and therefore, detailed financial information on the Access and Crisis Program is not available.*
*****Ventura County does not provide a specific behavioral health component for this program, and therefore, detailed financial information on the Access and Crisis Program is not available.*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Access and Crisis Services Division - SWOT Analysis

Strengths	Weaknesses
• **Streamlined Service Management:** The creation of the Access and Crisis Services Division Resonation has streamlined the management of multiple previously scattered services, leading to improved coordination and oversight. • **Innovative Community Action Team Services:** The Community Action Team (CAT) has creatively brought services to the field, such as telehealth and field medication administration, effectively diverting individuals from arrests. • **Enhanced Conservatorship Case Handling:** Improved processes and coordination have led to better handling of conservatorship cases, helping ensure people receive appropriate care. • **Effective Mobile Crisis Team:** The addition of a community-based mobile crisis team has led to a significant percentage of cases being resolved without hospital transport or admissions.	• **Service Gaps in Specialty Treatments:** There are significant gaps in services, including eating disorder treatment, ECT, inpatient youth psychiatric hospital, crisis residential for adults or youth, and step-down options. • **Limited Bed Capacity:** Limited bed capacity, with frequent denials due to beds being at full capacity, creating a bottleneck in service provision. • **Challenges in Newly Formed Division:** The new Access and Crisis Services Division Resonation inherited multiple contracts that had not been given sufficient attention previously, leading to a steep learning curve. • **Inadequate Facilities for Youth:** Lacking appropriate facilities for youth, leading to frequent out-of-county transfers. • **Difficulties in Tracking Outcomes and Placements:** Challenges in systematically tracking outcomes and placements, with dependency on external partners.
Opportunities	**Threats**
• **New Funding Opportunities through Proposition One:** The potential for new funding streams through Proposition One, which could support expanded housing and FSP programs. • **Expansion of Crisis Services with Law Enforcement:** Expansion of crisis services in partnership with law enforcement agencies provides opportunities for integrated care and community-based response (Access and Crisis Services Division team currently in talks to expand to 3.5 more agencies, placing them in every law enforcement agency). • **Enhancing CAT Team and Crisis Services:** Ongoing efforts to expand the CAT team and other crisis services can improve capacity and reduce pressure on emergency departments. • **Utilizing New Initiatives for Better Service Management:** Leveraging new initiatives like CalAIM and Crisis Benefits to improve service bundling and billing efficiency. • **Urgent Care Behavioral Health Center:** Establishing an urgent care behavioral health center to offer immediate crisis response and potentially reduce law enforcement involvement.	• **Challenges with Bed Capacity and Out-of-County Services:** Persistent bed capacity issues and reliance on out-of-county services can disrupt continuity of care and strain relationships with partners. • **Regulatory Changes Impacting Program Structures:** New state and federal regulations (e.g., changes under Proposition One) may challenge existing program structures and funding allocations. • **Increase in Severe Substance Abuse Cases:** Rising cases of severe substance abuse (e.g., Meth and Fentanyl) complicate service provision and increase the demand for high-acuity care. • **Impact of Law Enforcement Disengagement Policies:** New engagement with law enforcement agencies could hinder the effectiveness of the mobile crisis response. • **Funding Challenges and Sustainability – Homeless Outreach FSP Teams:** The homeless outreach FSP team faces funding challenges due to CalAIM mechanisms.

Mobile Crisis and Dispatch Services Contract - Key Opportunities

Opportunity 2.4	Redesign Mobile Crisis and Dispatch Services to align with community need, volume demand while being financially sustainable.

Current State

- **Utilization of Mobile Crisis and Dispatch Team:** Based on the recent CalAIM changes to Mobile Crisis Services, the team is now funded through Medi-Cal Crisis Benefits while the Dispatch team is funded through MHSA. SLO County contracts both services through Sierra Mental Wellness Group. Utilization across both teams are as follows:
  - **Mobile Crisis Team**: Direct client contract ranges from 8% to 16% per week.
  - **Average Number of clients per day/week:** Consistently below 2 clients per day.
  - **Dispatch Team**: Higher rates of direct client interaction as utilization ranges from 23% to 57%.
- **Volumes of Mobile Crisis and Dispatch Team:** Both teams have low volumes, which has resulted in the Mobile Crisis Team's revenue being subsidized by MHSA funds. The low volumes seen align with adjacent County's primarily due to the size of the population and the implementation of Co-Response teams with local law enforcement agencies. As Co-Response teams increase across SLO County, this will most likely further impact Mobile Crisis Team volumes.
  - To achieve efficiency and to optimize funding sources, there is an opportunity to merge both teams, responding accordingly to calls with priority given to community calls.
  - Consider merging roles and responsibilities among the following two programs. MHET/MCRT/Youth MC:17.85 FTE and Dispatch 4.85 FTE= Total: 22.70 FTE.
- **Stakeholder Feedback – Rapid Access to Outpatient Services:**
  - Two key concerns noted by both Mobile Crisis and the Dispatch/Evaluation team, which are (1) lack of rapid access to outpatient services for clients who require urgent follow up care, i.e., within 7 days and (2) that the process for referrals need a seamless transition for clients who the team has divert from a 5150/5585; however, the current process require clients to call the Access Line on their own to seek services. Mobile Crisis staff cannot expediate the referral process.
  - Stakeholders have identified that due to lack of outpatient services, clients are cycling through crisis services. Based on the quantitative analysis of outpatient services, there is substantial availability across all County services; therefore rapid follow-up care for referrals from Mobile Crisis Services could be accommodated. To align referral processes with leading practice, a warm hand off between the Mobile Crisis team and Outpatient Services should be considered as part of the standard workflow. This will address both issues noted during stakeholder engagement while providing clients with the care they need in a timely manner.

Mobile Crisis and Dispatch Services Contract - Key Opportunities

Opportunity 2.4	Redesign Mobile Crisis and Dispatch Services to align with community need, volume demand while being financially sustainable.

Key Opportunities for Consideration

- **Consider merging roles and responsibilities among the following two programs:**
  - While the volumes only support one dedicated team across the entire County, based on the geography/size of the County and the response time requirement under Medi-Cal Crisis Benefits, a more realistic model may be two teams to cover the County, stationing each team in a central location to accommodate travel time requirements.
  - Based on the low volumes, Community Calls can be directed through the Access Line for screening and dispatch during regular hours. After hours can be accommodated through the line being directed to a dedicated member of the Mobile Crisis Team to adhere to the Mobile Crisis Benefits requirement and dispatched to the most suitable Mobile Crisis team based on location and availability.
  - Calls coming from the community will be prioritized above services sought by hospitals, jails etc. in order to meet the Medi-Cal Crisis Benefits response requirement, i.e., 60 minutes in urban settings and 120 minutes in rural settings. Call takers should provide an ETA of Mobile Teams response time to continue to facilitate collaboration among key stakeholders.

Staffing Consideration Current vs. Future State:

- **Dispatch Team:**

Dispatch Team			
Current Positions	**Current FTE**	**Proposed Reduction**	**New FTE Totals**
Behavioral Health Clinicians	1.0	1.0	0
Peer/Family Support Specialists	0.50	0	0.50
Clinical Supervisor	0.08	0.08	0
Dispatchers	3.0	3.0	0
Total	**4.58 FTE**	**- 4.08 FTE**	**0.5 FTE**

Mobile Crisis and Dispatch Services Contract Key Opportunities

Opportunity 2.4	Redesign Mobile Crisis and Dispatch Services to align with community need, volume demand while being financially sustainable.

Key Opportunities for Consideration (Continued)

Staffing Consideration Current vs. Future State (Continued):

MHET/MCRT/Youth MC:

MHET/MCRT/Youth MC			
Current Positions	**FTE**	**Proposed Reduction**	**New FTE Totals**
Crisis Responders	4.0	0	4.0
After Hours Crisis Responders	4.0	0	4.0
On-Call Supervisor	1.0	1.0	0 Have one of the afterhours workers take the Supervisor role.
Administrative Staff	2.0	2.0	0
MHET Supervisor	1.0	0	1.0
Crisis Services Manager	0.60	0.30	0.30
Dignity MHET Staff	0.75	0.75	0
LPHA (1 on call)	2.00	2.00	0
Youth Crisis Clinician (CHFFA Grant)	1.00	0 (until Grant expires)	1.0 (until Grant expires) To replace Crisis Responder Workers until such time.
Crisis Triage Specialists (CHFFA Grant)	1.50	0 (until Grant expires)	1.50 (until Grant expires) To replace Crisis Responder Workers until such time.
Total	**22.70 FTE**	**-10.40 FTE**	**12.30 FTE**

Mobile Crisis and Dispatch Services Contract - Key Opportunities

Opportunity 2.4	Redesign Mobile Crisis and Dispatch Services to align with community need, volume demand, while being financially sustainable.	
Key Action Steps	**Benefit**	
• **Communication:** Prior to the changes taking place, Health Agency leads should provide written communication to key stakeholders, so they are aware of the impact to services. • **Renegotiate Contract:** Based on the funding implications, renegotiate the contract with the provider to align staffing with community need and volume demands. • **SmartCare documentation:** Staff should document, and supervisors should verify where services have been rendered to accurately reflect and facilitate billing and revenue streams. • **Quarterly Program Evaluation:** This program should be closely reviewed to evaluate impact on Mental Health Services Act (MHSA) and eventually Behavioral Health Services Act (BHSA) funding as it is unlikely that the team will receive enough volumes to financially breakeven.	• Aligns with Medi-Cal Crisis Benefit requirements. • Optimizes staffing while reducing overall cost in order to be financially viable. • Decreasing the number of contracts requiring oversight. • Model aligns with community need and volume demand. • Establishing monthly reporting to help ensure model fidelity and contractual obligations are being met.	**$1.48M*** ***Potential Annual Cost Efficiencies***

*This figure for potential annual Cost Efficiencies is an estimate based on a proportion aligning the actual total cost for the Dispatch and Mobile Crisis contract in FY23-24 to the proposed changes in number of FTEs for the service.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Current State

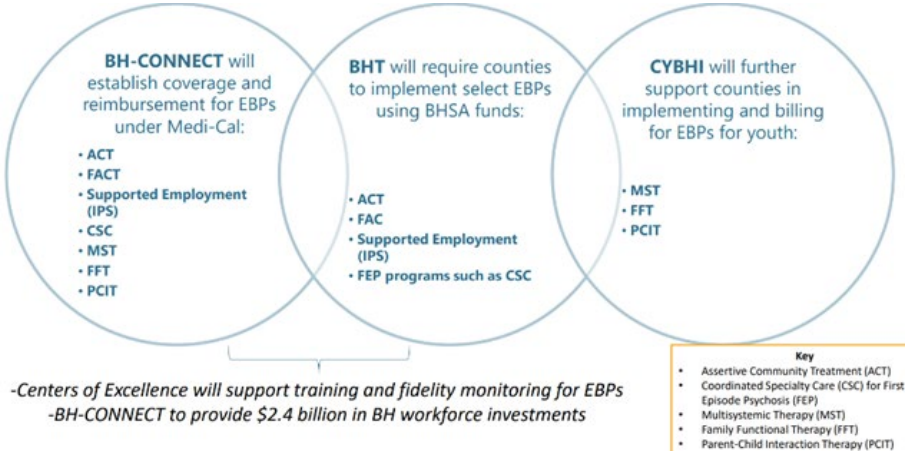
Full-Service Partnership (FSP) programs are intended to be recovery-oriented comprehensive services, targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe, chronic mental illness often with a history of criminal justice involvement, and repeat hospitalizations. FSP programs were designed to serve and maintain people in the community rather than to rely on state hospitals or other locked institutions to do so. Advocates and mental health professionals who implemented the first iterations of FSP programs were able to demonstrate that by engaging mental health consumers in their care and providing holistic services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. *(Retrieved from: Towards A New Contracting Model for Full Service Partnerships).*

Behavioral Health Transformation (BHT) and impact to FSP Model of Care

Proposition 1 maintains FSP as essential to the behavioral health continuum of care and expands eligibility for services to those individuals living with substance use disorder diagnoses. The goal is to build upon success of proven FSP interventions, standardize and scale evidence-based service models, improve financial, performance, and outcomes data collection, and maximize resources for behavioral health care and services, through dedicated housing interventions and insurance reimbursement.

Transition to Standardizing evidence-based practices (EBPs)

- Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Individual Placement and Support (IPS) model of Supported Employment & High-Fidelity Wraparound.
- New established FSP standards of care with levels based on an individual's acuity and criteria for step-down into the least intensive level of care in consultation with OAC, counties, providers, and other stakeholders. Outpatient behavioral health services, either clinic or field based, necessary for on-going evaluation and stabilization of an enrolled individual.



Full Service Partnership Contracts- Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Current State

- **Adult FSP Program Analysis:** FSP services is currently contracted out by SLO County to three organizations. Adult FSP and Homeless Outreach FSP is contracted to Transitions-Mental Health Association (TMHA), Older Adults FSP is contracted to Wilshire Health and Community Services and Youth and Transitional Age Youth is contracted through Family Care Network (FCNI).
  - **Contract requirement:** Program is funded for 13.04 FTEs. Annually Unique Clients = 40.

Adult FSP Program			
Positions	**FTE**	**Positions**	**FTE**
Clinical Therapist	3.0	Medical Scribe	0.5
Case Managers	3.0	Clinical Director	0.58
Clinical Team Leader	1.0	Assistant Program Manager	0.5
Case Manager with Lived Experience	1.0	Clinical Supervisor	0.03
Lead Clinician	1.0	Deputy Director	0.03
Medication Manager	1.0	Medical Assistant	0.8
Psychiatrist	0.2	Quality Assurance Manager	0.2
Nurse Practitioner	0.2		

Adult FSP Program	
Total Number of Staff for Case Load	7 FTE
Case Load Expectations	1.10
Potential Number of Unique Clients	70

  - **2023-24 Costs** associated with the program is reported by the department as follows:

CSS 2.1. Adult FSP Program			
Fiscal Year Estimate	**Persons Served**	**Total Funding**	**Cost per Client**
Actuals for FY 2022 - 2023	43	$1,985,838	$46,182
Actuals for FY 2023 - 2024	**40**	**$1,816,331**	**$45,408**
Projections for FY 2024 - 2025	45	$2,310,246	$51,339

Full Service Partnership Contracts- Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Current State

- **Adult FSP Program (continued)**
  - **2025 Utilization:**
    - Number of unique clients seen per week ranged from 25 to 36 clients.
    - Number of visits per client per week ranged from 2 to 3 visits.
    - Percentage of direct client contract per employee ranged from 11% to 22%.
- **Wait time to Access Care**
  - There is currently no wait list to access any of the FSP services across the County, which is not commonly seen for this type of service.
  - When engaging with the PHF in an effort to understand why there is a high 30-day readmission rate, 13%, management indicated that many of these clients require FSP care, which they indicate in the discharge note to the prescriber and treating team in Adult Outpatient Services, however, due to the fact that they are (1) unable to refer directly to the team and have to rely on the Adult outpatient services to refer and (2) the lengthy waitlist for FSP services, clients are not receiving the level of care they require upon being discharged, which is resulting in a high readmission rate.
  - Adult Outpatient Services Manager has also indicated that there are clients being cared for at the clinic level that would benefit from being cared for by FSP, however, they are informed that FSP is at capacity.
  - As there is currently *no wait to access* FSP services, and the teams utilization is well below expectations, there is an opportunity to streamline referrals directly from the PHF to FSP. Clear inclusionary and exclusionary criteria should be shared so referrals are in line with program requirements. While Adult Outpatient Services have advised that they are unable to attend the PHF to facilitate a warm hand-off and begin to engage with clients as they prepare for discharge, perhaps there is an opportunity for FSP services to conduct this practice with the goal of better engagement with the client prior to discharge. It will also facilitate discharge planning directly to the FSP/ACT team.
  - With regards to feedback shared by the Adult Outpatient Manager, clients should be placed on a waitlist so there is an understanding of demand vs. capacity. It also allows Leadership to work with the contractor to facilitate access to care.

Full Service Partnership Contracts- Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Current State

- **Older Adult FSP Program Analysis**
  - **Contract requirement:** Program is funded for 7.25 FTEs. Annually Unique Clients = 25.

Older Adult FSP Program			
Positions	**FTE**	**Positions**	**FTE**
Clinician	2.0	Program Administrator	1.0
Case Manager	2.0		
Case Aide	1.0		
Medication Manager	1.0		
Psychiatrist	0.25		

Older Adult FSP Program	
Total Number of Staff for Case Load	4 FTE
Case Load Expectations	1.10
Potential Number of Unique Clients	40

CSS 4. Older Adult Full Service Partnership (FSP)			
Fiscal Year Estimate	**Persons Served**	**Total Funding**	**Cost per Client**
Actuals for FY 2022 - 2023	23	$733,844	$31,906
Actuals for FY 2023 - 2024	**22**	**$767,710**	**$34,896**
Projections for FY 2024 - 2025	23	$799,585	$34,765

- **Older Adult 2025 Program Utilization:**
  - Number of unique clients seen per week ranged from 12-20 clients.
  - Number of visits per client per week ranged from 2 to 4 visits.
  - Percentage of direct client contract per employee ranged from 4% to 19%.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Key Opportunities for Consideration

- Based on the full-size total volumes across both Adult and Older Adult FSP, with no wait list for services, the County may consider merging both programs to become one. Current contract indicates a total number of 65 clients annually with 20.29 FTEs and a total budget of $2,479,479.00.
- Based on the transition of FSP to Assertive Community Treatment Teams, align performance against standards of care, i.e., staff to client ratios 1.10, frequency of weekly contact by multidisciplinary team, duration of client contact per week, implementation of vocational and substance use specialist as part of the treatment team etc.

Box 1. Sample Team Structure for ACT Teams
This specific team structure is not required of all ACT teams; for illustrative purposes only.

Full Size ACT Team	Small ACT Team
• 0.5 LPHA (ACT Team Lead) • 1 psychiatrist or psychiatric prescriber • 1 psychologist • 2 registered nurses • 1 peer support specialist • 2 employment specialists • 2 other qualified providers	• 0.5 LPHA (ACT Team Lead) • 0.5 psychiatrist or psychiatric prescriber • 1 psychologist • 1 registered nurse • 1 peer support specialist • 1 employment specialist • 1 other qualified provider
Total: 9.5 FTE	**Total: 6 FTE**
Caseload: 80-100 Members	**Caseload: < 60 Members**

- As the State has a transition plan for FSP in 2025, the County may wish to begin transitioning their contracts accordingly based on current and historical volumes. Adult and Older Adult FSP can carry a caseload of under 60 or 80-100 clients with a staff ratio of 1.10. Current volumes would suggest that a small team can be developed with 60 clients. An examination of current caseload should be conducted to determine if some clients can be stepped down to lower levels of care. The frequency and duration of visits may suggest that this is the first step required by the treating team and county oversight team. Secondly, a review of potential clients, specifically those that have a high readmission rate for inpatient psychiatric care should be reviewed by the Medical Director, PHF Psychiatrists, and FSP Psychiatrist to determine a true caseload.
- While the current volumes suggest a caseload of 60 clients and a total of 6 FTEs, the analysis on the following page outlines both a small ACT team and a full-size ACT team for consideration based on the aforementioned argument. The following staffing changes may be taken into consideration across both Adult (13.04 FTE) and Older Adult (7.25 FTE) FSP teams.

Full Service Partnership Contracts– Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Key Opportunities for Consideration

Full ACT Team Model

Full ACT Team Model			
Current Positions	**Current FTE**	**Proposed Reduction**	**New FTE Totals**
Clinical Therapist – A Clinician – OA	3.0 2.0	5.0	0
Case Manager – A Case Manager – OA	3.0 2.0	1.0	4.0 (2 employment specialists + 2 other qualified providers – usually with a specialty in Substance Abuse treatment)
Clinical Team Leader	1.0	0.5	0.5
Clinical Supervisor	0.03	0.03	0
Case Manager with Lived Experience - A	1.0	0	1.0
Case Aide - OA	1.0	1.0	0
Lead Clinician	1.0	1.0	0
Medication Manager - A & OA	1.0 1.0	0 0	2.0
Psychiatrist - A Psychiatrist - OA	0.2 0.25	0 0	0.45 (requires an increase to 1.0 between Psychiatry and/or NP)
Nurse Practitioner	0.2	0	0.2
Psychologist	0		+1.0 (requires recruitment)
Medical Assistant	0.8	0.8	0
Medical Scribe - A	0.5	0.5	0
Total	**17.98 FTE**	**-9.83 FTE**	**9.15+** **Recruitment: 1.0 Psychologist + 0.35 Psy or NP**

Full ACT Team Model The following positions should align with other vendors' contract practices for management/non-direct client staffing.	
Program Administrator	1.0
Assistant Program Manager	0.5
Clinical Director	0.58
Quality Assurance Manager	0.2
Deputy Director	0.03

Cost Reduction (for Full ACT Team Model)	$893,000*

*This figure for potential annual Cost Efficiencies is an estimate based on a proportion aligning the actual total cost for the FSP contract (reported in the FSP Outcomes document) in FY23-24 to the proposed changes in number of FTEs for the service.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Key Opportunities for Consideration

Small ACT Team Model

Small ACT Team Model			
Current Positions	**Current FTE**	**Proposed Reduction**	**New FTE Totals**
Clinical Therapist – A Clinician – OA	3.0 2.0	5.0	0
Case Manager – A Case Manager – OA	3.0 2.0	3.0	2.0
Clinical Team Leader	1.0	0.5	0.5
Clinical Supervisor	0.03	0.03	0
Case Manager with Lived Experience – A	1.0	0	1.0
Case Aide – OA	1.0	1.0	0
Lead Clinician	1.0	1.0	0
Medication Manager - A & OA	1.0 1.0	0 0	1.0
Psychiatrist - A Psychiatrist - OA	0.2 0.25	0 0	0.45
Nurse Practitioner	0.2	0.15	0.05
Psychologist	0	0	+1.0 (requires recruitment)
Medical Assistant	0.8	0.80	0
Medical Scribe - A	0.5	0.5	0
Total	**17.98 FTE**	**-11.83 FTE**	**6.0+ Recruitment: 1.0 Psychologist**

Small ACT Team Model The following positions should align with other vendors' contract practices for management/non-direct client staffing.	
Program Administrator	1.0
Assistant Program Manager	0.5
Clinical Director	0.58
Quality Assurance Manager	0.2
Deputy Director	0.03

Cost Reduction (for Small ACT Team Model)	$1.21M*

*This figure for potential annual Cost Efficiencies is an estimate based on a proportion aligning the actual total cost for the FSP contract (reported in the FSP Outcomes document) in FY23-24 to the proposed changes in number of FTEs for the service.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.5	Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Key Action Steps	Benefit	
• **Align Services:** Align Adult and Older Adult FSP Services to ACT over 2025. • **Review Caseloads:** Review current Adult and Older Adult FSP case loads and clients that may benefit from this model of care to determine actual caseload for the new established team, i.e., 60 clients vs. 80-100 clients. • **Renegotiate Contracts:** Renegotiate the contract with the 2 providers which will decrease to 1 provider under the new model. • **Establish Staffing:** Establish new contractual agreement and staffing, both personal and skill set, that aligns with ACT model of care. • **Require Metrics Reporting:** Contractual agreement requires alignment with ACT model of care metrics, which should be a reporting requirement by the vendor on a monthly basis. • **Monitor and Report Outcomes:** The Division Manager that oversees ACT Services, will be responsible for reporting on outcomes and variance during the monthly financial reporting. Where there is variance, both the Division Manager and the Vendor will be required to report on an action plan that is monitored. If improvement is not seen within 3 month of initial issue, the matter should be escalated to the Division Deputy and Director of Health Agency.	• **Evidence-Based Model:** Aligning model of care to BH-Connect requirements and evidence-based practice. • **Community Alignment:** Aligning model to community need and volume demand. • **Simplified Oversight:** Decreasing the number of contracts requiring oversight. • **Strengthen Transparency:** Establishing monthly reporting to help ensure model fidelity and contractual obligations are being met.	**$1.8M – 2.35M** *Potential Annual Cost Efficiencies**

*This potential annual Cost Efficiencies estimate is based on the actual costs indicated in the FSP Outcomes Report for the past three fiscal years.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.6	Transition Youth and TAY Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.

Current State

- **Youth and Transitional Age Youth FSP**
  - Program is funded for 13.50 FTEs. Contract requirement: 35 Clients Annually.

Youth and Transitional Age Youth FSP	
Positions	**FTE**
Social Workers	2.63
Rehab Specialists	2.0
Youth Specialist & Family Specialist	2.0
FSP Management	1.0
FSP Supervisor	0.9
Medication Manager	0.63
Direct Support	1.0
Total	**13.50 FTE**

CSS 2.1. Transitional Age Youth (TAY) Full Service Partnership			
Fiscal Year Estimate	**Persons Served**	**Total Funding**	**Cost per Client**
Actuals for FY 2022 - 2023	28	$561,415	$20,051
Actuals for FY 2023 - 2024	**32**	**$540,085**	**$16,878**
Projections for FY 2024 - 2025	25	$779,257	$31,170

**Four partners were served in both Youth and TAY.*

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  - **2025 Utilization:**
    - Number of unique clients seen per week ranged from 20 to 39 clients.
    - Number of visits per client per week ranged from 2 to 6 visits.
    - Percentage of direct client contract per employee ranged from 6% to 27% .
    - It is our understanding that the volume projections decreased in 2024-25 due to staffing challenges by the provider. As a result, there was unspent funding from 2023-24 which was carried over to 2024-25 hence the adjustment in cost per client.
- **Wait time to Access Care**
  - There is currently no wait list for any of the FSP Services. In comparison to other Counties, this is not common practice as there are often lengthy wait list for such services.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.6	Transition Youth and TAY Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.

Current State (Continued)

- BH Connect has not identified TAY FSP or TAY ACT models but rather has identified Coordinated Specialty Care (CSC) as an evidence-based community-based service for members experiencing a first episode of psychosis (FEP). CSC is tailored intervention for individuals who are experiencing initial signs of psychosis and are typically between the ages of 12 and 40. CSC is a collaborative, multidisciplinary team of behavioral health practitioners, who are expected to support the member in their treatment.
- This current contract will need to be reexamined as the expected caseload of 35 across 8 FTEs does not align with CSC requirements. “A fully staffed CSC team should include at least 4 FTE and serve a caseload of 35-40 members. Current caseload average is 23 with utilization averaging 20.65%. As a result of the analysis and BH-Connect requirement, the following key opportunity for consideration may be reviewed.

Key Opportunities for Consideration

- The County may wish to bring this service in house as the population aligns with the mandate of outpatient services. As the clinics have lost market share due to the changes in CalAIM screening, and the future impact based on CYBHI, there is capacity within the current staffing mix. Better synergy may be seen if all youth services are under the same portfolio, i.e., Youth FSP, Youth Services and Prevention and Outreach, who currently have 19 youth awaiting substance use treatment that could be served by upskilling staff and optimizing underutilized resources.
  - Pros: This will decrease the number of contract oversight. This will preserve some of the current County staffing.
  - Cons: Transitioning clients will require a thorough change management plan but can be done in a phased approach where one program is sun setting while all new referrals begin to be directed to the County.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.6	Transition Youth and TAY Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.

Key Opportunities for Consideration

- As described in BHIN 25-XXX, CSC teams are required to meet fidelity monitoring requirements specified by DHCS for the BHP to bill Medi-Cal for bundled CSC services. If fidelity is not met, this will further impact financial recovery for this service.
- If the County decided to continue to contract out the service, the following staffing reductions may be considered based on BH Connect requirements, current caseload and utilization. Another review will need to be undertaken when CYBHI is implemented.

Box 2. Sample Staffing Structure for CSC Teams
• 1 LPHA (CSC Team Lead) • 0.25 psychiatrist or psychiatric prescriber • 1 peer support specialist • 1 employment specialists • 1 other qualified provider
Total: 4.25 FTE
Caseload: 35-40 Members

CSC Teams			
Current Positions	**Current FTE**	**Proposed Reduction**	**New FTE Totals**
Social Workers	4.0	3.0	1.0
Rehab Specialists	4.0	3.0	1.0
Youth Specialist & Family Specialist	2.0	1.0	1.0
FSP Supervisor	2.0	1.0	1.0
Direct Support	0.25	0.25	0
Medication Manager	1.0	1.0	0
Total	**13.25 FTE**	**-9.25 FTE**	**4.0 (direct staff)** **0.25 FTE Psychiatrist is within Youth Services**

The following positions should align with other vendors' contract practices for management/non-direct client staffing.			
FSP Management	0.25	0	0.25

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.6	Transition Youth and TAY Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.

Key Action Steps	Benefit	

• **Decide on CSC Integration:** County to determine if they wish to fold in Coordinated Specialty Care (CSC) under the County's youth services.
  ◦ **If yes –** provide notice to vendor to dissolve contractual agreement with a phased in approach so to minimize impact on clients, i.e., sunset program will redirecting new referrals to youth services.
  ◦ **If no –** renegotiate contract base on proposed staffing and budget to align team with community need and volume demand.
• **Formulate New Agreements:** Establish new contractual agreement and staffing, both personal and skill set, that aligns with CSC model of care.
• **Define Reporting Metrics:** Contractual agreement requires metrics and outcomes that align with CSC requirements, which should be a reported by the vendor on a monthly basis.
• **Standardize Outcome Measures:** Standardize pre and post outcome measures should be established to determine effectiveness of the service.
• **Monitor and Report Outcomes:** The Division Manager that oversees this contract, will be responsible for reporting on outcomes and variance during the monthly financial reporting. Where there is variance, both the Division Manager and the Vendor will be required to report on an action plan that is monitored. If improvement is not seen within 3 month of initial issue, the matter should be escalated to the Division Deputy and Director of Health Agency.
	• **Optimized Staffing:** If CSC youth services are brought in house, it will optimize current county staffing while creating synergize by having all youth services under the same programs.
	• **Simplified Oversight:** Decreasing the number of contracts requiring oversight.
	• **No Change Management/Transition Planning Needed:** If youth services remain with current vendor, no change management or transition planning is required on behalf of the county.
	• **Model and Billing Alignment:** Both options align model to BH Connect requirements for model fidelity and billing requirements.
	• **Accountability:** Establishing monthly reporting to help ensure model fidelity and contractual obligations are being met.
		$500,000 – $800,000
		*Potential Annual Cost Efficiencies**

*This potential annual Cost Efficiencies estimate is based on the actual costs indicated in the FSP Outcomes Report for the past three fiscal years.

Full Service Partnership - Contract- Key Opportunities

Opportunity 2.7	Transition Homeless Outreach Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.

Current State

- **Homeless Outreach:** While the volumes are in line with contract requirements, utilization is significantly lower than desired. For outreach services, a 50% direct client contact should be targeted, however, a further examination is required as the low utilization may be due to unregistered clients due to the nature of the population serviced. Therefore, consideration in both volume and utilization of the team requires a deeper examination. In addition, some of these clients may be better serviced by ACT.

- **Homeless Outreach FSP**
  - Program is Funded for 12.02FTE. Annual Unique Clients = 35.

Homeless Outreach FSP	
Positions	**FTE**
Clinical Therapist	2.63
Outreach Workers	2.0
Case Manager	2.0
Nurse Practitioner	1.0
Team Leader	0.9
Nurse	0.63
LOT Outreach Worker	1.0
Total	**10.16 FTE**

  - **2025 Utilization:**
    - Number of unique clients seen per week ranged from 31 to 44 clients.
    - Number of visits per client per week ranged from 2 to 3 visits.
    - Percentage of direct client contract per employee ranged from 6% to 24%.

CSS 3.2. Homeless Outreach Team Full Service Partnership (FSP)			
Fiscal Year Estimate	**Persons Served**	**Total Funding**	**Cost per Client**
Actuals for FY 2022 - 2023	30	$1,074,367	$35,812
Actuals for FY 2023 - 2024	**33**	**$1,146,702**	**$34,896**
Projections for FY 2024 - 2025	35	$1,367,099	$39,060

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.7	Transition Homeless Outreach Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.

Key Opportunities for Consideration

- If the volumes and utilization are reflective of the team's actual performance, the County may wish to consider the reductions outlined across.

Homeless Outreach			
Current Positions	**Current FTE**	**Proposed Reduction**	**New FTE Totals**
Clinical Therapist	2.63	2.63	1.0
Outreach Workers	2.0	2.0	0.0
Case Manager	2.0	1.0	1.0
Nurse Practitioner	1.0	0.0	1.0
Team Leader	0.9	0.4	0.5
Nurse	0.63	0.0	0.63
LOT Outreach Worker	1.0	0.0	1.0
Total	**10.16 FTE**	**-5.03 FTE**	**5.13 dir. staff**
The following positions should align with other vendors' contract practices for management/non-direct client staffing.			
Division Director	0.13		
Assistant Program Manager	0.5		
Deputy Director	0.03		
Quality Assurance Mgr.	0.15		

- **Consolidation of Homeless Teams:** Sought by Fire and Law Enforcement, a consolidated Homeless Outreach team should be considered by the County in an effort to optimize the multiple teams that are often working with the same homeless population but do not collaborate in care planning.
- In addition, to align with BH- Connect, "assertive field-based initiation for SUD treatment services, including the provision of medications for addiction treatment (MAT) should be sought out.
- Use of community-defined evidence practices (CDEPs), as specified by DHCS," therefore the team should be staffed with Substance Use Specialists to offer rapid care in the field vs. office-based services, a noted challenge by multiple individuals during stakeholder engagement.

Full Service Partnership Contracts - Key Opportunities

Opportunity 2.7	Transition Homeless Outreach Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.

Key Action Steps	Benefit	

• **Determine Division Structure:** Determine if the County wishes to fold all Homeless Services under one Division with formal MOUs between the division and law enforcement, Fire Services etc.
  • **If yes** – begin developing the new Service through model design based on the number of current services under the County and in partnership with law enforcement and Fire Services.
  • **If no** - renegotiate contract base on proposed staffing and budget to align team with community need and volume demand.
• **Establish New Contracts:** Establish new contractual agreement and staffing, both personal and skill set, that aligns with new model of care (removing Homelessness FSP designation).
• **Define Metrics Requirement:** Contractual agreement requires metrics that outline unique number of clients, frequency of contact, duration of contact, which should be a reporting requirement by the vendor on a monthly basis.
• **Standardize Outcome Measures:** Standardize pre and post outcome measures should be established to determine effectiveness of the service.
• **Monitor and Report Outcomes:** The Division Manager that oversees this contract, will be responsible for reporting on outcomes and variance during the monthly financial reporting. Where there is variance, both the Division Manager and the Vendor will be required to report on an action plan that is monitored. If improvement is not seen within 3 month of initial issue, the matter should be escalated to the Division Deputy and Director of Health Agency.
	• **Streamlined Services:** If consolidating all Homeless Services under the County, it will streamline services, minimizing duplication currently seen across the multiple providers who may service the same individuals but do not coordinate care plans.
	• **Optimized Staffing:** It may optimize current county staffing while creating synergize by having all Homeless services under the same programs.
	• **Simplified Oversight:** Decreasing the number of contracts requiring oversight.
	• **No Transition Needed:** If Homeless Services remain with current vendor, no change management or transition planning is required on behalf of the county.
	• **Community Alignment:** Both options align model to community need and volume demand.
	• **Accountability:** Establishing monthly reporting to help ensure model fidelity and contractual obligations are being met.
		$1M – 1.2M
		*Potential Annual Cost Efficiencies**

*This potential annual Cost Efficiencies estimate is based on the actual costs indicated in the FSP Outcomes Report for the past three fiscal years.

TMHA and Iris Telehealth Contracts- Key Opportunities

Opportunity 2.8	Consider reducing contracts for duplication of services that are funded by the State, the County and Federally.

Current State

fHotline

- The County contracts with Transition Mental Health Association (TMHA) for the Central Coast Hotline. In July 2022, 988 was funded across the Nation to replace the National Suicide Prevention Lifeline. When a Californian calls 988, their call is routed based on their area code to one of 13 Lifeline crisis call centers. California's call centers are part of the broader 988 Lifeline crisis center network. If a local crisis center is unable to take the call, the caller is automatically routed to a national backup crisis center.
- It is our understanding that TMHA has sought Crisis Call center status through the state but has been unsuccessful in secure the funding. The risk noted by TMHA in having calls being redirected to 988, is the connection to local resources when needed. TMHA is reported to meet contract requirements as reported across.
- The County funds Transition Mental Health Association for Central Coast Hotline for the following:

Transition Mental Health Association (TMHA)	
Position	**FTE**
Program Manager	1.0
Crisis Line Specialist	3.2
Clinical Director	0.07
Lead Crisis Line Specialist	1.0
Total Funding	**$317,837.00**

TMHA ▪ MENTAL HEALTH SERVICES ACT PROGRAMS ▪ PERFORMANCE REPORT
TO SAN LUIS OBISPO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

Contractor: Transitions-Mental Health Association
MHSA Program: Central Coast Hotline – Suicide Prevention and Crisis Intervention Services
Program Director: Meghan Boaz Alvarez
Phone: 805-540-6587
Qtr/Month: 4th Qtr, Apr-Jun 2024

Goals	Activities	Target Units of Service / Annual Contract Outcomes	Performance Outcomes 4th Qtr	Cumulative 2023-24 FY Performance Outcomes
Provide a 24-hour, free and confidential call and text center, Central Coast Hotline, serving the entire county. These one-to-one engagements will deliver psychoeducation and referral options related to mental health concerns for underserved populations. Provide support, crisis and/or suicide intervention as a means of immediate support to callers and texters.	Contractor will recruit, train and supervise staff and community volunteers to maintain a 24/7 hotline, providing mental health referrals, information, support, stigma reduction and crisis and/or suicide intervention, including MHET referral. Contractor will provide suicide prevention and intervention trainings throughout the county to health and human service agencies, community based organizations, churches, law enforcement, etc. Provide English and Spanish language support to callers transferred from the County's BH Central Access Line after business hours.	Contractor will have 10,000 received and documented calls requesting support, information, referral information or crisis intervention.	3,063 documented calls. (Qtr target: 2,500)	10,048 documented calls as of 4th Qtr. (YTD target: 10,000)
		Contractor will provide 4 suicide intervention trainings to community groups.	5 trainings provided. (Qtr target: 1)	9 trainings provided as of 4th Qtr. (YTD target: 4)
		Contractor will provide texting services.	129 texts provided	395 texts provided as of 4th Qtr.
		90% of people calling in crisis will evidence a decrease in distress from start of call to end of call.	59% of people calling in crisis (35/59) evidenced a decrease in distress from start of call to end of call.	
		Community members attending suicide intervention training will show a 20% increase in their confidence that they can help a person at-risk of suicide.	Community members surveyed (47) showed a 25% increase in their confidence that they can help a person at-risk of suicide.	
		90% of all callers surveyed will agree that the support and early intervention that they received from Hotline contributed to improved mental wellness.	94% (96/102) of callers surveyed agree that the support and early intervention that they received from Hotline contributed to improved mental wellness.	
		90% of all callers surveyed will agree that they would use Hotline again in the future, if needed, or refer someone else to Hotline.	99% (101/102) of callers surveyed agree that they would use Hotline again in the future, if needed, or refer someone else to Hotline.	
		90% of all callers surveyed will agree that they received an increased knowledge of local mental health resources.	95% (97/102) of callers surveyed agree that they received an increased knowledge of local mental health resources.	

TMHA and Iris Telehealth Contracts- Key Opportunities

Opportunity 2.8	Consider reducing contracts for duplication of services that are funded by the State, the County and Federally.

Current State

Central Coast Hotline (Continued)

- There is a duplication of services between this contract and what 988 offers for the hotline calls and text support. The five (5) suicide training sessions required could transition to the County Prevention and Outreach team, as that is a service that is offered under Suicide Prevention and Workforce Training.
- As a result of the duplication, the County may wish to eliminate this contract. There should be no impact on clients seeking crisis services, as 988* is well publicized nationally; however, as part of the marketing campaign that is recommended to be undertaken by the County, information on 988, mobile crisis, and co-response teams should be included as part of the plan. In addition, the County should reach out to the 988 hotline and engage in information sharing of services and establishing a collaborative working relationship so there is familiarity with each others services.
    - While there is noted concern by the department that 988 is in the process of being defunded, the only public documentation with regards to this is the potential defunding of the LGBTQ Network under 988 NOT 988 as a whole. “If the leaked budget draft is enacted, the 988 Suicide & Crisis Lifeline’s LGBTQ+ youth specialized services could be defunded beginning in October, according to the nonprofit The Trevor Project, a suicide prevention organization for LGBTQ+ youth that has been a subcontractor to the specialized service since 2022, serving as one of seven call centers within the subnetwork that provides specialized services for LGBTQ+ youth.” https://www.cnn.com/2025/04/25/health/988-lgbtq-funding-plan- retrieved on 5.20.25.

Iris Telehealth Medical Group:

- The Department contracts with Iris Telehealth for a Clinical Social Worker and a Youth Psychiatrist to meet state requirement for assessment wait times and client needs. The Social Worker conducts assessments across both Child and Adolescents and Adult Services. Based on the low utilization across both services, there is an opportunity to eliminate the contract with Iris Telehealth for the Social Worker.
- There is also an opportunity to eliminate the agreement with Iris Telehealth for the Youth Psychiatrist, however, that would only leave 1 FTE Youth Psychiatrist for all of Youth and TAY services, which may impact access to care when that individual is on PTO, however, the Medical Director has confirmed that he is able to provide coverage during those times, therefore there is an opportunity to eliminate the full Iris Telehealth Contract.

Key Opportunities for Consideration

- **Central Coast Hotline:** Eliminate Central Coast Hotline and transition services to already established 988 Crisis Hotline. The decrease of this contract will be one less contract that the department will require to have oversight over.
- **Elimination of Iris Telehealth Clinical Social Worker**
    - Eliminate the Iris Telehealth Child and Adolescent Psychiatrist from 1.0 to 0 FTE.
    - Eliminate the use of Clinician for Adults and Children to conduct assessments as both programs have capacity to meet state requirements.

TMHA and Iris Telehealth Contracts- Key Opportunities

Opportunity 2.8	Consider reducing contracts for duplication of services that are funded by the State, the County and Federally.	
Key Action Steps	**Benefit**	
• **Notify Vendors:** Provide notice to vendors to sunset contracts. • **Inform Community:** Advise community of the changes to Central Coastal Hotline, highlighting the availability of 988 and the Mobile Crisis Teams.	• **Reduced Service Duplication**: Decreasing the duplication of services offered through the community. • **Cost Efficiencies:** Decreasing cost of services that the County has capacity to conduct.	*Central Coastal Hotline $318,000* *Iris Telehealth Medical Group $45,000 – $300,000**

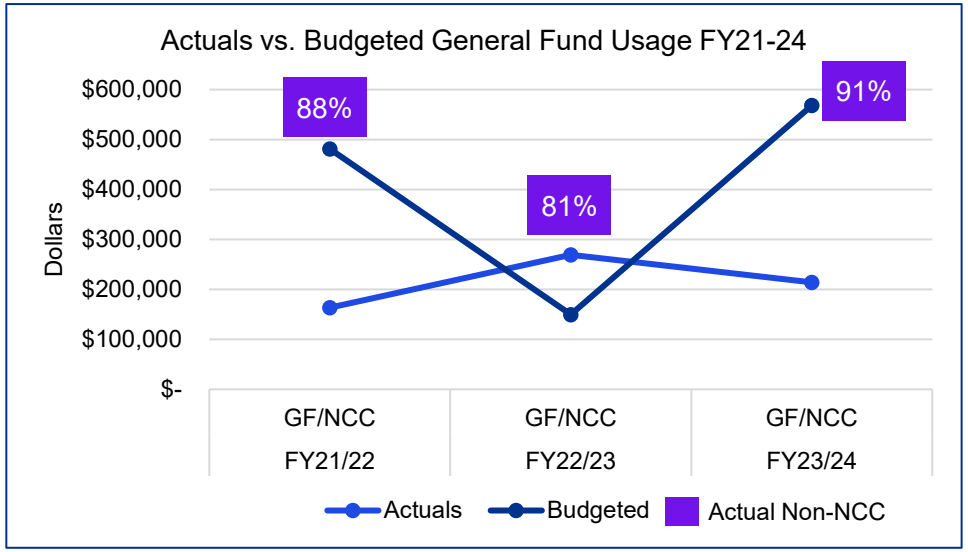
*Estimate based on invoiced amounts included in the FY23-24 Purchase Order Tracker. Contract for Iris Telehealth is rate-based, so invoices are dependent on hours charged.

Justice Services Division Overview

Division Overview

- The Justice Services Division provides alternatives to detention for individuals with mental health needs, at-risk of incarceration, and those who have already entered the criminal justice system. They work in coordination with criminal justice, mental health, substance use, and other community organizations to reduce recidivism.
- The Justice and Services Division offers over 9+ services ranging from adult drug court, assisted outpatient treatment, behavioral health treatment court, co-occurring treatment court, court screening, and mental health diversion court.
- The Justice Services Division works in alignment with the County's "Stepping Up" Strategic Plan to reduce the number of people with mental illness in the County Jail by connecting individuals to treatment over three-years.

27.00 *Total FTE*	**$6.43M** *Total Budget FY24-25*
84% *Budgeted FY24-25 Non-NCC*	**16%** *Budgeted FY24-25 General Fund*
91% *Actual FY23-24 Non-NCC*	**9%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)*

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$6,443,480	0.5%	$1,044,844	$4,398,069	27
Santa Barbara	441,257	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Monterey**	430,723	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Santa Cruz***	261,547	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Sonoma****	481,812	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Ventura	829,590	$86,376	0%	$0	$86,376	9

**The benchmark data included in this table excludes administrative costs as the counties listed administrative costs separately.*

***Monterey County does not include Justice Services within its behavioral health department, it is part of the probation program. Consequently, detailed financial information on the program is not available.*

****Santa Cruz County does not provide a specific behavioral health component for this program, and therefore, detailed financial information on the Justice Services Program is not available.*

****Sonoma County does not provide program level budget within its Budget Book with budget reported only at the Department level.*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Justice Services Division - SWOT Analysis

Strengths

- **Wide Variety Justice Services:** Wide variety of justice services including Adult Drug Court, Mental Health Diversion Court, Behavioral Health Treatment Court Program, and other specialty court programs focused on behavioral health.
- **Strong Interdepartmental Collaboration:** Interdepartmental collaboration with other treatment teams working across programs.
- **Community Partnerships:** Partnerships with sober living environments and other community service providers.
- **Community-Based Service Flexibility:** Flexibility in delivering services directly in the community, including meeting clients in their own environments.
- **New Treatment Models:** Open to exploring and implementing new treatment models in court, with generally high engagement from involved agencies.
- **Service Engage Model:** The community is “service-rich” with efforts to provide services to both residents and non-residents.

Weaknesses

- **High Staff Turnover:** High staff turnover due to challenges with the cost of living and pay not keeping up with inflation.
- **Gaps in Staff Knowledge:** Gaps in staff knowledge in certain areas, like billing and the use of SmartCare, due to insufficient role-specific training.
- **Resource Limitations:** Resource limitations, including the need for more qualified staff to meet increasing service demands.
- **Development Needs in the Forensic FSP Team:** The Forensic FSP team needs improvement and development to meet emerging needs and model requirement.
- **Spanish-Speaking Gap:** A significant gap exists in services for Spanish-speaking individuals, particularly in accessing justice and treatment programs.
- **Housing:** Ongoing issues with longer wait times for housing, especially for sober residences, due to a lack of beds in the County.

Opportunities

- **Enhanced and Expanded Training Program:** Enhance training to be more role-specific and comprehensive, particularly in the area of billing.
- **Streamlining Veterans Affairs Court Operations:** Opportunity to move the Veterans Affairs Court under the Justice Division to streamline all justice operations.
- **Strengthening Internal Quality Support Processes:** Strengthen internal quality support processes to help ensure compliance with evolving state and grant requirements.
- **Implementation of FACT Models:** Implement the FACT model as part of the CalAIM initiative to improve service delivery and client outcomes.
- **Integration with Drug & Alcohol Services:** Increase efforts to integrate services more effectively with the Drug & Alcohol team to provide a more continuum of care.
- **Behavioral Health Services:** Address the lack of a county psychiatric facility for youth and improving support within the juvenile hall is crucial.
- **Prevention Work:** Potential to create educational videos or modules for prevention, especially for out-of-county individuals without access to local services.

Threats

- **High Cost of Living Impacts Staffing:** The high cost of living in the area affects the ability to attract and retain qualified staff.
- **Regulatory Changes:** Changes in state regulations and billing requirements create challenges in maintaining compliance and consistent service delivery.
- **Financial Constraints Limit Service Capability:** Financial constraints and limited resources impact the Agency's ability to adequately respond to the growing needs of the justice-involved population.
- **Disruptions from New Model Implementations:** Potential disruptions associated with implementing new FACT model which may temporarily affect service delivery and outcomes.
- **Dependence on Grant Funding:** Dependence on grant funding necessitates to grant conditions and poses a risk if grants are not renewed or reduced.
- **System Impact:** Proposition 36 is expected to significantly affect the courts and Drug and Alcohol services.

Justice Services Division - Key Opportunities

Opportunity 2.9	Realign resources across Justice Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach.

Current State

With an average staff count of 13*, utilization varies greatly across all positions. Utilization ranges and averages by position are outlined in the table below with progress seen year over year in 6 of the 10 position categories, with a decline in utilization in 3 of the 10 position categories. Currently, 1 of the 10 position categories meet the County's breakeven target of 43.5%, while the other 9 position categories are well below industry average and DHCS targets.

Position	BH Clinician I	BH Clinician II	BH Clinician III	Specialist I	Specialist II	Specialist III
2023-24 Range	20-40%	0%-37%	6%-44%	N/A	6%-28%	8%-44%
Average Utilization	30%	20%	28%	N/A	32%	24%
2024-YTD Range	19-83%	14%-46%	2%-36%	N/A	3%-40%	0.3%-95%
Average Utilization	51%	34%	22%	N/A	21%	35%

Position	BH LPTI	BH LPT II	BH LPT III	BH LPT/ RN Manager	MH Nurse II & III	Nurse Practitioner	Psychiatrist
2023-24 Range	N/A**	13%	0.7%-27%	0.7%-27%	N/A**	N/A**	2%-27%
Average Utilization	N/A**	13%	14%	12%	N/A**	N/A**	15%
2024 YTD Range	N/A**	31%	0.1%-39%	0.1%-39%	0.11%	N/A**	2%-26%
Average Utilization	N/A**	31%	27%	20%	0.11%	N/A**	14%

*This FTE number is based on a Position Allocation List exported as of April 11, 2025. Since staff across programs bill to different cost centers, they may not be included as a result.

**Data was not available for the specific positions as they do not exist within this service.

Justice Services Division - Key Opportunities

Opportunity 2.9	Realign resources across Justice Services in order to improve access to care, meet client demand and achieve utilization targets through enhanced scheduling practices and a shift in a multidisciplinary approach.

Current State

- **Utilization:** As employees go across clinics and services, it is difficult to determine overall clinic utilization, therefore it was agreed that management will examine employee utilization and work with each employee on a weekly basis to optimize resources. The previous slide outlines the range per position with an average across the period of evaluation. The dashboard provides utilization by employee, positions, clinics and divisions. Utilization across positions vary but for the majority of positions, the average is below target. Psychiatry is well below expectations for this patient population.
  - While utilization is low and there is an opportunity to right size the program based on volumes and utilization, it is important to note that Proposition 1 will have an impact on Justice Services, specifically individuals coming from jails and prisons. This volume is expected to increase over the next 12+ months.
  - It is also a challenge to attract individuals who are comfortable in working with this population; therefore, it is more important to focus on optimizing staffing and preparing them for Prop 1 and FACT requirements.
- **Wait Time to Access Care:** Currently, there is no wait list for clients to access care across Justice Services.

Justice Services	
Assisted Outpatient Treatment	No clients on waitlist
Behavioral Health Treatment Court	No clients on waitlist
CARE Act	No clients on waitlist
Mental Health Diversion Court	No clients on waitlist
Co-occurring Treatment Courts (ATCC)	No clients on waitlist

- **Stakeholder Feedback:** There was very positive feedback received by the Courts with regards to SLO County Justice Services. The Judge indicated that the County is 'flush with services' in comparison to other counties and are able to provide clients with the services they need while updating the Courts on progress made. The model is seen as highly effective from the perspective of the Courts.
- One area for improvement is access to Spanish speaking professionals, which the County has acknowledged is a challenge in both recruitment and retention but are focused to continue progressing towards meeting this goal based on the population services.

** Please refer to page 50 for the action steps and benefits related to these opportunities given they mirror those to be completed for the Justice Services opportunities.*

Justice Services Division - Key Opportunities

Opportunity 2.10	Meet BH Connect requirements for Forensic Assertive Community Teams by enhancing current team structure and aligning model of care with FACT requirements. Consideration to be given to merge ACT and FACT teams to meet model fidelity and achieve economies of scale.

Current State

Background:

- FACT is typically only appropriate for members with the most complex and significant behavioral health needs who require the highest level of services, exhibit high risk for reincarceration or involuntary detention, and are willing to engage in frequent, intensive community-based contacts.
- FACT is the ACT model with additional training and staffing requirements to serve the needs of justice-involved members. In many cases, the same teams will deliver both ACT and FACT, but their caseload will include some members with criminal justice system involvement.
- Behavioral Health Providers (BHPs) may bill Medi-Cal for both ACT and FACT services delivered by the same team if the team serves a caseload of members in which some members have a high risk or recent history of criminal justice system involvement, and others do not.
- **Medi-Cal Coverage of FACT** will be authorized in the Medi-Cal program under the coverage for ACT in SPA 24-0042, effective January 1, 2025.
  - BHPs have the option to provide FACT as a bundled service under Medi-Cal. FACT is a covered Specialty Mental Health Services (SMHS). FACT is not covered in the Drug Medi-Cal (DMC) program or Drug Medi-Cal Organized Delivery System (DMC-ODS). FACT services billed to Medi-Cal must meet the requirements set forth in BHIN 25-XXX. BHPs may bill the bundled Medi-Cal rate for up to nine months before completing an initial fidelity assessment for services delivered by FACT teams. For BHPs to bill for bundled FACT services on an ongoing basis after the initial nine-month period, FACT teams must achieve and maintain Medi-Cal designation. Medi-Cal designation will be granted upon meeting fidelity threshold specified by Department of Health Care Services (DHCS).
- **Fidelity Monitoring & Medi-Cal Designation:** As described in BHIN 25-XXX, FACT teams are required to meet fidelity monitoring requirements specified by DHCS for the *BHP to bill Medi-Cal for bundled FACT* services. Fidelity assessments will be conducted on a regular cadence for all FACT teams. DHCS intends to identify and contract with a third-party administrator to deliver fidelity assessments on a specified cadence. Initial fidelity assessments will be available in 2025.
- **SLO County Justice Services – FACT Designation Utilization:**
  - The Justice Team is currently in the process of building both staffing and capabilities to meet CalAIM FACT Requirements.
  - Utilization for 2024 across three employees, two Behavioral Health Clinician IIIs and one LPT, range from 17% to 31% with an average of 24%.
  - Utilization for 2025 decreased to two employees, one BH Clinician III and LPT, with utilization ranging from 33% to 48% with an average of 41%. A noticeable improvement and close to projected targets of 50% of direct service for community-based staff.
- **Model Fidelity:** The team make does not align with CalAIM staffing requirements, however, management is in the process of enhancing team structure to align with model fidelity. If the County does not meet FACT requirements, this may impact funding received as per Medi-Cal Coverage stipulation.

Justice Services Division - Key Opportunities

Opportunity 2.10	Justice Services Key Opportunities for Considerations for 2.9 and 2.10

Key Opportunities for Consideration

This is a smaller program in comparison to the other behavioral health services across the County; however, the population is viewed as more complex in nature based on their level of acuity and court involvement. However, the team's utilization across all services are well below current targets and future targets. As a result, the following opportunities should be considered by the County:

- **Aligning All Justice Services:** Transition Veterans Justice Services that is currently under Prevention and Outreach to Justice Services to align all justice services under the same management team.
- **Span Of Control:** There is currently capacity under both manager and supervisors to accommodate this service and align span of control.
- **Scheduling Consideration:** Staff to be directed to schedule 80% of their day in direct client contact for office-based staffing and 60% for community-based staffing. Appointments should either decrease in time or be staggered to accommodate the high no show and cancellation rates. For clients with a high no-show and cancellation rates, consideration should be given to a 'drop in' clinic in addition to a wraparound model of care to support clients in the recovery journey.
- **Model of Care:** Consider a model of care shift if office-based services is not meeting client needs.
- **Consolidate ACT and FACT:** The County may wish to consider the consolidation of ACT and FACT to meet model fidelity and improve billable capabilities. Pending County decision, key action steps will vary.

Key Action Steps	Benefit	

• **Transition Services:** Transition Veterans Justice Services to Justice Services from Prevention and Outreach.
• **Decide on Consolidation:** Determine if the County wishes to fold FACT and ACT under one team.
  ○ **If yes** – determine if the team should be under the County or under an external contractor.
  ○ **If no** – develop plan on how Justice Services will meet CalAIM FACT requirements in order to meet model fidelity and billable requirements.
• **Formulate New Agreements:** If ACT and FACT are to be outsourced: Establish new contractual agreement and staffing, both personal and skill set, that aligns with ACT and FACT requirements.
• **Define Reporting Metrics:** Contractual agreement requires metrics and outcomes as directed by CalAIM.
• **Monitor:** The Division Manager that oversees this contract, will be responsible for reporting on outcomes and variance during the monthly financial reporting. Where there is variance, both the Division Manager and the Vendor (if contracted out) will be required to report on an action plan that is monitored. If improvement is not seen within 3 months of initial issue, the matter should be escalated to the Division Deputy and Director of Health Agency. Projected billables will need to be very closely monitored as part of the reporting process.
	• **CalAIM Compliance:** Meet CalAIM requirements for FACT.
	• **Capacity Building:** Be proactive in building capacity for projected volumes based on Prob 1 initiative.
	• **Economies of Scale:** Develop economies of scale if teams are consolidated.
		Pending integrating ACT and FACT into one team.
		
		Pending absorbing Veterans Justice Treatment.

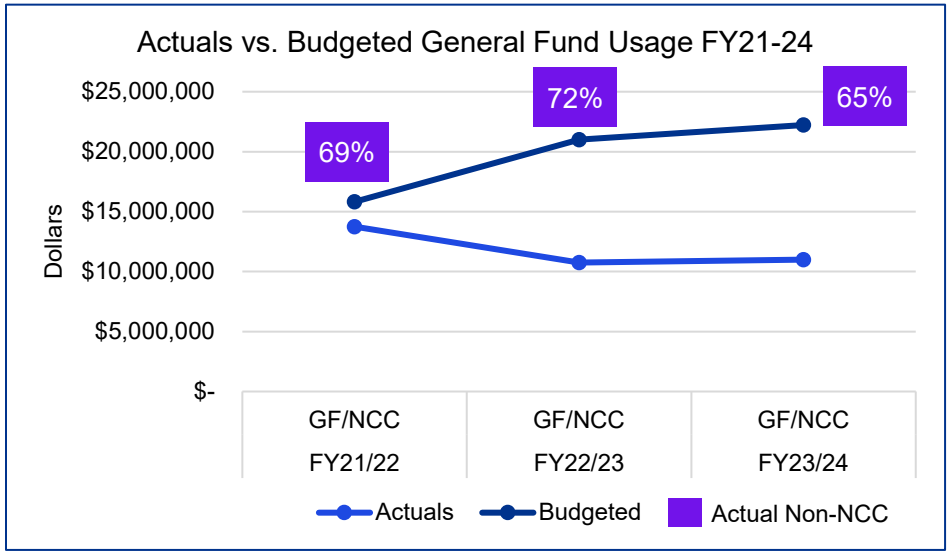
Public Health

Public Health – Overview

Division Overview

- The Public Health Department in San Luis Obispo County promotes and protects the community's health through ten divisions: Clinical & Communicable Disease, Environmental Health, Emergency Medical Services (EMS), Health Care Access, Health Promotion, and Maternal, Child, and Adolescent Health (MCAH), Planning, Evaluation, and Policy, Public Guardian, Public Health Laboratory as well as Health Agency Administration.
- The Public Health Department also collaborates with other county agencies, community organizations, and healthcare providers to address public health emergencies, such as disease outbreaks and natural disasters.
- The Department's mission is to promote, preserve and protect the health of all San Luis Obispo County residents through disease surveillance, health education, direct services, and health policy development.

238.25 *Total FTE*	**$42.53M** *Total Budget FY24-25*
66% *Budgeted FY24-25 Non-NCC*	**34%** *Budgeted FY24-25 General Fund*
65% *Actual FY23-24 Non-NCC*	**35%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

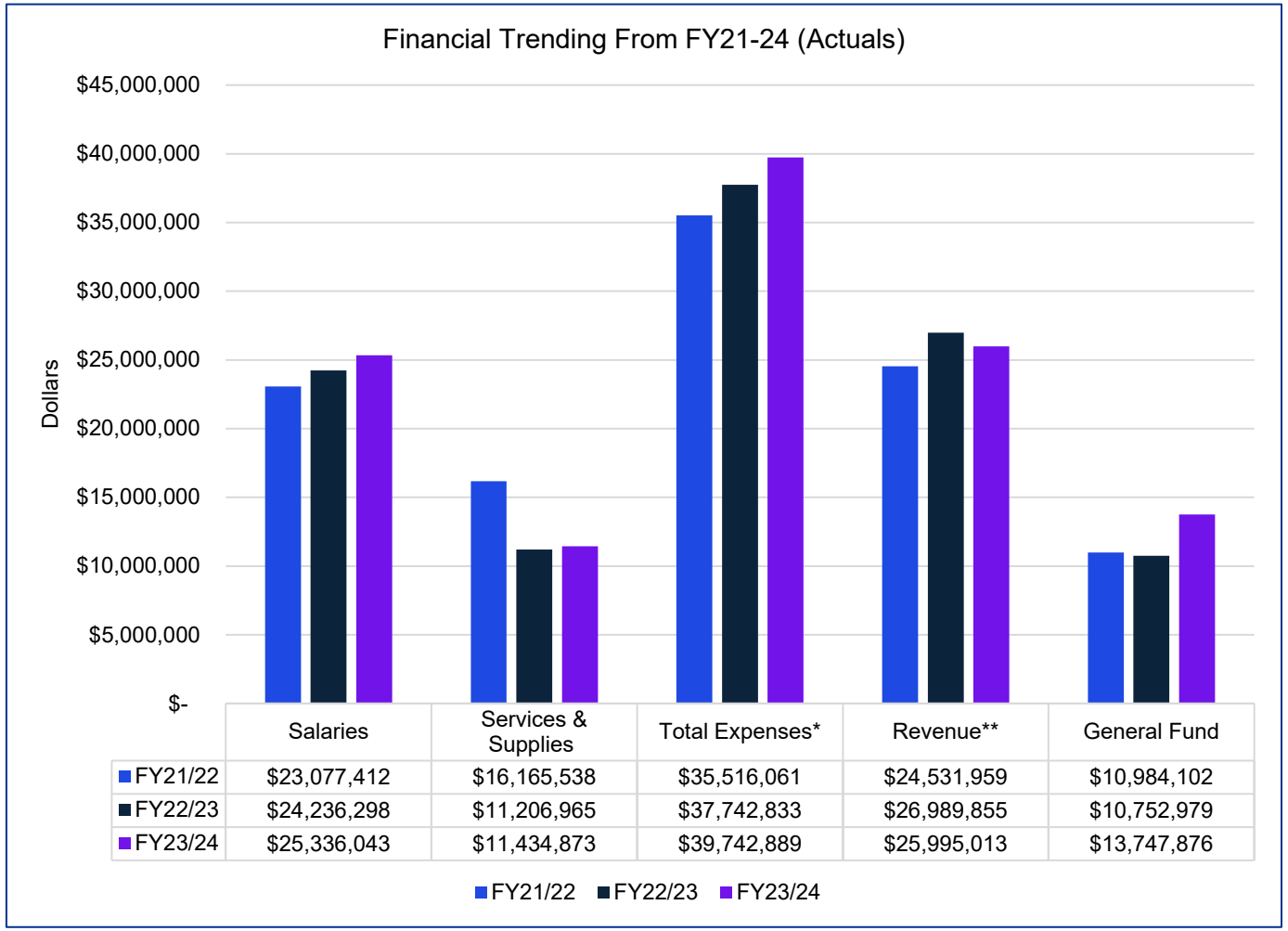
County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$42,525,572	18%	$14,664,464	$19,981,532	238.25
Santa Barbara	441,257	$113,450,000	52%	$10,490,000	$32,173,700	531.50
Monterey*	430,723	$133,042,289	52%	$15,903,081	$32,056,665	634
Santa Cruz*	261,547	$113,218,557	Not Publicly Available	Not Publicly Available	Not Publicly Available	416
Sonoma**	481,812	$68,964,772	Not Publicly Available	Not Publicly Available	Not Publicly Available	223.52
Ventura	829,590	$115,574,796	19%	$12,745,407	$82,015,996	690

*Similar to most counties, Monterey, Santa Barbara, Santa Cruz, Sonoma, and Ventura operate a Federally Qualified Health Center (FQHC) model increasing the total funding amount.
**Sonoma County operates a Department of Health Services Agency with a shared administration across its divisions. The County's budget book does not breakdown the portion on administration cost allocated to Public Health and this budget is exclusive of administrative cost.

Public Health – Trend Analysis

Between FY 21-22 and FY 23-24, the Public Health Division achieved a combined average Non-NCC rate of 69% requiring on average $11.83M General Fund use. In FY 21-22, the Division required $10.98M General Fund. In FY 22-33, General Fund use decreased 2%. However, between FY 21-22 and FY 23-24, General Fund use increased 28%.

- Salaries for the Division increased steadily over the past three fiscal years. Between FY 21-22 and FY 23-24, Salaries increased 10% due to the hiring of additional staff and expected increases in existing staff salaries.
- Expenses related to Services & Supplies have decreased significantly between FY 21-22 and FY 23-24. These expenses have decreased a total of 29%. This decrease was supported by a significant decrease (29%) in Services & Supplies for Public Health Administration and smaller decreases across Environmental Health, the Woman, Infants, and Children program, and the Public Lab.
- Total Expenses for the Division have increased 12% between FY 21-22 and FY 23-24 primarily due to the increase in Salaries noted earlier and changes in intrafund balances within the financial statements. This includes the increase in county-wide overhead for the Health Agency.
- Revenue (including grant funding) for the Division increased 10% between FY 21-22 and FY 22-23 because of increases in revenue from WIC and the Maternal, Child, and Adolescent Health program. However, revenue decreased 4% between FY 22-23 and FY 23-24 due to decreases experienced by Public Health Administration, Family Health Services, and the Public Lab.

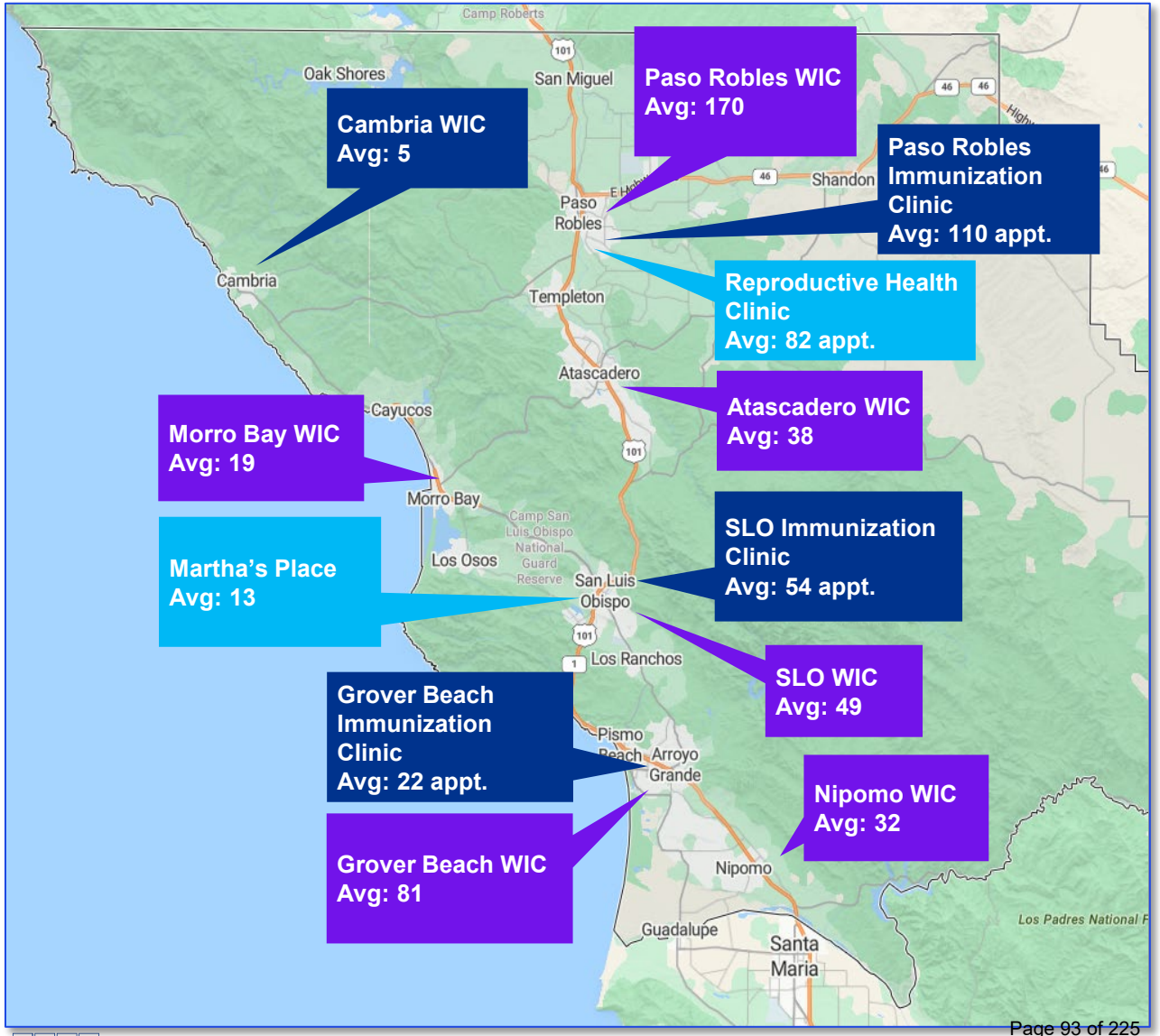


	Salaries	Services & Supplies	Total Expenses*	Revenue**	General Fund
FY21/22	$23,077,412	$16,165,538	$35,516,061	$24,531,959	$10,984,102
FY22/23	$24,236,298	$11,206,965	$37,742,833	$26,989,855	$10,752,979
FY23/24	$25,336,043	$11,434,873	$39,742,889	$25,995,013	$13,747,876

**The difference between the total of Salaries and Services & Supplies and Total Expenses is due to adjustments through Intrafund charges and balances.*
***Revenue includes charges for service, grant funding, and realignment.*

Public Health: Average Monthly Clients, Appointments, and Staff by Clinic*

Below is a summary of all Public Health clinics by location, with the average monthly clients seen, and average monthly appointments against the average staff.



Clinic	Average Monthly Clients	Average Monthly Appointments**	Average Staff
Martha's Place	13	N/A	2.6
Paso Robles WIC	170	N/A	4
Grover Beach WIC	81	N/A	3
San Luis Obispo WIC	49	N/A	3
Nipomo WIC	32	N/A	3
Morro Bay WIC	19	N/A	3
Atascadero WIC	38	N/A	3
Cambria WIC	5	N/A	3
Reproductive Health Clinic	N/A	82	4.5
Paso Robles Immunization Clinic	N/A	110	5.5 across clinics
Grover Beach Immunization Clinic	N/A	22	
San Luis Obispo Immunization Clinic	N/A	54	
Min	**5**	**22**	**2.6**
Max	**170**	**110**	**6**
Average	**51**	**67**	**3**

Key	
	WIC
	Immunization Clinic
	Other (Martha's Place / Reproductive Health Clinic)

** Data on the average number of monthly visits per public health clinic is unavailable.*

*** Data for Reproductive Health and Immunization Clinics are by the average number of monthly appointments only.*

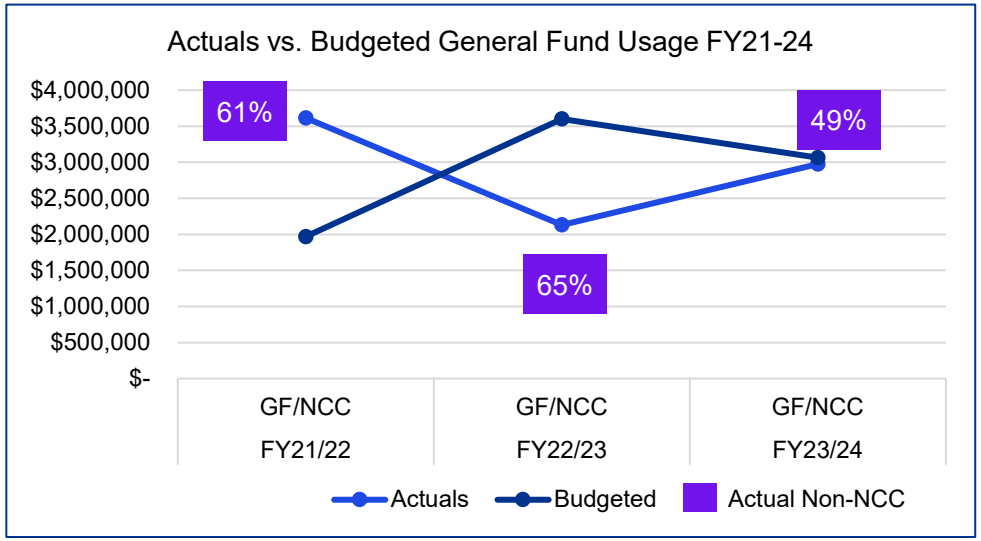
***Sources**: EHR Data.*

Clinical and Communicable Disease – Overview

Division Overview

- The Clinical and Communicable Disease Services Division have several key programs:
  - **Communicable Disease:** This program includes receipt of all mandated reportable conditions, outbreak response, viral hepatitis and HIV screening and referral, and communicable disease prevention education.
  - **Reproductive Health and Immunization Clinics:** The Division provides direct care in three geographically distributed clinics in North, Central, and South County. Services include immunizations (child, adult, and travel), tuberculosis and sexually transmitted disease screening, diagnosis and treatment, and reproductive health services including family planning and women's cancer screening.
  - **Suspected Abuse Response Team (SART):**The division also provides forensic medical services for adult clients referred to the Suspected Abuse Response Team related to sexual abuse.

28.25 *Total FTE*	**$5.45M** *Total Budget FY24-25*
39% *Budgeted FY24-25 Non-NCC*	**61%** *Budgeted FY24-25 General Fund*
49% *Actual FY23-24 Non-NCC*	**51%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$5,452,922	26%****	$3,318,108	$1,571,734	28.25
Santa Barbara*	441,257	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available
Monterey**	430,723	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available
Santa Cruz	261,547	$5,025,308	Not Publicly Available	Not Publicly Available	Not Publicly Available	26.00
Sonoma***	481,812	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available
Ventura	829,590	$9,818,910	11%	$1,077,378	$7,695,110	64.00

** In Santa Barbara County, Clinical and Communicable Disease Program is part of the Disease Control and Health Promotion Division. The County's budget book does not break down funding by program. However, the overall General Fund contribution for the Division is $2.77m (13%), with intergovernmental revenues amounting to $15.5 million (75%).*

***In Monterey, Clinical and Communicable Disease Program forms part of the Communicable Disease Prevention and Control Division; however, budgets are not separately reported for this division.*

****Sonoma County does not provide program level budget within its Budget Book with budget reported only at the Department level.*

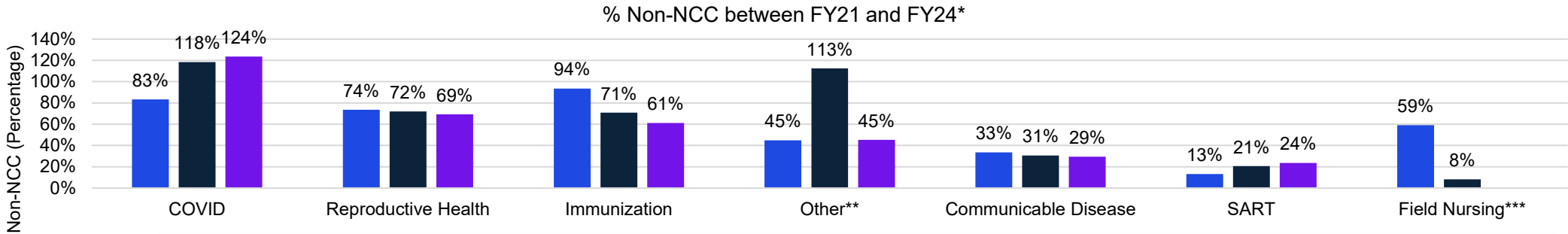
*****This is the combined charge for service % for Family Health Services (9%) and SART (26%).*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Clinical and Communicable Disease – Key Data Analysis

Between FY 21-22 and FY 23-24, the Clinical and Communicable Disease Division achieved a combined average Non-NCC rate of 58%, requiring an average of $2.91M from the General Fund each fiscal year. The primary drivers of General Fund usage are the following programs: Communicable Disease and Immunization which on average cost the General Fund $680,500 and $398,704 over the past three fiscal years, respectively.

- Communicable Disease experienced a 4% decline in Non-NCC between FY 21-22 and FY 23-24, this is largely due to a 37% increase (from $745,269 to $1.02M) in salaries due to COLA increases, market equity adjustments, and increased benefit costs.
- Immunization experienced a significant decline of 33% in Non-NCC. This is largely due to a 40% decrease in revenue (including grant funding), from $1.44M to $856,234 between FY 21-22 and FY 23-24 due to the close out of COVID Immunization grants. Despite a 9% decrease (from $1.53M to $1.40M) in total expenses, the program's decrease in revenue (including grant funding) requires additional General Fund use.
- The Reproductive Health program operates one clinic in Paso Robles and it has experienced declining Non-NCC (5% decrease) over the past three fiscal years. Between FY 21-22, service and supply costs increased 24% from $349,634 to $462,406 requiring an additional $47,485 in General Fund. In FY 23-24, salaries and service and supply costs remained relatively consistent with FY22-23, but revenue (including grant funding) decreased 7% from $859,588 to $800,816.
- The SART program experienced an 11% increase in Non-NCC. While revenue (including grant funding) has doubled from $42,937 to $103,166 between FY 21-22 and FY 23-24, total expenses have also increased 35% (from $324,730 to $437,736) requiring additional General Fund use.



	General Fund Usage						
	COVID	Reproductive Health	Immunization	Other**	Communicable Disease	SART	Field Nursing***
FY21/22	$ 118,566	$ 288,508	$ 98,650	$ 541,560	$ 609,809	$ 281,793	$ 1,393,225
FY22/23	$ (95,418)	$ 335,993	$ 551,367	$ (73,002)	$ 672,487	$ 296,263	$ 145,758
FY23/24	$ (27,744)	$ 355,380	$ 546,094	$ 671,472	$ 759,205	$ 334,570	$ -

FY21/22 FY22/23 FY23/24

This chart has been generated using actuals versus budgeted revenue and expenditures. The expenditures include Services & Supplies and Salaries related to each individual program. "Other Expenses" have been aggregated at the division level and not allocated across the programs.

***The following internal orders / costs have been combined for the "Other" entry in the table: Non-Grant Funded Programs, MAA Revenue, PH Admin Costs, Countywide Overhead, and Liability Charges.*

****This source of funding or program is no longer active or has been transferred to another cost center.*

Clinical and Communicable Disease – SWOT Analysis

Strengths

- **Strong Commitment to Mission:** Throughout FY 2023-2024, the Division demonstrated a strong commitment to its mission by addressing 95 outbreaks in high-risk congregate settings. They provided essential resources such as personal protective equipment (PPE) and COVID-19 point-of-care tests and offered critical guidance to limit disease transmission. This proactive approach not only supported the health and safety of vulnerable populations but also underscored their dedication to managing and mitigating public health risks.
- **Increased enrollment due to PrEP-AP enrollment across Reproductive Health Clinics:** Paso Robles Reproductive Health Clinic has successfully become a PrEP-AP enrollment site after an extensive application process. PrEP medications can be expensive and are often required long-term. As a PrEP enrollment center, the Reproductive Health Program can now enroll individuals who are uninsured or underinsured into the state's payment assistance program for PrEP.
- **Immunization Clinic Hosting Vaccination Events:** Organized vaccination events which were held at the County's Health clinics to provide flu and COVID-19 vaccines to all county employees. Additionally, partnerships were established with 11 schools to offer flu vaccines at school-based clinics, supporting wider community access and protection.

Weaknesses

- **CalREDIE System Limitations for Communicable Diseases:** Communicable Diseases face limitations with the CalREDIE system, which does not facilitate clear tracking of workloads for communicable diseases. This hinders effective caseload management and prevents the identification of opportunities to enhance staff productivity or identify opportunities for improvement.
- **Limited Staff Productivity Tracking:** Staff work across Immunization and Communicable Disease, and there is limited insight into staff productivity, with no established targets for staff to achieve.
- **Clinical Staff Time Inefficiencies due to Administrative Tasks:** Clinical staff across the reproductive health clinics spend considerable time on administrative activities, often related to supporting multilingual clients or those with lower levels of education in filling out forms upon arrival at the clinic. These processes can take up to an hour and can result in appointment delays.
- **EHR System Billing Challenges:** The current EHR system is not interfacing properly with the clearinghouse because of an expired form. As a result, 260 claims have recently been rejected and had to be resubmitted manually, resulting in significant effort and delay in payment.

Opportunities

- **Include Patient Portal in Business Requirements for new EHR:** Confirm the new EHR system includes a patient portal feature that allows clients to submit their forms/information in advance of appointment in their preferred language.
- **Enhance Disease Management Tracking through Acuity Models:** Implement an acuity model in Communicable Disease to better understand investigation duration by disease complexity and track against this mode to gain insights into staff caseloads and time allocation.
- **Enhance Staff Utilization:** Implement initiatives to enhance staff utilization to identify opportunities to enhance client service delivery.

Threats

- **Risk of payment delay:** Delays in payment risk increasing potential for financial instability and general fund use to cover shortfalls.
- **Inefficient Use of Staff Time:** The increased administrative workload for clinical staff reduces the time available for direct client services, and the need for manual resubmission of billing claims diminishes the time allocated to other critical financial activities for billing staff.
- **Risk of Inefficiencies and unbalanced workload:** Without clear tracking and established productivity targets, there is a risk of inefficiencies and unbalanced workloads, potentially leading to decreased overall performance and unmet program goals.

Clinical and Communicable Disease – Key Opportunities

Opportunity 3.1	Enhance reporting and analysis through development of an Acuity Model and Power BI Dashboard to better understand staff workload, productivity, caseload allocation, and overall divisional performance.

Current State

- The Communicable Disease program utilizes the California Reportable Disease Information Exchange (CalREDIE), implemented by the California Department of Public Health (CDPH), for electronic monitoring and reporting of diseases. CalREDIE captures various data points including disease type, patient details, investigator names, case creation date, date of last edit, case status, and closure date. However, it does not track the actual hours staff spend on investigation tasks, only the days from case creation to closure.
- According to interviewees, this data is not accurate for determining investigation timelines as it fails to consider the complexities and specific hours dedicated by staff to each case. This inadequacy makes it difficult to assess the timeliness of investigations, manage workloads effectively, and identify opportunities for process improvements. Additionally, since nurses work across both immunization and communicable diseases, it further complicates the analysis and ability to evaluate and compare workloads.
- Estimated timelines for disease investigations by disease type were shared with KPMG; however, applying these timelines to disease counts indicates that staff would have spent 27,203 hours on investigations in 2023 and 23,538 hours in 2024. Converting these hours to full-time equivalents (FTEs) by dividing by 1,800 productive hours per year per FTE suggests that the division would have needed 15 FTEs in 2023 and 13 FTEs in 2024 to work exclusively on communicable diseases. Given that the Division currently has 9.5 FTE, including the program supervisor, with only 5.5 FTE nurses working across both Immunization and Communicable Diseases, this implies that the time estimates may be higher than the actual time spent on average.

Key Opportunity for Consideration

- To support better workload tracking and achieve greater parity in caseload assignments among public health nurses and communicable disease investigators, the Division should develop an acuity model. This model would assign a complexity weighting to each disease investigation by disease type based on the average number of hours it takes to complete an investigation, identified through a time study. The complexity weighting can then be used to develop and evaluate weighted caseloads and assess productivity for each staff member, promoting equitable and balanced workloads. Additionally, the division should develop a Power BI dashboard to facilitate the review of weighted caseloads by nurse. This. This tool should be integrated with immunization workload data to provide a holistic view of nurse workloads and utilizations. Please refer to Agency-wide Opportunity 1.9 for further detail on the development of a utilization dashboard.

Clinical and Communicable Disease – Key Opportunities

Opportunity 3.1	Enhance reporting and analysis through development of an Acuity Model and Power BI Dashboard to better understand staff workload, productivity, caseload allocation, and overall divisional performance.

Key Opportunity Action Steps	Benefit	
• **Conduct a Time Study:** Perform a low-barrier pilot time study to measure the average number of hours required to complete investigations for each disease type over a 2-3 month period. This pilot can be facilitated via a simple spreadsheet with prepopulated drop-down fields to reduce the time it takes to enter information. Staff should be encouraged to populate the spreadsheet daily to obtain the most accurate view of how staff members are spending their time. • **Develop the Acuity Model:** Use the time study results to develop an acuity model by identifying average investigation time by disease type, assign a complexity weighting to each disease type based on investigation time, and create a framework for applying these weightings to individual cases. • **Pilot and Refine the Model:** Implement the acuity model on a trial basis, gather feedback, and make necessary adjustments. During this process, supervisors should evaluate staff caseloads by case complexity and staff performance against average times and refine the model as needed to increase or reduce complexity. • **Implement the Model:** Following optimization, the Division should utilize the model to allocate caseloads based on complexity, supporting balanced workloads across staff and establishing a process for measuring staff productivity. • **Create a Power BI Dashboard:** Develop a Power BI dashboard that integrates the acuity model, displaying key metrics such as case acuity, total case acuity, and case status. This dashboard should also provide key metrics on Immunization caseloads and volumes as outlined in Agency-wide Opportunity 1.9 to provide a holistic overview of staff workload and productivity.	• **Enhanced Workload Equity:** Implementing the acuity model will support equitable and balanced workload distribution among public health nurses. • **Improved Productivity Monitoring:** Increased data tracking and the adoption of a Power BI dashboard will support enhanced monitoring of staff productivity across communicable disease and immunization, enabling a more holistic view of staff workloads, supporting the Division to optimize staff activities, identify areas for improvement, and allocate resources more efficiently. • **Data-Driven Decision Making:** The development of a Power BI dashboard incorporating the acuity model will provide leadership with actionable insights into staff workloads and performance, facilitating greater data-driven decision-making on staffing allocations.	*While not yielding immediate calculable Cost Efficiencies, this opportunity will enhance operational efficiencies and support staff to increase efficiency and effectiveness.*

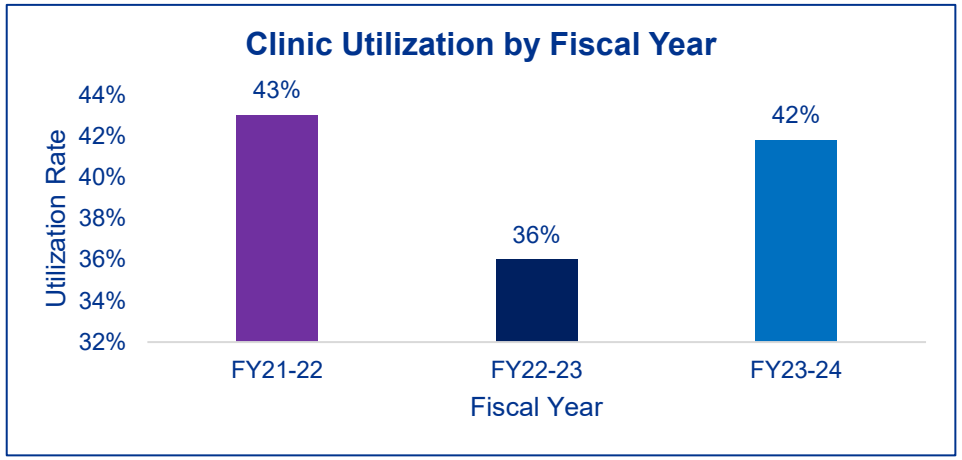
Clinical and Communicable Disease – Key Opportunities

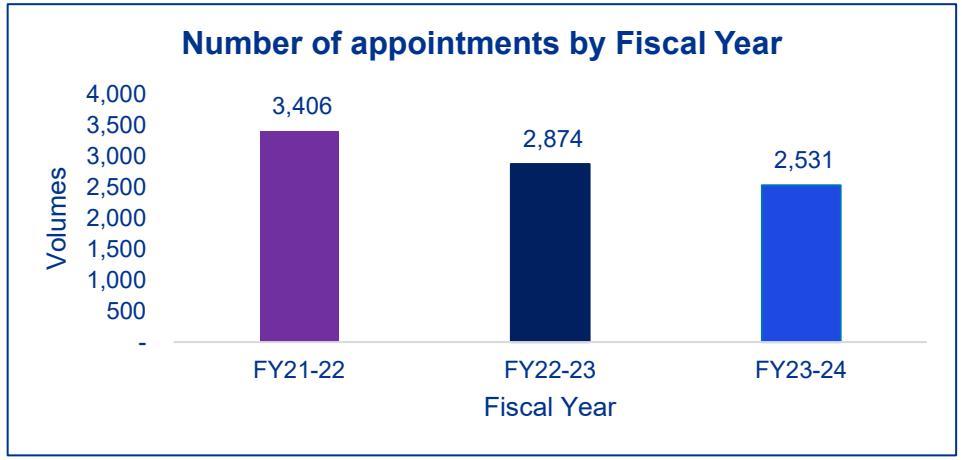
Opportunity 3.2	Reevaluate staffing levels at the Reproductive Health Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Current State

Currently, the Reproductive Health Clinic is staffed with 4.5 FTEs, including a 1 FTE supervising nurse, a 0.5 FTE nurse, and 2 FTE public health aides. In the current state, both the supervising nurse and the nurse practitioner provide direct service to clients. Public health aides are responsible manning the front desk, taking vitals, checking insurance eligibility, issuing appointment reminders, following up with clients, and coordinating with the Public Laboratory to obtain results.

- Based on data analysis undertaken from FY21-24, the Reproductive Health Clinic averages 42% utilization across the three years. While this is below target, the program has much higher utilization that other Public Health programs analyzed. With regards to utilization expectations and scheduling practices, please refer to Opportunity 1.8.





- Based on this analysis, the program has sufficient volumes for a 1 FTE nurse; this suggests that the program is currently appropriately staffed with nurses, given that the program supervisor is a seeing clients and also have supervisory responsibilities. However, the program currently has twice the number of public health aides compared to nurses. While there is limited data available on utilization across public health aides, given they serve the same volume of clients as the nurses, there may be an opportunity to redirect one of the public health aides to another program with greater need.

Clinical and Communicable Disease – Key Opportunities

Opportunity 3.2	Reevaluate staffing levels at the Reproductive Health Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Key Opportunities for Consideration

- In the future, to better align staffing levels to demand, the Division should consider:
  - Redirecting 1 FTE public health aide from the program to better align staffing levels to demand. In considering this redirection.
  - Implementing utilization tracking as recommended in Agency wide opportunity 1.9 aiming for nurses to spend 80% of their time in direct client billable services with staff utilization monitored on a weekly basis by supervisors with administrative staff verifying that all visits are recorded. In the future, staff utilization should be presented in a dashboard with action plans developed in collaboration with supervisors for staff not meeting targets. The process should be reviewed weekly at the departmental and agency level.

Key Opportunity Action Steps	Benefit	
Redirect 1 FTE position from the program: • **Conduct a Role and Responsibility Analysis:** Review current roles and identify positions for reduction without compromising service quality. • **Align Staffing Levels with Service Demand:** Analyze data regularly to identify service demand trends and adjust staffing levels accordingly to optimize client service delivery. **Implement staff utilization tracking:** • Please refer to Agency-wide Opportunity 1.9 for further detail on the action steps required to implement this opportunity	• **Optimized Staffing Levels:** Redirecting 1 FTE public health aide position from this program will support staffing levels to be more closely aligned with service demand, improving overall efficiency and resource allocation. • **Enhanced Performance Monitoring:** By tracking encounter data and time spent on direct client service, and documentation, the Division can gain valuable insights into how staff allocate their time. This enables better performance monitoring and understanding of workload distribution. • **Improved Service Delivery:** Regular monitoring of this data by supervisory staff will facilitate meaningful discussions with team members, fostering a culture of continuous improvement. This can lead to increased client service delivery, higher employee motivation, and more responsive adjustments to staffing levels based on actual service demand.	**$88,000*** *Potential Annual Cost Efficiencies*

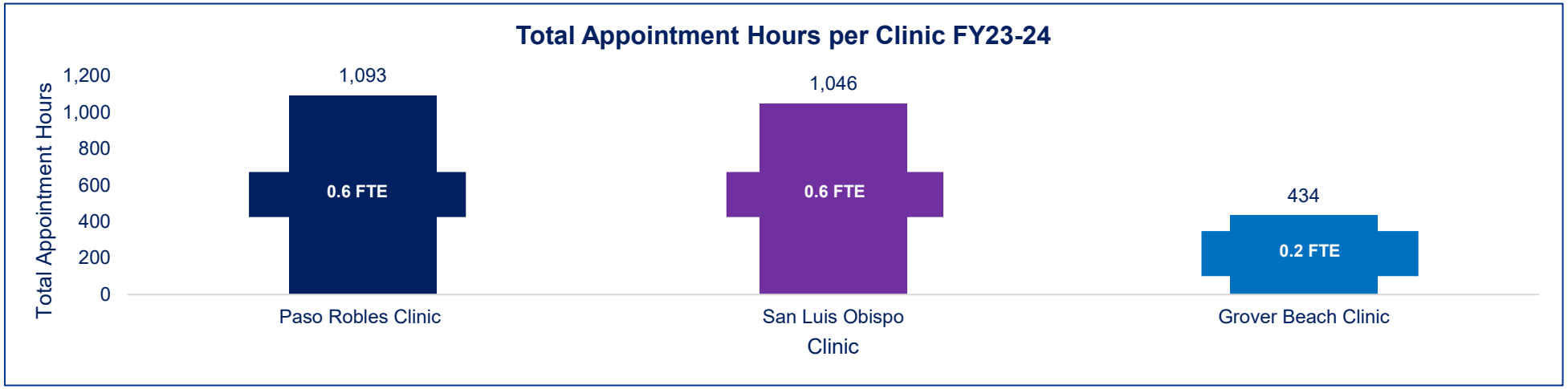
** This cost saving has been developed based on the average fully burdened salary for a public heath aide within the program.*

Clinical and Communicable Disease – Key Opportunities

Opportunity 3.3	Reevaluate staffing levels at the Immunization Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Current State

- Currently, the Immunizations program operates three clinics across the County in Paso Robles, San Luis Obispo, and Grover Beach, staffed by 5.5 FTEs who also support the Communicable Disease Division with disease investigations.
- While we cannot accurately calculate staff utilization due to the dual responsibilities across immunizations and communicable disease, it is possible to measure the time spent on immunization-related activities. The data, outlined in the chart below, suggests that Paso Robles and San Luis Obispo each need 0.6 FTE to meet demand, while Grover Beach requires 0.2 FTE, based on an average of 1,800 productive hours per year.



- However, since the Division does not track staff utilization and the percentage of time spent in each program, it is difficult to determine how the 5.5 FTE nurses divide their time between Immunizations and Communicable Disease. This lack of data makes it challenging to identify potential staffing levels available for redirection.

Clinical and Communicable Disease – Key Opportunities

Opportunity 3.3	Reevaluate staffing levels at the Immunization Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Key Opportunity for Consideration

- In the future, to better align staffing levels to demand, the Division should consider:
  - Implementing utilization tracking as recommended in Agency wide opportunity 1.9. This Opportunity aims to support nurses to schedule 80% of their time in direct client billable services with staff utilization monitored on a weekly basis by supervisors with administrative staff verifying billing and helping ensure that all visits are recorded. In the future staff utilization should be presented in a dashboard with action plans developed in collaboration with supervisors for staff not meeting targets. The process will be reviewed weekly at the departmental and agency level, with formal reviews by the Assistant COE.

Key Opportunity Action Steps	Benefit	
Implement staff utilization tracking: • Please refer to Agency-wide Opportunity 1.9 for further detail on the action steps required to implement this opportunity. It is important to note that in analyzing this data, the Division should consider the level of staffing (if any) that should be redirected to better align staffing levels to demand for service.	• **Optimized Staffing Levels:** By evaluating service demand and aligning staffing levels accordingly, the Division can support resources to be more efficiently allocated, leading to improved overall efficiency. • **Enhanced Performance Monitoring:** Tracking encounter data and time spent on direct client services provides valuable insights into staff time allocation. This allows for better performance monitoring and an improved understanding of workload distribution. • **Improved Service Delivery:** Regularly monitoring this data enables supervisory staff to hold meaningful discussions with team members, fostering a culture of continuous improvement. This can result in increased client service delivery, higher employee motivation, and more responsive staffing adjustments based on actual service demand.	*It is not possible to calculate Potential estimated cost efficiencies for this opportunity given data on staff utilization across program is unavailable*

Clinical and Communicable Disease – Key Opportunities

Opportunity 3.4	Engage Divisions in developing EHR business requirements and enhance pre-clinic communication processes to improve efficiency and Patient experience.

Current State

- Clinical staff within the Reproductive Health Clinic spend considerable time on administrative activities, primarily supporting multilingual clients in filling out forms upon arrival. This process can take up to an hour, leading to appointment delays and reduced patient throughput. Although forms are sometimes emailed to patients before their appointments, the staff frequently do not know the client's preferred language beforehand, resulting in challenges when clients arrive at the clinic. Additionally, while administrative assistants conduct pre-clinic insurance checks to identify additional needs, they do not assist with form completion at this stage, given the main goal is to determine insurance and eligibility for service.
- Additionally, integration of laboratory results is problematic as the current EHR system does not support integration with the Public Laboratory system to provide direct lab result uploads, requiring staff to manually follow up and obtain these results from the Laboratory. This increases administrative burden for staff requiring staff to manually track tests in queue and follow up with the Lab manually.
- Moreover, the current Electronic Health Record (EHR) system lacks a patient portal with multilingual support, which would otherwise streamline the form completion process and does not currently support integration with the Public Laboratory system.

Key Opportunities for Consideration

- The Department is in the process of obtaining a new EHR system. Moving forward, it is essential for the Division, along with all other divisions, to identify key business requirements so that the new EHR can be tailored to resolve current inefficiencies and enhance overall productivity. Two critical components should include integration with the Public Laboratory system and the implementation of a multilingual patient portal. Ensuring that all relevant stakeholders are involved in this process is vital to meeting the needs of the users.
- In the meantime, there is an opportunity for administrative assistants to confirm the preferred language of individuals during pre-clinic insurance checks. Additionally, revising the email templates sent to patients to include clearer instructions and necessary forms prior to their visit in their preferred language can improve the process.

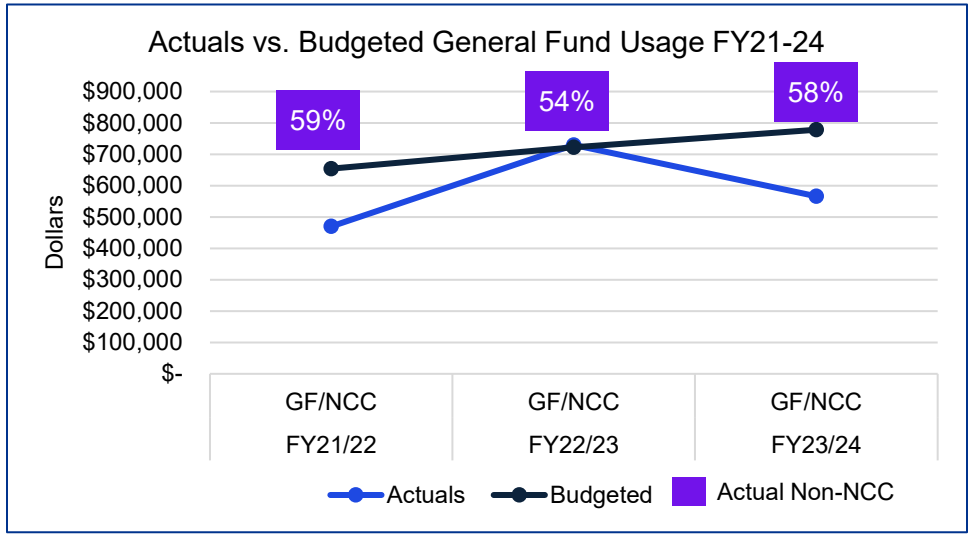
Key Opportunity Action Steps	Benefit	
• **Engage Divisions:** Conduct workshops with representatives from each division to identify and document key business requirements for the new EHR system. • **Develop a Task Force:** Form a task force including stakeholders from all relevant divisions to participate in the EHR implementation process and support testing. • **Enhance Pre-Clinic Communication:** Train administrative assistants to confirm patient language preferences during pre-clinic checks and develop standard email templates with clear instructions and necessary forms in multiple languages.	• **Enhanced Efficiency:** A new EHR system with integrated lab results and a multilingual patient portal will streamline workflows, reduce administrative burdens, and expedite patient processing. • **Improved Patient Experience:** Confirming language preferences and providing clear instructions in multiple languages will better prepare patients for appointments, reducing wait times and increasing satisfaction.	*While not yielding immediate calculable Cost Efficiencies, this opportunity will enhance operational efficiencies and help ensure that the EHR aligns with system needs.*

Emergency Medical Services Division – Overview

Division Overview

- The Emergency Medical Services Division encompasses the County's Emergency Medical Services Agency (EMSA) and the Public Health Emergency Preparedness (PHEP) Program.
- The EMSA is responsible for training and regulatory oversight of the County's pre-hospital care system, which includes first responder medical direction, ambulance contracts, base station hospitals (where hospital-based medical staff communicate by radio with field medics), and Specialty Care Centers for conditions such as ST-Elevation Myocardial Infarction and Trauma.
- The PHEP program manages planning, training, drills, and response for health and medical aspects of disaster events within the county, in collaboration with healthcare partners and other emergency management responders.

8.00 *Total FTE*	**$1.56M** *Total Budget FY24-25*
45% *Budgeted FY24-25 Non-NCC*	**55%** *Budgeted FY24-25 General Fund*
58% *Actual FY23-24 Non-NCC*	**42%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$1,559,175	13%	$854,311	$501,113	8
Santa Barbara*	441,257	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*
Monterey**	430,723	$3,409,867	7%	4%	*0*	9
Santa Cruz	261,547	$1,573,321	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	6
Sonoma***	481,812	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*
Ventura	829,590	$6,871,481	57%	$1,096,173	$1,892,526	21

** In Santa Barbara County, EMSA and PHEP are part of the Regulatory Programs & Emergency Preparedness Division, which also includes Environmental Health. Since the County's budget book does not break down funding by program, we cannot determine specific funding and General Fund contributions specifically for EMSA and PHEP. However, the overall General Fund contribution for the entire division is $162,500 (1.4%), with intergovernmental revenues amounting to $1.15 million (10%).*

*** Monterey have introduced a Measure A Tax which supports the provision of EMS Service; therefore, the low Charges for Services is a result of the County obtaining Tax revenues, excluding this tax, the Division has a Non-NCC of 26%.*

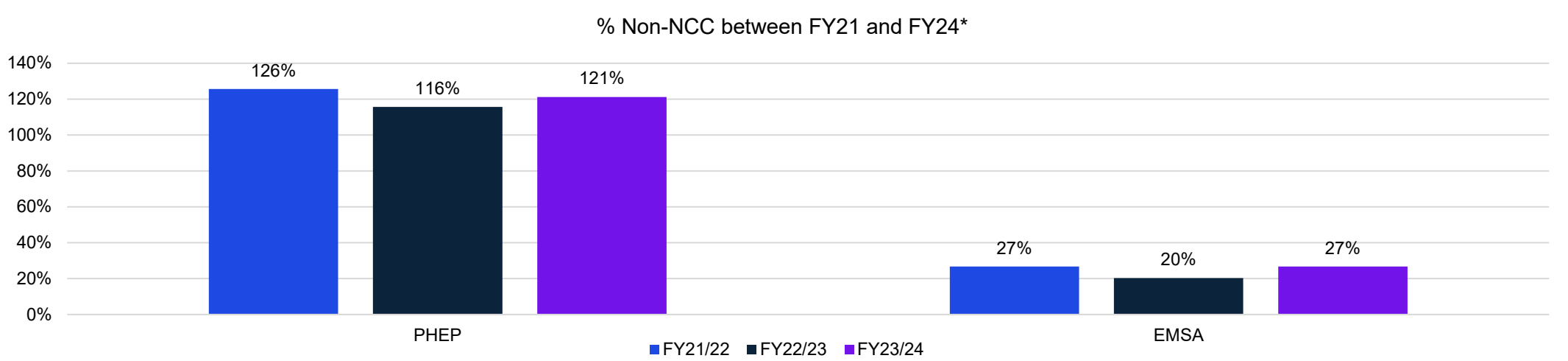
****Sonoma County does not provide program level budget within its Budget Book with budget reported only at the Department level.*

***Disclaimer:** Financial information for this Division was derived from workpapers provided by the Health Agency.*

Emergency Medical Services Division – Key Data Analysis

Between FY 21-22 and FY 23-24, the Emergency Medical Services Division achieved a combined average Non-NCC rate of 57%, requiring an average of $588,648 from the General Fund each fiscal year. The primary driver of General Fund usage is the Emergency Medical Services Agency (EMSA) accounted for 100% of General Fund usage for the division during this period.

- The Public Health Emergency Preparedness (PHEP) program did not utilize General Funds between FY 21-22 and FY 23-24, being fully funded by the Hospital Preparedness Program (HPP), PHEP, and Pan Flu Grants. In FY 23-24, the program received nearly $499,004 in grants but did not utilize all available funding, resulting in a surplus of $93,739 and an average Non-NCC rate of 121%.
- Conversely, the EMSA program experienced an average Non-NCC rate of 25% between FY 21-22 and FY 23-24 due to revenue not meeting expenditures. Although revenue increased by 16% to $240,216 in FY23-24, expenditures rose by the same percentage to $900,236, necessitating the use of $660,019 from the General Fund.



	General Fund Usage	
	PHEP	EMSA
FY21/22	$ (97,623)	$ 567,569
FY22/23	$ (85,865)	$ 815,583
FY23/24	$ (93,739)	$ 660,019

*This chart has been generated using actuals versus budgeted revenue and expenditures. The expenditures include Services & Supplies and Salaries related to each individual program. "Other Expenses" have been aggregated at the division level and not allocated across the programs. Percentages higher than 100% represent instances where funds were surplus and carried forward to the next fiscal year as allowed by PHEP grants.

Emergency Medical Services Division – SWOT Analysis

Strengths

- **Ambulance Service Contracting:** EMSA has begun engaging a consultant to assist in developing a Request For Proposal (RFP) for services currently provided by San Luis Obispo Ambulance to continue to support best value for money while maintaining high standards of service.
- **Hospital Oversight Services:** EMSA provides oversight services to the County's four hospitals to monitor their equipment and evaluate compliance with state and local laws. The program has recently implemented a $100k fee for these services.
- **Improved Patient Care Reporting:** 90% of Emergency Services providers managed by EMSA have migrated to the Image Trend platform, streamlining patient care reporting.
- **Strong Volunteer Network Support:** The Health Preparedness Division has a strong volunteer network, which has supported various initiatives and reduced divisional staff time on key initiatives.
- **Limited General Fund Utilization**: PHEP is solely funded by cyclical grant funding and are currently not relying on any general fund dollars.
- **Enhanced Divisional Culture:** Division staff across both EMSA and PHEP are committed to their mission, and staff have reported that the divisional culture has notably improved in recent times.

Weaknesses

- **EMT Certification Funding:** EMSA is responsible for EMT certifications; however, certification fees do not adequately cover the cost of providing the service. Initial certification fees are currently $105 and $67 for recertification, and in FY23-24, the Program received $28k from certification issuance. However, the State took 75% of these fees, leaving the Program with only $8k.
- **Response Time Penalties:** Typically, contracts incur penalties for late response times; however, this practice was not implemented in San Luis Obispo until July 2024. The current penalty system is tiered for late responses and starts at $500, with an expected response time of 10.59 minutes, which must fall within the 90th percentile. Current response times are high compared to industry standards of between 8 and 9 minutes.
- **Dispatch Protocols:** 14 local government agencies provide fire protection and a mix of Advanced Life Support (ALS) and Basic Life Support (BLS) services, along with two ALS ambulance providers and one ALS air rescue. Both Fire and EMS respond to all calls except lift aid, which is handled solely by the fire departments. Limited procedures exist to prioritize calls requiring ambulance services over fire services. This can result in service duplication in some instances with increased costs for clients of service.
- **Grant Funding:** The PHEP program is not utilizing the entirety of its grant funding, resulting in an underusage of $94k at the end of FY23-24. Please refer to page 21 for an overarching opportunity relate to enhancing the grant management process.

Opportunities

- **Certification Fee Adjustment:** Increase EMT and Paramedic certification fees to achieve greater Non-NCC in undertaking this process.
- **Response Time Standardization:** Adjust response time requirements to align with industry standards and realign penalties to align with these response times where there are not met.
- **Revise Dispatch Protocols:** Revise dispatch protocols to expand use of an "ambulance alone" response to more efficiently respond to low-urgency calls.

Threats

- **General Fund Dependence:** Higher reliance on the General Fund may strain other county resources and limit funding for other county projects.
- **Response Time and Penalty Concerns:** Current response times exceed industry standards, and the low penalty fees may be insufficient to effectively deter delays, potentially impacting the quality of service and patient outcomes.
- **Increased Patient Costs:** The limited dispatch protocols for dispatching ambulance services over fire services may lead to increased costs for patients.

Emergency Medical San Luis Obispo

Opportunity 3.5	Increase EMT certification fees to achieve better Non-NCC for providing these services.

Current State

- EMSA is the county agency responsible for EMT certification. The certification costs $105 per certification, including the state's fee of $75. In FY 23-24, the Division collected $28,000 from EMT certification fees. However, after accounting for the state's portion, the County retained approximately $8,000 of the total fees collected.
- Currently, the County has one administrative staff member dedicated to processing certifications. Interviewees report that this staff member spends 75% of her time on this task. Based on the average salary for administrative personnel, this equates to a fully burdened salary of $66,750, excluding other key operational costs.
- Based on a review of benchmark counties, San Luis Obispo County's EMT certification fees are significantly lower than most others with the exception of Monterey County, as shown in the table below. This may be attributed to the fact that San Luis Obispo County absorbs the state fees, while counties like Santa Barbara and Santa Cruz pass these costs on to their applicants. Monterey County only charges the state's fee for this service; however, they have introduced a Measure A Tax to support the provision of EMS services, which likely enables them to absorb the costs of this service.

County	EMT Fee	EMT Recertification Fee
San Luis Obispo	$105	$67
Monterey*	$75	$38
Santa Barbara	$116 (County fee) + $75 (State fee)	$59 (County fee) + $37 (State fee)
Santa Cruz	$100 (County fee) + $75 (State fee)	$100 (County fee) + $37 (State fee)
Sonoma	$155	$155

Key Opportunity for Consideration

- The Division should increase EMT certification and recertification fees to align with the cost of providing this service to support full Non-NCC.

Key Opportunity Action Steps

- **Conduct a Cost Analysis:** Conduct a cost analysis to determine the cost of providing certification services. The cost analysis should include staffing cost; as well as allocation for operational costs (i.e., supplies, facilities, technology etc.)
- **Develop a business plan:** This plan should include the cost analysis, justification, and benefits to increasing fees.
- **Obtain approval:** Obtain approval from the Board of Supervisors for the increase by developing a board letter and providing the business plan.

Benefit

- **Cost Coverage:** Supports the Division to recoup the expenses associated with processing credit card payments.
- **Enhanced Financial Stability**: Improves overall Non-NCC, reducing the financial burden on the Division and reliance on General Fund.

$40,000 – 67,000*

Potential Annual Cost Efficiencies

Emergency Medical Services
EMT Application Frequently Asked Questions | County of Monterey, CA
EMT-Optional Scope | Santa Barbara County, CA - Official Website
Fee Schedule - Coastal Valleys EMS Agency - CVEMSA

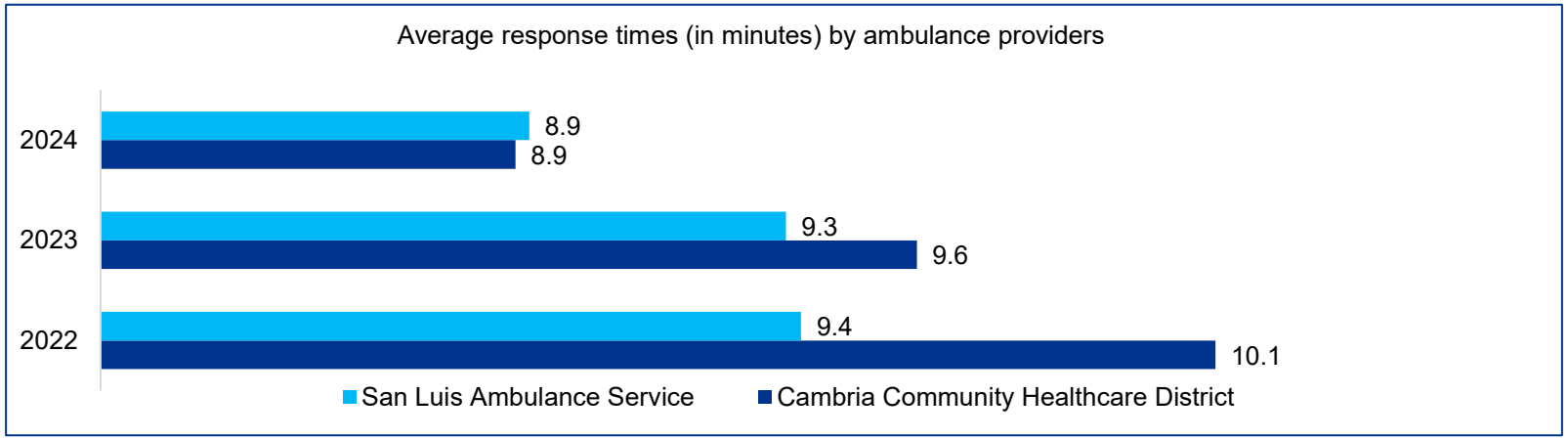
*The savings relates only to the cost of salary which may be recouped as a result of increased cost. It does not account for other operating service costs.

Emergency Medical Services Division – Key Opportunities

Opportunity 3.6	Adjust response time requirements to match industry standards and realign penalties accordingly for non-compliance.

Current State

- Currently, EMSA contracts with two Advanced Life Support (ALS) ambulance providers, San Luis Obispo Ambulance and Cambria Ambulance, to deliver services in the County. According to the contracts, the current response times for services in Urban areas are set at 10 minutes and 59 seconds in the 90th percentile. If ambulances fail to meet this metric, they are charged a fee *starting* at $500. However, this fee has only been implemented since July 2024, with no fee prior to that date.
- Based on a review of response time data, benchmarking analysis, and a review of leading practice, the County's response times are higher than leading practice, and the penalties for not meeting service standards are lower than those charged in other counties:



  - The current target response time of 10 minutes and 59 seconds in the 90th percentile is higher than National Fire Protection Association (NFPA) standards which established a 60 second “turnout time” and 480 second “travel time” (together, 9 minute “response time”) benchmark time goal for “the arrival of an ALS unit at an emergency medical incident” at not less than 90% of dispatched incidents.
  - Further, on average both Cambria and San Luis Obispo ambulances are responding to all call on average in under 9 minutes.
  - Additionally, the current target response time of 10 minutes 59 seconds is also 3 minutes higher than Santa Barbara County who recently reduced its contracted response time for its ambulance service provider (American Medical Response) to 7 minutes and 59 seconds for priority 1 calls in urban areas.
  - Finally, the penalty for not meeting service standards in San Luis Obispo is 3 times less than that the starting fee of $1,500 charged by Santa Barbara County to its ambulance service provider

County Supervisors OK 4-Year AMR Ambulance Contract, Discuss Response Time Concerns | Local News | Noozhawk

Emergency Medical Services Division – Key Opportunities

Opportunity 3.6	Adjust response time requirements to match industry standards and realign penalties accordingly for non-compliance.

Key Opportunity for Consideration

There is an opportunity for the Division to reduce response times for calls in urban areas to better align with industry standards and benchmark counties. Additionally, the Division should consider increasing liquidated damages for failure to meet response times to match practices in counties such as Santa Barbara. As the County develops an RFP to solicit services, reducing response times and increasing penalties for non-compliance should be key considerations in this process.

Key Opportunity Action Steps	Benefit	
• **Evaluate Current Performance:** Assess how well ambulance providers are meeting the existing response time requirements. • **Set New Standards and Penalties:** Establish response time targets that align with NFPA standards (e.g., 9 minutes in the 90th percentile) and consider increasing penalties to match those of neighboring counties. • **Amend Provider Contracts:** Negotiate with ambulance service providers to update contracts to reflect the new response time requirements and penalties. • **Monitor Performance Regularly:** Conduct ongoing analysis to evaluate provider performance against the new standards.	• **Enhanced Service Quality:** Aligning response time requirements with industry standards enables quicker medical intervention and better patient outcomes. • **Increased Accountability:** Realigned penalties for non-compliance will incentivize providers to meet performance standards more consistently. • **Informed Decision-Making:** Regular analysis and monitoring of response times and compliance generate valuable data, informing future policy decisions and strategic planning.	*The Potential for Cost Efficiencies as a result of this will be dependent on agreements reached with existing ambulance providers with regards to response times and penalties*

Emergency Medical Services Division – Key Opportunities

Opportunity 3.7	Establish contract oversight fees for Air Ambulance oversight ensuring that the charges reflect the actual costs incurred for providing the service.

Current State

- There are four hospitals in San Luis Obispo County, all designated as base hospitals, with two also serving as specialty centers—a Level III Trauma Center and a STEMI Receiving Center. Additionally, the County has one ALS air rescue service providing pre-hospital care across its 3,299 square miles, catering to a population of approximately 282,424.
- The EMS Division provides oversight for base hospitals and air rescue services by monitoring their equipment and conducting thorough walkthroughs to help ensure compliance. Recently, the Division has begun charging hospitals a fee of $25,000 for this oversight service and plans to extend similar charges to air rescue services in the future. Interviewees reported that oversight activities consume approximately 3% of staff time across services; however, this figure is not based on a time study or data-driven analysis and does not account for operational costs, such as the overhead charged to the Health Agency for supporting countywide operations.

Key Opportunities for Consideration

In the future, the Division should develop a fee schedule for air rescue services that accurately reflects both staff time and operational costs to support full Non-NCC. Additionally, the recently implemented $25,000 fee for hospitals should be reviewed at the end of the year to help ensure it accurately covers the cost of services, and adjustments should be made as necessary.

Key Opportunity Action Steps	Benefit	
• **Verify Initial Fee Estimate:** Assess the estimated cost of service provision using data-driven methods (e.g., reviewing time sheets over 2-3 fiscal years) and consider other operational costs incurred to provide the service. • **Negotiate with Air Rescue:** Engage in negotiations with the air rescue to establish a fee and associated contract. • **Monitor and Evaluate:** Monitor the actual costs of both hospital and air rescue oversight (once implemented) and conduct an annual fee analysis to help ensure the fees continue to cover the associated costs.	• **Non-NCC:** Helps ensure that all expenses related to contract oversight are fully covered, preventing the EMS Division from absorbing extra costs. • **Financial Sustainability:** Contributes to the long-term financial stability of the EMS Division by aligning fees with actual service delivery costs. • **Service Quality:** help ensures that hospitals receive consistent and high-quality oversight due to adequately funded monitoring and compliance operations.	**$25,000*** *Potential Annual Cost Efficiencies*

* In the absence of time data and operational cost, we have assumed that the $25,000 identified by Management will be the minimum potential saving.

Emergency Medical Services Division – Key Opportunities

Opportunity 3.8	Adopt dispatch protocols to expand use of an "ambulance alone" response to most efficiently respond to low-urgency medical calls.

Current State

- Currently, the Sheriff's Medical Communications (MedCom) dispatch center handles dispatch of fire and EMS services for the County. However, there are no dispatch protocols or advanced software systems, such as ProQA, in place to support the identification of **priority 1 ambulance-only calls**.
- Consequently, both fire services and EMS respond to all calls with the exception of lift aide which is responded to only by Fire. In FY23-24, 27,464 calls were responded to; however, it is not possible to determine the percentage of calls that are exclusively life aide as this data is unavailable. Furthermore, only 53% of these calls required transport to hospitals. This suggests that many of the calls being attended to by EMS are low-priority medical cases. Interviewees confirmed this, with respondents indicating that the low transportation rates are due to being dispatched to low-priority medical calls that do not require hospital intervention, or cases where individuals decline service.
- Despite this, both EMS and fire services are dispatched, leading to duplicated service efforts. This duplication not only increases regulatory costs for EMSA but also results in higher service costs for clients, as multiple agencies respond to calls that may not require such extensive resources. Implementing more effective dispatch protocols and advanced system support could streamline responses, reduce costs, and help ensure that resources are allocated more efficiently.

Key Opportunity for Consideration

- There is an opportunity to enhance current dispatch protocols by introducing an "ambulance alone" category. This would allow Dispatch to send only a fire engine or ambulance to low-acuity calls based on the information provided during the call. Division leadership should explore the feasibility of creating this category for calls that require a significant medical response. King County, Washington, has implemented EMS protocols that include ambulance-only responses for specific low-acuity calls, aiming to match the level of response to the severity of the incident, and utilizes programs like OneCall to address such cases.
- To support this strategy, dispatch protocols should incorporate specific questions that enable dispatchers to quickly and accurately assess the caller's medical needs. This will help determine whether to dispatch (1) an ambulance staffed with paramedics, or (2) an ambulance along with a fire apparatus.

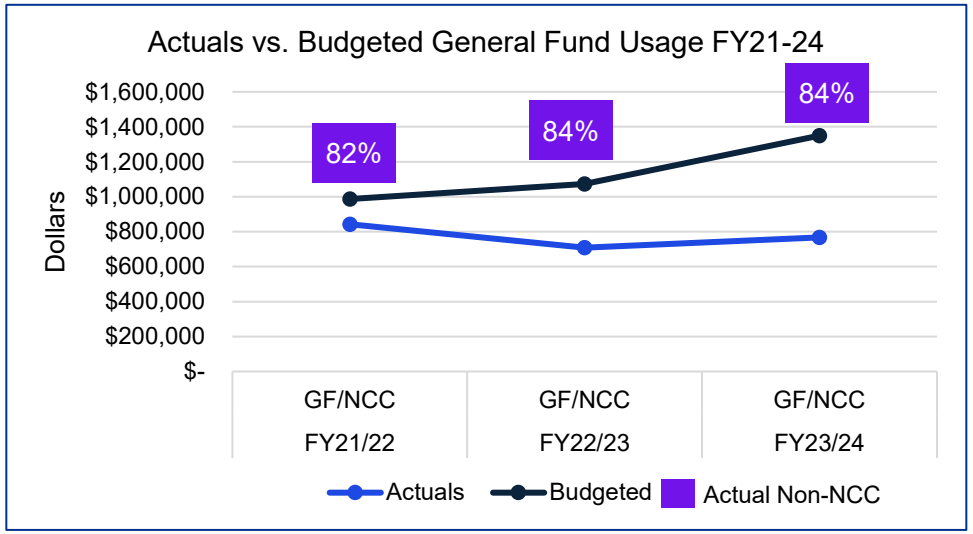
Key Opportunity Action Steps	Benefit	
• **Consider Future Technology**: Consider implementing software such as PROQA in the future to streamline the response process. • **Conduct Collaborative Assessment**: Collaborate with EMS, Fire, and Dispatch to identify key calls that may require an ambulance-only response. • **Develop Response Protocols:** Jointly develop protocols that outline the criteria and procedures for these types of responses. • **Train Dispatch Personnel**: Train dispatch personnel on the new protocols to help ensure accurate and efficient assessment and response. • **Implement and Monitor**: Implement and monitor the new protocols to assess their effectiveness and make necessary adjustments.	• **Optimized Resource Allocation**: Introducing an "ambulance alone" category supports more efficient dispatch reducing the over-deployment of resources. • **Reduced Response Times**: By sending the appropriate response unit based on the acuity of the call, emergency services can respond quicker to high-acuity calls, potentially improving patient outcomes. • **Cost Efficiency:** Streamlined dispatch protocols can result in Cost Efficiencies for patients, as they will only need to pay for one vehicle, and can also reduce operational costs for EMSA with less calls meaning less monitoring etc.	*This opportunity will result in increased efficiency and reduce cost for clients. It may also result in reduced administrative costs for EMSA. However, an accurate dollar value saving is difficult to develop without data on the number of calls that may be considered ambulance alone in the future.*

Environmental Health Division Overview

Division Overview

- The Environmental Health Services Division protects public health and the environment by preventing disease and exposure to harmful environmental contaminants. This is achieved through undertaking a range of key activities including inspections, education, investigations, and enforcement of regulations related to various areas such as food safety, water quality, and solid waste management.
- The Division runs a range of key programs encompassing body art regulation, food safety, hazardous material management, land use planning and well drilling, radiological health, recreational swimming facilities (including pools, spas, and ocean water), mosquito surveillance and control, waste management, water quality monitoring and protection, and stormwater management.

27.75 *Total FTE*	**$5.3M** *Total Budget FY24-25*
80% *Budgeted FY24-25 Non-NCC*	**20%** *Budgeted FY24-25 General Fund*
84% *Actual FY23-24 Non-NCC*	**16%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$5,291,405	75%	$1,049,146	$277,966	27.75
Santa Barbara*	441,257	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*
Monterey	430,723	$11,199,162	88%	$819,256	$568,881	62
Santa Cruz	261,547	$13,831,131	*Not Publicly Reported*	*Not Publicly Reported*	*Not Publicly Reported*	43
Sonoma**	481,812	Not Publicly Reported	Not Publicly Reported	Not Publicly Reported	Not Publicly Reported	Not Publicly Reported
Ventura	829,590	$13,251,064	98%	$0	$292,022	80.78

** Environmental Health in Santa Barbara County forms part of the Regulatory Programs & Emergency Preparedness Program which includes Environmental Health, Emergency Medical Services (EMS), and Emergency Preparedness and the County's Budget Book does not breakdown funding program component. However, the overall General Fund contribution for the entire division is $162,500 (1.4%), with intergovernmental revenues amounting to $1.15 million (10%).*

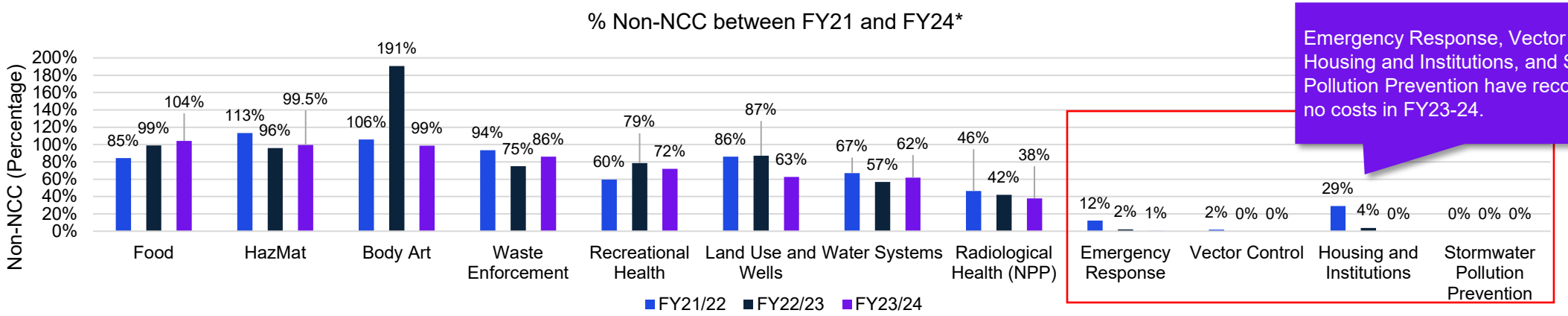
*** Sonoma County does not separate its public health budget into specific component programs, and therefore, detailed financial information on the Environmental Health Program not available*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency..*

Environmental Health Division – Key Data Analysis

Between FY 21-22 and FY 23-24, the Environmental Health Division achieved a **combined average Non-NCC rate of 83%** (versus a budgeted Non-NCC rate of 80%), requiring an average actual General Fund use of $772,932 each fiscal year. The primary drivers of General Fund usage include Water Systems, Emergency Response, Land Use, and Recreational Health (Ocean Water), which collectively accounted for **90% of General Fund expenditures in FY23-24 alone.**

- Though Vector Control, Housing and Institutions, and Stormwater Pollution Prevention rely entirely on general fund support, they constitute only a small portion of general fund usage each year. These programs collectively accounted for an average of 2% ($12,476), 4% ($29,168), and 2% ($14,969), respectively, of the total general fund expenditures over the past three fiscal years.
- Conversely, Non-NCC for the following programs has been declining between FY21-22 and FY23-24. Land Use (-23%), Recreational Health, Radiological Health – NPP Grant Program (-8%), and Emergency Response (-11%). General Fund use for Land Use increased nearly 1.4x in the same period due to a significant decrease in revenue (34%) which may be due to fees not keeping up with cost-of-living increases.
- For Recreational Health and Radiological Health, this is driven by grant funding not keeping up with the cost of operating the program, while for programs such as Emergency Response, it is driven by an increase in Emergency Response events.



Emergency Response, Vector Control, Housing and Institutions, and Stormwater Pollution Prevention have recovered little to no costs in FY23-24.

	General Fund Usage											
	Food	HazMat	Body Art	Waste Enforcement	Recreational Health	Land Use and Wells	Water Systems	Radiological Health (NPP)	Emergency Response	Vector Control	Housing and Institutions	Stormwater Pollution Prevention
FY21/22	$ 257,642	$ (121,091)	$ (3,038)	$ 5,307	$ 164,217	$ 63,780	$ 222,534	$ 42,344	$ 151,563	$ 23,407	$ 20,479	$ 15,352
FY22/23	$ 16,903	$ 44,190	$ (27,154)	$ 26,860	$ 67,482	$ 60,889	$ 279,284	$ 47,397	$ 123,290	$ 7,566	$ 45,761	$ 16,060
FY23/24	$ (66,587)	$ 5,266	$ 913	$ 13,375	$ 115,250	$ 153,558	$ 251,581	$ 80,023	$ 173,178	$ 6,456	$ 21,264	$ 13,497

**This chart has been generated using actuals versus budgeted revenue and expenditures. The expenditures include Services & Supplies and Salaries related to each individual program. "Other Expenses" have been aggregated at the division level and not allocated across the programs.*

Environmental Health Division – SWOT Analysis

Strengths

- **Process automation:** Inspectors utilization automated processes and tablets to complete inspections increasing efficiency in inspection completion.
- **Performance Management:** Leadership operate strong performance management processes with inspectors allocated by district and each given specific targets to reach monthly based on district and inspection type. Regular coaching occurs monthly where inspectors do not reach targets.
- **Data-Driven Allocation:** The Division completes annual workload studies to justify the number of inspectors needed based on time-study data, emphasizing data-driven decision-making.
- **Cross-Training:** Inspectors are cross-trained across different programs to support knowledge sharing and resiliency.
- **Strong Training Program:** The Division has a strong training program for new inspectors providing them with the necessary experience and study time to pass certification exams. This has resulted in a 0% failure rate.

Weaknesses

- **Non-NCC Challenges:** The Division is not fully recovering its costs, with 84% of total recovered in FY 23-24, leaving $767k (16%) to be covered by the General Fund. The is a higher general fund use than other counties, such as Santa Cruz who have a budgeted 92% Non-NCC.
- **Revenue Recognition:** Revenue is recognized when received rather than when earned. For example, in programs like Land Use where engagements with customers may span several years and invoices are issued at the end, this practice can lead to fluctuations in revenue and general fund use across different years.
- **Fee Development Timing:** Fees are developed before the budget which result in fees that do not accurately reflect the actual costs and financial requirements of the Division.
- **Low Emergency Response Reimbursement:** The majority of Emergency Response program costs are not included in existing fees, resulting in low reimbursement levels, comprising 23% of the General Fund amount in FY 23-24.
- **Credit Card Fees:** The Division does not charge a credit card convenience fee for payments made.

Opportunities

- **Fee Increases for Non-NCC:** Improve Non-NCC by increasing fees for key programs such as Land Use, Water Systems, and Radiological Health.
- **Cost Reimbursement:** Explore opportunities for reimbursement of emergency response, storm water pollution, and waste enforcement services.
- **Post-Budget Fee Development:** Develop annual fees after finalizing the annual budget to help ensure alignment.
- **Credit Card Fees:** Implement a 3% credit card fee across the Division to cover transaction costs, ranging from $22k – $27.5k across the past three fiscal years.
- **Revenue Recognition:** Consider accruing for revenue in the period in which it is earned to prevent peaks and throughs. *This is an opportunity to consider countywide, please refer to opportunity 1.5.*

Threats

- **General Fund Dependence:** Higher reliance on the General Fund (17% or $773K, on average between FY 21-22 and FY 23-24) may strain other county resources and limit funding for other county projects.
- **Inaccurate Fee Setting:** Developing fees before finalizing the budget can result in fees that do not accurately cover actual costs, leading to a gap in reimbursement which can deplete resources for other critical services.
- **No Credit Card Fee Recovery:** Not charging a credit card convenience fee for payments can lead to unrecouped transaction costs, impacting the Division's overall budget.

Environmental Health Division – Key Opportunities

Opportunity 3.9	Re-evaluate fees for Water Systems and Land Use program fees to support full Non-NCC and reduce reliance on the General Fund.

Current State

- Based on a review of the Department's actual versus budgeted funding for FY23-24, the Department had a budgeted Non-NCC of 80% and actual Non-NCC of 84%. This is considerably lower compared to benchmark counties like Santa Cruz and Ventura, which have budgeted Non-NCC rates of 92% and 100% respectively.
- This lower-than-benchmark Non-NCC rate is primarily due to several programs not charging sufficient fees to support full Non-NCC. Specifically, the Land Use and Water Systems programs collectively cost the General Fund $405,139 representing 53% of the total General Fund expenditure of $767,775 in FY23-24.

Water Systems

- The goal of the Water System program is to evaluate public water systems to help ensure the delivery of safe, potable water and prevent backflow contamination through inspections, sampling, plan checks, permitting, enforcement, and public education.
- The program does not achieve full Non-NCC, resulting in a general fund expense of $251,581 for FY23-24, which represents 32% of general fund utilization for that fiscal year. Permit fees are the primary revenue source; however, the Division encounters the following challenges:
  - Permit fees are not aligned with the cost of service delivery and have not been updated for several years.
  - The Division spends significant time evaluating small water systems to determine permit eligibility, thereby incurring time and expenses that are currently not being recovered. For example, they have identified 75 systems, mainly wineries that have gone undetected over several years. The goal was to evaluate these systems over a specified period; however, they have only been able to evaluate 20 systems over the past four years due to the time-intensive nature of this work which is not being Non-NCC. Additionally, these systems are often not responsive to the permitting process and obtaining information/payment can be challenging.
  - In addition to challenges in determining permit eligibility, many water systems engage the Department to obtain technical assistance which is not currently cost recoverable.
  - Finally, the Division operates a BACT water program that supports monitoring the chemical and bacteriological quality of water of over 20 systems countywide. The program cost the general fund $35,797 in FY23-24. The Division charges a flat fee for each system; however, systems are located various distances away, some requiring over an hour of travel time each way and resultantly, the cost of the fee is not covering the cost of service.

Land Use

- The Land Use Program assesses the environmental health aspects of land development projects referred by the County of San Luis Obispo Planning and Building Department, primarily focusing on ensuring a potable water supply and safe, sanitary waste removal.
- Although revenue is generated through permit fees, these fees have not been updated in several years. As a result, they do not cover the cost of the service, leading to the program requiring $153,558 from the general fund in FY23-24—an increase of 150% from FY22-23.

Environmental Health Division – Key Opportunities

Opportunity 3.9	Re-evaluate fees for Water Systems and Land Use program fees to support full Non-NCC and reduce reliance on the General Fund.

Key Opportunities for Consideration

In the future, the Division should consider undertaking the following:

- Conduct a fee study to accurately determine the costs of services and help ensure that fees align appropriately with these expenses.
- Integrate the expenses incurred for assessing water system eligibility into the overall permitting process and include them in the permitting fees, as this is a critical service provided by the Division.
- In cases, where a water system requires technical assistance, consider charging an hourly rate for services to better reflect the actual time and resources utilized.
- Implement penalties for water systems that refuse service or payment to better motivate compliance.
- Update the BACT water program to implement a rate structure based on geographic location, where systems situated farther away incur higher fees to account for additional travel and associated costs.

Transitioning to full Non-NCC for these programs would increase the Division's overall Non-NCC to 92%, based on budgeted revenue for FY 24-25. This is more aligned with benchmark counties like Santa Cruz. Furthermore, although not a benchmark county, in 2022, San Mateo County undertook a Non-NCC analysis across all services provided to enhance Non-NCC from 87% to 97%.

Key Opportunity Action Steps	Benefit	
• **Conduct Cost Analysis:** Evaluate the actual costs of delivering services for the program over a 3-year period. • **Develop Fee Adjustments:** Propose fee adjustments based on cost analysis and consider fee benchmarking included on page 186 - 188 of this report for both programs. • **Obtain Approvals:** Present proposed fee adjustments to Board of Supervisors. • **Implement New Fees:** Roll out the adjusted fee rates using a phased approach. • **Communicate Changes:** Inform the public about the new fee structures. • **Monitor and Review:** Continuously monitor fee revenue and service costs to support alignment and make adjustments on an annual basis.	• **Increased Non-NCC:** Aligning fees with the actual cost of service delivery supports higher Non-NCC, enhancing financial stability. • **Better Financial Planning:** Realistic fee rates improve budget forecasts and reduce the risk of budget shortfalls. • **Reduced General Fund Reliance:** By generating more revenue, the Division can lessen its dependence on the General Fund, freeing resources for other priorities. • **Fairness and Equity:** True cost fees provide a fair price for both users and the Division, promoting equity and transparency.	**$280,000 – $435,000** *Potential Annual Cost Efficiencies*

Environmental Health Division – Key Opportunities

Opportunity 3.10	Consider incorporating the cost of Emergency Response into regular fees to improve Non-NCC for this service.

Current State

- The Division responds to emergency complaints from the public, fire, police, sheriff's departments, and other government agencies regarding environmental health issues. These calls include sewage spills, abandonment and illegal dumping of hazardous waste, vehicle accidents involving spillage, foodborne illnesses, and restaurant staff issues, with staff on call 24/7.
- In FY23-24, the cost of this service was $174,113, with only $936 (1%) of this Non-NCC. This left the general fund to cover the remaining $173,178. Additionally, the revenue collected was 8% less than the budgeted amount of $11,025.
- Stakeholders indicated that this significant variance resulted from a high number of emergency response incidents in FY23-24, which were not budgeted for, could not be recovered, and were not factored into overall service fees across programs to cover this service. In FY24-25, the budget for this service is projected to be $125,000 with a budgeted revenue of $10,335.

Key Opportunity for Consideration

In the future, considering the cost of this service could be attributed to any program or service provided by the Division, the Division may consider implementing a flat fee across all programs to support the continued operation of this service. This fee should be based on the budgeted future costs of the service to support adequate cost coverage.

Key Opportunity Action Steps

- **Conduct Cost Analysis:** Evaluate the actual costs of delivering this service over the past 3-5 years and analyze the volume and time intensity for service providers.
- **Develop Fee Adjustments:** Based on the cost analysis, propose fee adjustments and allocate them across program fees. Consider weighting based on the proportion of costs applicable to key program areas.
- **Obtain Approvals:** Present the proposed fee adjustments to the Board of Supervisors for approval.
- **Implement New Fees:** Roll out the adjusted fee rates as approved.
- **Communicate Changes:** Inform the public about the new fee structures and the rationale behind these changes.
- **Monitor and Review:** Continuously monitor fee revenue and service costs to support alignment and make necessary adjustments on an annual basis.

Benefit

- **Enhanced Financial Stability:** Improved Non-NCC to support financial sustainable of service.
- **Reduced General Fund Reliance:** Less reliance on the General Fund frees up resources for other needs.
- **Consistent Funding:** Provides a more predictable and steady stream of revenue to cover emergency response costs.
- **Better Financial Planning:** Improves budget forecasts and reduces the risk of budget shortfalls.

$120,000 - $175,000

Potential Annual Cost Efficiencies

Environmental Health Division – Key Opportunities

Opportunity 3.11	Collaborate with other county departments such as Public Works to consider adoption of surveillance cameras in illegal dumping hotpots.

Current State

- The Division operates a water enforcement program that addresses public complaints regarding the illegal dumping of both liquid and solid waste. While it is the responsibility of the Division to investigate this instances, it is the responsibility of Public Works to undertake clean up in public areas. This requires significant investigation and review, which is time-consuming, and the cost of this service is often not recovered due to challenges often experience in identifying responsible parties.
- In FY23-24, this led to an expense of $13,375 from the general fund for Environmental Health. Although this represents a relatively low cost of 2%, there is an opportunity to better recover these expenses in the future. For example, Monterey County has recently installed six cameras in three hotspot locations for illegal dumping. The cameras are equipped with cellular capabilities, enabled for motion-activated image capture, playback, and archiving. The cameras have successfully detected multiple instances of illegal dumping, with enforcement actions including the identification and citation of offenders. The County has also increased its penalties from between $100 - $500 to $2,500 to $10,000.

Key Opportunity for Consideration

- Consider collaborating with complimentary departments such as Public Works to implement surveillance systems in areas considered hotspots for dumping and consider increase penalties for illegal waste dumping to better recover the costs associated with the Division's water enforcement program.

Key Opportunity Action Steps	Benefit	
• **Analyze Data:** Collaborate with relevant agencies, such as Public Works, to evaluate dumping hotspots. • **Conduct a cost-benefit analysis**: Assess the advantages of adopting surveillance systems and initiate the procurement process where necessary. • **Obtain Approvals:** Seek Board approval for procurement and propose any necessary penalty adjustments to the Board of Supervisors. • **Communicate Changes:** Inform the public about the new penalty structure. • **Monitor and Review:** Continuously monitor hotspot activities and make adjustments as needed.	• **Enhanced Financial Stability:** Improved Non-NCC to support financial sustainable of service. • **Reduced General Fund Reliance:** Less reliance on the General Fund frees up resources for other needs. • **Consistent Funding:** Provides a more predictable and steadier stream of revenue to cover costs.	*As data on the number of violations is not available, it is not possible to calculate the cost efficiencies that can be achieved.*

Environmental Health Division – Key Opportunities

Opportunity 3.12	Update the fee schedule after finalizing the budget to better align fees with departmental costs in collaboration with County leadership.

Current State

- Currently, the Division updates its fee schedules before finalizing the budget, causing challenges in aligning fees with actual costs. This misalignment likely contributes to the reliance on General Fund dollars. Additionally, the Division, along with other divisions, operates on an informal target of 80/20 General Fund use. A 20% General Fund reliance is high compared to other counties, such as Santa Cruz who budgets for a 92% Non-NCC and San Mateo who budgets for a 97% Non-NCC.

Key Opportunity for Consideration

The Division should consider establishing reduced goals for General Fund use, aiming for a range of at least 5-10%, based on benchmarks from other counties.

Key Opportunity Action Steps	Benefit	
• **Update Fee Schedule Process:** Collaborate with key county stakeholders to revise the fee schedule development process, ensuring it takes place after the budget is finalized or becomes an integral part of the budgeting process. • **Set Non-NCC Targets:** Establish clear goals to reduce reliance on the General Fund, targeting a range of 5-10% based on successful practices from other counties.	• **Improved Financial Accuracy:** Helps ensure fees are based on actual operational costs, leading to more accurate financial planning and stability. • **Enhanced Non-NCC:** Aligning fees with budgeted expenses improves Non-NCC rates, reducing reliance on the General Fund.	*This opportunity will further support the Division to achieve greater Non-NCC; however, will not be in addition to the Cost Efficiencies already identified on prior pages*

Opportunity 3.13	Implement credit card convenience fees for payments made via credit card to cover transaction costs and enhance Non-NCC.

Current State

- Currently, the Department does not charge a fee to cover the cost of processing credit card payments for permits, licenses, etc. This cost the Department $26,562 in FY23-24.

Key Opportunity for Consideration

- In the future, the Division should implement a credit card processing fee to cover the full cost of all credit card processing fees which are currently a divisional expense.

Key Opportunity Action Steps	Benefit	
• **Analyze and Determine Fee Structure:** Conduct an analysis to determine the actual costs of processing credit card payments and establish a fee rate. • **Implement and Communicate:** Integrate the credit card convenience fee into the payment system and inform all stakeholders about the new fee.	• **Cost Coverage:** Supports the Division to recoup the expenses associated with processing credit card payments. • **Enhanced Financial Stability**: Improves overall Non-NCC, reducing the financial burden on the Division.	**$20,000 - $30,000** *Potential Annual Cost Efficiencies*

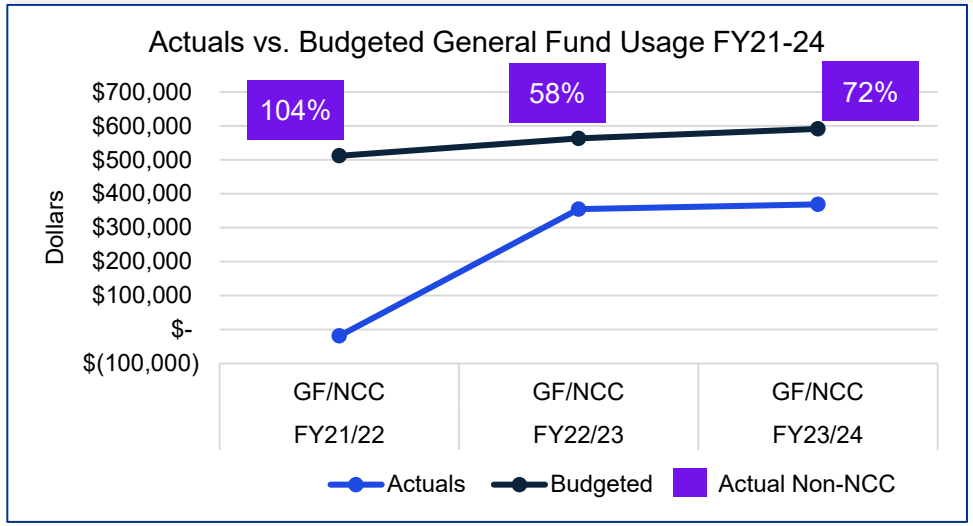
Health Care Access Division – Overview

Division Overview

The Health Care Access Division offers services to help low-income, high-need populations access healthcare:

- **Medically Indigent Services Program (MISP):** This mandated program handles enrollment, utilization review, and payment for healthcare for low-income residents with immediate medical needs.
- **Care Coordination Coalition and the Whole Person Care:** This program provides integrated health, behavioral health, and social services for vulnerable populations.
- **Oral Health Program:** This program supports low-income children in the County to have access to preventive, diagnostic, and treatment dental services, as well as a dental home.
- **Juvenile Services Center (JSC) medical services:** This program provides medical care for JSC wards, including evaluations, daily sick calls, medications, and coordinating referrals for substance use and mental health services.

13 *Total FTE*	**$1.75M** *Total Budget FY24-25*
71% *Budgeted FY24-25 Non-NCC*	**29%** *Budgeted FY24-25 General Fund*
72% *Actual FY23-24 Non-NCC*	**28%** *Actual FY23-24 General Fund*



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Sonoma***	481,812	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*
Ventura****	829,590	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*

**In Santa Barbara County, Enhanced Care Management forms part of the County's Health Centers Division budget and a program level budget breakdown is not available.*

***In Monterey, Enhanced Care Management forms part of the Health Preparedness Division; however, budgets are not separately reported for this division.*

In Santa Cruz, Enhanced Care Management is managed by Behavioral Health, while the Oral Health Program forms part of Community Education and program level budgets are not reported

****Sonoma County does not provide program level budget within its Budget Book with budget reported only at the Department level.*

Santa Cruz, Enhanced Care Management is managed by Behavioral Health, while the Oral Health Program forms part of Community Education and program level budgets are not reported

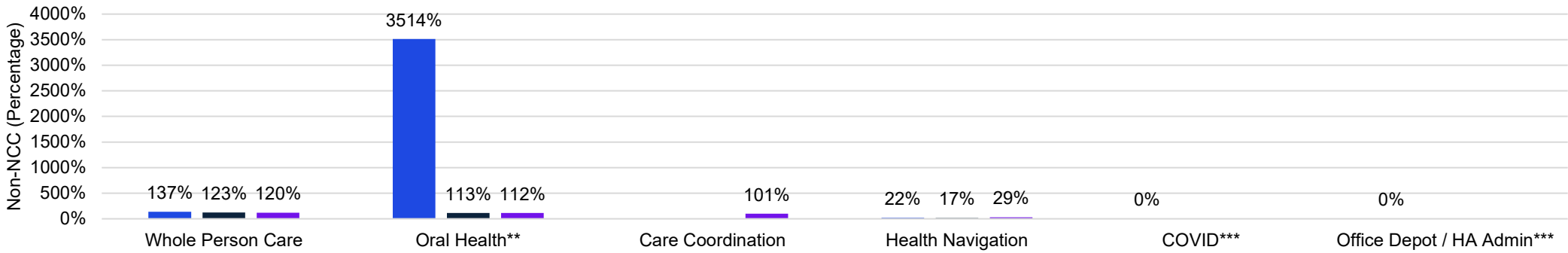
*****In Ventura, Enhanced Care Management is allocated a budget of $904,823, funded by 24% from the general fund and 63% from intergovernmental revenues. However, Oral Health is included within the Health Education Division, and a detailed funding breakdown for it is not provided.*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Health Care Access – Key Data Analysis

Between FY 21-22 and FY 23-24, the Health Care Access Division achieved a combined average Non-NCC rate of 78%. Between FY 21-22 and FY 22-23, the combined average Non-NCC rate for the Division fell 26% because of Oral Health's multiple funding streams and charge back from other cost centers. The Health Navigation (MISP) program being the primary driver of General Fund usage, requiring an average of $369,451 in the same period.

- Health Navigation (MISP), a state mandated program that requires minimum staffing, is the only program within Health Care Access requiring general fund support. In FY 21-22, the program required $264,598 in general fund support. After that, the program required $412,590 general fund support in FY 22-23 (an increase of 56%) due to an 84% in salaries and $431,165 in FY 23-24 (an increase of 4.5%). While revenue doubled in the same period from $86,756 to $179,694, expenses also increased by 22% from $499,346 to $610,859.
- Oral Health in FY 21-22 achieved a Non-NCC rate of 3,514% because it was returned $206,166 in Services & Supplies, while receiving $354,361 in grant funding. This resulted in a surplus of $344,277 against the General Fund. In FY 21-22 and FY 23-24, the program continued to achieve a surplus averaging $28,160 between both fiscal years. This is due to Oral Health's multiple funding streams. Staff salary & benefits are charged 100% to MCAH (housed in 16005 /16017). The portion not covered by MCAH is charged back to the Oral Health program and ultimately funded with LOHP & First 5 funding.



	General Fund Usage					
	Whole Person Care	Oral Health**	Care Coordination	Health Navigation (MISP)	COVID***	Office Depot / HA Admin***
FY21/22	$ (19,034)	$ (344,277)	$ -	$ 264,598	$ 70,334	$ 9,468
FY22/23	$ (30,556)	$ (27,505)	$ -	$ 412,590	$ -	$ -
FY23/24	$ (30,884)	$ (28,815)	$ (2,630)	$ 431,165	$ -	$ -

This chart has been generated using actuals versus budgeted revenue and expenditures. The expenditures include Services & Supplies and Salaries related to each individual program. "Other Expenses" have been aggregated at the division level and not allocated across the programs.

***Oral Health had a net positive related to Services and Supplies in FY21-22 resulting in a very high Non-NCC for that fiscal year.*

****This source of funding or program is no longer active or has been transferred to another cost center.*

Health Care Access Division – SWOT Analysis

Strengths

- **Overall – Strongly Grant Funded:** All programs are fully grant funded with the exception of MISP, a mandated program which supports vulnerable populations by helping low-income residents access the care they need. This program assists individuals who have immediate medical needs but lack the means to pay for them.
- **JSC – Reduction in Emergency Department Visits:** Collaborated with probation leadership to divert patients from local emergency departments by establishing a service agreement with Cottage Health Urgent Care. This initiative successfully reduced the number of visits to local emergency departments. In 2023, 16 patients were redirected from local EDs.
- **Care Coordination – Key Data Sharing Initiative:** The aim of this initiative is to enhance collaboration between agencies by facilitating data sharing, funded through a grant. The program is supporting the development of a Community Information Exchange (CIE), a leading practice which will help identify high utilizers of services and support targeted interventions and care coordination in the future.
- **Oral Health – Strong collaboration with community partners:** Continue to develop key partnerships with preschools, dental societies, Jubilee Hall, homeless centers, and WIC programs to expand service outreach and improve access to dental care.

Weaknesses

- **JSC – Recruitment and Retention Challenges:** Maintaining staff levels can be challenging. Temporary nurses, in particular, are hard to recruit and retain due to factors such as pay, hours, and the correctional environment itself.
- **JSC – Roles and Responsibilities Uncertainty:** The JSC program involves collaboration between the Sheriff, Public Health, and Mental Health. However, the outdated MOU creates challenges in defining staff roles and responsibilities.
- **Oral Health – Dental Staff Shortages:** The shortage of dental staff and the limited number of Medi-Cal dental providers in the region make timely referrals challenging.
- **MISP – High General Fund reliance:** The MISP program relies heavily on the General Fund, with limited grant funding available ($431,165 in FY 23-24); however, it is state-mandated. Notably, the transition to the Affordable Care Act has reduced program demand and funding year-over-year; however, cases remain. Budgeting is challenging due to the unpredictability of case numbers and the extent of medical issues and bills that must be paid.
- **MISP – Ineligibility of Undocumented Individuals for MISP:** Undocumented individuals in SLO County are not eligible for the program, making it impossible for those in need to receive assistance.

Opportunities

- **Care Coordination –Future-Proofing CIE:** Conduct a jurisdictional scan and stakeholder engagement for CIE to determine future system needs and support the design and operating model.
- **JSC – Interagency MOU Renewal:** Revise and renew the MOU between the Sheriff, Public Health, and Mental Health to help ensure clarity of roles and responsibilities among partner agencies
- **Oral Health – Explore collaboration with key other agencies:** Explore collaboration with First 5, local dental health colleges, and the Office of Education to utilize AI support to expand service access, similar to initiatives in Riverside County.

Threats

- **Oral Health – Funding Sustainability:** The grant cycle for this program ends in 2027 and sustained funding will need to be identified to continue the program.
- **Care Coordination –Future-Proofing CIE:** If not designed correctly, CIE could result in fragmented services, data privacy issues, and ineffective resource allocation, undermining the system's ability to support coordinated care.
- **MISP – Funding Challenges:** High General Fund Reliance may impact the sustainability of providing these services as the County faces financial challenges.

Dental Screenings Using Artificial Intelligence Now Supporting Oral Health of Students in Riverside County | News List | Riverside County Office of Education

Health Care Access– Key Opportunities

Opportunity 3.14	Adopt a Community Approach aligned with leading practices for the development of a Community Information Exchange (CIE) to improve data sharing and coordinated care system.

Current State

- Enhanced Care Management (ECM) is a Medi-Cal program in San Luis Obispo County for members with complex medical and social needs. It offers coordinated care to improve health through services like outreach and engagement, assessment and care management planning, enhanced care coordination, health promotion, transitional care, member and family supports, and referrals to community and social support services.
- The program targets homeless individuals, those at high risk of hospital visits, and recent justice-involved individuals. To qualify, individuals must be enrolled in CenCal Health. ECM is grant funded and provides these services at no cost to help improve overall health.
- To further enhance collaboration between health and human services agencies by facilitating data sharing, the Division, funded through a grant is supporting the development of a CIE, with the aim of helping identify high utilizers of services and supporting targeted interventions and care coordination in the future.

Key Opportunity for Consideration

- **Promising Practices:** In the future, as the Division supports the development of the CIE, they should consider leading practices adopted by other counties in developing this system. For example, San Diego and Humboldt counties have recently adopted a CIE using the following approach:
  - **San Diego County:** In 2017, 211 San Diego launched the region's first CIE to streamline care coordination across health, human services, and social services sectors. By sharing data across multiple systems, CIE better understands individuals within their environments, coordinates care more effectively and expands knowledge of how systems influence social determinants of health such as healthcare, education, economic stability, housing, and community context. 211 used human-centered design to improve care coordination, holding exercises to capture community experiences and organizing regular partner meetings to discuss network composition and identify missing perspectives. They learned from community-based organizations' advocacy work to inform outreach, and through conversations with underserved populations, including immigrants. Recognizing gaps in social service systems, they developed a CIE newsletter for stakeholder updates, fostered community involvement in CIE governance via an Advisory Board and Community Voice working group, and held focus groups to and help ensure community participation.
  - **Humboldt County:** The North Coast Health Improvement and Information Network (NCHIIN) was established by the Humboldt Independent Practice Association in 2010 to improve medical care through a health information exchange connecting nearly all medical organizations in Humboldt County. In 2017, with support from the California Accountable Community for Health Initiative (CACHI), NCHIIN expanded its mission to include community health improvement, focusing on substance use disorder (SUD). This initiative involved creating an Accountable Community for Health (ACH) with governance and workgroups of cross-sector leaders, conducting community systems mapping, and developing an ACH wellness fund. Community members actively participated in the ACH Governance Committee and contributed to CIE planning and design, particularly on data ownership and consent issues, with a focus on involving individuals with lived experience and an equity mindset.

Community-Profiles-FINAL.pdf

Health Care Access– Key Opportunities

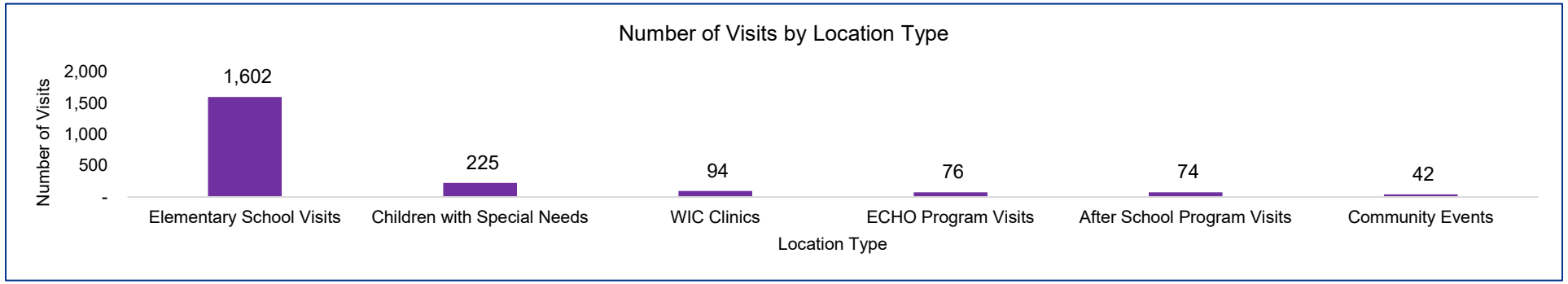
Opportunity 3.14	Adopt a Community Approach aligned with leading practices for the development of a CIE to improve data sharing and coordinated care system.	
Key Opportunity Action Steps	**Benefit**	
• **Engage Community Voice:** If additional resources become available, support inclusive representation by involving diverse community members in planning sessions and conducting stakeholder interviews to gather broad insights. • **Use Human-Centered Design:** Support the community and lead organization of workshops and focus groups where individuals with lived experience can describe their experiences with current systems to inform a more user-centric design. • **Structure Community Engagement:** Support the community's establishment of advisory boards and community boards with dedicated seats for community members to help ensure continuous leadership and input in decision-making. • **Leverage Existing Networks:** Support continued engagement of CBOs, trusted leaders, and partners from health and social services sectors to collaborate on the initiative. • **Educate and Train Team:** Support and require staff that will be using the CIE to attend training on equity, cultural competency, and community engagement methodologies to help ensure they can effectively support the CIE's goals.	• **Improved Care Coordination:** By integrating data across multiple systems in health, human services, and social services, the CIE will facilitate seamless and effective care coordination, supporting individuals to receive comprehensive and timely support. • **Enhanced Understanding of Social Determinants of Health:** The CIE will expand knowledge of how various factors like healthcare, education, economic stability, housing, and community context influence individuals' health. This allows for more targeted and effective interventions. • **Increased Community Involvement:** Engaging community members, particularly those with lived experience and from underserved populations, in the CIE planning and governance supports the system to be inclusive, relevant, and responsive to actual community needs. • **Informed and Effective Outreach:** Learning from the advocacy work of community-based organizations and conducting regular community engagement exercises will inform the outreach efforts, making them more targeted and effective in addressing the most pressing needs of the community.	*This program does not utilize general fund and this opportunity will not result in Potential estimated cost efficiencies, but support the Division to align to leading practices in considered the development of a CIE.*

Health Care Access – Key Opportunities

Opportunity 3.15	Collaborate with key partners to consider the adoption of artificial intelligence to support the Oral Health program.

Current State

- The Oral Health Program is entirely grant-funded with some Medi-Cal reimbursement and staffed by 3 full-time employees comprised of a program manager, health education specialist and admin officer as well as 2 intern hygienists. The program primarily focuses on children aged 0-5 and aims to collaborate with community partners to develop policies, provide oral health education, and expand access to dental care. It connects children with dental providers who accept Denti-Cal or offer pro-bono services. Additionally, the program offers preventive services for children enrolled across WIC clinics and 16 home-based Head Start programs.
- Cal Poly pre-dental students visit classrooms to teach children about effective brushing techniques and the impact of sugary drinks, achieving high retention rates. Parents are also engaged, receiving information on the importance of daily dental care for their children. While the primary focus is on young children, the team also strives to provide information on resources and services for older children, adults, and the elderly whenever possible. In FY23-24, the program undertook the following visits:



- Across interviews, staff reported that they faced challenges by the program relates to staffing, expanding service access, and locating providers for referral in hard to access areas.
- **Promising Practice:** In responding to similar challenges, Riverside County, have recently collaborated with key partners to adopt artificial intelligence to support with this challenge:
  - Riverside County launched a pilot program in partnership with the County Office of Education, Riverside University Health System-Public Health, First 5 Commission, California Northstate University College of Dental Medicine, and Dental.com to bring dental screenings using artificial intelligence directly into classrooms. This initiative aims to improve access to oral health care for students by conducting in-school oral health assessments, where trained school staff use smartphones to capture images of students' mouths. These images are then reviewed remotely by dentists who provide comprehensive reports and referrals. The program, which successfully piloted at Nuview Elementary and Valley View Elementary, seeks to address barriers to oral health care, prevent severe dental issues, and ultimately enhance student health and academic performance

Health Access – Key Opportunities

Opportunity 3.15	Collaborate with key partners to consider the adoption of artificial intelligence to support the Oral Health program.

Key Opportunity for Consideration

In the future, the program may explore partnerships with key organizations such as the local education office, First Five, and local universities to assess the feasibility of integrating artificial intelligence to enhance current processes, reduce challenges, and increase the number of elementary schools served. This technology could enable initial dentist reviews to be conducted remotely, eliminating the need for students to visit the office for an initial assessment and reducing the number of visits the program needs to make to each school. As a result, the program would be able to increase its overall service capacity. The adoption of AI and strategic partnerships would thus support the continued delivery of services and help ensure the program can meet its objectives despite potential funding challenges.

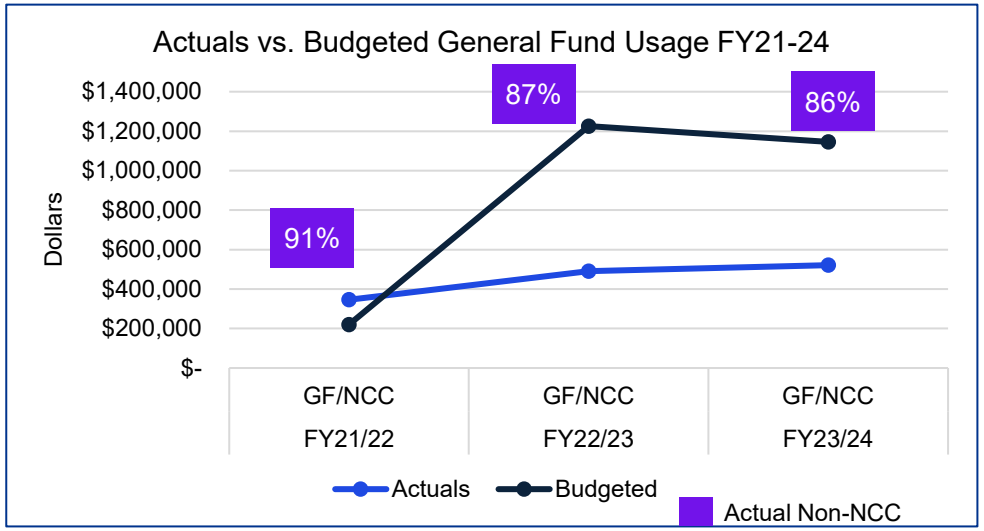
Key Opportunity Action Steps	Benefit	
• **Identify Key Partners:** Engage with relevant organizations such as the County Office of Education, First 5 Commission, and local universities to discuss the feasibility of adopting artificial intelligence**.** • **Conduct a Cost-Benefit Analysis:** Evaluate the potential costs and benefits of implementing AI for dental screenings to help ensure that the program is financially viable and effective. • **Formal Agreements:** Draft and sign partnership agreements to outline the roles and responsibilities of each partner. • **Program Planning:** Develop an implementation plan that identifies the number of schools, students, and the overall geographical area to pilot the program. • **Conduct Screenings:** Obtain informed consent from parents or guardians for student participation. • **Monitor and Evaluate:** Collect data, assess program effectiveness, gather feedback, and determine opportunities for potential program scaling.	• **Increased Coverage:** The program will expand coverage by enabling school staff to use smartphones to capture images, which are then reviewed by dentists with follow up care coordinated by the Oral Health Program, reducing the need for in person visits by dental hygienists. • **Improved Access to Care:** The program facilitates in-school oral health assessments, making dental care more accessible to students who might otherwise face barriers to visiting a dentist.	*This program does not utilize general fund and this opportunity will not result in Potential estimated cost efficiencies; however, it may support the Program to service more schools across the County.*

Health Promotion – Overview

Division Overview

- The Health Promotion Division's goal is to promote a healthy community by empowering individuals and organizations to take responsibility for adopting healthy behaviors and supporting policies that enhance health. Program include:
  - **Community Wellness:** This program teaches CalFresh eligible individuals about nutrition and food budgeting and promotes equitable access to nutritious foods through outreach to schools and collaborating with Social services.
  - **Injury Prevention:** This program focuses on making walking and biking safer, promoting active and healthy living, and promoting safe driving, including supporting older adults to prevent falls through workshops and home visits.
  - **Tobacco Control:** This program educates the public and offers technical assistance to providers, community groups, law enforcement, and retailers with the aim of reducing tobacco consumption and smoke exposure.
  - **Women, Infants, and Children (WIC):** This program provides nutrition education, nutritious foods, breastfeeding support and referrals to healthcare for income-eligible women, infants, and children.

26.00 *Total FTE*	**$4.23M** *Total Budget FY24-25*
81% *Budgeted FY24-25 Non-NCC*	**19%** *Budgeted FY24-25 General Fund*
86% *Actual FY23-24 Non-NCC*	**14%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$4,225,205	13%	$793,300	$2,986,699	26
Santa Barbara*	441,257	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*
Monterey**	430,723	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*
Santa Cruz***	261,547	*$2,516,557*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	6
Sonoma****	481,812	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*
Ventura*****	829,590	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	*Not Publicly Available*	35

** In Santa Barbara County, the Health Promotion is part of the Disease Control and Health Promotion Division. The County's budget book does not break down funding by program.*

***In Monterey, WIC, Community Wellness, Tobacco Control, and Injury Prevention form part of the Chronic Disease and Injury Prevention Division; however, program level budgets are not separately reported for this division.*

****In Santa Cruz, the comparable program includes Oral Health and excludes WIC and while budget has been included for this program, it is not an accurate comparison.*

*****Sonoma County does not provide program level budget within its Budget Book with budget reported only at the Department level.*

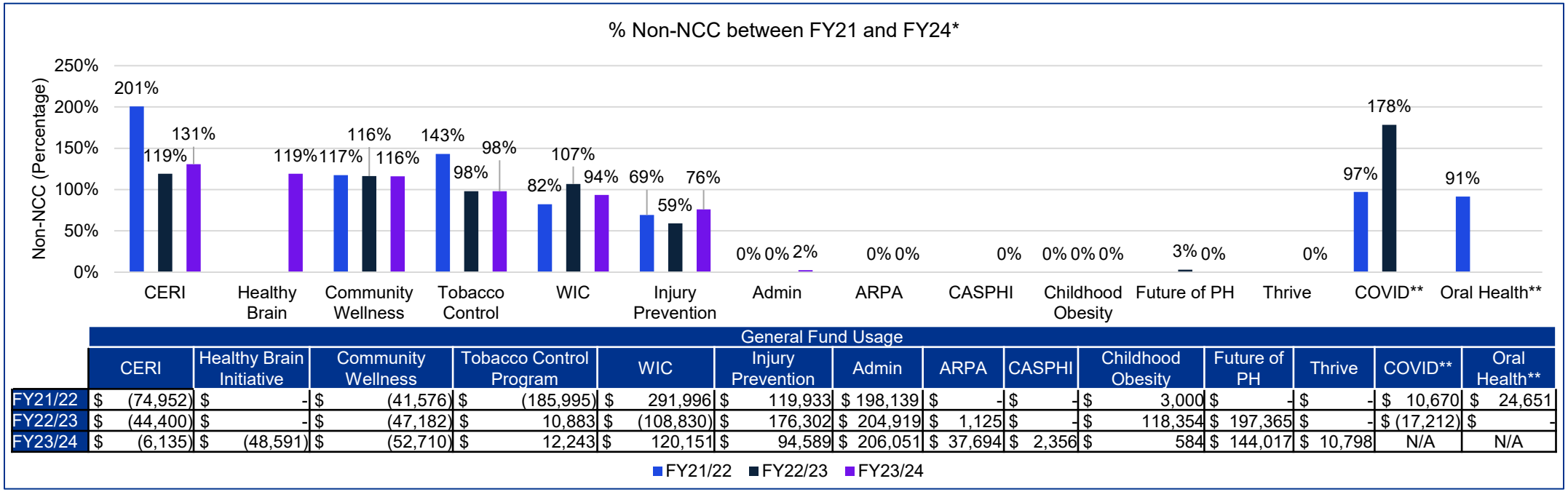
******In Ventura County, Health Promotion is part of the Health Education and Oral Health cost center and a separate budget breakdown is not available per program; however, an FTE breakdown was provided and included above.*

Disclaimer: *Financial information for this Division was derived from workpapers provided by the Health Agency.*

Health Promotion – Key Data Analysis

Between FY 21-22 and FY 23-24, the Health Promotion Division achieved a combined average Non-NCC rate of 88%, requiring an average of $452,745 from the General Fund each fiscal year. The primary drivers of General Fund usage are the following programs: WIC, Injury Prevention, Admin, and the Future of Public Health Initiative requiring on average $101,106, $130,275, $203,036, and $113,794, General Fund use in the past three fiscal years, respectively.

- The WIC program operates seven clinics in Atascadero, Cambria, Grover Beach, Morro Bay, Nipomo, Paso Robles, and San Luis Obispo. Total Salaries for the program have increased across the past three fiscal years by 10% (from $1.37M to $1.51M) between FY 21-22 to FY 23-24, with the Paso Robles having the highest salary expense of $638,579. Revenues (including grant funding) stayed consistent between FY 22-23 and FY 23-24 at $1.70M and $1.74M, respectively.
- The Injury Prevention program decreased Non-NCC by 10% between FY 21-22 and FY 22-23; however, increased by 17% in FY 23-24. Expenses for the program have stayed relatively consistent across the past three fiscal years at an average of $404,908; however, revenue (including grant funding) increased 10% between the same period from $271,100 to $298,808 reducing the amount of General Fund use by 46% or $81,713.
- The Future of Public Health is a relatively recent initiative where the only expense is salaries in FY 23-24. The program is experiencing a decline in its funding source, requiring 97% in FY22-23 and 100% General Fund use in FY23-24.



	General Fund Usage													
	CERI	Healthy Brain Initiative	Community Wellness	Tobacco Control Program	WIC	Injury Prevention	Admin	ARPA	CASPHI	Childhood Obesity	Future of PH	Thrive	COVID**	Oral Health**
FY21/22	$ (74,952)	$ -	$ (41,576)	$ (185,995)	$ 291,996	$ 119,933	$ 198,139	$ -	$ -	$ 3,000	$ -	$ -	$ 10,670	$ 24,651
FY22/23	$ (44,400)	$ -	$ (47,182)	$ 10,883	$ (108,830)	$ 176,302	$ 204,919	$ 1,125	$ -	$ 118,354	$ 197,365	$ -	$ (17,212)	$ -
FY23/24	$ (6,135)	$ (48,591)	$ (52,710)	$ 12,243	$ 120,151	$ 94,589	$ 206,051	$ 37,694	$ 2,356	$ 584	$ 144,017	$ 10,798	N/A	N/A

FY21/22 FY22/23 FY23/24

This chart has been generated using actuals versus budgeted revenue and expenditures. The expenditures include Services & Supplies and Salaries related to each individual program. "Other Expenses" have been aggregated at the division level and not allocated across the programs. Percentages higher than 100% represent instances where funds were surplus and either used in the next fiscal year or against General Fund.

***This source of funding or program is no longer active or has been transferred to another cost center.*

Health Promotion – SWOT Analysis

Strengths

- **Community Wellness – High Degree of Innovation and Increasing Performance:** The program partnered with key partners to create a GIS map showing household income and CalFresh enrollment, identifying neighborhoods with high food insecurity. This led to 676 new CalFresh applications through targeted outreach.
- **Injury Prevention – Commitment to Mission:** Program staff are deeply committed to their mission. This is evidenced by an 196% increase in community outreach and engagement across Heathy Aging, Child Passenger Safety, and Bike and Pedestrian Safety between FY22-23 and FY23-24.
- **Tobacco Control – Strong Collaboration and Partnership:** Program staff have developed strong collaboration with key partners. For example, in responding to parent's seeking support for teen vaping, the program collaborated with the Office of Education to create a guide connecting parent to youth counseling and treatment.
- **Women, Infants, Children (WIC) – Increasing participation and strong outcomes:** In FY23-24, the program saw an overall increase of 8.5% in average monthly participants while breastfeeding rates of 70% for program participants exceeded the state average by 20%.

Weaknesses

- **Community Wellness – Limited Capacity/Funding to Expand Outreach to additional schools:** The program is limited to supporting income-eligible schools. While several income-eligible schools are interested in participating, current funding only covers outreach to 3 schools.
- **Tobacco Control – Increasing Costs:** Over the past several years, program cost has been increasing without a corresponding increase in revenues. For example, in FY 22-23 and FY 23-24, the program used General Fund, $10,882 and $12,243.
- **WIC – High Rental Cost:** The WIC program recently moved to a new facility which has drastically increased rental costs by 1,200%, from $8k to $109k per year.
- **WIC – Telehealth Challenges:** Providing telehealth services can be challenging as the current Microsoft Teams system does not support in-team calling, making it challenging to offer this service.
- **WIC – Clinic Operation Challenges:** The program operates 7 clinics across the County; however, several of these clinics have low volumes and are only open once or twice weekly, while the Cambria Clinic is open once a month; however, operational costs (e.g., rent) continue to be incurred.

Opportunities

- **Community Wellness – Explore Collaborative Funding Opportunities:** Engage with interested schools to explore collaborative funding opportunities for expanding community wellness services.
- **Community Wellness – Enhance Collaborate with County Departments to enhance CalFresh Enrollments:** Collaborate with the Social Services and other key departments to adopt leading practices for enhancing CalFresh enrollment.
- **WIC - Clinic Reduce Rental Expenses:** Evaluate the financial feasibility of remaining in the Paso Robles WIC clinic given the large rental expense of $109,000.
- **WIC – Transition to Mobile Clinics:** Consider transitioning from a clinic model to mobile service delivery in areas with low volumes..

Threats

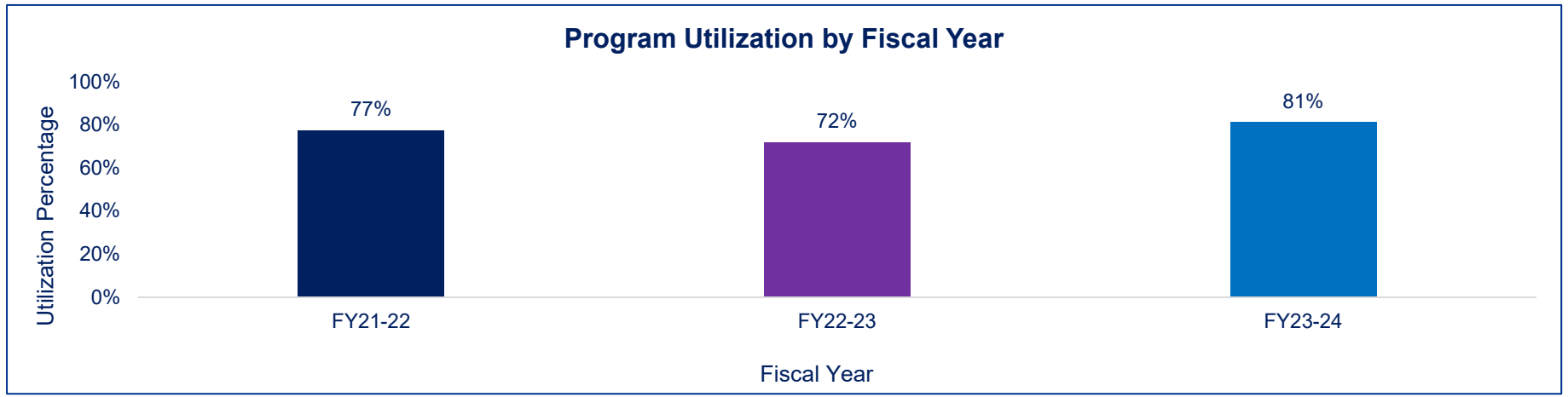
- **Community Wellness – Program Impact Threat:** Program impact is restricted as a result of limited state funding for expansion.
- **Injury Prevention – Funding Threat:** A potential shortfall in state funding could jeopardize the continuation of programs supported by the Health Brain Initiative.
- **WIC – Clinic Financial Data Monitoring:** The program does not track the cost per clinic across its 7 WIC clinics, leading to a lack of data to support financial decision-making, effective budgeting, resource allocation, and proactively identifying necessary improvements to support financial sustainability.
- **General Fund Dependence:** Risk of reliance on the General Fund as a result of increasing costs in certain programs which may strain other county resources and limit funding for other county projects.

Health Promotion – Key Opportunities

Opportunity 3.16	Implement processes for tracking staff utilization and setting utilization targets within the WIC Program to enhance program service delivery and cost efficiency.

Current State

- The WIC program helps families by providing nutrition education, breastfeeding support, healthy foods, and referrals to health care and other community services. The program operates seven clinics across the County including Paso Robles, Grover Beach, Atascadero, San Luis Obispo, Nipomo, Morro Bay, and Cambria. The Paso Robles Clinic is open five days a week; however, the other clinics are open with reduced hours, with some such as Grover Beach open four days a week, and others open once or twice a week or in the case of Cambria, once a month.
- The program is staffed by 14 full-time equivalent (FTE) employees, with one position currently vacant. The team includes 1 FTE Program Director, 4.4 FTE Nutritionists, and 6 FTE Public Health Aides. The remaining 3.6 FTEs are funded through other programs, including BABES and Maternal Child and Adolescent Health (MCAH).
- The Division currently does not have a system for tracking staff utilization and does not have established targets for staff productivity. Although the Division conducts time studies for state reporting purposes that document time spent on direct client services and general administrative time. However, they do not regularly evaluate this information to determine productivity by staff number and review caseload data instead.
- Based on available data, KPMG calculated staff utilization by dividing the total direct client care service hours recorded between FY21-24 by the total office hours for the 10.4 FTEs funded by the program, resulting in a utilization rate of 81% for FY23-24. While this represents a high utilization rate, there is an opportunity for the Division to track utilization by staff member on a weekly basis in line with Opportunity 1.9 to continue to evaluate whether staff levels align to service demand.



Health Promotion – Key Opportunities

Opportunity 3.16	Implement processes for tracking staff utilization and setting utilization targets within the WIC Program to enhance program service delivery and cost efficiency.

Key Opportunity for Consideration

- In the future, to better align staffing levels to demand, the Division should implement utilization tracking as recommended in Agency wide Opportunity 1.9.

Key Opportunity Action Steps	Benefit	
Implement staff utilization tracking: • Please refer to Agency-wide Opportunity 1.9 for further detail on the action steps required to implement this opportunity	• **Enhanced Performance Monitoring:** Tracking encounter data and time spent on direct client service, travel, and documentation provides valuable insights into staff time allocation, enabling improved performance monitoring and understanding of workload distribution. • **Improved Service Delivery:** Regular data monitoring by supervisors will facilitate constructive discussions with team members, promoting continuous improvement. This leads to increased client service delivery, higher employee motivation, and more responsive staffing adjustments based on actual service demand.	*This opportunity will not result in immediate Cost Efficiencies but will support operational efficiency which may result in future Cost Efficiencies once utilization tracking has been implemented*

Health Promotion – Key Opportunities

Opportunity 3.17	Consider transitioning to mobile clinics in low-volume locations, implementing telehealth to reduce costs and enhance client accessibility, and commencing the tracking of key financial metrics across clinics to optimize resource allocation and increase cost efficiency.

Current State

- As noted, the WIC program operates seven clinics with varying caseloads and operating hours each month. These clinics serve multiple locations and services are provided by staff who work across different clinics. Due to the movement of staff between clinics, specific utilization data for each clinic is not available. However, caseload detail has been included below and the overall low utilization rate of 23% in FY23-24 across the program suggests that individual clinics may be underutilized.

Clinic	Monthly Hours of Operation	Number of FTE during clinic opening hours	Current Caseload
Paso Robles WIC Office	184	4	2,045
Grover Beach WIC Office	106	3	971
San Luis Obispo WIC Office	57	3	589
Nipomo WIC Office	36	3	378
Morro Bay WIC Office	32	3	232
Atascadero WIC Office	16	3	451
Cambria WIC Office	7.5	3	55

- Several clinics, such as Atascadero, Cambria, Morro Bay, and Nipomo, have relatively low caseloads compared to larger clinics like Paso Robles and are only open for one or two days a week or in the case of Cambria, once a month. As outlined in the table above, the caseload per FTE varies significantly across clinics, for example, Cambria has a caseload of 2,045, between 5 and 37 times than the lowest four clinics highlighted in the table above.
- Despite the low volumes experienced at regional clinics like Atascadero, Cambria, Morro Bay, and Nipomo, rental and operating costs continue to accrue. Currently, revenue and costs are not tracked by individual clinic, making it difficult to determine if any of the clinics are breaking even and to understand key metrics such as cost per client. This information is crucial for making data-driven decisions regarding the operation and continuation of clinic operations.
- Furthermore, the Division has not implemented a telehealth strategy that could reduce reliance on physical clinics. This is largely due to technological constraints, specifically challenges with their current Microsoft Teams setup, which is unable to accept consumer calls effectively.

Health Promotion – Key Opportunities

Opportunity 3.17	Consider transitioning to mobile clinics in low-volume locations, implementing telehealth to reduce costs and enhance client accessibility, and commencing the tracking of key financial metrics across clinics to optimize resource allocation and increase cost efficiency.

Key Opportunities for Consideration

- For smaller clinics, such as Atascadero, Cambria, Morro Bay, and Nipomo the Division should consider transitioning to mobile clinic services at local libraries or community centers, which would eliminate the need for permanent physical clinics by having monthly service stations at community locations, thereby reducing rental and operating costs.
- Additionally, the Division should engage with IT Services to adopt a system that supports telehealth, decreasing reliance on physical locations and increasing flexibility for clients to receive services without the need to travel.
- In the future, the Division should also begin tracking key financial metrics at the clinic level to evaluate the break-even point and revenue-generating potential of each clinic. This will support informed decision-making regarding financial operations. Essential metrics to track include:
  - **Revenue per Clinic:** Total revenue generated by each clinic on a monthly and annual basis.
  - **Operating Costs per Clinic:** Detailed breakdown of all expenses, including rent, utilities, salaries, and other operational costs.
  - **Client Volume:** The number of client visits undertaken per clinic on a monthly and annual basis.
  - **Cost per Client:** Average cost incurred per client visit, including direct service costs and overhead.
  - **Break-Even Analysis:** Calculation to determine the number of client visits required for the clinic to cover its costs.
  - **Slot Utilization Rate:** Percentage of available appointment slots that are filled, indicating clinic capacity utilization.

Key Opportunity Action Steps	Benefit	
• **Evaluate Mobile Clinic Feasibility:** Conduct an assessment to determine the feasibility of transitioning smaller clinics to mobile services at local libraries or community centers, considering logistics, community needs, and potential savings. • **Develop Implementation Plan:** Create a detailed implementation plan for the transition to mobile clinic services, including schedules, locations, staffing, equipment needs, and communication strategies for informing the community. • **Engage with IT Services:** Collaborate with IT Services department to implement a telehealth system that supports virtual consultations and client interactions.	• **Cost Efficiencies:** Transitioning to mobile clinic services and adopting telehealth can reduce rental and operating costs associated with maintaining permanent physical clinics. • **Increased Accessibility:** Utilizing telehealth services enhances accessibility for clients, allowing them to receive care without the need to travel long distances. • **Enhanced Community Integration:** Offering services at local libraries and community centers can strengthen community ties and increase awareness of services.	*As the Division does not track cost per clinic, it is not possible to calculate the cost efficiencies that can be achieved from transitioning to mobile clinics at low volume locations.*

Health Promotion – Key Opportunities

Opportunity 3.18	Conduct a cost-benefit analysis to explore the feasibility of relocating the WIC clinic in Paso Robles to a more cost-effective facility, considering both County-owned and alternative rental properties.

Current State

- In 2022, the WIC clinic relocated from a County-owned building at 723 Walnut Avenue in Paso Robles to a third-party facility at 825 4th Street in Paso Robles under a 15-year lease. The WIC Clinic now shares the second floor with Behavioral Health Services, while Social Services is located in an adjacent building. The relocation aimed to centralize services; however, it has led to a substantial increase in rental costs, from $8,000 to $109,000 per year.
- The clinic, staffed by 4 FTEs with a caseload of 2,045, operates from Monday to Thursday from 8:00 am to 5.30 pm and Friday from 8:00 am to 5.00 pm. As noted in Opportunity 3.17, the Division does not track revenue and costs by individual clinic, making it difficult to determine whether the clinic is operating at a loss or breaking even, or to assess the financial impact of the rent increase. However, the significant cost increase would have exponentially raised the cost per patient by $49.

Key Opportunities for Consideration

- The Division should conduct a cost-benefit analysis to determine if increased rental costs are justified by improvements in client service access, impact, and outcomes. This analysis should evaluate key performance indicators such as patient satisfaction, service delivery efficiency, and health outcomes. Based on the findings, the Division should then explore the feasibility of relocating the WIC clinic and Behavioral Health to a more cost-effective facility to reduce cost, while still supporting co-location. This exploration should consider changes across the Health Agency and the availability of County-owned facilities, particularly within the Behavioral Health youth programs. Both County-owned properties and alternative rental options should be reviewed to identify potential sites that could reduce expenses while maintaining or enhancing the quality of services provided.

Key Opportunity Action Steps	Benefit	
• **Conduct Cost-Benefit Analysis:** Conduct a cost-benefit analysis to evaluate whether increased rental costs are justified by improvements in client service access, impact, and outcomes. • **Explore Relocation Feasibility:** Based on the results of the cost benefit analysis, explore the feasibility of relocating the Paso Robles WIC clinic to a more cost-effective facility, including County-owned properties and alternative rental options. • **Identify Relocation Options:** Identify and compare potential relocation sites based on cost, location, accessibility, and the ability to maintain quality of services.	• **Optimized Resource Allocation:** Identifying cost-effective facility options can help reduce rental expenses, freeing up resources for other essential services and programs. • **Financial Sustainability:** Supporting the clinic to operate within a sustainable budget helps maintain long-term financial health, preventing operating losses and ensuring continued support for the community. • **Reduced General Fund Dependency:** Reducing rental expenses will result in reduced reliance on the General Fund liberating count resources for other essential needs and priorities.	**$101,000*** *Potential Annual Cost Efficiencies*

*The Estimated Cost Efficiencies is on the basis that rental experience are reduced to the level incurred post transition to the new facility.

Health Promotion – Key Opportunities

Opportunity 3.19	Based on Funding availability, engage with interested schools to explore collaborative funding opportunities for expanding community wellness services.

Current State

- The Community Wellness Program oversees the CalFresh Healthy Living grant, delivering nutrition education to three eligible schools across the County. The County was allocated $284,349, on average across the past three fiscal years, in funding to manage this federally mandated program. The Program employs three full-time staff members, including two educators and a program manager.
- During interviews, staff indicated that additional eligible schools within the County have shown interest in the program. However, due to limited funding and staff capacity, the program is currently unable to accommodate these additional schools.
- Recently, one school offered to provide financial support for the service, but the proposed amount was insufficient to sustainably fund a full-time position. As a result, the program was unable to accept the offer.

Key Opportunity for Consideration

- In the future, there is an opportunity to identify key schools that may be interested in receiving nutrition education services. The Division should pinpoint these schools, form partnerships with them, and evaluate the efforts required to provide the service, including the necessary funding. This funding may align to the cost of 1 FTE which is a fully burdened cost of $138,400 based on current average salaries for educators within the Division. This can support the development of a collaborative funding model between schools to support this service.

Key Opportunity Action Steps	Benefit	
• **Form Partnerships:** Engage with interested schools to discuss potential partnerships and collaboration. • **Create a Working Group:** Consider establishing a working group consisting of representatives from interested schools to facilitate communication and planning. • **Based on funding availability, develop a Collaborative Funding Model:** Determine the total funding required to support an additional FTE and deliver the program to multiple schools. • **Pool Resources:** Encourage schools to pool their resources to collectively meet the funding requirements. • **Formalize Agreements:** Create Memorandums of Understanding (MOUs) outlining each school's financial commitment and the program's responsibilities and obtain approval from the Board of Supervisors. • **Launch the Program**: Roll out the program across the participating schools.	• **Increased Funding for Expansion:** Collaborative funding opportunities allow the program to secure additional resources, enabling the expansion of community wellness services to more schools and students. • **Broader Impact:** By engaging more schools, the program can educate a larger number of children on the benefits of good nutrition, promoting healthier eating habits across the community. • **Strengthened Partnerships:** Collaborating with schools fosters stronger relationships and mutual support, enhancing the Program's effectiveness and reach. • **Sustainable Growth:** A collaborative funding approach supports a more sustainable financial model, allowing the program to grow and continue benefiting future generations.	*This will not result in cost efficiencies; however, it will result in an increase in service provision for no net new cost.*

Health Promotion – Key Opportunities

Opportunity 3.20	Collaborate with the Social Services Department and other key health services departments to adopt leading practices for enhancing CalFresh enrollment across the County, to increase CalFresh Healthy Living grant funding for the Division.

Current State

- While CalFresh participation has increased by 65% between 2021 and 2024, San Luis Obispo County continues to have one of the lowest participation rates in the state.
- This low participation affects the dollar value of the CalFresh Healthy Living grant administered by the Health Promotion Division, as funding is based on the number of CalFresh participants. Since the program aims to support CalFresh-eligible adults and children in the County who are at or below the federal poverty level, increasing participation would lead to more grant funding for education and support services.

Key Opportunities for Consideration

To increase CalFresh participation, the Division could collaborate with key county departments, such as Social Services, to implement leading practices aimed at boosting enrollment.

Promising Practices: Key initiatives based on promising practice include:

- Developing a Benefits Collaborative to enhance collaboration between key agencies such as Social Services, Public Health, Behavioral Health, and Community Based Organizations (CBOs) to support enhanced collaboration on CalFresh enrollment. This may include engaging with providers and CBOs to screen clients for CalFresh when they are providing other services.
- Incorporate Data Matching to Target Enrollment "In-reach" Efforts. In Los Angeles and San Francisco, data matching was used to target Supplemental Security Income (SSI) recipients who were not enrolled in the CalFresh program. In San Francisco, the city and county Human Services Agency pulled lists of clients identified as having SSI but not CalFresh benefits. They then sent informative mailers, and conducted follow-up calls to help with applications. Los Angeles collaborated with CBOs for extensive coverage, while San Francisco enlisted San Diego 211 for additional support. These efforts supported eligible recipients were informed and assisted effectively.

Key Opportunity Action Steps	Benefit	
• **Maintain the CalFresh Alliance:** Maintain partnerships between Social Services, Public Health, and CBOs for coordinated CalFresh enrollment efforts. • **Leverage CBO Networks:** Collaborate with CBOs for extensive community outreach and screening and enlist additional support, such as from 211. • **Use Data Matching for In-Reach Efforts:** Develop a process to identify and target SSI recipients not enrolled in CalFresh through data matching, followed by informative mailers and follow-up calls. • **Monitor and Evaluate:** Track enrollment results, adjust strategies, and reinforce successful practices for continuous improvement.	• **Increased Grant Funding:** Enhancing CalFresh enrollment will directly increase CalFresh Healthy Living grant funding for the Division, allowing for more resources. • **Improved Program Reach:** Collaborating with Social Services and key health services departments extends the reach of enrollment efforts, supporting more eligible individuals to benefit from CalFresh. • **Improved Coordination:** Establishing a Benefits Collaborative enhances coordination between Social Services, Public Health, Behavioral Health, and CBOs, leading to more efficient CalFresh enrollment efforts.	*This will not result in cost efficiencies; however, it will result in an increase in revenues based on percentage increase in CalFresh enrollment*

Maternal Child Adolescent Health Division – Overview

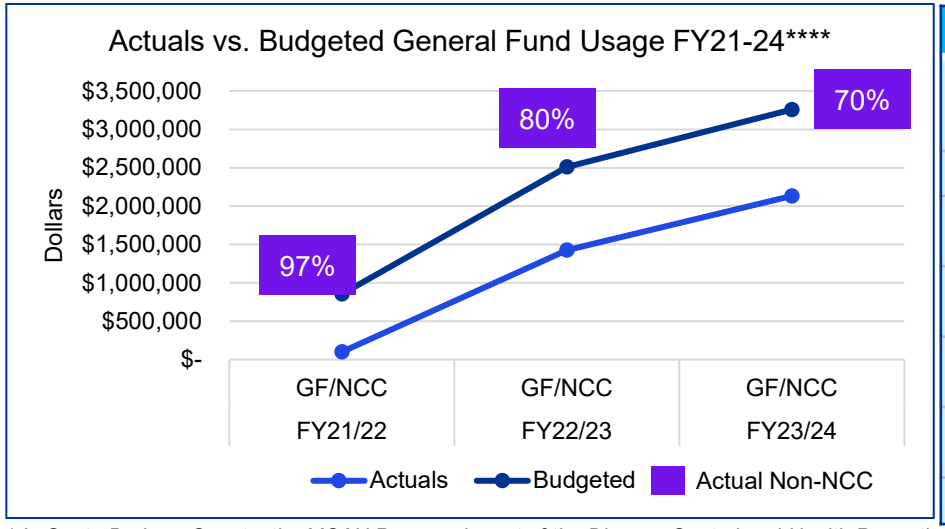
Division Overview

The Maternal and Child Health (MCAH) Division provides a range of services to improve birth and early childhood outcomes. This includes prenatal nutrition education, substance use screening during pregnancy, support for perinatal mood and anxiety disorders, and home visiting by field nurses for high-risk pregnant and parenting families. Medical case management programs within the division encompass:

- California Children's Services eligibility determination and medical therapy for children with illnesses/disabilities.
- Child Health and Disability Prevention services, addressing medical and behavioral concerns (Martha's Place)
- Health Care support for children in foster care.
- Childhood Lead Poisoning Prevention efforts.

Several of the programs in this Division are state mandated with minimum staffing needs, such as the California Children's Services and the Foster Care program.

49.75 *Total FTE*	**$8.85M** *Total Budget FY24-25*
76% *Budgeted FY24-25 Non-NCC*	**24%** *Budgeted FY24-25 General Fund*
70% *Actual FY23-24 Non-NCC*	**30%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$5,009,561	0%	$1,798,315	$3,211,246	49.75
Santa Barbara*	441,257	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available
Monterey**	430,723	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available
Santa Cruz	261,547	$7,743,933	Not Publicly Available	$146,264	Not Publicly Available	35.7
Sonoma***	481,812	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available
Ventura	829,590	$27,930,898	7%	$3,203,872	$23,107,374	164

** In Santa Barbara County, the MCAH Program is part of the Disease Control and Health Promotion Division. The County's budget book does not break down funding by program. However, the overall General Fund contribution for the Division is $2.77m (13%), with intergovernmental revenues amounting to $15.5 million (75%).*

***In Monterey, MCAH forms part of the Health Preparedness Division; however, budgets are not separately reported for this division. The County does not operate an Oral Heath program or MISP program and does not fund services in the JSC.*

****Sonoma County does not provide program level budget within its Budget Book with budget reported only at the Department level.*

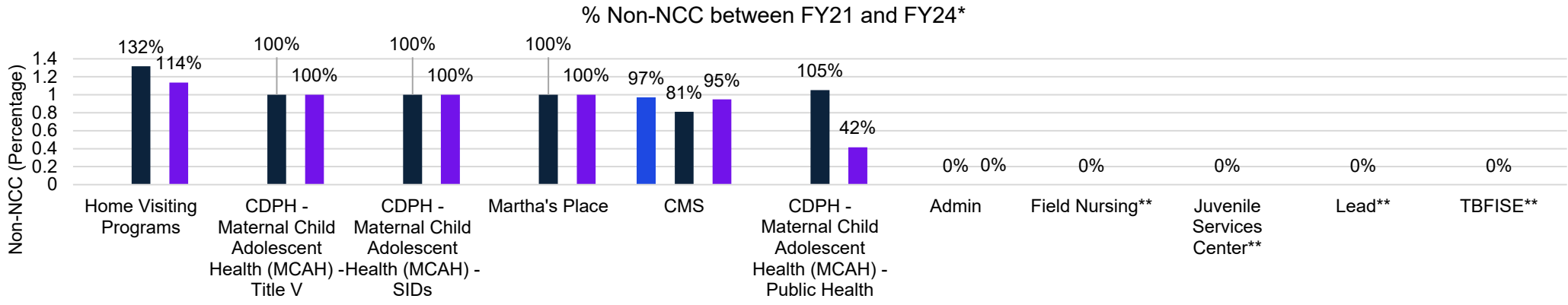
*****Financial information for a majority of the programs, with the exception of Children's Medical Services, for FY 21-22 is not available as MCAH was consolidated with another cost center.*

***Disclaimer:** Financial information for this Division was derived from workpapers provided by the Health Agency.*

Maternal Child Adolescent Health – Key Data Analysis

Between FY 21-22 and FY 23-24, the Maternal Child Adolescent Health Division achieved a combined average Non-NCC rate of 82%, requiring an average of $1.22M from the General Fund each fiscal year. The primary drivers of General Fund usage are the following programs: Children's Medical Services (CMS), Public Health Nursing (PHN), and Admin requiring on average $500,424, $302,784, and $977,649 General Fund use in the past three fiscal years, respectively

- CMS provides mandated services that require minimum staffing levels. In FY21-22, revenue (including grant funding) was $3.05M while expenses totaled to $3.15M. Between FY 21-22 and FY 22-23, revenue (including grant funding) decreased by 11% to $2.73M while total expenses increased 7% to $3.37M requiring $642,475 General Fund during that fiscal year. Then in FY23-24, revenue (including grant funding) increased 10% to 3M while total expenses decreased 6% to 3.17M, decreased the amount of General Fund needed for the fiscal year.
- The PHN program experienced a 63% decrease in Non-NCC between FY22-23 and FY 23-24. In the same period, revenue significantly decreased by 62% from $2.09M to $785,611 requiring $1.10M General Fund use in FY 23-24 due to a large reversal on accruals captured in FY 22-23. This may be a result of a sharp 55% decrease in Federal Funding due to restructuring and splitting between cost centers.



	General Fund Usage										
	Home Visiting Programs	CDPH - MCAH - Title V	CDPH - MCAH - SIDs	Martha's Place	CMS	CDPH - MCAH - Public Health	Admin	Field Nursing**	Juvenile Services Center**	Lead**	TBFISE**
FY21/22	$ -	$ -	$ -	$ -	$ 99,899	$ -	N/A	N/A	N/A	N/A	N/A
FY22/23	$ (118,037)	$ -	$ -	$ -	$ 642,476	$ (101,417)	$ 1,000,017	$ 435	$ 2,071	$ 532	$ 75
FY23/24	$ (90,598)	$ -	$ -	$ -	$ 165,979	$ 1,102,265	$ 955,281	N/A	N/A	N/A	N/A

FY21/22 FY22/23 FY23/24

This chart has been generated using actuals versus budgeted revenue and expenditures. The expenditures include Services & Supplies and Salaries related to each individual program. "Other Expenses" have been aggregated at the division level and not allocated across the programs.

***This source of funding or program is no longer active or has been transferred to another cost center.*

Maternal Child Adolescent Health Division– SWOT Analysis

Strengths	Weaknesses
• **Public Health Nursing – Quality Improvement:** Implemented processes to streamline workflows for home visiting referrals, ensuring timely evaluation and assignment within 3 business days. • **Home Visiting Program – Multidisciplinary Team:** Services are delivered using a multidisciplinary team, including public health nurses, social workers, social work aides, and administrative professionals, to support clients in being connected to essential services and provided with a wraparound model of care. • **Health Care Program for Children in Foster Care – Strong Collaboration with Child Welfare:** Established strong collaboration with Child Welfare to align with key legislative guidelines. This collaboration has provided crucial feedback to partners, advocating for necessary resources to prioritize both preventive and complex health care needs of children in foster care. • **Children's Services Medical Therapy Program – Strong Audit Results:** Demonstrated strong audit results and performance. Passed the state outpatient rehabilitation certification audit, the first in 15 years, showcasing compliance and quality in service. Additionally, received the SLO Moment Award from the Board of Supervisors in recognition of outstanding contributions to the community.	• **Children's Services Medical Therapy Program – High no show rates:** Due to practices in place for scheduling and in part due to its population, this program experiences high no show rates which reduces staff utilization, increases costs and wait times. • **Home Visiting Program and Martha's Place – Low Staff Utilization:** Data analysis indicates that Martha's Place and the Home Visiting programs are overstaffed for the current volume of cases. • **Outdated EHR**: The current Electronic Health Record (EHR) system is limited in its ability to collect, analyze, and utilize data effectively, creating challenges in analyzing program capacity, identifying trends, allocating resources, and measuring outcomes effectively. Additionally, the EHR system differs from that used by other areas, resulting in some areas still relying on paper charting due to lack of EHR capability. • **Limited Staff Productivity Tracking:** The Division tracks program outcomes and impacts instead of individual staff productivity. However, monitoring staff productivity is also crucial for understanding staff utilization, making informed staffing decisions, and ensuring staff focus on direct client services
Opportunities	**Threats**
• **Implement Enhanced Tracking of Staff Utilization:** Implement a system to track and report staff utilization, manage caseloads, monitor direct client services across programs, and establish a targeted strategy for improvement. • **Identify new EHR Requirements:** As the County procures a new EHR system, the division should identify the program's critical business needs to help ensure they are included as essential requirements for the new EHR. *Please refer to opportunity 3.4 for actions steps related to support this.* • **Reducing No-Show Rates:** Implement processes to decrease no-show rates in the Medical Therapy Program, thereby reducing costs and wait times.	• **MCAH Public Health Nursing Program:** Stability is challenged by fluctuations in state and local revenue, leading to uncertainty and difficulty in long-term planning. Revenue decreased 62% (from $2,088,103 to $785,611) between FY 22-23 and FY 23-24, drastically increasing reliance on General Fund. • **Admin Costs:** Admin costs across the Division are high despite a slight 4% decrease in FY 23-24. This reduces funding available for direct client services. • **Increased Operational Costs:** High no-show rates and overstaffing lead to low staff utilization and higher costs, which may impact resource allocation and service delivery • **Longer Wait Times:** Limited staff productivity tracking results in longer wait times and less effective service delivery, leading to increased cost.

Maternal Child Adolescent Health – Key Opportunities

Opportunity 3.21	Reevaluate staffing levels within the Home Visiting Program to better match demand and reallocate full-time equivalents (FTEs) to areas with greater need and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Current State

- The Nurse Visiting Program connects pregnant women and parents of young children with specially trained nurses and family advocates who offer support and guidance to enhance family health and well-being. The program aims to improve pregnancy outcomes, foster nurturing parenting skills, support positive child health and development, and promote family self-sufficiency. Services are voluntary and provided in the comfort of the client's home or a location of their choice.
- The program is funded by State and Local Grants ($760,788 in FY23-24) and is currently staffed by 19 FTE, comprised of 11.5 FTE Public Health Nurses, 2 FTE social workers, and 3 FTE social worker aides, 1 FTE Supervising Public Health Nurse, and 1 FTE Program Manager.
- Data was provided on caseloads per staff member; however, the Division does not track the time spent per encounter or direct client service time. This prevents understanding if how staff spend their time, particularly in direct client service delivery, which is crucial for determining staff utilization (i.e., the percentage of time spent on direct client services versus total time). As a result, it is challenging to accurately determine the FTE needed to align with service demand.
- However, based on discussions with Division and Department leadership, it was determined that a minimum of 4 FTE positions can be redirected from the program.

Key Opportunities for Consideration

- In the future, the Division should undertake the following actions:
  - Redirecting a minimum of 4 FTE positions from the program as determine by the Department leadership.
  - Implementing utilization tracking as recommended in Agency wide opportunity 1.9 aiming for home visiting nursing staff to schedule 60% of their time in direct client care and aiming for staff utilization to be monitored on a weekly basis by supervisors with administrative staff verifying billing and helping to help ensure that all visits are recorded. In the future staff utilization should be presented in a dashboard with action plans developed in collaboration with supervisors for staff not meeting targets. The process will be reviewed weekly at the departmental and agency, with formal reviews by the Assistant COE. Implementing this process will require the program to begin tracking encounter data and time spent by staff in undertaking direct client service, travel, and documentation. Initially, this may need to be tracked using a low-burden Excel sheet if the EHR cannot capture this data. However, in the long-term, this will be tracked via the new EHR and time-sheet system being adopted.

Maternal Child Adolescent Health – Key Opportunities

Opportunity 3.21	Reevaluate staffing levels within the Home Visiting Program to better match demand and reallocate full-time equivalents (FTEs) to areas with greater need and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Key Opportunity Action Steps	Benefit	
Redirect a minimum of 4 FTE* positions from the program as recommended by the Division leadership: • **Conduct a Role and Responsibility Analysis:** Review current roles and identify positions for reduction without compromising service quality. • **Align Staffing Levels with Service Demand:** Analyze data monthly to identify service demand trends and adjust staffing levels accordingly to optimize client service delivery. **Implement staff utilization tracking:** • Please refer to Agency-wide Opportunity 1.9 for further detail on the action steps required to implement this opportunity, noting that home visiting nursing staff should schedule 60% of their time in direct client care to take account for travel time and no-show rates.	• **Optimized Staffing Levels:** Redirecting a minimum of 4 FTE positions from this program as recommended by Division leadership will support staffing levels to be more closely aligned with service demand, improving overall efficiency and resource allocation. • **Enhanced Performance Monitoring:** By tracking encounter data and time spent on direct client service, travel, and documentation, the Division can gain valuable insights into how staff allocate their time. This enables better performance monitoring and understanding of workload distribution. • **Improved Service Delivery:** Regular monitoring of this data by supervisory staff will facilitate meaningful discussions with team members, fostering a culture of continuous improvement. This can lead to increased client service delivery, higher employee motivation, and more responsive adjustments to staffing levels based on actual service demand.	**$700k** *Potential Annual Cost Efficiencies*****

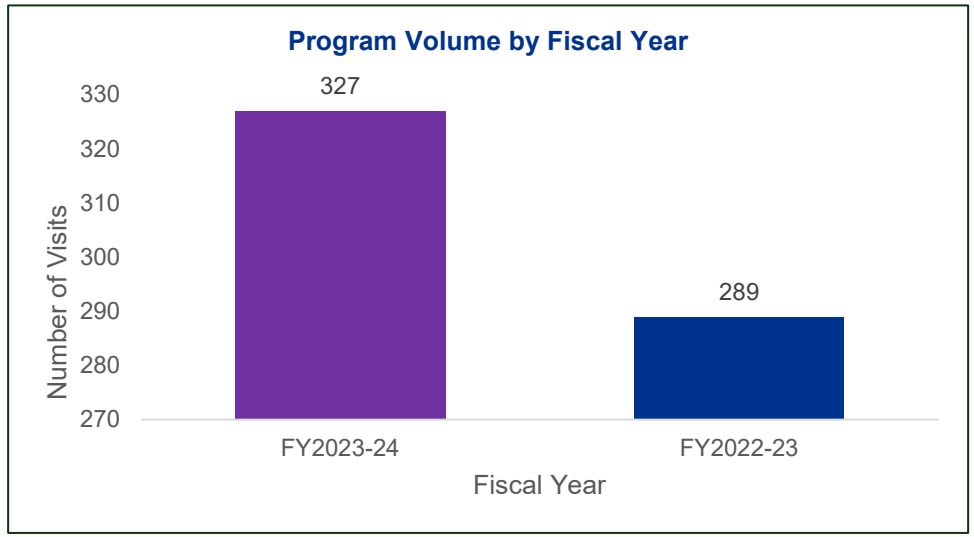
**Additional FTEs have been removed from this program by the department during the time KPMG undertook this review.*
***This estimated cost efficiency has been developed based on the average fully burdened salary for nurses across the Division of $174,173*

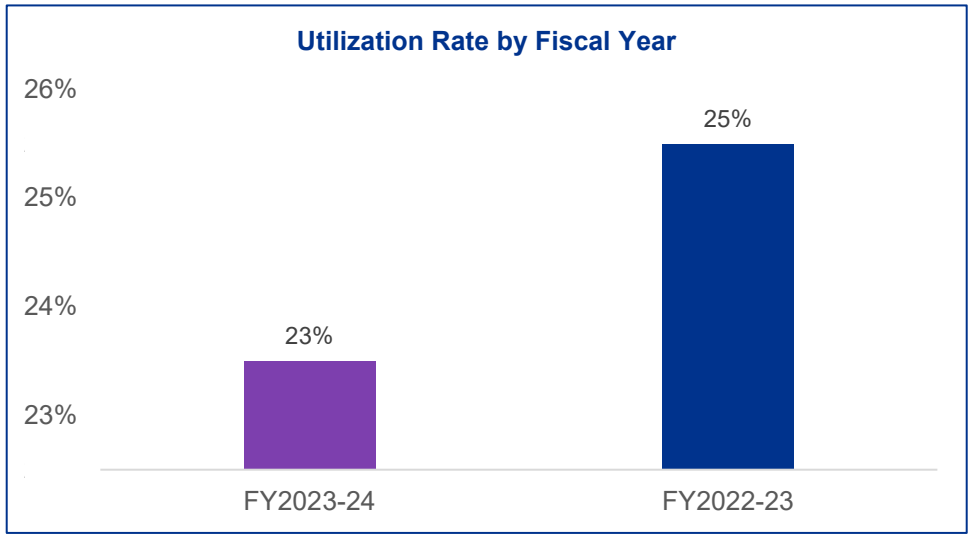
Maternal Child Adolescent Health – Key Opportunities

Opportunity 3.22	Reevaluate staffing levels at Martha's Place to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Current State

- Martha's Place offers assessments for children aged 0-5 with special healthcare needs and behavioral concerns, such as developmental delays, prenatal substance exposure, neglect, abuse, trauma, and foster care placement. The program provides multidisciplinary assessments, including screenings, connections to services, follow-up care, coordination, and case management. Additionally, it offers medical evaluations and collaborates with Behavioral Health for mental health screening, assessment, therapy, and treatment.
- The program is funded by Behavioral Health ($68,340) and partially Title XIX ($140,424 in FY 23-24) and is currently staffed by two contracted Medical Doctors (MDs) (0.6 FTE), a 1 FTE nurse, and a 1 FTE administrative assistant. One of the MDs works Tuesdays and Thursdays, while the other MD works Wednesdays.
- Based on data analysis, the program completes an average of 308 visits per year with the number of visits increasing by 13% between FY22-23 and FY23-24. While the Program does not track utilization by MD, in considering the number of visits by type and the time taken to undertake each visit *(initial assessment (90 minutes), follow-up (30 minutes), and medication management (30 minutes)),* the program has an average utilization of 24% across the past two fiscal years. Actual utilization per fiscal year has been outlined in the chart below as well as program volumes. This utilization rate is well below industry standards for clinic programs which are more aligned to 60%, suggesting that staffing levels within this program may not be aligned with demand for service.





Maternal Child Adolescent Health – Key Opportunities

Opportunity 3.22	Reevaluate staffing levels at Martha's Place to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.

Key Opportunities for Consideration

- Based on current volumes, MDs spend an average of 270 hours per year with clients, equivalent to 0.2 FTE. However, this does not account for documentation or other administrative activities that may be undertaken as a result of medical visits. In the future, to better align staffing levels to demand, the Division should consider:
  - Reducing the contracted FTE count to 0.4 FTE to account for administrative time and other related duties and continue to support coverage three days per week. For instance, MDs could have office hours for 4 hours a day across 3 days.
  - Implement utilization tracking as recommended in Agency wide opportunity 1.9 aiming for MDs to schedule 80% of their time in direct client billable services and staff utilization will be monitored on a weekly basis by Division Manager with administrative staff verifying billing and helping to help ensure that all visits are recorded. In the future staff utilization should be presented in a dashboard with action plans developed in collaboration with supervisors for staff not meeting targets. The process will be reviewed at the departmental and agency level on a weekly basis, with formal reviews by the Assistant COE.

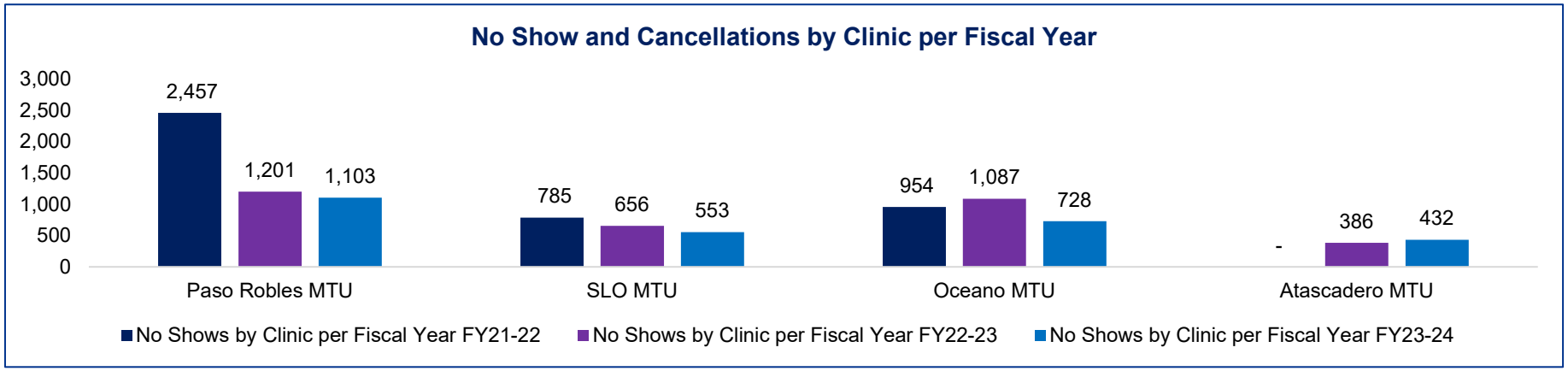
Key Opportunity Action Steps	Benefit	
Reducing the contracted FTE count to 0.4 FTE: • **Consider Optimal Coverage Hours:** Identify the necessary office hours and administrative time needed for effective operations. Based on current demand, aim for 0.4 FTE to cover three days per week. • **Propose New Office Hour Schedule**: Develop a proposed schedule where contracted staff, have office hours for 4 hours per day across 3 days per week. • **Communicate with Contracted Staff**: Discuss the proposed changes with the contracted staff to help ensure they understand the reasons and benefits of the new schedule. • **Implement Schedule Adjustments**: Adjust the contracts to reflect the new reduced 0.4 FTE allocation and revised office hours. help ensure that administrative duties are clearly defined within these hours. **Implement staff utilization tracking:** • Please refer to Agency-wide Opportunity 1.9 for further detail on the action steps required to implement this opportunity.	• **Improved Resource Allocation:** Aligning staffing levels with workload demands will optimize resource allocation and reduce the risk of underusing staff and enhance cost efficiency. • **Data-Driven Management:** Using tracking systems to monitor staff workload on a weekly basis and providing actionable insights into staff productivity will aid in making informed decisions, setting productivity targets, and improving overall program effectiveness and client service delivery. • **Increased Efficiency:** More effective scheduling will support staff to spend the majority of their time on direct client care, improving service delivery and the number of clients receiving care timely. • **Better Client Outcomes:** Focusing staff efforts on direct client interactions enhances the quality of care, leading to improved client satisfaction and better health outcomes.	**$20,000 – $50,000** *Potential Annual Cost Efficiencies*

Maternal Child Adolescent Health – Key Opportunities

Opportunity 3.23	Implement processes to decrease no-show rates in the Medical Therapy Program to increase staff utilization and reduce wait times and cost of service.

Current State

- California Children's Services (CCS) is a statewide program that arranges, directs, and funds medical care, equipment, and rehabilitation for children and young adults under 21 with eligible medical conditions, whose families cannot fully pay for their care. CenCal provides case management for children of Medi-Cal eligible families, while the County manages case services for the safety net population and children with severe health diagnoses. Regardless of which organization provides case management support, the County is responsible for determining program eligibility for all participants. Additionally, the County is responsible for providing medical therapy to all eligible populations.
- The program is state-mandated, and although funding is received from the federal government, there is a Maintenance of Effort (MOE) requirement of $1.2 million. The program is encouraged to align with a staffing methodology for staffing numbers which the County currently aligns to. For the provision of Medical Therapy services, the County operates 4 clinics and has attempted to outsource service provision for occupational therapy to contractors; however, identifying qualified providers has been challenging. Consequently, the majority of occupational therapists in the program are county employees.
- While staffing levels must remain unchanged, the program faces several challenges, particularly related to appointment scheduling. Appointments are often scheduled six months in advance, with limited follow-up and outreach prior to the appointment, leading to a high no-show rate and scheduling inefficiencies. The number of no shows and cancellations by Clinic is outlined in the table below. While no shows and cancellation have decreased by 33% between FY21-22 and FY23-24, they continue to remain high.



Maternal Child Adolescent Health – Key Opportunities

Opportunity 3.23	Implement processes to decrease no-show rates in the Medical Therapy Program to increase staff utilization and reduce wait times and cost of service.

Key Opportunities for Consideration

To improve appointment attendance and scheduling efficiency, the CCS program should help ensure reminder calls and texts are sent to all clients, schedule clinicians and prescribers to dedicate 80% of their time to direct client care and reduce length of appointment times. Additionally, staggering appointment times for clients with multiple no-shows and developing community-based care models to better meet client needs versus traditional office-based services can further enhance overall efficiency and effectiveness.

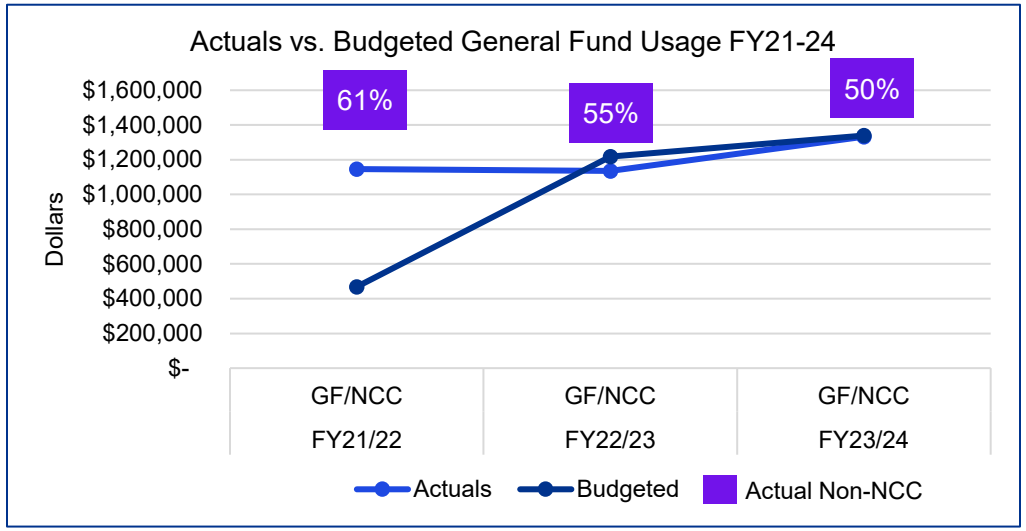
Key Opportunity Action Steps	Benefit	
• **Enhance Appointment Scheduling:** Update the current process for appointment scheduling which schedules appointments 6 months out. • **Scheduling Practices:** Advise all staff to book their schedule in 80% direct client care. • **Enhance Process for Reminder Calls:** Consider opportunities to enhance the call reminder process which may include reviewing the procedures which requires appointments to be booked 6 months in advance. • **Review Current Clientele:** Review current clientele and determine which clients would be best serviced via drop-in clinic.	• **Improved Attendance Rates:** Reminder calls and texts help ensure clients remember their appointments, leading to higher attendance rates and better continuity of care. • **Enhanced Efficiency:** Scheduling clinicians and prescribers for 80% direct client care and reducing appointment lengths maximizes staff utilization, allowing more clients to be seen in less time. • **Increased Accessibility:** Staggering appointment times for clients with frequent no-shows and developing community-based care models make services more accessible and convenient, potentially reducing barriers to care and improving overall client satisfaction.	*Since total number of visit data is unavailable, an estimate for Potential estimated cost efficiencies cannot be determined.*

Public Laboratory – Overview

Division Overview

- The San Luis Obispo Public Health Laboratory operates daily from 8 am to 5 pm and remains on call during weekends. It offers clinical and environmental testing services, collaborating with key partners to diagnose and monitor infectious diseases in local communities. Key county partners include:
  - Communicable Disease Division
  - Environmental Health
  - Suspected Abuse Response Team
  - Reproductive Health Clinic
  - Hospitals
  - Pediatric Clinics
  - Animal Services and Pacific Wildlife Care
  - Grassy Bar and Morro Oyster Companies
- The lab also serves **Santa Barbara and Ventura counties in conducting bioterrorism testing.**

9.25 *Total FTE*	**$3.24M** *Total Budget FY24-25*
47% *Budgeted FY24-25 Non-NCC*	**53%** *Budgeted FY24-25 General Fund*
50% *Actual FY23-24 Non-NCC*	**50%** *Actual FY23-24 General Fund*



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Santa Barbara	441,257	$1,199,600	44%	$0	$819,100	7
Monterey*	430,723	*Program level budget not publicly reported*				
Santa Cruz**	261,547	*Program level budget not publicly reported*				
Sonoma	481,812	*Not Publicly Available – Sonoma operates a Regional Public Health Laboratory with Mendocino, Lake, and Humboldt*				
Ventura***	829,590	*Program level budget not publicly reported*				

* In *Monterey, the Public Health Laboratory is part of the Public Health Bureau. The County's budget does not breakdown funding by program. However, the overall General Fund contribution for the Division is $5 million (14.5%), with intergovernmental revenues totaling $19 million (55%).*

** *In Santa Cruz County, the Environmental Health Laboratory is part of the Health Agency and program level budget is not available.*

***In Ventura County, Public Health Laboratory and Vital Records are included within the same cost center with program level budget not available. However, the overall General Fund contribution for the cost center is $279,180 (8%), intergovernmental revenues totaling $504,784 (15%).*

***Disclaimer:** Financial information for this Division was derived from workpapers provided by the Health Agency.*

Public Health Laboratory– SWOT Analysis

Strengths

- **Strong quality assurance program:** The Laboratory excels in quality testing, conducting quarterly audits to help ensure documentation accuracy, support robust quality control, and drive continuous improvement.
- **Strong performance on proficiency event**s: In FY23-24, the Laboratory participated in 74 proficiency events to demonstrate the reliability of its testing services, achieving high scores in all events, including a 100% score on 72 out of 73 events.
- **High staff retention rate:** Interviewees reported that the team has a strong dynamic and positive culture, demonstrated by a high retention rate with 9.25 of the Laboratory's employees having been with the organization for over three years.
- **Quick Turnaround Times:** Based on engagement with stakeholders, positive feedback was provided regarding fast turnaround times, which is recognized as a key strength of the Laboratory.
- **New technology/instrument adoption:** The Laboratory validated a MALDI-TOF instrument to rapidly detect tuberculosis-like organisms and fungi. The technology decreased the result turnaround time for identifying Valley Fever from weeks to hours.

Weaknesses

- **Budget pressures and low-test volumes:** The Laboratory faces difficulty in achieving cost efficiency due to insufficient test volumes for batch processing, coupled with the need to meet fast turnaround times.
- **Uncompetitive costs leading to low test volumes:** The Laboratory faces challenges in competing with large labs such as LabCorp and Quest Diagnostics, with the Public Lab charges fees that are 53 times more expensive for tests like RPR Syphilis testing. These larger labs benefit from economies of scale due to high-volume batch testing, which the Public Laboratory cannot match.
- **Challenges in obtaining full cost reimbursement:** The Laboratory provides testing for clinics with a high proportion of Medi-Cal clients. Medi-Cal funding only covers a portion of the test cost, and often there is no copay, leaving the lab to absorb the remaining expenses.
- **Manual inventory management:** The lack of an inventory management system requires staff to manually track supplies/consumables using spreadsheets, sourced from multiple suppliers to save costs, and place orders on a weekly schedule, resulting in significant time inefficiencies. Additionally, it creates challenges in efficiently managing inventory and determining the optimal timing for orders.

Opportunities

- **Enhance collaboration with county departments and local hospitals/clinics to increase service volumes:** Expand testing through partnerships with agencies like WellPath, local universities, Employee Health, and other county entities by developing memorandums of understanding (MOUs) or service contracts.
- **Expand to consolidate county contracts for laboratory consumables to reduce costs:** Collaborate with neighboring laboratories across the state to create joint or piggyback contracts, aiming to leverage economies of scale and lower supply expenses.
- **Satellite site feasibility assessment:** Assess the feasibility of acting as a satellite site for commercial laboratories such as LabCorp or Quest Diagnostics to increase volumes and increase revenues.

Threats

- **General fund dependence:** Higher reliance on the General Fund (45% or $1.2M, on average between FY 21-22 and FY 23-24) may strain other county resources and limit funding for other county projects.
- **Threat to long term cost efficiency:** The combination of low-test volumes, quick turnaround requirements, and insufficient Medi-Cal reimbursement threatens the Laboratory's ability to achieve cost efficiency, potentially leading to budget shortfall.
- **Barrier to growth and efficiency:** Inability to expand due to high cost, preventing the achievement of cost efficiency through increased volumes and revenue.
- **Risk of supply expiration and loss:** High risk of supplies expiring unnoticed, causing financial losses from wasted resources.

Public Health Laboratory– Key Opportunity

Opportunity 3.24	**Explore three key options for the Laboratory's future operations to enhance Non-NCC and decrease reliance on the general fund:** • **Option 1. Maintain the Status Quo and report the annual deficit to the BOS** • **Option 2. Strengthen collaboration with county departments and local hospitals/clinics to boost service volume and consolidate county contracts for laboratory consumables to lower costs.** • **Option 3. Transition to a Regional Laboratory**

Current State

- In FY23-24, the annual cost to operate the lab was $2,668,823. Despite receiving $326,798 in grant funding, $732,381 in other state and federal funding, and generating $277,205 from service charges, the majority of lab funding (50%) comes from the general fund or realignment funding. This trend has been consistent over the past three years, as shown in the table below.

FY21-22*					FY22-23					FY23-24				
Revenue**	Expenses	General Fund	Test Volumes	Cost per Test	Revenue**	Expenses	General Fund	Test Volumes	Cost per Test	Revenue**	Expenses	General Fund	Test Volumes	Cost per Test
$1,774,602	$2,921,544	$1,146,942	44,203	$66.09	$1,409,790	$2,545,335	$1,135,545	30,015	$84.80	$1,336,384	$2,668,823	$1,332,439	30,539	$87.39

**FY 21-22 data may be skewed due to additional testing as a result of the COVID-19 Pandemic.*
***This revenue includes all State and Federal funding as well as services fees.*

- The Laboratory reviews its fee schedule annually to support Non-NCC; however, challenges in achieving this goal are driven by several factors:
  - **Competitive Pricing:** The Laboratory's prices are not competitive with private labs such as LabCorp and Quest Diagnostics. These laboratories benefit from high testing volumes, which significantly lowers their costs through economies of scale, reducing prices to levels that the Public Laboratory cannot achieve. For example, stakeholder engagement revealed that some fees were up to 52 times (5,000%) higher at Public Laboratory compared to LabCorp, as outlined in the table below:

Test Type	LabCorp Fee	Public Laboratory Fee	% Difference
MTB Amplification	$89	$244	170%
TB QuantiFERON	$34	$99	190%
RPR Syphilis Testing	$1.63	$85	5,000%

  - **Low Test Volumes:** There is insufficient test volumes to support cost-effective batch testing. For example, in 2024, the lab conducted 30,539 tests. However, to achieve full Non-NCC, the lab would need to perform an estimated 70,900 tests annually based on a weighted blended fee rate of $48.26 and discounting by 22% to accounting for Medi-Cal recovery. Furthermore, agencies such as WellPath (serving the County Jail), local universities, and larger hospitals and clinics currently send their lab testing requests to private laboratories instead of the County lab, due to the high cost, which further hinders volume increases.
  - **Reimbursement Issues:** Many clients are Medi-Cal patients, and Medi-Cal does not typically reimburse the full fee. Additionally, the laboratory cannot charge copays to Medi-Cal clients. This resulted in a cost of $94,362 in 2024 that was absorbed by the Laboratory.

Public Health Laboratory– Option 1

Option 1	Maintain the Status Quo. In considering this option, the Laboratory will continue to report an annual deficit and require ongoing general fund use.

Key Changes

- Under this option, there will be no changes to the Laboratory's operations. However, if selected, the Department should inform the Board of Supervisors that ongoing general fund support will be required annually to maintain the Lab's operations, due to its low Non-NCC from insufficient test volumes.
- In the event this option is chosen, a business case around the value provided by using general fund to fund the lab should be created with regards to ability to respond to local public health emergency, scope and range of testing, faster turnaround times, for example.

Pros	Cons	
• **Limited Resistance:** This option will result in minimal resistance to change and no challenges from staff or the community, as it maintains the status quo. • **Stability in Operations:** The Laboratory can continue its current operations without the need for immediate structural or procedural changes. • **Avoidance of Disruption:** Minimizes the risk of disruption that might come from attempting to change operations or transition to a new model. • **Continued Control:** Under this option, the county will retain full control over the laboratory, its resources, and its testing procedures.	• **Dependence on General Funds:** The requirement for annual general fund support limit the County's flexibility in allocating resources to other critical projects and initiatives • **Lack of Improvement:** Without operational changes, the Laboratory will continue to experience low volumes and low Non-NCC, potentially missing opportunities to enhance efficiency, increase test volumes, or adopt new technologies, which could lead to stagnation. • **Limited Growth Opportunity:** The Laboratory may face limited motivation for growing its services, expanding its capabilities, or exploring new revenue streams due to the continued reliance on financial support.	**$0** *Potential Annual Cost Efficiencies*

Activities

- Prepare a communication to the Board of Supervisors, advising that the Laboratory will require ongoing general fund support due to volumes being insufficient to achieve full Non-NCC. This communication should include projections of the required general fund amounts over the next 3 – 5 years to facilitate proactive planning for general fund allocation. It should also include the benefit offered with regards to scope and range of testing, faster turnaround times, for example.

Public Health Laboratory– Option 2

Option 2	Strengthen collaboration with county departments and local hospitals/clinics to boost service volume and consolidate county contracts for laboratory consumables to lower costs.

Key Changes

- Under Option 2, the Laboratory will undertake the following:
  - Actively engage key agencies such as WellPath, local universities, employee health, and other county entities to identify opportunities for increasing test volumes through the development of memorandums of understanding (MOUs) or service contracts.
  - Engage local hospitals, clinics, and private services to explore potential collaborations for expanding test volumes. While large hospitals and clinics like Adventist Health may initially present barriers due to high fee rates, there are growth opportunities in offering high-priority tests such as QuantiFERON TB or pneumonia panels.
  - Collaborate with neighboring laboratories across the state to develop joint or piggyback contracts for lab consumables, with the goal of increasing economies of scale

Pros	Cons	
• **Increased cost efficiency:** It may enable greater opportunity for Non-NCC through increased test volumes and batch testing. • **Long-Term Viability:** It may (dependent on increased volumes received) secure the lab's competitiveness and sustainability and reduces reliance on General Fund Contributions. • **Improved Negotiating Power:** By combining demand, counties can negotiate better terms, prices, and conditions with suppliers, leading to more favorable contracts.	• **Dependence on stakeholder collaboration:** This option is dependent on cooperation of key stakeholders. • **Challenges in Achieving Cost-Effective Agreements:** It may be challenging to reach a mutually beneficial agreement due to the low-cost fees offered by private labs. Focusing on high-priority tests that require a quick turnaround alone may not suffice to achieve overall Non-NCC for the lab. • **Implementation Time:** The process of developing MOUs or joint contracts with key agencies can be time-consuming, potentially delaying immediate improvements in Non-NCC.	*This option is dependent on negotiation with key partner agencies and cost efficiencies will be based on volume increases; however it is unlikely that it will result in the cost saving necessary to support full general fund reduction.*

Activities

- **Initiate Stakeholder Engagement:** Identify and initiate discussions with key agencies such as California Association of Public Health Laboratory Directors (CAPHLD) and California Department of Public Health (CDPH) to explore purchasing and contracts collaborations. Where engagement is successful the following action may be considered.
- **Identify key tests:** Identify the key tests that the Public Laboratory is best positioned to support and based on increased volumes, assess the financial viability of reducing rates in exchange for higher test volumes with key partners on a case-by-case basis.
- **Conduct Needs Assessment:** Collect data on current lab consumables, spending patterns, and identify common requirements across counties to standardize specifications.
- **Develop Agreements:** Negotiate terms including pricing and finalize MOUs or procurement contracts with partner agencies to formalize partnerships.

Public Health Laboratory– Option 3

Option 3	Transition to a Regional Laboratory similar to counties such as Sonoma and Marin.

Key Changes

- Under this option, the County will collaborate with neighboring counties to explore the development of a regional laboratory system. This system would support testing needs while achieving economies of scale and meeting state mandates which require counties to have *access to the services of a public health laboratory*. Given that the County currently contracts with Santa Barbara and Ventura counties for bioterrorism testing, there may be an opportunity to develop a shared regional laboratory with these counties.
- It is important to note that other counties facing similar challenges of low-test volumes have collaborated with neighboring counties to enhance test volumes, increase economies of scale, and reduce cost. For example:
  - In 2018, Marin County joined Napa, Solano, and Yolo counties to develop a regional laboratory with an estimated cost reduction of 50%.
  - Sonoma County has entered into a Memorandum of Understanding (MOU) with neighboring counties including Mendocino County, Humboldt County, and Lake County to provide laboratory services to these counties for a fee, thereby increasing its test volumes and opportunities for Non-NCC.

Pros	Cons	
• **Enhanced Testing Capabilities:** It will increase test volumes for more efficient batch processing and reduced cost. This will support the County to better compete were private, high-volume labs. • **Economies of Scale:** It will support cost efficiencies through shared resources and bulk purchasing, reducing expenses for each county. • **Cost Sharing:** It results in distribution of financial responsibility among counties, easing budget constraints and use of General Fund dollars.	• **Dependence of regional collaboration:** This option is dependent on performance and cooperation of neighboring counties. • **Geographic Limitations:** The physical distance between participating counties might result in reduced turnaround times. • **Loss of Individual Control:** The County may have less direct control over laboratory operations and policies.	**$500 – 750k*** *Potential Annual Cost Efficiencies*

Activities

- **Conduct a cost-benefit analysis:** This analysis will evaluate the feasibility, cost, and benefit in transitioning to a regional laboratory system.
- **Initiate Inter-County Collaboration**: Engage in discussions with neighboring counties such as Ventura and Santa Barbara to explore interest and establish partnerships for developing a regional public health laboratory.
- **Form Joint Task Force:** Create a task force with representatives from each participating county to develop a collaborative strategy and oversee the planning process.
- **Conduct Feasibility Study:** Assess the combined needs, testing volumes, and potential benefits, and outline the operational, financial, and consider logistical aspects of the regional laboratory.
- **Develop Implementation Plan:** Create a detailed implementation plan, including funding sources, resource allocation, facility, and timeline for establishing the lab.

*This cost reduction is based on the potential cost reduction to be brought about by transitioning to a regional model as informed by the operational cost current incurred by Marin County.

Public Health Laboratory, Marin, Napa, Solano, Yolo | Marin Health and Human Services

Public Health Regional Laboratory

Public Health Laboratory – Additional Opportunities

Opportunity 3.25	Optimize staffing to test ratios to better align with demand for service and support greater Non-NCC.

Current State

- The lab is currently staffed by 10.25 full-time equivalents, as outlined in the table below. In 2024, the lab conducted 30,529 tests, averaging 4,210 tests per staff member, excluding the Lab Manager and Supervisor. In comparison, Santa Barbara has 7 full-time equivalents and conducted 26,651 tests in 2024, averaging 5,330 tests per staff member, excluding the Supervisor and Business Specialists. This is 39% higher in tests per staff member compared to San Luis Obispo.
- In addition, in Santa Barbara, has a staff to supervisory ratio of 1.6; however, in San Luis Obispo, given the Laboratory employs a manager a supervisor, the staff to supervisor ratio is 1.4.

San Luis Obispo County Laboratory Staffing	
Position	**FTE**
Lab Manager	1
Lab Supervisor	1
Microbiologist	5.25
Lab Technician	2 including 1 vacancy
Biller	1
Total	**10.25**

Santa Barbara County Laboratory Staffing	
Position	**FTE**
Lab Supervisor	1
Microbiologist	3
Lab Assistants	2
Department Business Specialist	1
Total	**7**

- This suggests that San Luis Obispo has more FTEs than necessary for the services provided. Based on the current volume of 30,529 tests, 5.7 FTEs (30,529/5,330) would be required if considering Santa Barbara County's test volumes per FTE.

Key Opportunities for Consideration

- In the near term as the leadership consider the options outlined in Opportunity 3.1, the Division may consider undertaking the following to better align staffing levels to demand:
  - Given the high supervisory to staff ratio, the Division may consider transitioning the supervisor to perform testing for 0.7 FTE and spend the remaining 0.3 FTE on supervisory activities.
  - Having reassigned a portion of the supervisors time to undertake testing, the Division may subsequently reallocate 2.25 FTEs.
- The Lab may undertake this staffing redirection to achieve some short-term Cost Efficiencies; however, it is important to note that **it will not resolve the challenges faced with regards to low test volumes and uncompetitive costs in the long-term.**

Public Health Laboratory – Additional Opportunities

Opportunity 3.25	Optimize staffing to test ratios to better align with demand for service and support greater Non-NCC.	
Current State		
Key Opportunity Action Steps	**Benefit**	

• **Assess and Plan:** Analyze the current workforce structure to identify key supervisory activities that can be reallocated, facilitating the supervisor's transition to a 0.7 FTE testing capacity.
• **Engage Stakeholders:** Engage Human Resources and communicate the new role expectations to the supervisor and inform all staff of the upcoming changes.
• **Implement Role Changes:** Adjust the supervisor's job description to allocate 0.7 FTE for testing and 0.3 FTE for supervisory duties.
• **Reallocate FTEs:** Collaborate with Human Resources to identify the 2.25 FTEs positions that can be redirected and plan their reallocation.
• **Monitor and Adjust:** In the future, regularly track performance, and make necessary adjustments to support continue effective alignment with demand. Example of key metrics that can be tracked to support this process include:
  ○ Test volumes per staff member
  ○ Turnaround time by staff member per staff member
  ○ The number of errors or failed quality control checks per staff member.
  ○ The percentage of staff time that is spent on productive activities versus total available work hours.
	• **Enhanced Resource Utilization:** Transitioning the supervisor to perform testing for 0.7 FTE and supervisory activities for 0.3 FTE allows the Division to maximize productive work hours.
	• **Cost Efficiencies:** By reallocating 2.25 FTEs, the Division can potentially reduce staffing costs, improving overall financial efficiency without compromising the quality of service provided.
		$295,000
		Potential Annual Cost Efficiencies

*This potential saving is based on average full-burdened salaries for Microbiologists and Lab Technicians

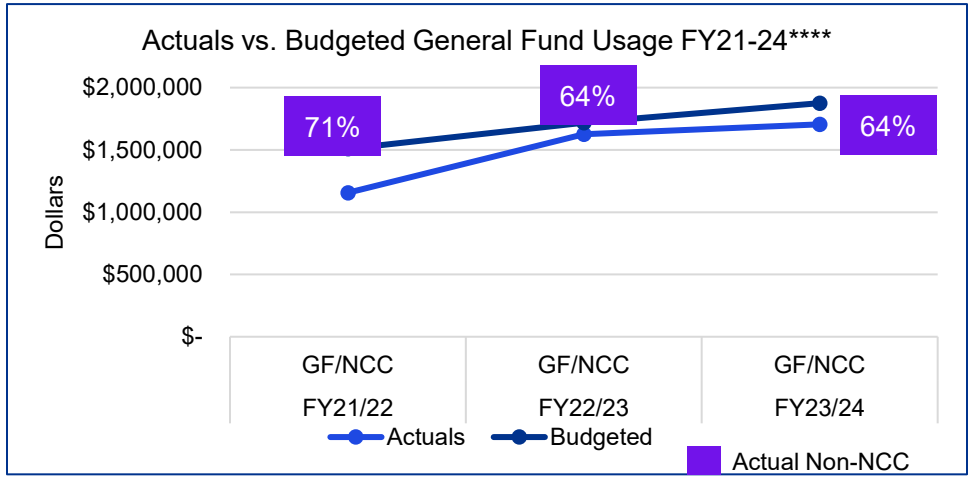
Animal Services

Animal Services – Overview

Division Overview

- The Animal Services Division provides a range of services to support the health, safety, and welfare of domestic animals and the people they serve. The Division operates the only open-intake animal shelter in the county, offering a variety of programs and services:
  - **Field Services:** Respond to complaints, enforce animal-related laws, and assist with lost and found pets and animal bites.
  - **Shelter Operations:** Operate an open-intake animal shelter, providing adoption, fostering, and spay/neuter services.
  - **Licensing:** Administer the County's animal licensing program, ensuring dogs and cats are licensed and vaccinated.
  - **City Fees:** Contract with incorporated cities for animal control services.
- The Division collaborates with local rescue organizations, veterinarians, and animal welfare advocates to provide care and support for the animals in their charge.

24.50 *Total FTE*	**$5.3M** *Total Budget FY24-25*
62% *Budgeted FY24-25 Non-NCC*	**38%** *Budgeted FY24-25 General Fund*
64% *Actual FY23-24 Non-NCC*	**36%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$5,333,160	32%	$2,041,275	$1,616,656	24.50
Santa Barbara*	441,257	$6,945,900	58%	$1,684,800	$2,400	38.55
Monterey**	430,723	$6,142,768	53%	$2,870,110	Not Publicly Available	28.00
Santa Cruz**	261,547	$2,232,645	Not Publicly Available	$1,232,645	Not Publicly Available	14.00
Sonoma**	481,812	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available
Ventura*	829,590	$11,771,913	69%	$3,671,036	0	79.00

**Santa Barbara and Ventura County provide services to both incorporated and unincorporated areas.*

*** Monterey County services the unincorporated and the City of Salinas with the remaining cities managing their own animal services.*

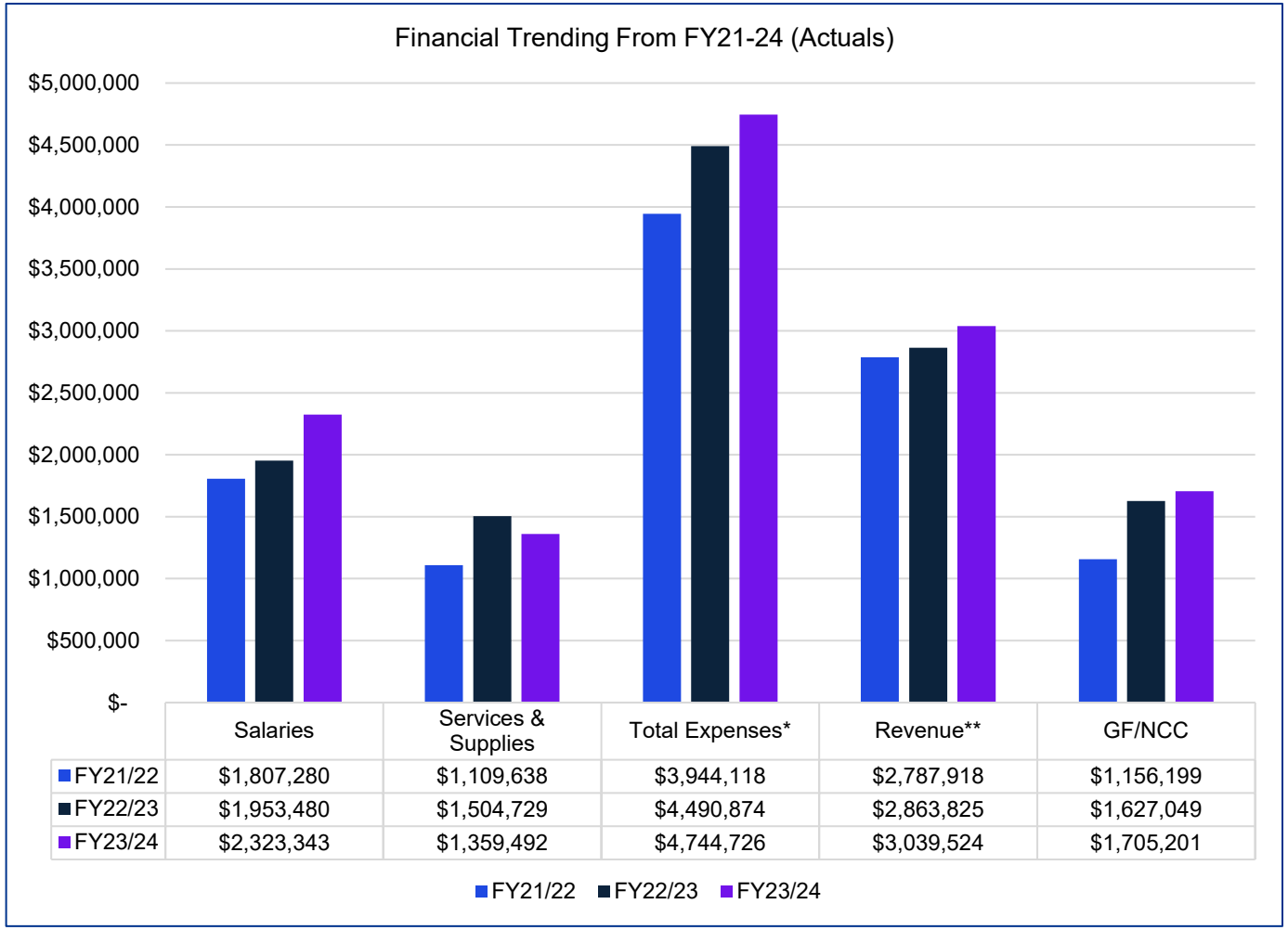
***In Santa Cruz County, animal services are under the jurisdiction of the Santa Cruz County Animal Services Authority (SCCAS), a joint powers authority serving the county and the cities of Capitola, Santa Cruz, Scotts Valley, and Watsonville. The County provides funding, but does not offer direct FTEs, therefore, FTEs are 0.*

***Sonoma County does not provide program level budget within its Budget Book with budget reported only at the Department level; however, manages animal services for the unincorporated areas and cities of Santa Rosa and Sonoma, the remaining cities manage their own animal services.*

Animal Services – Trend Analysis

Between FY 21-22 and FY 23-24, the Animal Services Division achieved a combined average Non-NCC rate of 66% requiring an average of $1.50M General Fund use. In FY 21-22, the Division required $1.16M General Fund. Between FY 21-22 and FY 22-23, General Fund increased 40%. In FY 23-24, General Fund used increase another 5%.

- Salaries have increased steadily over the past three fiscal years, but most notably in FY 23-24. Between FY 21-22 and FY 22-23, salaries increased 8%. In FY 23-24, salaries increased 19%, more than double the increase in FY 22-23. This is mainly due to the filling of vacant positions.
- Expenses related to Services & Supplies increased 36% between FY 21-22 and FY 22-23 due to a 94% increase in Services & Supply costs related to Shelter Operations. However, in FY 23-24, Services & Supply costs for Shelter Operations fell by 37% decreasing total Services & Supply costs for the Division by 10%.
- Total Expenses for the Division increased steadily over the past three fiscal years due to the increases in Salaries, Services & Supplies, and changes in intrafund balances. Between FY 21-22 and FY 23-24, total expenses increased 20%.
- Revenues (including grant funding and donations) also increased steadily over the past three fiscal years. Between FY 21-22 and FY 23-24, revenue for the Division increased 9%. This was mainly due to an 18% increase in revenue from City Fees and a 10% increase in revenue from Licensing over the same period.



	Salaries	Services & Supplies	Total Expenses*	Revenue**	GF/NCC
FY21/22	$1,807,280	$1,109,638	$3,944,118	$2,787,918	$1,156,199
FY22/23	$1,953,480	$1,504,729	$4,490,874	$2,863,825	$1,627,049
FY23/24	$2,323,343	$1,359,492	$4,744,726	$3,039,524	$1,705,201

**The variance in the difference between the total of Salaries and Services & Supplies and Total Expenses is due to adjustments through Intrafund charges and balances.*
***Revenue includes charges for service, grant funding, and realignment.*

Animal Services – SWOT Analysis

Strengths	Weaknesses
• **Consistent financial performance:** The Division has maintained consistent revenues and expenditures year over year, providing stability and predictability in its operations. • **Diverse range of services:** The Division offers a wide range of services, including animal care and control, licensing, permitting, and shelter operations, allowing it to address key animal-related issues in the County. • **Strong partnerships:** The Division has established partnerships with local veterinarians and organizations like Woods Humane Society Animal Shelter to provide medical care and surgical services for animals in their care.	• **Limited medical capabilities:** The department has limited in-house medical capabilities, with only one veterinarian on staff, which may impact the speed and efficiency of providing medical care to animals. • **Reliance on external funding:** There is a high level of reliance external funding sources, such as General Fund, donations and city contributions, which may create financial vulnerabilities if these sources become unstable. • **Challenges with licensing compliance:** The Division faces challenges in achieving high licensing compliance rates, with approximately 40% of animals currently licensed, limiting potential revenue from this source. • **Custodial impounding:** Animals under custodial impounding have the highest length of stay, which may strain resources and capacity within the shelter.
Opportunities	**Threats**
• **Explore new revenue streams:** Investigating potential new revenue streams, such as establishing to a 501(C3) or implementing initiatives to increase donations to help diversify and stabilize the Division's funding sources. • **Enhance community outreach:** Increasing community outreach efforts could help raise awareness about the department's services, promote responsible pet ownership, and encourage donations and support from the public. • **Shared Governance**: There is an opportunity to develop a shared governance model with other partners who fund Animal Services.	• **Economic fluctuations:** Economic downturns or fluctuations could impact the funding sources, such as donations and city contributions, creating financial instability. • **Increasing costs:** Rising costs for veterinary care, supplies, and other operational expenses could strain budget and resources in the future. • **Potential loss of partnerships:** Any disruptions or changes in partnerships with local veterinarians or organizations could impact its ability to provide necessary medical care and services to animals in its care.

Animal Services – Key Opportunities

Opportunity 4.1	Consider the feasibility of establishing to a 501(c)(3) organization to collect donations for animal services and increase cost efficiency, similar to the approach taken by Ventura County.

Current State

- The Animal Services Division has an important mission in providing a range of services to support the health, safety, and welfare of domestic animals and the people they serve. The Division is currently funded via a range of sources, including General Fund with an average of $2.41M across the past three fiscal years coming from charges for services. This rate of Non-NCC is relatively low compared to benchmark counties.
- Other counties such as Ventura County have adopted innovative methods to enhance funding available to support the 500 stray and abandoned animals being cared for at Ventura County Animal Services (VCAS) daily. One such initiative is the creation of the Animal Services Foundation of Ventura County, a 501(c)(3) non-profit organization that supports the mission of VCAS. Through the charity, individuals can make donations using various methods:
  - **Credit Card Donations:** Donations can be made directly on the Foundation's website.
  - **Vehicle Donations:** Individuals can donate cars, trucks, motorcycles, or RVs. The Foundation arranges for the pick-up of the vehicle at no cost to the donor, who may qualify for a tax deduction. Once the vehicle is sold, the Foundation received the cash and provides the proper tax forms to the donator.
  - **Supermarket Collaborations:** The Foundation has partnered with Ralphs supermarket, allowing supporters to link their Ralphs card to the Animal Services Foundation. Every time a purchase is made, 4.0% of the purchase value is donated to the organization.

These strategies not only increase funding but also engage the community in supporting animal welfare efforts.

Key Opportunity for Consideration

- In the future, the Division may consider enhancing its approach to donations by exploring the feasibility of establishing a 501(c)(3) non-profit organization or implementing initiatives such as vehicle donation programs and partnerships with local supermarkets, similar to those successfully adopted by Ventura County.

Key Opportunity Action Steps	Benefit	
• **Conduct Feasibility Study:** Assess the benefits and costs of establishing a 501(c)(3) non-profit and/or implementing donation programs. This analysis should include stakeholder engagement to evaluate the County's desire to adopt such as initiative. • **Seek Approval:** If the feasibility study is successful, the Division should seek approval for this initiative from the Board of Supervisors. • **Implement Initiative:** Develop an implementation plan which should include a steering committee, timeline and milestones, resource allocation, clearly defined roles and responsibilities, a communication strategy, monitoring and evaluation processes, and risk management.	• **Increased Funding:** Establishing a 501(c)(3) and implementing donation initiatives can significantly boost financial support for services and programs, reducing reliance on General Fund. • **Enhanced Community Engagement:** These initiatives promote greater community involvement and support through diverse donation options.	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency.*

Animal Services – Key Opportunities

Opportunity 4.2	Consider the implementation of a coordinated governance model with the cities to increase collaboration and enhance the shared decision-making process.

Current State

- Animal Services supports both the unincorporated areas and the County's seven cities. Although the overall budget for Animal Services in FY24-25 is $5.3M, the labor and services & supply expenses across field services, shelter operations, licensing, city fees, and administration for FY23-24 was $3.68m with 35% ($1.3M) contributed by the cities with the County covering General Fund covering 32% ($1.2M) and revenues covering the remaining 33% ($1.2M) of the total cost.
- Based on feedback from engagement with city stakeholders, there is a recognized opportunity to implement a more shared governance model. This would support greater collaboration in decision-making processes, particularly related to hiring and department operations. Specifically, stakeholders identified the following key challenges with the current model:
  - Rising cost allocation to the cities which increased by 15% this year is becoming unsustainable.
  - The cities bear the cost of maintenance for the new facility without participating in the decision-making process.

Key Opportunity for Consideration

- There is an opportunity to create a more sustainable and collaborative model by implementing a shared governance structure with the County's seven cities.

Key Opportunity Action Steps	Benefit	
• **Consider Establishment of a Shared Decision-Making Process:** Consider Establishing a shared decision-making process through formal consensus or voting on operational decisions, such as hiring new positions, setting hours of operation, and vendor negotiations and approval. • **Refine Standardized Metrics and Data Definitions:** Refine the standardized set of metrics and data definitions agreed upon by all parties funding Animal Services, including service calls by day, hour, and zip code. • **Implement Regular Review Meetings:** Implement monthly meetings to review metrics and financials to address current stakeholder concerns. Once issues are more stable, consider moving the governance meetings to quarterly, with access to financials and metrics shared on a shared drive	• **Enhanced Collaboration:** Developing a shared governance model fosters enhanced collaboration between the County and the cities, leading to more informed and accepted outcomes. • **Improved Decision-Making:** Shared governance will facilitate better-informed decisions that reflect the interests and needs of all parties. • **Increased Transparency**: Regular reporting and consistent information sharing will build trust and reduce the need for stakeholders to chase updates.	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency.*

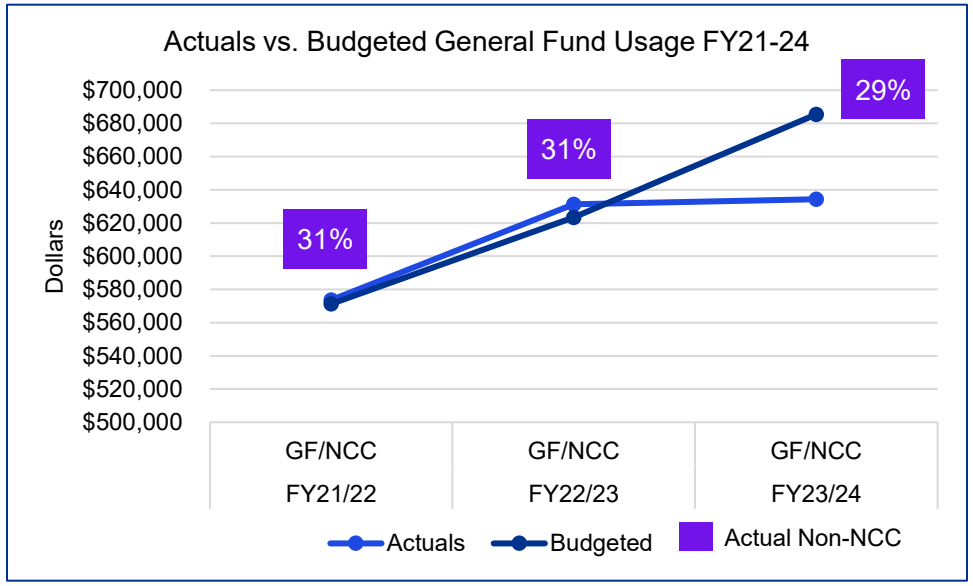
Public Guardian

Public Guardian – Overview

Division Overview

- The San Luis Obispo Office of the Public Guardian is appointed by the Superior Court of California and serves as the Probate or Lanterman-Petris-Short (LPS) Conservator for individuals requiring conservatorship when no other viable option exists. This role involves managing finances, coordinating long-term health or psychiatric care placements, and addressing daily needs for those who cannot independently provide for themselves and lack family or friends to assist them.
- Additionally, the Office acts as a Public Representative Payee, designated by the Social Security Administration, to help individuals who struggle with managing their financial affairs. By overseeing their monthly income benefits, the Public Guardian enables these individuals to maintain housing and meet their basic needs while being case managed by other public agencies or non-profit organizations.

5.75 *Total FTE*	**$923k** *Total Budget FY24-25*
22% *Budgeted FY24-25 Non-NCC*	**78%** *Budgeted FY24-25 General Fund*
29% *Actual FY23-24 Non-NCC*	**71%** *Actual FY23-24 General Fund*



Benchmark Counties Budget and FTEs (FY24-25)

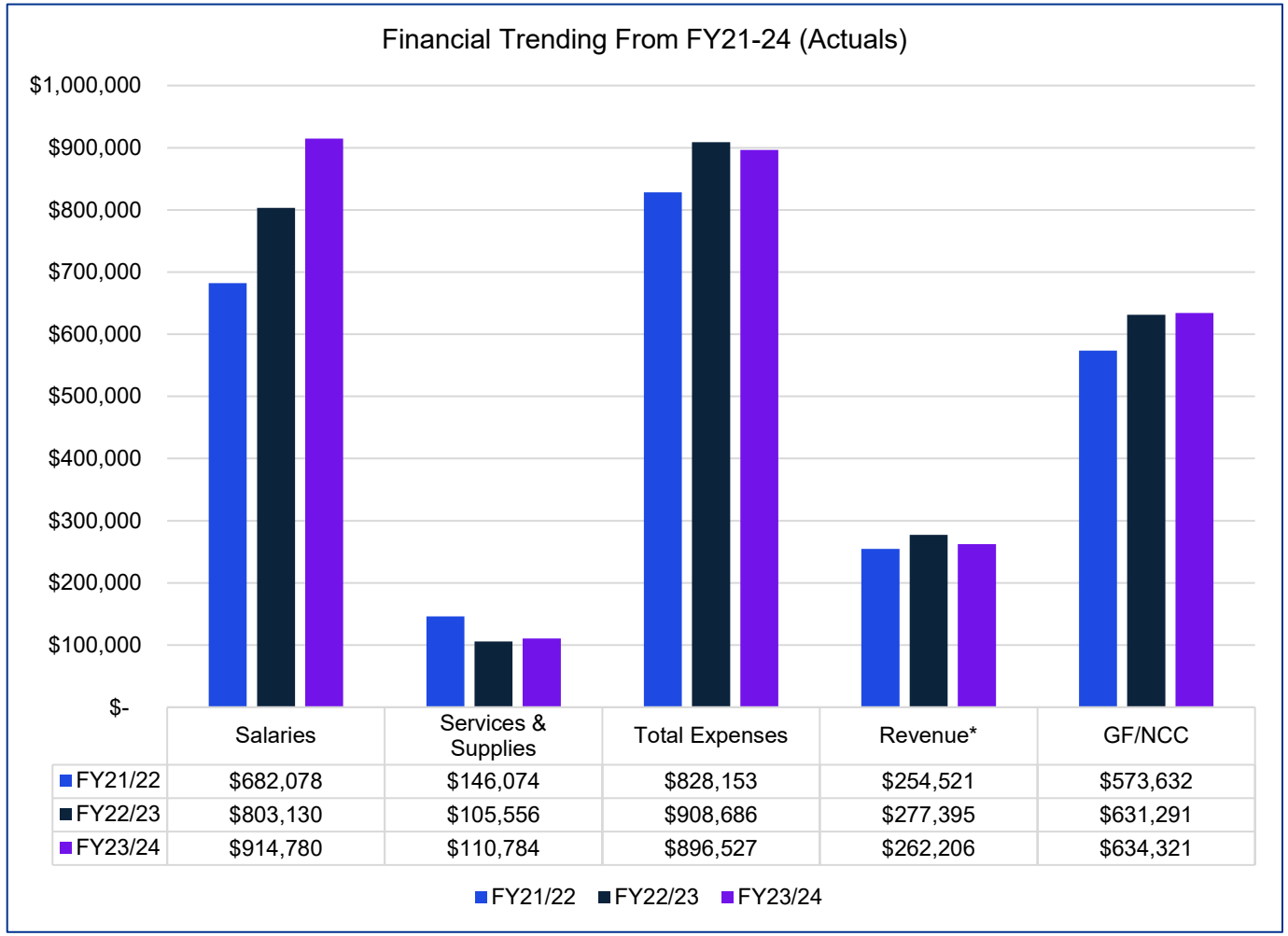
County	Population	Total Funding	Charge for Service %	General Fund Use	Intergov. Revenue	FTEs
SLO	281,639	$922,957	22%	$716,405	$65,000	5.75
Santa Barbara*	441,257	$2,848,230	6%	$2,214,230	$212,000	19.25
Monterey**	430,723	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	10
Santa Cruz	261,547	$882,576	Not Publicly Available	Not Publicly Available	Not Publicly Available	7
Sonoma***	481,812	Not Publicly Available	Not Publicly Available	Not Publicly Available	Not Publicly Available	10
Ventura	829,590	$2,765,735	6%	$2,270,035	$320,700	28

**In Santa Barbara County, Public Guardian forms a part of the Treasurer Tax Collector and also includes public support related to Veterans Administration and other state and federal benefits.*
*** In Monterey, the Public Guardian comprises Public Guardian, Public Administrator, and Public Conservator*
****In Sonoma County, Public Guardian is part of the Human Services Department and does not provide program level budget within its Budget Book with budget reported only at the Department level. FTE numbers are based on outreach already undertaken by SLO County.*

Public Guardian – Trend Analysis

Between FY 21-22 and FY 23-24, the Public Guardian Division achieved a combined average Non-NCC of 70% requiring an average of $613,081 General Fund. In FY 21-22, the Division required $573,632 General Fund use. In FY 22-23, General Fund use increased 10%. In FY 23-24, General Fund use increased again, but only slightly (.5%).

- Salaries for the division have increased over the past three fiscal years as staff has been hired to keep up with growing demand for services. Between FY 21-22 and FY 23-24, salaries for the Division increased 34%.
- Expenses related to Services & Supplies have decreased from FY 21-22. Between FY 21-22 and FY 22-23, Service & Supply costs decreased 28% due to a 121% decrease in costs related to Professional and Special Services (anticipated legal fees were not required in FY 22-23). In FY 23-24, Services & Supplies increased slightly by 5%.
- Total Expenses fluctuated over the past three fiscal year increasing 10% between FY 21-22 and FY 22-23 due to the increase in salaries during that period. In FY 23-24, Total Expenses decreased slightly by just over 1%.
- Revenue (including federal funding) also fluctuated over the past three fiscal years. Between FY 21-22 and FY 22-23, revenue increased 9% due to a 1.5x increase in federal funding. In FY 23-24, revenue decreased 5% due to 13% decrease in Conservatorship Fees.



	Salaries	Services & Supplies	Total Expenses	Revenue*	GF/NCC
FY21/22	$682,078	$146,074	$828,153	$254,521	$573,632
FY22/23	$803,130	$105,556	$908,686	$277,395	$631,291
FY23/24	$914,780	$110,784	$896,527	$262,206	$634,321

**Revenue includes charges for service, federal funding, and realignment.*

Public Guardian – SWOT Analysis

Strengths

- **Successful Transition to Electronic Record Keeping:** In the past several years, the Office successfully transitioned from paper files to a fully electronic system, incorporating eFax, Microsoft Teams, and telework solutions. This shift has significantly enhanced operational efficiency, data accessibility, and enabled more flexible work arrangements.
- **Successful Implementation of SB 43.** The Public Guardian's Office successfully implemented SB 43, which expands the definition of "gravely disabled" to include individuals with severe substance use or co-occurring disorders. This legislative change has challenged the Office to adapt and efficiently manage the higher volume of cases.
- **Enhanced Divisional Culture:** Division staff across the Public Guardian are deeply committed to their mission. Recent feedback indicates that the divisional culture has notably improved, fostering a more supportive, collaborative, and motivated work environment.

Weaknesses

- **Technology Challenges:** Interviewees reported that the current case management technology is outdated and challenging to work with, making it difficult to track staff performance and run reports on hours worked per case or conservatee placement.
- **Insufficient Beds for LPS Conservatorship:** The Psychiatric Health Facility (PHF) is often at capacity. While the PHF admits clients under LPS Conservatees there is not a set of beds that are reserved for these admissions. Due to the recent adoption of SB 43, there is a risk of the PHF not having sufficient turnover among the patient population as long-term placement for this population is challenging across the state, therefore having an acute care unit function more like a long-term care home, resulting in a shortage of beds for new LPS conservatorships and clients requiring psychiatric admissions necessitating costly out-of-county placements.
- **High Administrative Burden:** Public Guardian Leadership spend a significant amount of time on administrative tasks. For example, they are required to sign 400 checks per week manually, leaving less time to spend on more strategic priorities.
- **Representative Payee Fees:** The County charges a $55 fee to undertaken responsibilities related to representative payee cases. However, this is typically insufficient to cover costs; however, SSI mandate the fee at this rate therefore, they Division cannot increase this rate.

Opportunities

- **Consider adopting Integrated check signing:** Implement Integrated check signing to automate the process of signing checks, eliminating the need for manual signatures.
- **Transition to a New Technology Solution:** Consider the feasibility of transitioning to an alternative technology solution to reduce manual efforts and administrative burden and support greater tracking of staff caseloads, productivity, and reporting.
- **Post-Implementation Staffing Analysis for Data-Driven Decisions:** Conduct a staffing analysis post technology implementation to support future data-driven decision-making on staffing levels.

Threats

- **Increase in case complexity:** The implementation of SB 43 and CARE Court has led to a significant increase in both the number and complexity of cases without a corresponding increase in staffing.
- **Inefficiencies due to Outdated Case Management Technology:** The challenges with the case management system may lead to difficulties in accurately tracking staff performance and generating reliable reports on hours worked per case or conservatee placement, potentially risking inefficiencies in resource allocation and case management operations.
- **Cost Threat as a result of SB43.** The adoption of SB43 has exacerbated the shortage of available beds in the County, forcing the County to rely on expensive contracted facilities to accommodate individuals in need of care which risks financial strain.

Public Guardian – Key Opportunities

Opportunity 5.1	Transition to an alternative technology solution to reduce manual efforts and administrative burden and support future data-driven decision-making on staffing levels.

Current State

- The Public Guardian currently has 5.75 FTEs, comprised of a Division Manager, two social workers, a 0.75 FTE investigator, and an accountant. The Public Guardian currently manages 119 conservatees cases and 67 representative cases, with the caseload having increased by 4% since the implementation of SB43.
- Based on FTE numbers, San Luis Obispo County has fewer FTEs compared to other counties relative to its population as outlined in the table below. However, it is important to note that detailed caseload information for each Public Guardian is not publicly available, making it challenging to determine and compare the caseload/workload per staff member across other counties to allow for a more accurate comparison of benchmark FTEs.

Public Guardian FTE Benchmarking

County	Population	Budgeted FTEs	FTE per 100k Population
SLO	281,639	5.75	2
Santa Barbara*	441,257	19.25	4.4
Monterey**	430,723	10	2,3
Santa Cruz	261,547	7	2.7
Sonoma***	481,812	10	2
Ventura	829,590	28	3.4

- Additionally, the Division's case management system does not facilitate effective tracking of staff performance. It is challenging to generate reports on staff activities, caseloads, case tracking, court reporting and financial information. This limitation necessitates manual tracking of key case information. Furthermore, Division management spend significant time on administrative tasks such as signing approximately 200 checks per week, which can take up to 2 hours. These system shortcomings lead to several key challenges:
  - Increased administrative work and inefficiencies across staff which if alleviated could allow staff to redirect time to more value-add activities related to case management.
  - Reduced capacity to monitor staff workload and productivity, hindering data-driven decision-making regarding future staffing needs, balanced caseloads, and opportunities for improvement.

Public Guardian – Key Opportunities

Opportunity 5.1	Transition to an alternative technology solution to reduce manual efforts and administrative burden and support future data-driven decision-making on staffing levels.

Key Opportunity for Consideration

- As an initial step, the Division should consider transitioning to an alternative technology solution to reduce manual efforts and administrative burden and allow for integrated check signing. Once this new system is implemented and staff time is optimized, the Division can consider conducting a staffing analysis to determine if additional staff are needed based on current demand. Example software systems to consider include:
  - **PGPro by Panoramic** is a software solution designed for Public Guardians, managing all aspects of guardianship from client intake and case tracking to financial management and court reporting. The platform includes reporting tools to create custom reports, track important metrics, and automate accounting tasks. It has been implemented in over 70 counties and/or states, including Placer County in 2015.
  - **My Junna** is a platform designed to streamline administrative tasks for public guardians, offering centralized client management, secure e-signatures, and task management features. It aims to enhance efficiency by providing court-compliant form templates, and access to national community resources. The system's calendar keeps track of important events, while its analytics offer insights into team performance and finances.

Key Opportunity Action Steps	Benefit	
• **Evaluate Key Software:** Conduct an analysis of key business requirements and research and compare options like PGPro by Panoramic and My Junna based on features, benefits, and user reviews. • **Obtain Necessary Approvals:** Secure approval from the Board of Supervisors to initiate an RFP • **Initiate an RFP Process:** Conduct an RFP process to identify and select a vendor. • **Plan the Implementation**: Form an implementation team, set a timeline for key milestones, and outline responsibilities. • **Configure and Train:** Work with the vendor to install and configure the system and then provide training for all staff. • **Go Live and Optimize:** Transition to the new system, monitor its performance, gather staff feedback, and make necessary adjustments to optimize workflows. • **Conduct Staffing Analysis:** After optimizing staff workflows, evaluate data on staff caseloads and workloads to analyze whether the current number FTEs is sufficient to meet service demand.	• **Improved efficiency:** Implementing a new software solution may streamline administrative tasks and automate workflows, significantly reducing the time and effort required for manual processes. • **Enhanced Decision-Making:** Conducting a thorough evaluation and RFP process supports the selection of the most suitable software, tailored to meet the Division's specific needs and improving overall decision-making. • **Accurate Staffing Needs Assessment:** Conducting a staffing analysis based on optimized workflows and workload data allows for a data-driven determination of staffing requirements. • **Improved Service Delivery:** With staff spending less time on administrative tasks, more attention can be given to client services, leading to better service outcomes. PGPro - Panoramic Software, Inc. For Guardians - Client Management Software to Simplify Your Day | MyJunna	*This opportunity may not yield immediate tangible cost efficiencies; however, it will support operational efficiency and more accurately alignment of workload to demand.*

Appendix A: Span of Control Analysis

Span of Control Analysis – Public Health

A Span of Control Analysis was conducted for both the Public Health and Behavioral Health departments using their organizational charts and key position-level data provided by the County. The purpose of this analysis is to assess the number of direct reports that managers and supervisors oversee, as well as the ratio of administrative positions to staff members with the aim of identifying opportunities to better align staffing levels with service demand in each department.

Public Health – Span of Control Analysis

The span of control analysis for Public Health is detailed in the tables below, covering division managers, supervisors, and administrative staff across all levels. Public Health provides a wide range of services, from managing a public health lab to providing environmental health services to operating a nurse visiting program. Given this diversity, identifying and comparing the optimal span of control ratios across these three levels is complex and will necessitate further analysis by Health Agency and county leadership. However, some key insights are outlined below.

Key Insights:

- **Ratio of Division Manager to Supervisory/Direct Report Staff:** The Public Lab has a division manager and a supervisor overseeing a total of 7.25 FTE line staff. In the future, the County may consider transitioning the supervisor to perform testing for 0.7 FTE and spend the remaining 0.3 FTE on supervisory activities as outlined in opportunity 3.25.
- **Ratio of Division Supervisor/Program Manager to Line Staff:** EMSA's Public Health Preparedness Program is currently staffed by 2 FTEs, including one program supervisor and one administrative assistant. There may be an opportunity to have the division manager manage this program directly and reclassify the supervisor position to an administrative position.
- **Ratio of Administrative Staff to Division Staff:** The Clinical and Communicable Disease Division has one administrative staff member for every 1.2 FTE line staff, which is significantly higher than any other divisions. Health Agency and County leadership should further evaluate this ratio once other opportunities have been implemented and potentially redirect administrative positions, where possible.

Ratio of Division Manager to Supervisory/Direct report staff

Division	Ratio
EMSA	1:5
EH	1:6.75
Public Guardian	1:4.75
Public Lab	1:1
Clinical and Communicable Disease	1:7
Healthcare Access	1:4
Healthcare Promotion	1:4
Maternal and Child Health	1:5

Ratio of Division Supervisor/Program Manager to line staff

Division	Ratio
EMSA - PHEP	1:1
EH	1:5.3
Public Guardian*	N/A
Public Lab	1:7.25
Clinical and Communicable Disease	1:4.5
Healthcare Access	1:2.3
Healthcare Promotion	1:4.75
Maternal and Child Health	1:5.6

Ratio of Administrative Staff to Division staff

Division	Ratio
EMSA	N/A
EH	1:7.5
Public Guardian	N/A
Public Lab	N/A
Clinical and Communicable Disease	1:1.2
Healthcare Access	1:11
Healthcare Promotion	1:23
Maternal and Child Health	1:5.8

*Public Guardian does not have any supervisors.

Span of Control Analysis – Behavioral Health

Behavioral Health – Span of Control Analysis*

The span of control analysis for Behavioral Health is detailed in the tables below, covering division managers, supervisors, and administrative staff across all levels. Behavioral Health is divided into five cost centers but composed of several different divisions. Given this diversity, identifying and comparing the optimal span of control ratios across these three levels is complex based on the consumer population served, and the potential decrease is personal based on the current hiring freeze, which will necessitate further analysis by Health Agency and county leadership. However, some key insights are outlined below.

Key Insights:

- **Ratio of Division Manager to Supervisory/Direct Report Staff:** Drug & Alcohol have Division Managers overseeing 7 FTEs and operates out of 4 sites, where there are multiple program supervisors in Grover Beach and Paso Robles, With the proposed staffing reduction, a reduction in supervisors may also be considered. For Psychiatric Services, the Medical Director has 18 direct reports with 8 of them contracted staff. Reducing the number of contracts (as noted in opportunity 2.8) and introducing a joint roles and responsibilities with regards to utilization accountability with the program manager will support better oversight. The smallest Span of Control is seen in Access & Crisis Services and Adult Services, which is below the industry average of 1.6 – 1.7****.
- **Ratio of Division Supervisor/Program Manager to Line Staff:** Drug & Alcohol, Adult, and Youth Services have, on average, 8, 13.3, and 9 FTEs reporting to each program supervisor, respectively. A majority of these FTEs are LPTs/LV Nurses. These Divisions may consider the proposed reductions outlined in opportunities 2.1a-c and 2.2. The Quality Division has a substantially low span of control with supervisor to line staff at 1.2.5. The Prevention and Outreach team also has a low Supervisor to line staff ratio, however, if leadership accepts the reallocation of services under this program, both manager and supervisor level will need to be reallocated accordingly. The industry average for Supervisor to Line Staff span of control is 1.5 – 1.6****.
- **Ratio of Administrative Staff to Division Staff:** The Business Systems Division has a high ratio (1 to 1) of Administrative staff to Division staff, but it is important to note this Division only has two total staff with one being an Admin Services Officer II. On the other hand, Drug & Alcohol has 1 Administrative staff for every 4 FTEs, which is a higher ratio than the other Divisions within Behavioral Health. One team within the Division operates with 4 Administrative FTEs, so the Division may consider reducing Administrative staff. As volumes have significantly decreased in Youth Services and there are staffing reduction based on the hiring freeze and future impact on volumes based on CYBHI, even with a high Administrative staff to front line staff, further reduction may be considered to align with the current and future volumes.

Until County Leadership makes decisions based on the Opportunities for Consideration in this report, it is difficult to quantify the Potential estimated cost efficiencies under the Span of Control.

*Due to the position allocation list being aligned to the five cost centers, this span of control is based on the Organizational Chart submitted by the Health Agency with the FY25-26 budget shared on March 27, 2025.
**This is the average across all Supervisors/Program Managers. However, the distribution across them is not equal (i.e. one Program Manager has 6 direct reports, while the others only have 1).
***The staff type for which span of control needs to be determined does not exist.
****Source: Executive Span of Control | SullivanCotter

Span of Control Analysis – Behavioral Health

Ratio of Division Manager to Supervisory/Direct report staff	
Division	**Ratio**
Access & Crisis Services	1:4
Business Systems	N/A***
Drug & Alcohol Services	1:7
Quality Support Team	1:6
Justice Services	1:5
Adult Services	1:4
Youth Services	1:6
Psychiatric Services	1:18
Prevention & Outreach	1:5

Ratio of Division Supervisor/Program Manager to line staff***	
Division	**Ratio**
Access & Crisis Services	1:7.5
Business Systems	N/A***
Drug & Alcohol Services	1:8
Quality Support Team	1:2.5
Justice Services	1:7
Adult Services	1:13
Youth Services	1:9
Psychiatric Services	N/A***
Prevention & Outreach	1:2.7

Ratio of Administrative Staff to Division staff	
Division	**Ratio**
Access & Crisis Services	1:6
Business Systems	1:1
Drug & Alcohol Services	1:4
Quality Support Team	1:7.5
Justice Services	1:10.33
Adult Services	1:6
Youth Services	1:14.3
Psychiatric Services	N/A***
Prevention & Outreach	1:17.5

*Due to the position allocation list being aligned to the five cost centers, this span of control is based on the Organizational Chart submitted by the Health Agency with the FY25-26 budget shared on March 27, 2025.
**This is the average across all Supervisors/Program Managers. However the distribution across them is not equal (i.e. one Program Manager has 6 direct reports, while the others only have 1).
***The staff type for which span of control needs to be determined does not exist.

Appendix B: Vacancy Analysis

Overview of Vacancies: Public & Behavioral Health

Across both Public and Behavioral Health, a significant amount of costs related to staffing vacancies may be recovered. For Public Health, there is a total of 24.75 vacancies that may result in $3.26M - $3.85M potential costs recovered. For Behavioral Health, there is a total of 61.25 vacancies that may result in $5.98M – $11.59M potential costs recovered.

If certain vacancies are required to be filled due to provide services for a specific population within the community (e.g., ability to speak certain languages), the Health Agency would need to make that determination to fill those positions in order to meet consumers needs. This must be done through presenting a business case to the County with Fiscal sign-off.

Methodology

The cost takeout analysis for vacant positions is based on a Position Allocation List extracted from SAP on April 11, 2025 and a list of total costs for personnel provided as part of the initial data request on February 17th, 2025 for the Health Agency Review. The following steps were taken to reach the figures included in the tables below:

1. Each position in the Position Allocation List was mapped to the appropriate division names since certain divisions allocate positions across cost centers.
2. The number of total vacancies by division and position was calculated.
3. Using the total costs for personnel, a minimum and maximum total cost for each position was calculated. The minimum and maximum total cost for each applicable position was then multiplied across the number of vacancies within each division thus establishing the range for minimum and maximum total Cost Efficiency. The tables below represent the consolidated total across Public and Behavioral Health, please review pages 172 – 180 for each Public Health Division and 181 – 185 for each Behavioral Health Division.

Public Health

Division	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Children's Med Services	5.00	$ 452,482	$ 612,370
Environmental Health	2.00	$ 213,402	$ 292,219
Healthcare Access	1.00	$ 190,071	$ 190,071
Healthcare Promotion	1.00	$ 110,879	$ 158,743
Maternal Child Adolescent Health	10.75	$ 1,460,304	$ 1,657,962
Public Health Admin	1.00	$ 157,720	$ 185,322
PH EMSA	1.00	$ 114,474	$ 150,561
PH Nursing	2.00	$ 430,147	$ 449,594
WIC Program	1.00	$ 134,174	$ 151,331
Total	**24.75**	**$ 3,263,654**	**$ 3,848,173**

Behavioral Health

Division	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Mental Health	12.75	$ 1,834,679	$ 3,314,896
Drug & Alcohol	24.00	$ 1,421,802	$ 4,016,337
Prevention & Outreach	12.50	$ 1,080,284	$ 2,309,260
Access and Crisis Services Division	5.00	$ 681,217	$ 786,370
Justice Services	7.00	$ 965,104	$ 1,159,683
Total	**61.25**	**$ 5,983,086**	**$ 11,586,546**

Vacancies: Children's Medical Services

Within the Children's Medical Services Division, there is a total of 5 vacancies that may result in $452k - $612k potential costs recovered.

Children's Medical Services*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Administrative Asst	1.75	-	1.75	$ 178,947	$ 178,947
Phys Or Occupational Therapy	6.75	5.50	1.25	$ 109,313	$ 238,551
Public Health Nurse	1.00	-	1.00	$ 164,223	$ 194,873
Health Education Specialist**	1.00	-	1.00	$ -	$ -
Program Manager	1.00	1.00	-	$ -	$ -
Patient Svcs Representative	1.00	1.00	-	$ -	$ -
Sr Phys Or Occupational Therapy	1.00	1.00	-	$ -	$ -
Supv Admin Clerk	1.00	1.00	-	$ -	$ -
Supv Phys Or Occupational Therapy	1.00	1.00	-	$ -	$ -
Community Health Nurse	3.00	3.00	-	$ -	$ -
Supv Public Health Nurse	1.00	1.00	-	$ -	$ -
Phys Or Occupational Therapy Aide	3.00	3.00	-	$ -	$ -
Total	**22.50**	**17.50**	**5.00**	**$ 452,482**	**$ 612,370**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.
**Total Cost data for the Health Education Specialist position was not available.

Vacancies: Environmental Health

Within the Environmental Health Division, there is a total of 2 vacancies that may result in $213k - $292k potential costs recovered.

Environmental Health*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Administrative Asst	2.00	1.00	1.00	$ 90,192	$ 102,179
Envir Health Specialist	17.00	16.00	1.00	$ 123,210	$ 190,039
Admin Services Officer	1.00	1.00	-	$ -	$ -
Accountant	1.00	1.00	-	$ -	$ -
Environmental Health Technician	1.00	1.00	-	$ -	$ -
Sr Geographic Info Systems Analyst	0.75	0.75	-	$ -	$ -
Supv Envir Health Specialist	3.00	3.00	-	$ -	$ -
Cross Connection Inspector	1.00	1.00	-	$ -	$ -
Div Mgr	1.00	1.00	-	$ -	$ -
Total	**27.75**	**25.75**	**2.00**	**$ 213,402**	**$ 292,219**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Healthcare Access

Within the Healthcare Access Division, there is a total of 1 vacancy that may result in $190k potential cost efficiencies.

Healthcare Access*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Sr Public Health Nurse	1.00	-	1.00	$ 190,071	$ 190,071
Patient Svcs Representative	1.00	1.00	-	$ -	$ -
Public Health Nurse	1.00	1.00	-	$ -	$ -
B.H. Specialist	1.00	1.00	-	$ -	$ -
Program Manager	1.00	1.00	-	$ -	$ -
Div Mgr	1.00	1.00	-	$ -	$ -
Social Worker Aide	1.00	1.00	-	$ -	$ -
Health Education Specialist	1.00	1.00	-	$ -	$ -
Admin Services Officer	1.00	1.00	-	$ -	$ -
Oral Health Program Manager	1.00	1.00	-	$ -	$ -
Total	**10.00**	**9.00**	**1.00**	**$ 190,071**	**$ 190,071**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Healthcare Promotion

Within the Healthcare Promotion Division, there is a total of 1 vacancy that may result in $111k - $159k potential cost efficiencies.

Healthcare Promotion*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Health Education Specialist	7.00	6.00	1.00	$ 110,879	$ 158,743
Program Manager	3.00	3.00	-	-	-
Admin Services Officer	1.00	1.00	-	-	-
Div Mgr	1.00	1.00	-	-	-
Total	**12.00**	**11.00**	**1.00**	**$ 110,879**	**$ 158,743**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Maternal Child Adolescent Health

Within the Maternal Child Adolescent Health Division, there is a total of 10.75 vacancies that may result in $1.46M - $1.66M potential costs recovered.

Maternal Child Adolescent Health*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Social Worker Aide	4.00	-	4.00	$ 349,289	$ 376,226
Sr Public Health Nurse	5.00	3.00	2.00	$ 393,672	$ 444,183
Community Health Nurse	6.75	4.00	2.75	$ 470,460	$ 470,460
Program Manager	1.00	-	1.00	$ 173,752	$ 173,752
Public Health Nurse	2.50	1.50	1.00	$ 73,132	$ 193,343
Admin Services Officer	1.00	1.00	-	$ -	$ -
Administrative Asst	3.00	3.00	-	$ -	$ -
Supv Public Health Nurse	1.00	1.00	-	$ -	$ -
Social Worker	2.00	2.00	-	$ -	$ -
Div Mgr	1.00	1.00	-	$ -	$ -
Total	**27.25**	**16.50**	**10.75**	**$ 1,460,304**	**$ 1,657,962**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Public Health Administration

Within Public Health Administration, there is a total of 1 vacancy that may result in $158k - $185k potential cost efficiencies.

Public Health Admin*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Program Manager	5.00	4.00	1.00	$ 157,720	$ 185,322
Epidemiologist	2.00	2.00	-	$ -	$ -
Public Information Specialist	1.00	1.00	-	$ -	$ -
Admin Services Officer	5.00	5.00	-	$ -	$ -
Health Education Specialist	1.00	1.00	-	$ -	$ -
Administrative Asst	2.00	2.00	-	$ -	$ -
Pub Health Admn/Health Officer	1.00	1.00	-	$ -	$ -
Deputy County Health Officer	1.00	1.00	-	$ -	$ -
Accountant	3.00	3.00	-	$ -	$ -
Div Mgr	1.00	1.00	-	$ -	$ -
Total	**22.00**	**21.00**	**1.00**	**$ 157,720**	**$ 185,322**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Emergency Medical Services

Within the Emergency Medical Services Agency, there is a total of 1 vacancy that may result in approximately $114k - $151k potential cost efficiencies.

EMSA*							
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency		Maximum Total Cost Efficiency	
Admin Services Officer	5.00	4.00	1.00	$	114,474	$	150,561
Div Mgr	1.00	1.00	-	$	-	$	-
Program Manager	1.00	1.00	-	$	-	$	-
Administrative Asst	1.00	1.00	-	$	-	$	-
Total	**8.00**	**7.00**	**1.00**	**$**	**114,474**	**$**	**150,561**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Public Health Nursing

Within Public Health Nursing, there is a total of 2 vacancies that may result in $430k - $450k potential costs recovered.

PH Nursing*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Nurse Practitioner/Phys Asst	1.00	-	1.00	$ 233,311	$ 233,311
Sr Public Health Nurse	2.00	1.00	1.00	$ 196,836	$ 216,283
Administrative Asst	7.00	7.00	-	$ -	$ -
Comm Disease Investigator	1.00	1.00	-	$ -	$ -
Public Health Aide	2.75	2.75	-	$ -	$ -
Public Health Nurse	1.00	1.00	-	$ -	$ -
Supv Public Health Nurse	2.00	2.00	-	$ -	$ -
Community Health Nurse	3.50	3.50	-	$ -	$ -
Admin Services Officer	5.00	5.00	-	$ -	$ -
Health Information Tech	2.00	2.00	-	$ -	$ -
Total	**27.25**	**25.25**	**2.00**	**$ 430,147**	**$ 449,594**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Women, Infants, and Children

Within the Women, Infants, and Children (WIC) program, there is a total of 1 vacancy that may result in approximately $134k - $151k potential cost efficiencies.

WIC Program*					
Position	Budgeted FTE	Current FTE	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
Public Health Nutritionist	5.00	4.00	1.00	$ 134,174	$ 151,331
Nutrition Services Program Manager	1.00	1.00	-	$ -	$ -
Public Health Aide	8.00	8.00	-	$ -	$ -
Total	**14.00**	**13.00**	**1.00**	**$ 134,174**	**$ 151,331**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Mental Health

Within the Mental Health Division, there is a total of 12.75 vacancies that may result in approximately $1.83M - $3.31M potential costs recovered.

Mental Health*					
Position	Budgeted	Current	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
B.H. Clinician	46.00	39.00	7.00	$ 528,751	$ 1,326,969
Staff Psychiatrist	3.50	1.50	2.00	$ 503,022	$ 1,090,693
B.H. Nurse Practitioner	2.00	1.00	1.00	$ 233,367	$ 265,143
Health Information Tech	9.00	8.00	1.00	$ 98,626	$ 148,252
Licensed Psych Tech/LV Nurse	14.00	13.00	1.00	$ 152,364	$ 165,292
M.H. Medical Director	0.75	0.00	0.75	$ 318,548	$ 318,548
Accountant	2.00	2.00	0.00	$ -	$ -
Accounting Technician	1.00	1.00	0.00	$ -	$ -
Admin Services Officer	1.00	1.00	0.00	$ -	$ -
Administrative Asst	11.00	11.00	0.00	$ -	$ -
B.H. Program Supervisor	7.00	7.00	0.00	$ -	$ -
Behavioral Health Administrator	1.00	1.00	0.00	$ -	$ -
Deputy Director-Behavioral Health	1.00	1.00	0.00	$ -	$ -
Div Mgr Behavioral Health	3.00	3.00	0.00	$ -	$ -
Health Information Supervisor	1.00	1.00	0.00	$ -	$ -
M.H. Nurse	1.00	1.00	0.00	$ -	$ -
Program Manager	1.00	1.00	0.00	$ -	$ -
Sr Account Clerk	1.00	1.00	0.00	$ -	$ -
Supv Admin Clerk	1.00	1.00	0.00	$ -	$ -
Total	**107.25**	**94.50**	**12.75**	**$ 1,834,679**	**$ 3,314,896**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Drug & Alcohol

Within the Drug & Alcohol Division, there is a total of 24 vacancies that may result in approximately $1.42M - $4.02M potential costs recovered.

Drug & Alcohol Services*					
Position	Budgeted	Current	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
B.H. Clinician	23.75	12.75	11.00	$ 433,783	$ 2,012,332
B.H. Specialist	32.00	25.50	6.50	$ 241,850	$ 1,018,013
B.H. Program Supervisor	9.00	7.00	2.00	$ 337,635	$ 399,241
B.H. Worker	7.50	6.00	1.50	$ 65,295	$ 180,206
Administrative Asst	9.00	8.00	1.00	$ 83,835	$ 111,657
Health Information Tech	6.00	5.00	1.00	$ 104,365	$ 139,848
Licensed Psych Tech/LV Nurse	2.00	1.00	1.00	$ 155,040	$ 155,040
Accountant	2.00	2.00	0.00	$ -	$ -
Admin Services Officer	3.00	3.00	0.00	$ -	$ -
B.H. Nurse Practitioner	1.00	1.00	0.00	$ -	$ -
Div Mgr Behavioral Health	1.00	1.00	0.00	$ -	$ -
M.H. Nurse	2.00	2.00	0.00	$ -	$ -
Program Manager	1.00	1.00	0.00	$ -	$ -
Total	**99.25**	**75.25**	**24.00**	**$ 1,421,802**	**$ 4,016,337**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Prevention & Outreach (MHSA)

Within the Prevention & Outreach (MHSA) Division, there is a total of 12.50 vacancies that may result in approximately $1.08M - $2.31M potential costs recovered.

Prevention & Outreach (MHSA)*					
Position	Budgeted	Current	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
B.H. Clinician	15.75	9.25	6.50	$ 529,900	$ 1,189,105
B.H. Specialist	18.00	14.00	4.00	$ 140,585	$ 682,859
Admin Services Officer	6.00	5.00	1.00	$ 132,465	$ 159,961
Staff Psychiatrist	1.00	0.00	1.00	$ 277,334	$ 277,334
Accountant	2.00	2.00	0.00	$ -	$ -
Admin Services Manager	1.00	1.00	0.00	$ -	$ -
Administrative Asst	2.00	2.00	0.00	$ -	$ -
B.H. Program Supervisor	3.00	3.00	0.00	$ -	$ -
Business Systems Analyst	1.00	1.00	0.00	$ -	$ -
Div Mgr Behavioral Health	1.00	1.00	0.00	$ -	$ -
Health Information Supervisor	1.00	1.00	0.00	$ -	$ -
Health Information Tech	2.00	2.00	0.00	$ -	$ -
Licensed Psych Tech/LV Nurse	3.00	3.00	0.00	$ -	$ -
Program Manager	5.00	5.00	0.00	$ -	$ -
Public Information Specialist	2.00	2.00	0.00	$ -	$ -
Total	**63.75**	**51.25**	**12.50**	**$ 1,080,284**	**$ 2,309,260**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Access and Crisis Services Division

Within the Access, Crisis, and Psychiatric Health Facility (PHF) Division, there is a total of 5 vacancies that may result in approximately $681k - $786k potential costs recovered.

Access, Crisis, and PHF*					
Position	Budgeted	Current	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
B.H. Specialist	5.00	3.00	2.00	$ 235,852	$ 294,686
Licensed Psych Tech/LV Nurse	8.00	6.00	2.00	$ 279,576	$ 325,895
B.H. Clinician	1.00	0.00	1.00	$ 165,789	$ 165,789
Admin Services Officer	1.00	1.00	0.00	$ -	$ -
Administrative Asst	2.00	2.00	0.00	$ -	$ -
B.H. Program Supervisor	1.00	1.00	0.00	$ -	$ -
Div Mgr Behavioral Health	1.00	1.00	0.00	$ -	$ -
M.H. Nurse	1.00	1.00	0.00	$ -	$ -
Program Manager	1.00	1.00	0.00	$ -	$ -
Total	**21.00**	**16.00**	**5.00**	**$ 681,217**	**$ 786,370**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Vacancies: Justice Services

Within the Justice Services Division, there is a total of 7 vacancies that may result in approximately $965k - $1.16M potential costs recovered.

Justice Services*					
Position	Budgeted	Current	Vacancies	Minimum Total Cost Efficiency	Maximum Total Cost Efficiency
B.H. Clinician	9.00	6.00	3.00	$ 437,272	$ 508,530
B.H. Specialist	7.00	4.00	3.00	$ 391,435	$ 490,888
Licensed Psych Tech/LV Nurse	4.00	3.00	1.00	$ 136,397	$ 160,265
Admin Services Officer	3.00	3.00	0.00	$ -	$ -
Administrative Asst	1.00	1.00	0.00	$ -	$ -
B.H. Program Supervisor	2.00	2.00	0.00	$ -	$ -
Div Mgr Behavioral Health	1.00	1.00	0.00	$ -	$ -
Total	**27.00**	**20.00**	**7.00**	**$ 965,104**	**$ 1,159,683**

*As noted in Opportunity 1.2a-b, vacancies that must be filled to meet a grant requirement or serve a specific population can be presented along with a business case and sign-off from the Fiscal Division to the County Administrator.

Appendix C: Benchmarking of Environmental Health Fees

Land Use Fees

The following provides an overview of the Environmental Health Land Use Fees adopted by benchmark counties. It is important to note that service names vary across counties, making direct comparisons challenging. A similar challenge is in place with fees for Small Water Systems included on the following page.

Monterey County

Topic	Fees
Compliance Review	$301
Minor Plan Check or Report Review	$603
Major/Major Plan Check Permit Review	$1,206
Major Discretionary Permit Review	$2,412
Deposit Project (Time & Material)	$2,750
Commercial Cannabis Permit – Permit	$1,465
Commercial Cannabis Permit – Renewal	$732

Santa Barbara County

Topic	Fees
Application Fee (collected by Planning & Development department) - Annual	$255
Hourly Case Review Fee	$161/hr

Ventura County

Topic	Fees
Review of Environmental Impact Report	$1,112
Review of Minor Modification/Adjustment to an existing CUP or PD	$221
Review of Change-of-Use Notifications	$114
2 - Lot Subdivision	$922
3 - Lot Subdivision	$1,086

Ventura County

Topic	Fees
CUP Projects with no plumbing, or are connecting to public water purveyor and public sewer system	$627
CUP projects utilizing an OWTS	$1,308
PD Projects with no plumbing or are connecting to public water	$400
PD Projects utilizing an OWTS	$800
Wildlife Corridor Vegetation Removal for Fuel Modification within a Surface Water	$0
Conditional Certificate of Compliance	$786
Projects with no plumbing or are connected to public water purveyor and public sewer system	$400
Projects utilizing an OWTS or private well	$641
Variance	$647
Zone Change	$660
General Plan Amendment	$1,707
Review of County-initiated Projects (Public Works, General Services Agency)	$720
4+ Lot Subdivision The contract hourly	$1,086
Emergency Use Authorization	303
Equivalent Fee for Services Not Listed	$165+

Santa Cruz County

Topic	Fees
Full Site Evaluation Review Fee	$1,272
Repair Site Evaluation Review Fee	$496
Lot Evaluation for Sewage Disposal/Minor	$1,268
5+ lots in the same subdivision (each)	$634
Minor Consultation (Winter Water Test/Soil Test/Perc. Test)	$635
Evaluation of septic/water: file and record	$254
Evaluation of septic/water: record review and field inspection	$604
Urgent repair assessment	$609
Individual Sewage Disposal System	$4,024
Individual Sewage Permit and Construction Inspections	$1,327
Indiv Sewage Permit and Construction Inspections Hourly after 13	$230
Individual Sewage Disposal Application Review and Approval	$2,795
Major Repair	$1,223
Minor Repair	$637
Application Review and Approval	$2,976
App Review & Approv Per Hour over 12	$230

Santa Cruz County

Topic	Fees
Upgrade to ISDS	$3,277
Upgrade to ISDS: Application Review	$2,129
Upgrade to ISDS: Permit and Construction Inspections	$1,147
Grey Water System Installation Permit	$637
Tank Replacement	$1,223
Preliminary Site Check for Alt system	$883
Experimental Waste Water Disposal System Review (Up to 25 Hours)	$5,486
At Cost Hourly Charge	$230
Alternative/innovative individual ISDS	$6,126
Alternative/innovative individual ISDS Application Review & Approval	$3,882
Alternative/innovative individual ISDS Permit & Construction Inspections	$2,244
Alt System Repair	$2,038
Alternative System Upgrade	$4,352
Alt System Upgrade - Permit and Construction Inspection	$1,376
OSSP Certification Fee	$283
Septic Tank & Chemical Toilet Cleaning	$510

Small Water System Fees

Santa Cruz County

Topic	Fees
Permit application	$1,076
Amended Permit	$284
5-10 Connection systems	$471
(+ $ per hour after 4 hours)	$240
11-14 Connection Systems	$570
(+ $ per hour after 4 hours)	$240
Purchased Water	$1,035
15-24 Connections	$1,715
25-99 Connections	$2,129
100-199 Connections	$2,789
Non-Transient, Non-Community	$2,156
Transient, Non-Community	$1,078
Surface Water Treatment Plant - Annual Fee	$1,037
(+ $ per hour after 8 hours)	$240
Treatment Plant (other than SW) - Annual	$542
(+ $ per hour after 4 hours)	$240
Amended Permit	$1,034
Request for variance, exemption, waiver	$240
Plan Review	$240
Bacterial Sampling	$504
Consultation or Enforcement Action	$240

Santa Barbara County

Topic	Fees
Private State Small Water Systems (5-15 Connections) - Annual	$529
Private Single Parcel Water Systems (1-4 Connections)	$1,604
Private Multiple Parcel Water Systems (2-4 Connections)	$1,018
Plan Review Application Fee: State Small Water Systems	$255
Hourly Fee Plan Review (New Systems, Modification/Amendment to Permit, Evaluation)	$161/hr
Community Water System	$2,022
Non-Community Water System	$1,654
Amendment / Change in Ownership	$276
Application Fee Plan Review (New)	$255
Hourly Fee Plan Review (New)	$161/hr

Ventura County

Topic	Fees
Plan check for new system	$2,147
Plan check for modification to an existing system	$991
Annual Permit to Operate	$908
Permit Replacement Fee	$20
Plan check for new system	$2,147

Sanoma County

Topic	Fees
Water - State Small	$1,583
Water - State Small at a Dairy	$783
Water - Hourly Rate	$261
Water - Water System Site Review	$522
Water - Site Review Additional Hours	$261
Water - Water System Plan Review (2 hr min + hrly)	$522
Water - Plan Review Additional Hours	$261
Water - Violation Reinspection (1 hr + hrly)	$261
Water - Water Well at a Food Facility	$583
Water - Water Tank at a Food Facility	$452

Monterey County

Topic	Fees
Plan Check Fee for a local small water system for which no domestic water supply permits have been issued	$1,233
A state small water system for which no domestic water supply permits have been previously issued	$1,626
Plan Check Fee for an existing state or local small water system applying for an amendment to a domestic water supply permit due to an addition or modification of the source of supply	$213

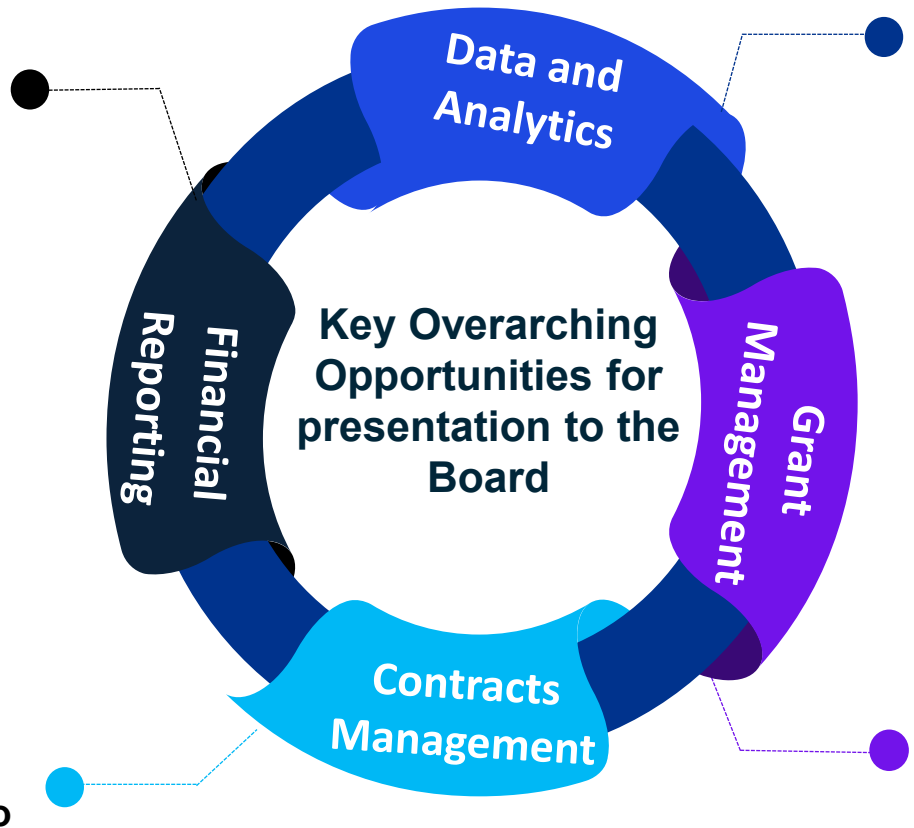
Appendix D: Implementation Plan Roadmap

Overarching

Key Opportunities for Board Presentation

Overarching

Implement a standardized financial reporting process to bridge the gap between clinical, operational, and financial management.



Resolve data quality challenges, standardize data collection and management to enhance data analytic capabilities and support data-driven decision-making.

Implement a Contract Management System, standardize processes, establish clear roles and responsibilities, and review the current contract portfolio to improve the contract management process.

Streamline the allocation and grant request and approval process, enhance the management and monitoring of allocations and grants by utilizing a grant/allocation management dashboard, and assess equipment life cycle costs when considering the acceptance of grant or allocation of funding.

Overview of Key Opportunities

Overarching

KPMG collaborated with department leaders and managers on several occasions to evaluate each opportunity and create the following roadmap, which assigns an owner, co-owner and timeline for each opportunity to support future prioritization and implementation of each opportunity. This process was finalized during an all day workshop on May 13th, 2025 with SLO County Administration, Health Agency and Department leadership.

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Agency-Wide	1.1a	**Implement a Contract Management System, standardize processes, establish clarified roles and responsibilities, and review the current contract portfolio to improve the contract management process.**			
		• Develop and Implement Standardized Purchasing Processes	**Long-term**	Leigh Ann Alcorn	Kristin Ventresca
		• Assess and Select a Contract Management System via an RFI/RFP process	**Long-term**		
		• Redefine Roles, Responsibilities, and Processes by facilitating workshops with key personnel across departments	**Short-term**		
		• Establish a joint task force with Contracts and Public Health to review existing contracts, identify opportunities for consolidation and assess the impact on the Contracts Department's workload and personnel requirements.	**Short-term**		
	1.1b	• Assess current processes and gather stakeholder input to identify improvement areas.	**Long-term**		
		• Evaluate potential AI solutions through a procurement process.	**Long-term**		
		• Implement a pilot program to test the AI solution's functionality and gather feedback	**Long-term**		
		• Continuously track the system's performance, making adjustments as needed	**Long-term**		
		• Develop a governance framework and define roles for managing the AI-driven processes.	**Long-term**		
		• Upon implementation of an AI solution, evaluate roles and responsibilities of current team to determine the right size of the team based on enhancement of AI solution. Oversight of contract performance based on established KPIs as detailed in their contracts should be realigned to Program management and when required Quality reporting.	**Long-term**		

Overview of Key Opportunities

Overarching

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Agency-Wide	1.2a	**Streamline the Allocation and Grant Request and Approval Process including enhancing the current e-form being used for better information collection.**			
		• Involve key stakeholders including leadership and staff from Health Agency Administration, IT, Fiscal, Billing, Division and Program Leadership, and staff from the County Administrator's office in the design of the new form, development, and testing of the new process.	**Medium-term**	Leigh Ann Alcorn	Kristin Ventresca
		• Work with the Administrative Office and other relevant parties to streamline the approval process.	**Medium-term**		
		• Incorporate formal sign-off requirements into the redesigned Allocation and Grant forms and establish a monthly review process and assign responsibilities for monitoring and escalation.	**Medium-term**		
		• Evaluate separate e-forms for Allocation and Grant requests, incorporating the specific requirements and frequent information that is currently requested from the County Administrator.	**Medium-term**		
		• Inform all relevant parties of the new process and provide training to promote effective implementation.	**Medium-term**		
	1.2b	**Enhance the Management and Monitoring of Allocations and Grants by considering moving away from excel sheets and utilizing a grant/allocation management dashboard.****			
		• Perform a review of the grant management process identifying areas of improvement and increased standardization.	**Short-term**	Leigh Ann Alcorn	Kristin Ventresca
		• Outline the responsibilities of all staff and leadership involved in managing grants.	**Short-term**		
		• Collaborate with IT to develop a Grants and Allocation Dashboard that provides real-time data, spend analytics, and risk identification for overspend or upcoming renewals for grants.	**Medium-term**		
		• Inform all relevant parties of the new grant management and monitoring processes and provide training as necessary.	**Medium-term**		
	1.2c	**Assess equipment life cycle costs when considering the acceptance of grant or allocation of funding related to equipment to support more informed grant/allocation of funding decisions.**			
		• Create clear guidelines for evaluating the life cycle costs of equipment, including contracts, contract oversight, maintenance, operation, consumable expenses, billing and reporting.	**Medium-term**	Leigh Ann Alcorn	Kristin Ventresca
		• Establish a standardized review process to help ensure life cycle cost assessments are included in all grant/ allocation applications related to equipment.	**Medium-term**		
		• Develop and provide training to staff on conducting impact assessments.	**Medium-term**		
		• Require that all grant / allocation proposals related to equipment submitted to the Health Agency leadership and Board of Supervisors include a detailed life cycle cost analysis.	**Medium-term**		

Overview of Key Opportunities

Overarching

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Agency-Wide	1.3	**Implement a standardized financial reporting process to bridge the gap between clinical, operational, and financial management.**			
		• Collaborate with relevant stakeholders to design a variance report template that includes budget versus actuals, projected revenue, and other key financial metrics at both the division and clinic level.	**Short-term**	Kellie Burns	Kristin Ventresca/ Sarah Hayter*
		• Clearly define the roles and responsibilities of the Division Manager, Billing, Accountant, Contracts and Grants/Allocation lead, Deputy Director, and Department Director in the financial reporting process.	**Short-term**	Kellie Burns	
		• Set up a monthly reporting schedule across all divisions and clinics within the Health Agency and require that the designated team members adhere to the reporting frequency and requirements.	**Short/Medium-term**	Kellie Burns	
		• Work with IT and finance teams to develop a user-friendly dashboard that allows for easy month-over-month analysis of financials and service volumes.	**Medium-term**	Jonatan Woolery	
		• Communicate the new financial reporting process to all relevant stakeholders and provide training to support effective implementation.	**Medium-term**	Kellie Burns	
		• Continuously monitor the effectiveness of the financial reporting process and make necessary refinements based on feedback and lessons learned.	**Medium-term**	Kellie Burns	
	1.4	**Consolidate the Fiscal and Billing departments into a single, cohesive unit to improve financial processes and enhance decision-making.**			
		• Conduct a thorough analysis of the current processes, workflows, and organizational structures of the Fiscal and Billing departments.	**Medium-term**	Leigh Ann Alcorn/ Kellie Burns	Kristin Ventresca
		• Create a detailed plan for consolidating the Fiscal and Billing departments including timelines, structure, and milestones.	**Medium-term**		
		• Review and update policies, procedures, and workflows to reflect the consolidated department structure. Identify and implement necessary changes to financial systems and tools to support the integrated processes.	**Medium-term**		
		• Develop a communication plan to inform all relevant stakeholders about the consolidation and its benefits. Provide training to staff on the new policies, procedures, and workflows to help ensure a successful transition.	**Medium-term**	Kellie Burns	
		• Regularly gather feedback from stakeholders to assess the effectiveness of the consolidation and make necessary adjustments.	**Medium/Long-term**		

Opportunity may require additional resources, coordination, or investment approval from County

*Sarah will participate from a lessons learned perspective

Overview of Key Opportunities

Overarching

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Agency-Wide	1.5	**Partner with ACTTC to align Revenue Recognition with GASB 62 and account for COLA increases for Accurate Financial Reporting and Improved Decision-Making.**			
		• Conduct a review of the Health Agency's current revenue recognition practices across all divisions and programs.	**Short-term**	Kellie Burns	Nick Drews/ Mike Stevens
		• Clearly define the principles, criteria, and procedures for recognizing revenue in different scenarios as it related to GASB 62.	**Short-term**		
		• Partner with the ACTTC to undertake provide training to all relevant staff members on the new revenue recognition policy and its application.	**Short-term**		
		• Implement the revenue recognition policy across all departments and programs within the Health Agency. Regularly monitor compliance with the policy and address any deviations or challenges promptly.	**Medium-term**		
		• Periodically review the revenue recognition policy to support ongoing compliance with GASB standards and any updates or revisions.	**Long-term**		
	1.6	**Develop a marketing strategy for Health Agencies services to increase awareness of services offered among diverse community members.****			
		• Evaluate current awareness and demographic/language requirements to support targeted marketing.	**Medium-term**	Tom Cuddy	Nick Drews
		• Collaborate with the Public Information Officer to develop clear, compelling, and multilingual messages about the Agency's key services and the 24/7 Access Line.	**Medium-term**		
		• Partner with local law enforcement, fire departments, schools, and community organizations at the program manager level to disseminate information on key service offerings including front line front-line to inform their public engagement.	**Short-term**		
		• Enhance leveraging of social media, local media, and public announcements to reach a broad audience.	**Medium-term**		
		• Attend community events such as health fairs and informational sessions to directly engage with residents.	**Medium-term**		
		• Help ensure a detailed marketing/engagement plan is developed annually, implemented and evaluated.	**Long-term**		

Overview of Key Opportunities

Overarching

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Agency-Wide	1.7	**Implement AI solutions to support documentation practices across the agency by reducing time spent by clinicians and psychiatrists.**			
		• Identify and select the most suitable HIPAA-compliant AI documentation tools that integrate well with the Agency's existing EHR systems, if applicable.	**Short-term**	Scott Gill	Nick Drews
		• Implement a small-scale pilot to test the chosen AI tool with select clinicians and monitor its impact on documentation efficiency.	**Medium-term**		
		• Offer training sessions to support staff to use the AI tool effectively.	**Long-term**		
		• Continuously collect feedback from users and track KPIs such as time saved, adoption rates, and patient satisfaction.	**Long-term**	Jon Woolery	
		• Roll out the AI tool across the entire Agency based on the pilot's success and adjust to improve performance and user satisfaction.	**Long-term**		
	1.8	**Adjust the model of care for clients with a high rate of No-Show/Cancellation while implementing operational efficiency practices.**			
		• Advise all staff to book their schedule in 80% direct client care.	**Short-term**	Dr. Star Graber/ Dr. Borenstein	Nick Drews
		• Establish Reminder Calls: (1) Administer SmartCare reminder call process. (2) have administrative staff conduct reminder calls. (3) have peer support specialists conduct reminder calls.	**Short-term**		
		• If the above is not feasible, utilize volunteers to conduct reminder calls.	**Short-term**		
		• Determine which clients would be best serviced (1) in the community or (2) via drop-in service.	**Short-term**		

Overview of Key Opportunities

Overarching

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Agency-Wide	1.9	**Improve productivity through verification of staff activities and billing eligibility**			
		Staff and Prescribers to allocate 80% of their time to direct client services (billable or based on other funding) and assign Administrative Service Officers and supervisors to review compliance weekly.	**Medium-term**	Dr. Borenstein/ Dr. Star Graber	Nick Drews
		• Train ASOs to verify billing eligibility through Medi-Cal – Meds light and Ability insurance screener for all clients and develop a process for ASO to confirm all visits are accounted for weekly and report variances to supervisors.	**Medium-term**		
		• Consider implementing AI technology to support documentation.	**Long-term**	County &HA-IT	
		• Assign a member of Health Agency IT or Division staff to pull and present weekly staff activity data in a dashboard format and schedule weekly meetings for supervisors and managers to review utilization and develop action plans for staff and prescribers not meeting targets.	**Medium-term**	Jon Woolery	
		• Hold weekly meetings with staff and prescribers until they demonstrate consistent improvement over a 3-month period, establish bi-weekly departmental-level analysis, and conduct monthly agency-level reviews for corrective actions.	**Short-term**	Dr. Borenstein/ Dr. Star Graber	
	1.10	**Resolve data quality challenges, standardize data collection and management to enhance data analytic capabilities and support data-driven decision-making.**			
		• Conduct an analysis of key data quality challenges highlighted in this report and commence tracking key data fields are within critical data outputs, including staff positions and clinic assignments.	**Short-term**	Jon Woolery	Nick Drews
		• Conduct an assessment of the Health Agency's current data management practices, identifying data silos, inconsistencies, and inefficiencies across departments and programs.	**Short-term**		
		• Create a data management strategy that outlines the goals, objectives, and key initiatives for improving data management and analytics within the Health Agency.	**Short-term**		
		• Select and implement a centralized data management system that integrates data from various sources, help ensures data consistency, and enables easy access to information across the Health Agency. Consider establishing a data management committee involving IT, Division Managers, and Contracts / Grants Management.	**Medium-term**		
		• Develop and implement data governance policies and procedures to promote data quality, security, and compliance.	**Medium-term**	Kristin Ventresca	
		• Invest in data analytics tools and training to enable staff to derive meaningful insights from the available data.	**Medium-term**		

Opportunity may require additional resources, coordination, or investment approval from County

Behavioral Health

Key Opportunities for Board Presentation

Behavioral Health

Resolve data quality challenges, standardize data collection and management to enhance data analytic capabilities and support data-driven decision-making.

Optimize staffing across all Mental Health Adult, Youth Services, Drug and Alcohol Services and Justice Services to improve access to care, meet client demand, and achieve utilization targets through enhanced scheduling, right-sizing, and shifting to a multidisciplinary team approach.

Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.

Consider reducing contracts for duplication of services that are funded by the State, the County and Federally.

Overview of Key Opportunities

Behavioral Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Mental Health and Drug and Alcohol Services	2.1a-c and 2.2	**Optimize staffing across all Mental Health Adult, Youth Services, Drug and Alcohol Services and Justice Services to improve access to care, meet client demand, and achieve utilization targets through enhanced scheduling, right-sizing, and shifting to a multidisciplinary team approach.**			
		Right Size all Outpatient Services by meeting client treatment needs while remaining financial sustainable.		Frank Warren	Dr. Star Graber
		• Remain on a hiring 'chill' until overall productivity improves across the service and by position.	**Short-term**		
		• Develop exceptions to the hiring 'chill', such as the position is crucial in order to provide the service, i.e., Spanish speaking Practitioners, Prescribers etc. All other consideration should be sought prior to triggering the exception, such as, Can the service be offered via telehealth by another County provider? etc.	**Short-term**		
		• Evaluate staffing productivity within 3 months once formal weekly evaluations have begun to determine if further right sizing of the program is required.	**Short-term**		
		Enhance Youth Services Skill Set to meet Co-Occurring Disorder treatment modalities.			
		• Scale up Clinical Staff within the Youth Clinics to treat Co-occurring Disorders.	**Short-term**		
		Market Behavioral Health Services County Wide			
		• Conduct Formal Engagement with Key Stakeholders: Engage and educate key stakeholders in the services offered by the County, which includes front line responders who interact with clients in the community. This process should incorporate front line managers in order to develop collaborative relationships with key stakeholders.	**Short-Long-term**		
		• Establish pre and post evaluation when conducting marketing for services to determine if marketing process has been successful. Present pre and post evaluation as part of the marketing campaign to BH Leadership.	**Short-Medium - Long-term**		

Overview of Key Opportunities

Behavioral Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Prevention and Outreach	2.3 and 2.9	**Realign Services from Prevention and Outreach to programs more aligned with service offering to develop synergies across similar services and achieve economies of scale among staff and management.**			
		• Transition Veterans Justice Services to Justice Services portfolio to allow all Justice Services to be under the same service, optimize Justice Staff and management span of control.	**Short-term**	Josh Woodbury & Dr. Christina Rajlal	Dr. Star Graber
		• Transition Youth Substance Abuse Treatment to Youth Services to improve access to care, optimize clinic staff and span of control while consolidating all youth services under the same portfolio.	**Short-term**	Jill R & Christina Rajlal	
		• Transition MHSA reporting and staff to the Quality Division.	**Long-term**	Amanda Getten	
		• Behavioral Health Promotion: Formal collaboration, coordination and evaluation between BH and PH promotional teams.	**Medium-term**	Dr. Christina Rajlal	
		• Evaluate transferring both function and staffing to the Public Health Promotional team in order to develop synergies and optimize promotional efforts across the County and County staff.	**Medium-term**	Frank Warren	
		• Determine if School Based Services will conclude as planned for 2026. If so, develop transition plan for the employees under service, as transitioning to youth services is not a viable option due to the high underutilization across all youth clinics and the future impact that CYBHI will have on the County.	**Long-term**	Dr. Christina Rajlal	
		• Scale up Clinical Staff within the Youth Clinics to treat Co-occurring Disorders.	**Long-term**	Amanda Getten	
Access and Crisis Services Division	2.4	**Redesign Mobile Crisis and Dispatch Services to align with community need, volume demand, while being financially sustainable.**			
		• Prior to the changes taking place, Health Agency leads should provide written communication to key stakeholders, so they are aware of the impact to services	**Short-term**	Frank Warren	Dr. Star Graber
		• Based on the funding implications, renegotiate the contract with the provider to align staffing with community need and volume demands.	**Short-term**	Samantha Parker	
		• Consider merging roles and responsibilities among the following two programs. (MHET/MCRT/Youth MC:17.85 FTE and Dispatch 4.85 FTE= Total: 22.70 FTE to 12.30 FTE	**Medium-term**		
		• Develop Standardized Workflow for referral process from Mobile Crisis Service to Outpatient.	**Short-term**		
		• Implement rapid access to outpatient services for clients who have been assessed by the Mobile Crisis Services who require urgent follow up care, i.e., within 7 days.	**Short-term**		
		• Allow for warm handoff from Mobile Crisis Staff to Access Line during regular hours and a referral from Mobile Crisis Staff after hours allowing them to expediate the referral process.	**Short-term**		
		• Closely reviewed the Program to evaluate impact on MHSA and eventually BHAI funding as it is unlikely that the team will receive enough volumes to financially breakeven.	**Medium-term**	Rachael Koenig	

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Behavioral Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Access and Crisis Services Division	2.5	**Transition Full-Service Partnerships to Assertive Community Treatment Team, aligning model of care to community need, volume demand while meeting financial sustainability.**			
		• Align Adult and Older Adult FSP Services to ACT over 2025.	**Medium-term**	Dr. Christina Rajlal	Dr. Star Graber
		• Review current Adult and Older Adult FSP case loads and clients that may benefit from this model of care to determine actual caseload for the new established team, i.e., 60 clients vs. 80-100 clients.	**Medium-term**		
		• Renegotiate the contract with the 2 providers which will decrease to 1 provider under the new model.	**Medium-term**		
		• Establish new contractual agreement and staffing, both personal and skill set, that aligns with ACT model of care taking staffing from 17.98 FTE to 9.50 FTE	**Medium-term**		
		• Standardize non-direct front line staff and management across all contracts.	**Medium-term**		
		• Monitor and Report Outcomes (The Division Manager that oversees ACT Services, will be responsible for reporting on outcomes and variance during the monthly financial reporting.	**Long-term**		
Youth Mental Health	2.6	**Transition Youth and TAY Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.**			
		• Decide on CSC Integration by the determining if the County wishes to fold in Coordinated Specialty Care (CSC) under the County's youth services.	**Medium-term**	Dr. Christina Rajlal	Dr. Star Graber
		○ If yes – provide notice to vendor to dissolve contractual agreement with a phased in approach so to minimize impact on clients.	**Medium-term**		
		○ If no – renegotiate contract base on proposed staffing and budget to align team with community need and volume demand taking the team from 13.25 FTE to 4.0 FTE.	**Medium-term**		
		• Standardize non-direct front line staff and management across all contracts.	**Medium-term**		
		• Define contractual reporting Metrics and outcomes that align with CSC requirements, which should be a reported by the vendor on a monthly basis.	**Medium-term**		
		• Standardize pre and post outcome measures should be established to determine effectiveness of the service.	**Medium-term**		
		• Monitor and Report Outcomes (The Division Manager that oversees this contract, will be responsible for reporting on outcomes and variance during the monthly financial reporting.	**Medium-term**		

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Behavioral Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Access and Crisis Services Division	2.7	**Transition Homeless Outreach Full-Service Partnerships to alternatives model of care that aligns to community need, volume demand while meeting financial sustainability.**			
		• Determine if the County wishes to fold all Homeless Services under one Division with formal MOUs between the division and law enforcement, Fire Services etc.	**Medium-term**	Frank Warren	Dr. Star Graber
		○ If yes – begin developing the new Service through model design based on the number of current services under the County and in partnership with law enforcement and Fire Services.	**Medium-term**		
		○ If no - renegotiate contract base on proposed staffing and budget to align team with community need and volume demand taking the current contract from 10.16 FTE to 5.13 FTE.	**Medium-term**	Dr. Christina Rajlal	
		• Establish new contractual agreement and staffing, both personal and skill set, that aligns with new model of care (removing Homelessness FSP designation).	**Medium-term**		
		• Define metrics requirement per the contract that outlines unique number of clients, frequency of contact, duration of contact, which should be a reporting requirement by the vendors on a monthly basis.	**Medium-term**		
		• Standardize pre and post outcome measures should be established to determine effectiveness of the service.	**Medium/Long-term**		
		• Monitor and Report Outcomes (The Division Manager that oversees this contract, will be responsible for reporting on outcomes and variance during the monthly financial reporting.	**Long-term**	Frank Warren	

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Behavioral Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Access and Crisis Services Division	2.8	**Consider reducing contracts for duplication of services that are funded by the State, the County and Federally.**			
		• Eliminate Central Coast Hotline and transition services to already established 988 Crisis Hotline. The decrease of this contract will be one less contract that the department will require to have oversight over.	**Medium-term**	Frank Warren	Dr. Star Graber
		• Eliminate Iris Telehealth Clinical Social Worker	**Short-term**	Dr. Star Graber	
		• Eliminate Iris Telehealth Child and Adolescent Psychiatrist	**Short-term**		
Justice Services	2.10	**Realign resources across Justice Services to improve access to care and meet client demand through enhanced scheduling and a multidisciplinary approach, while also meeting requirements for Forensic Assertive Community Teams by aligning the model of care with FACT standards.**			
		• Determine if the County wishes to consider merging ACT and FACT teams to meet model fidelity and achieve economies of scale.	**Short-term**	Joshua Woodbury/ Dr. Christina Rajlal	Dr. Star Graber
		○ If yes – determine if the team should be under the County or under an external contractor.	**Short-term**		
		○ If no – develop plan on how Justice Services will meet BH Connect FACT requirements in order to meet model fidelity and billable requirements.	**Medium-term**		
		• Formulate New Agreements: If ACT and FACT are to be outsourced: Establish new contractual agreement and staffing, both personal and skill set, that aligns with ACT and FACT requirements.	**Medium Term**		
		• Define Reporting Metrics: Contractual agreement requires metrics and outcomes as directed by BH Connect.	**Medium-term**		
		• Monitor: The Justice Division Manager that oversees this contract, will be responsible for reporting on outcomes and variance during the monthly financial reporting. Where there is variance, both the Division Manager and the Vendor (if contracted out) will be required to report on an action plan that is monitored. If improvement is not seen within 3 months of initial issue, the matter should be escalated to the Division Deputy and Director of Health Agency. Projected billables will need to be very closely monitored as part of the reporting process.	**Medium-term**		

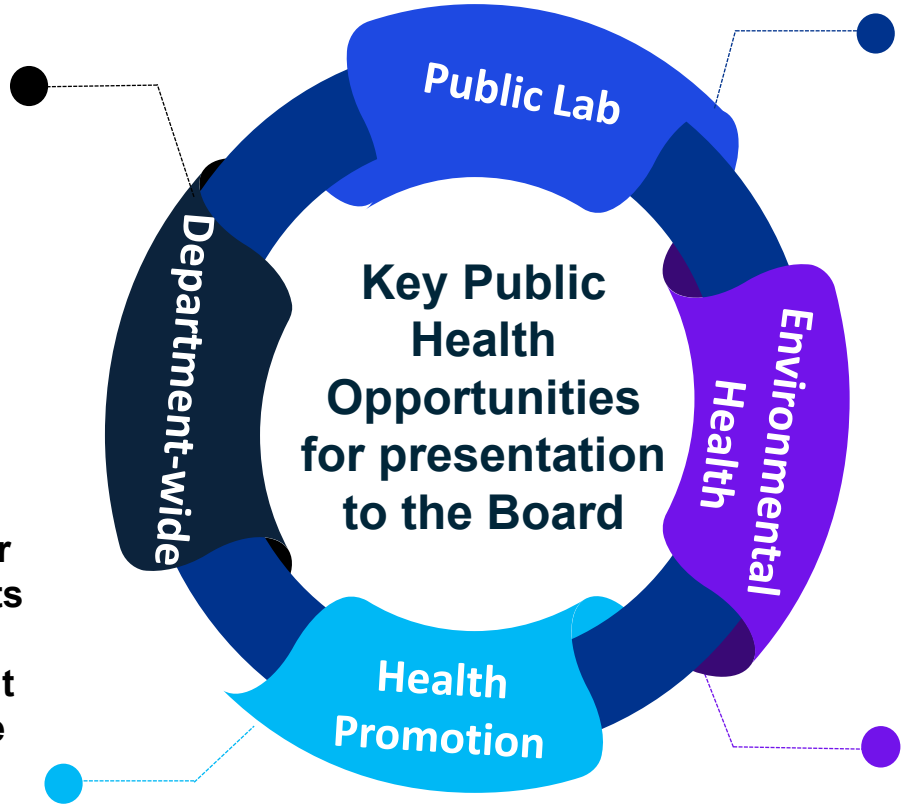
Public Health

Key Opportunities for Board Presentation

Public Health

Implement processes for tracking staff utilization across the Public Health Department and setting utilization targets to enhance program service delivery and cost efficiency.

Collaborate with the Social Services Department and other key health services departments to adopt leading practices for enhancing CalFresh enrollment across the County, to increase CalFresh Healthy Living grant funding for the Division.



Explore three key options for the Laboratory's future operations to enhance Non-NCC and decrease reliance on the general fund.

Re-evaluate fees across Environmental Health for Water Systems and the Land Use program fees, consider incorporating the cost of Emergency Response into regular fees, and update the fee schedule after finalizing the budget to better align fees with departmental costs.

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Clinical and Communicable Disease	3.1	**Enhance reporting and analysis through development of an Acuity Model and Power BI Dashboard to better understand staff workload, productivity, caseload allocation, and overall divisional performance.****			
		• Perform a low-barrier pilot time study to measure the average number of hours required to complete investigations for each disease type over a 2-3 month period.	**Long-Term**	Dr. Rosen	Dr. Borenstein
		• Develop an acuity model by identifying average investigation time by disease type, assign a complexity weighting to each disease type based on investigation time, and create a framework for applying these weightings to individual cases.	**Long-Term**		
		• Implement the acuity model on a trial basis, gather feedback, and make necessary adjustments.	**Long-Term**		
		• Following optimization, the Division should utilize the model to allocate caseloads based on complexity, supporting balanced workloads across staff and establishing a process for measuring staff productivity.	**Long-Term**		
		• Develop a Power BI dashboard that integrates the acuity model, displaying key metrics such as case acuity, total case acuity, and case status.	**Long-Term**		
	3.2	**Reevaluate staffing levels at the Reproductive Health Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.**			
		• Redirect 1 FTE position from the program by reviewing current roles and identify positions for reduction without compromising service quality.	This opportunity is no longer feasible as the Reproductive Health program has been eliminated post KPMGs draft report submission.		
		• Analyze data regularly to identify service demand trends and adjust staffing levels accordingly to optimize client service delivery.			
		• Direct staff must allocate 80% of their time to direct client billable services and assign Administrative Service Officers and supervisors to review compliance weekly.			
		• Train ASOs to verify billing eligibility through Medi-Cal – Meds light and Ability insurance screener for all clients and develop a process for ASO to confirm all visits are accounted for weekly and report variances to supervisors.			
		• Consider implementing AI technology to support documentation.			
		• Develop Utilization Tracking and Action Planning.			
		• Conduct Regular Staff Utilization Reviews and Reporting.			

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Clinical and Communicable Disease	3.3	**Reevaluate staffing levels at the Immunization Clinic to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.**			
		• Direct staff must allocate 80% of their time to direct client services and assign Administrative Service Officers and supervisors to review compliance weekly.	**Long-Term**	Dr. Rosen	Dr. Borenstein
		• Consider implementing AI technology to support documentation.	**Long-Term**		
		• Develop Utilization Tracking and Action Planning.	**Long-Term**		
		• Conduct Regular Staff Utilization Reviews and Reporting.	**Long-Term**		
	3.4	**Engage Divisions in developing EHR business requirements and enhance pre-clinic communication processes to improve efficiency and Patient experience.**			
		• Conduct workshops with representatives from each division to identify and document key business requirements for the new EHR system.	**Short-Term**	EHR Implementation Team	Dr. Borenstein
		• Form a task force including stakeholders from all relevant divisions to participate in the EHR implementation process and support testing.	**Short-Term**		
		• Train administrative assistants to confirm patient language preferences during pre-clinic checks and develop standard email templates with clear instructions and necessary forms in multiple languages.	**Medium-Term**		

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
EMSA	3.5	**Increase EMT certification fees to achieve better Non-NCC for providing these services.**			
		• Conduct a cost analysis to determine the cost of providing certification services. The cost analysis should include staffing cost; as well as allocation for operational costs (i.e., supplies, facilities, technology etc.)	**Short-Term**	Ryan Rosander	Dr. Borenstein
		• Develop a business plan to include the cost analysis, justification, and benefits to increasing fees.	**Short-Term**		
		• Obtain approval from the Board of Supervisors for the increase by developing a board letter and providing the business plan.	**Short-Term**		
	3.6	**Adjust response time requirements to match industry standards and realign penalties accordingly for non-compliance.**			
		• Evaluate Current Performance by assessing how well ambulance providers are meeting the existing response time requirements.	**Long-Term**	Ryan Rosander	Dr. Borenstein
		• Establish response time targets that align with NFPA standards (e.g., 9 minutes in the 90th percentile) and consider increasing penalties to match those of neighboring counties.	**Long-Term**		
		• Negotiate with ambulance service providers to update contracts to reflect the new response time requirements and penalties.	**Long-Term**		
		• Conduct ongoing analysis to evaluate provider performance against the new standards.	**Long-Term**		

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
EMSA	3.7	**Establish contract oversight fees for Air Ambulance oversight ensuring that the charges reflect the actual costs incurred for providing the service.**			
		• Assess the estimated cost of service provision using data-driven methods (e.g., reviewing time sheets over 2-3 fiscal years) and consider other operational costs incurred to provide the service.	**Short-Term**	Ryan Rosander	Dr. Borenstein
		• Engage in negotiations with the air rescue to establish a fee and associated contract.	**Short-Term**		
		• Monitor the actual costs of both hospital and air rescue oversight (once implemented) and conduct an annual fee analysis to help ensure the fees continue to cover the associated costs.	**Short-Term**		
	3.8	**Adopt dispatch protocols to expand use of an "ambulance alone" response to most efficiently respond to low-urgency medical calls.** Dr.			
		• Consider implementing software such as PROQA in the future to streamline the response process.	**Medium-Term**	Ryan Rosander	Dr. Borenstein
		• Collaborate with EMS, Fire, and Dispatch to identify key calls that may require an ambulance-only response.	**Long-Term**		
		• Jointly develop protocols that outline the criteria and procedures for these types of responses.	**Long-Term**		
		• Train dispatch personnel on the new protocols to help ensure accurate and efficient assessment and response.	**Long-Term**		
		• Implement and monitor the new protocols to assess their effectiveness and make necessary adjustments.	**Long-Term**		

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Environmental Health	3.9	**Re-evaluate fees for Water Systems and Land Use program fees to support full Non-NCC and reduce reliance on the General Fund.** J Damery			
		• Evaluate the actual costs of delivering services for the program over a 3-year period through time task analysis.	**Medium-Term**	Peter Hague	Dr. Borenstein
		• Propose fee adjustments based on cost analysis and consider fee benchmarking for both programs.	**Medium-Term**		
		• Present proposed fee adjustments to Board of Supervisors.	**Medium-Term**		
		• Roll out the adjusted fee rates using a phased approach.	**Medium/Long-Term**		
		• Inform the public about the new fee structures.	**Medium-Term**		
		• Continuously monitor fee revenue and service costs to support alignment and make adjustments on an annual basis.	**Medium/Long-Term**		
	3.10	**Consider incorporating the cost of Emergency Response into regular fees to improve Non-NCC for this service.**			
		• Evaluate the actual costs of delivering this service over the past 3-5 years and analyze the volume and time intensity for service providers.	**Medium-Term**	Peter Hague	Dr. Borenstein
		• Propose fee adjustments and allocate them across program fees. Consider weighting based on the proportion of costs applicable to key program areas.	**Medium-Term**		
		• Present the proposed fee adjustments to the Board of Supervisors for approval.	**Medium-Term**		
		• Roll out the adjusted fee rates as approved.	**Medium/Long-Term**		
		• Inform the public about the new fee structures and the rationale behind these changes.	**Medium-Term**		
		• Continuously monitor fee revenue and service costs to support alignment and make necessary adjustments on an annual basis.	**Medium/Long-Term**		

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Environmental Health	3.11	**Collaborate with other county departments such as Public Works to consider adoption of surveillance cameras in illegal dumping hotpots.**			
		• Collaborate with relevant agencies, such as Public Works, to evaluate dumping hotspots.	**Short-Term**	Peter Hague	Dr. Borenstein
		• Assess the advantages of adopting surveillance systems and initiate the procurement process where necessary.	**Short-Term**		
		• Seek Board approval for procurement and propose any necessary penalty adjustments to the Board of Supervisors.	**Short-Term**		
		• Inform the public about the new penalty structure.	**Medium/Long-Term**		
		• Continuously monitor hotspot activities and make adjustments as needed.	**Short-Term**		
	3.12	**Update the fee schedule after finalizing the budget to better align fees with departmental costs in collaboration with County leadership.****			
		• Collaborate with key county stakeholders, including administration and the Auditor's Office to revise the fee schedule development process, ensuring it takes place after the budget is finalized or becomes an integral part of the budgeting process.	**Medium-Term**	County Administration /Auditor Controller	Dr. Borenstein
		• Establish clear goals to reduce reliance on the General Fund, targeting a range of 5-10% based on successful practices from other counties.	**Medium-Term**		
	3.13	**Implement credit card convenience fees for payments made via credit card to cover transaction costs and enhance Non-NCC.**			
		• Conduct an analysis to determine the actual costs of processing credit card payments and establish a fee rate.	**Short-Term**	Peter Hague	Dr. Borenstein
		• Integrate the credit card convenience fee into the payment system and inform all stakeholders about the new fee.	**Short-Term**		

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Healthcare Access	3.14	**Adopt a Community Approach aligned with leading practices for the development of a Community Information Exchange (CIE) to improve data sharing and coordinated care system.**			
		• If additional resources become available, support inclusive representation by involving diverse community members in planning sessions and conducting stakeholder interviews to gather broad insights.	**Long-Term**	Michelle Shoresman	Dr. Borenstein
		• Support the community and lead organizing workshops and focus groups where individuals with lived experience can describe their experiences with current systems to inform a more user-centric design.	**Long-Term**		
		• Support the community's establishment of advisory boards and community boards with dedicated seats for community members to help ensure continuous leadership and input in decision-making.	**Long-Term**		
		• Support the continued engagement of CBOs, trusted leaders, and partners from health and social services sectors to collaborate on the initiative.	**Long-Term**		
		• Support and require staff that will be using the CIE to attend training for on equity, cultural competency, and community engagement methodologies to help ensure they can effectively support the CIE's goals.	**Long-Term**		
	3.15	**Collaborate with key partners to consider the adoption of artificial intelligence to support the Oral Health program.**			
		• Engage with relevant organizations such as the County Office of Education, First 5 Commission, and local universities to discuss the feasibility of adopting artificial intelligence.	**Short-Term**	Michelle Shoresman	Dr. Borenstein
		• If sufficient interest from partners exists, conduct a cost-benefit analysis.	**Medium-Term**		
		• Develop an implementation plan that identifies the number of schools, students, and the overall geographical area to pilot the program.	**Long-Term**		
		• Draft and sign partnership agreements to outline the roles and responsibilities of each partner.	**Long-Term**		
		• Obtain informed consent from parents or guardians for student participation.	**Long-Term**		
		• Collect data, assess program effectiveness, gather feedback, and determine opportunities for potential program scaling.	**Long-Term**		

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Health Promotion	3.16	**Implement processes for tracking staff utilization within the WIC Clinic and setting utilization targets to enhance program service delivery and cost efficiency.**			
		• Direct staff must allocate 80% of their time to direct client contact.	**Short-term**	Shannon Massey	Dr. Borenstein
		• Consider implementing AI technology to support documentation.			
		• Implement Utilization Tracking and Action Planning.	**Short-term**		
		• Conduct Regular Staff Utilization Reviews and Reporting.	**Short-term**		
	3.17	**Consider transitioning to mobile clinics in low-volume locations, implementing telehealth to reduce costs and enhance client accessibility, and commencing the tracking of key financial metrics across clinics to optimize resource allocation and increase cost efficiency.**			
		• Conduct an assessment to determine the feasibility of transitioning smaller clinics to mobile services at local libraries or community centers, considering logistics, community needs, and potential savings.	**Medium-term**	Jen Miller	Dr. Borenstein
		• Create a detailed implementation plan for the transition to mobile clinic services, including schedules, locations, staffing, equipment needs, and communication strategies for informing the community.	**Medium-term**		
		• Collaborate with IT Services department to implement a telehealth system that supports virtual consultations and client interactions.	**Medium-term**		
	3.18	**Conduct a cost-benefit analysis to explore the feasibility of relocating the WIC clinic in Paso Robles to a more cost-effective facility, considering both County-owned and alternative rental properties.**			
		• Conduct a cost-benefit analysis to evaluate whether increased rental costs are justified by improvements in client service access, impact, and outcomes.	**Short-term**	Jen Miller	Dr. Borenstein
		• Explore the feasibility of relocating the Paso Robles WIC clinic to a more cost-effective facility, including County-owned properties and alternative rental options.	**Short-term**		
		• Identify and compare potential relocation sites based on cost, location, accessibility, and the ability to maintain quality of services.	**Short-term**		

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Health Promotion	3.19	**Based on funding availability, engage with interested schools to explore collaborative funding opportunities for expanding community wellness services. *(Based on uncertainty of Federal Funding this opportunity may not be started until 2026)***			
		• Engage with interested schools to discuss potential partnerships and collaboration.	**Medium-term**	Francine Levin	Dr. Borenstein
		• If funding is available, establish a working group consisting of representatives from interested schools to facilitate communication and planning.	**Medium-term**		
		• Consider developing a Collaborative Funding Model and determine the total funding required to support an additional FTE and deliver the program to multiple schools.	**Medium-term**		
		• Encourage schools to pool their resources to collectively meet the funding requirements.	**Medium-term**		
		• Create Memorandums of Understanding (MOUs) outlining each school's financial commitment and the program's responsibilities and obtain approval from the Board of Supervisors.	**Medium-term**		
		• Roll out the program across the participating schools and regularly monitor impacts.	**Medium-term**		
	3.20	**Collaborate with the Social Services Department and other key health services departments to adopt leading practices for enhancing CalFresh enrollment across the County, to increase CalFresh Healthy Living grant funding for the Division.**			
		• Maintain the CalFresh Alliance partnerships between Social Services, Public Health, and CBOs for coordinated CalFresh enrollment efforts.	**Short-term**	CalFresh Alliance/Jen Miller	Dr. Borenstein
		• Collaborate with CBOs for extensive community outreach and screening and enlist additional support, such as from 211.	**Short-term**		
		• Develop a process to identify and target SSI recipients not enrolled in CalFresh through data matching, followed by informative mailers and follow-up calls.	**Short-term**		
		• Track enrollment results, adjust strategies, and reinforce successful practices for continuous improvement.	**Short-term**		

Opportunity may require additional resources, coordination, or investment approval from County

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Maternal Child and Adolescent Health	3.21	**Reevaluate staffing levels within the Home Visiting Program to better match demand and reallocate full-time equivalents (FTEs) to areas with greater need and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.**			
		• Redirect 4 FTE nursing positions from the program as recommended by the Division leadership.	**Short-Term**	Sarah Lack	Dr. Borenstein
		• Review current roles and identify positions for reduction without compromising service quality.	**Short-Term**		
		• Direct staff must maintain at least 60% of the required caseload, or in alignment with model fidelity expectations. Administrative Services Officers and direct supervisors will review caseload compliance monthly.	**Medium-Term**		
		• Undertake a Perpetual time study.	**Long-Term**		
		• Train direct supervisor to verify time study aligns to requirements and develop a process for direct supervisor to confirm all visits are accounted for weekly and report variances to supervisors..	**Medium-Term**		
		• Develop Utilization Tracking and Action Planning.	**Medium-Term**		
		• Conduct Regular Staff Utilization Reviews and Reporting.	**Medium-Term**		

Overview of Key Opportunities

Public Health

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Maternal Child and Adolescent Health	3.22	**Reevaluate staffing levels at Martha's Place to better match demand for service and implement processes for tracking staff utilization and setting utilization targets to enhance program service delivery and cost efficiency.**			
		• Identify the necessary office hours and administrative time needed for effective operations. Based on current demand, aim for 0.4 FTE to cover three days per week.	**Medium-Term**	Sarah Lack	Dr. Borenstein
		• Develop a proposed schedule where contracted staff, have office hours for 4 hours per day across 3 days per week.	**Medium-Term**		
		• Discuss the proposed changes with the contracted staff to help ensure they understand the reasons and benefits of the new schedule.	**Medium-Term**		
		• Adjust the contracts to reflect the new reduced 0.4 FTE allocation and revised office hours. Help ensure that administrative duties are clearly defined within these hours**.**	**Short-Term**	PH Admin	
		• County staff must maintain at least 80% of the required caseload, or in alignment with model fidelity expectations. Direct supervisor will review caseload compliance monthly.	**Medium-Term**	Sarah Lack	
		• Train direct supervisor to verify time study aligns to requirements and develop a process for direct supervisor to confirm all visits are accounted for weekly and report variances to supervisors	**Medium-Term**		
		• Develop Utilization Tracking and Action Planning and Conduct Regular Staff Utilization Reviews and Reporting	**Long-Term**		
		• Conduct Regular Staff Utilization Reviews and Reporting.	**Long-Term**		

Overview of Key Opportunities

Public Health

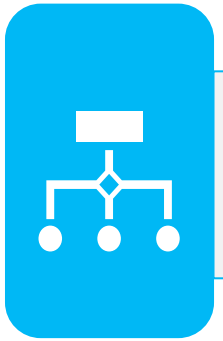
Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-owner	Owner
Maternal Child and Adolescent Health	3.23	**Implement processes to decrease no-show rates in the Medical Therapy Program to increase staff utilization and reduce wait times and cost of service.**			
		• Update the current process for appointment scheduling which schedules appointments 6 months out.	**Short-Term**	Natalie Angelo	Dr. Borenstein
		• Advise all staff to book their schedule in 80% direct client care.	**Medium-Term**	Sarah Lack	
		• Enhance call reminder process.	**Medium-Term**		
		• Review Current Clientele and determine which clients would be best serviced via drop-in clinic.	**Short-Term**	Natalie Angelo	
Public Lab	3.24	**Explore three key options for the Laboratory's future operations to enhance Non-NCC and decrease reliance on the general fund.** Public Health Director			
		• Option 1. Maintain the Status Quo and report the annual general fund reliance to the BOS	**Short-Term**	Dr. Miller	Dr. Borenstein
		• Option 2. Strengthen collaboration with county departments and local hospitals/clinics to boost service volume and consolidate county	**Medium-Term**		
		• Option 3. Transition to a Regional Laboratory**	**Long-Term**	Dr. Borenstein/ County Admin	
	3.25	**Optimize staffing to test ratios to better align with demand for service and support greater Non-NCC..**			
		• Analyze the current workforce structure to identify key supervisory activities that can be reallocated facilitating the supervisor's transition to a 0.7 FTE testing capacity.	**Short-Term**	Dr. Miller	Dr. Borenstein
		• Engage Human Resources and communicate the new role expectations to the supervisor and inform all staff of the upcoming changes.	**Short-Term**		
		• Adjust the supervisor’s job description to allocate 0.7 FTE for testing and 0.3 FTE for supervisory duties.	**Short-Term**		
		• Collaborate with Human Resources to identify the 2.25 FTEs positions that can be redirected and plan their reallocation.	**Short-Term**		
		• Regularly track performance, and make necessary adjustments to support continue effective alignment with demand.	**Short-Long-Term**		

Animal Services

Key Opportunity for Board Presentation

Animal Services

Key Public Health Opportunity for presentation to the Board



Consider Implementation of a coordinated governance model with the cities to increase collaboration and enhance the shared decision-making process.

Overview of Key Opportunities

Animal Services

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term)	Co-Owner	Owner
Animal Services	4.1	**Consider the feasibility of establishing to a 501(c)(3) organization to collect donations for animal services and increase cost efficiency, similar to the approach taken by Ventura County.**			
		• Assess the benefits and costs of establishing a 501(c)(3) non-profit and/or implementing donation programs. This analysis should include stakeholder engagement to evaluate the County's desire to adopt such as initiative.	**Short-term**	Eric Anderson	Nick Drews
		• If the feasibility study is successful, the Division should seek approval for this initiative from the Board of Supervisors.	**Medium-term**		
		• Develop an implementation plan which should include a steering committee, timeline and milestones, resource allocation, clearly defined roles and responsibilities, a communication strategy, monitoring and evaluation processes, and risk management.	**Medium-term**		
		Consider Implementation of a coordinated governance model with the cities to increase collaboration and enhance the shared decision-making process.			
	4.2	• Consider establishing a shared decision-making process through formal consensus or voting on operational decisions, such as hiring new positions, setting hours of operation, and vendor negotiations and approval.	**Short-term**	Eric Anderson	Nick Drews
		• Refine standardized set of metrics and data definitions agreed upon by all parties funding Animal Services, including service calls by day, hour, and zip code.	**Short-term**		
		• Implement monthly meetings to review metrics and financials to address current stakeholder concerns. Once issues are more stable, consider moving the governance meetings to quarterly, with access to financials and metrics shared on a shared drive	**Short-term**	County Administrator	

Public Guardian

Overview of Key Opportunities

Public Guardian

Division	#	Opportunity and Action	Timeline (Short-, Medium,- Long-Term	Co-owner	Owner
Public Guardian	5.1	**Transition to an alternative technology solution to reduce manual efforts and administrative burden and support future data-driven decision-making on staffing levels.****			
		• Conduct an analysis of key business requirements and research and compare options like PGPro by Panoramic and My Junna based on features, benefits, and user reviews.	**Short-term**	Ashley Bier	Nick Drews
		• Secure approval from the Board of Supervisors to initiate an RFP	**Medium-term**	Leigh Ann Alcorn	
		• Conduct an RFP process to identify and select a vendor.	**Medium-term**		
		• Form an implementation team, set a timeline for key milestones, and outline responsibilities.	**Medium-term**	Ashley Bier	
		• Work with the vendor to install and configure the system and then provide training for all staff.	**Medium-term**		
		• Transition to the new system, monitor its performance, gather staff feedback, and make necessary adjustments to optimize workflows.	**Medium-term**		
		• After optimizing staff workflows, evaluate data on staff caseloads and workloads to analyze whether the current number FTEs is sufficient to meet service demand.	**Long-term**		

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The scope of our work has been limited by the time, information, and explanations obtained from San Luis Obispo County and certain third-party sources that are referenced in this Report. Further, any results from the analysis contained in this Report are reliant on the information available at the time of writing this Report. KPMG has not updated this Report since the conclusion of its work and this Report should not be used in subsequent periods. The scope of our work was defined by San Luis Obispo County and no other parties have agreed the scope for the intended purpose or any other purpose.

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