COMMUNITY
Medical Centers
MOBILE COMMUNITY RESPONSE

MOBILE COMMUNITY RESPONSE DATA

June 2024- August 2024

City Council Meeting

October 1, 2024

Item #15.2

MOBILE COMMUNITY RESPONSE

Agenda

Program Goals & Shared Objectives

- Calls over time
- Origin of calls
- Demographics of persons in need
- MCRT response to calls
- Clinical resolutions and outcomes
- Case studies
- Shared Objectives
- Atlanta

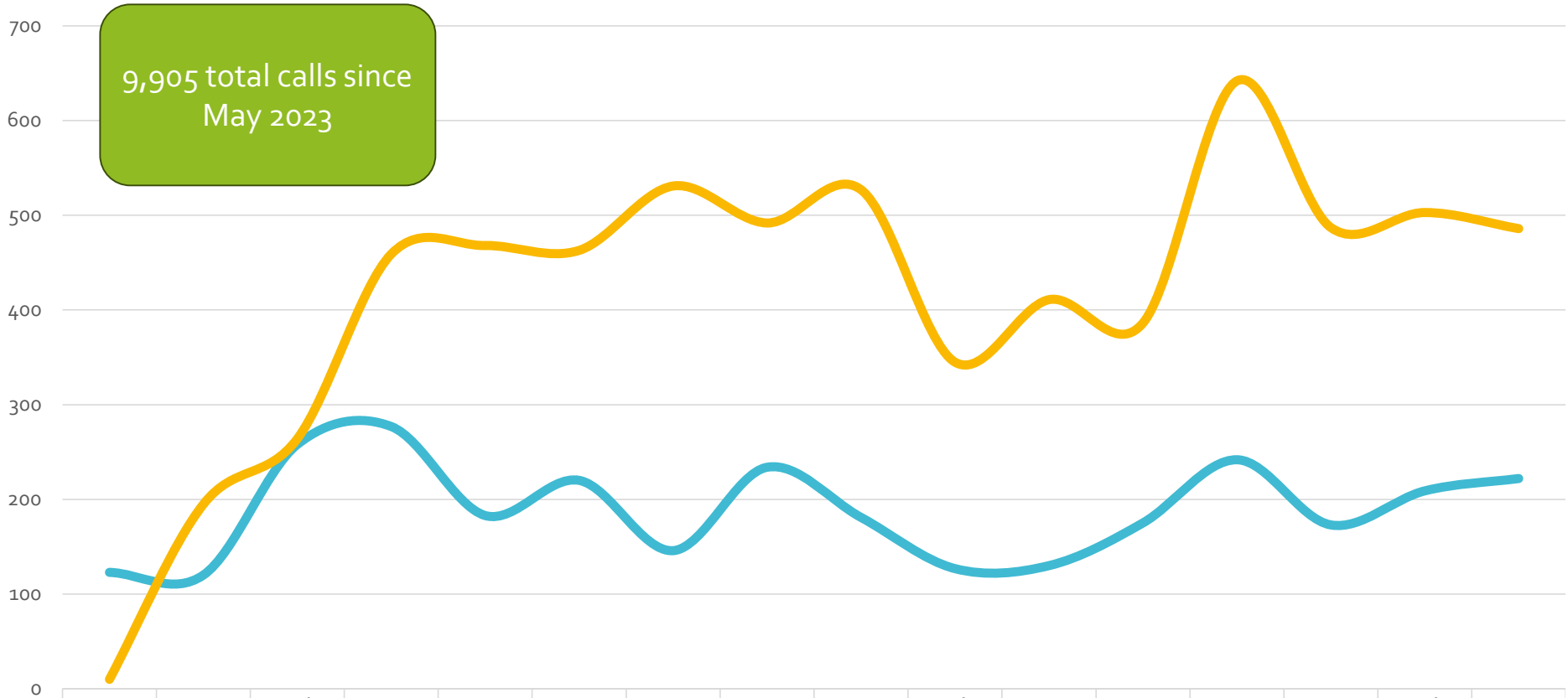
Program Goal

To develop and implement an efficient and sustainable model to mental health intervention based on known and documented best practices, which supports and enhances the well-being of Stockton residents.

Shared Objectives

1. Decrease recidivism or repeat callers
2. Increase follow-up with wraparound services
3. Decrease fear or hesitancy to call for police
4. Increase community trust
5. Decrease costs related to emergency calls
6. Divert individuals from the criminal justice system

Calls Over Time

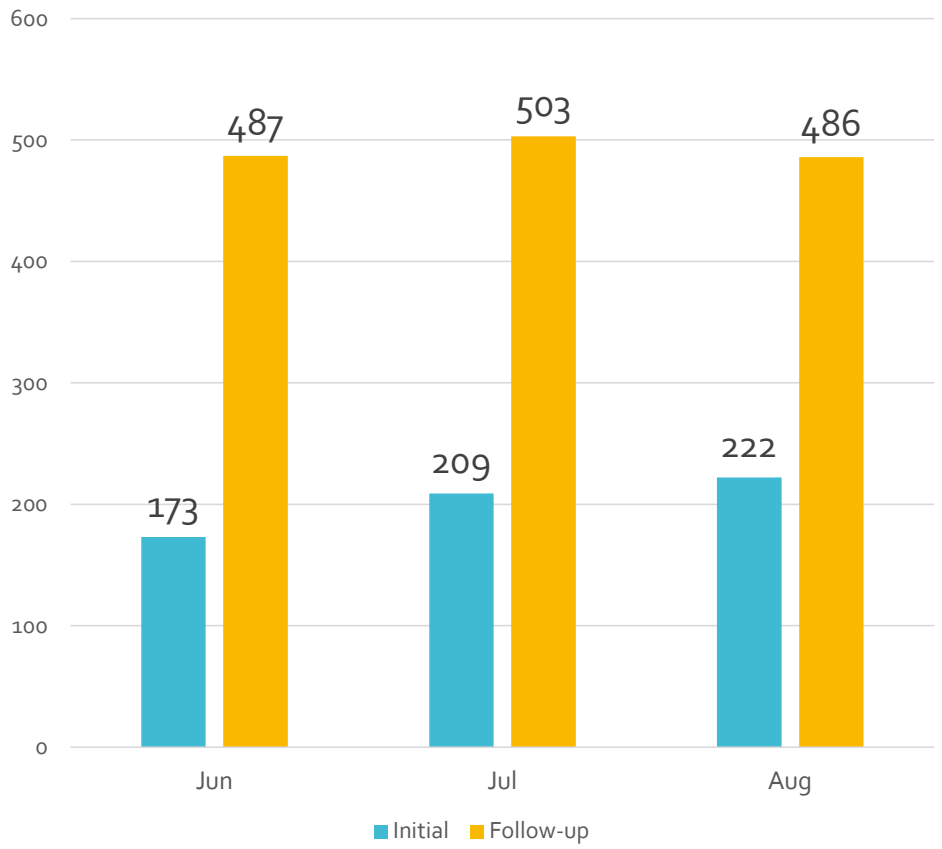


	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Initial	123	120	258	277	183	220	146	234	181	127	130	175	242	173	209	222
Follow-up	10	195	264	459	468	463	531	492	527	345	411	386	642	487	503	486

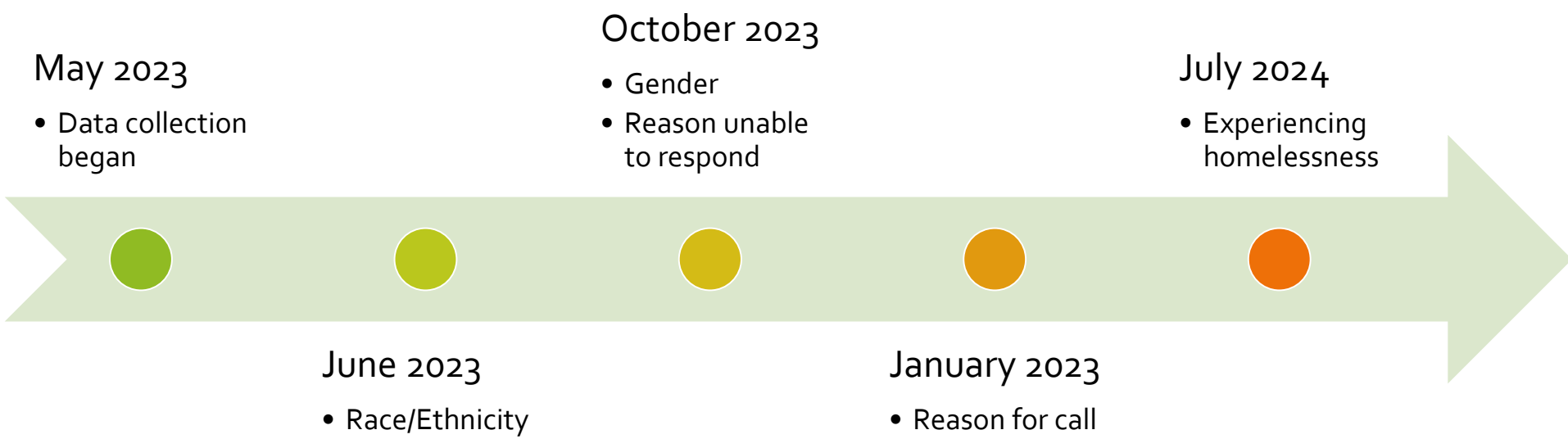
Calls June – August 2024

- During this period:
  - 604 initial calls
  - 1,476 follow-up calls

- Of known reason for call:
  - **76%** for welfare/wellness checks
  - **11%** mild to moderate BH intervention
  - **7%** emotional disturbance



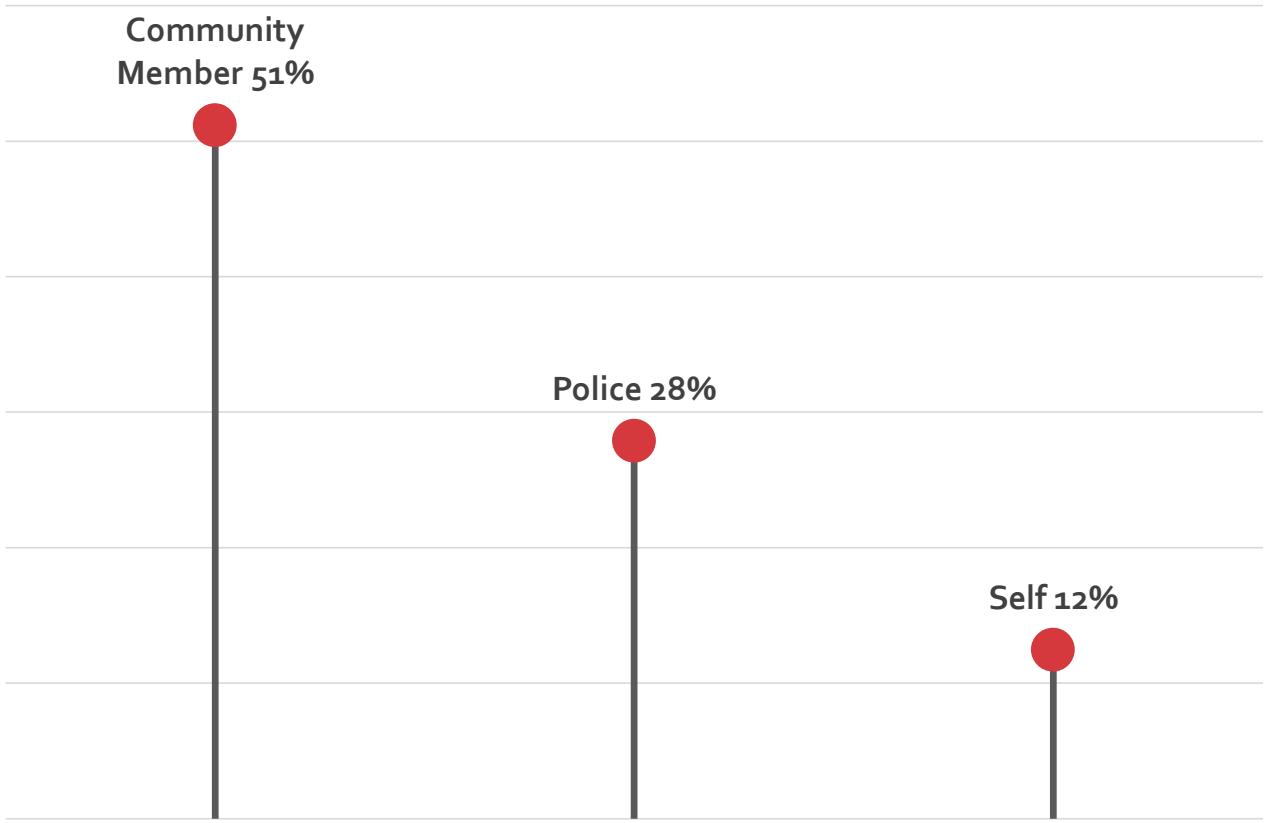
Evolution of MCRT Data Collection: Variables Added



Origin of Calls

June '24 – Aug '24

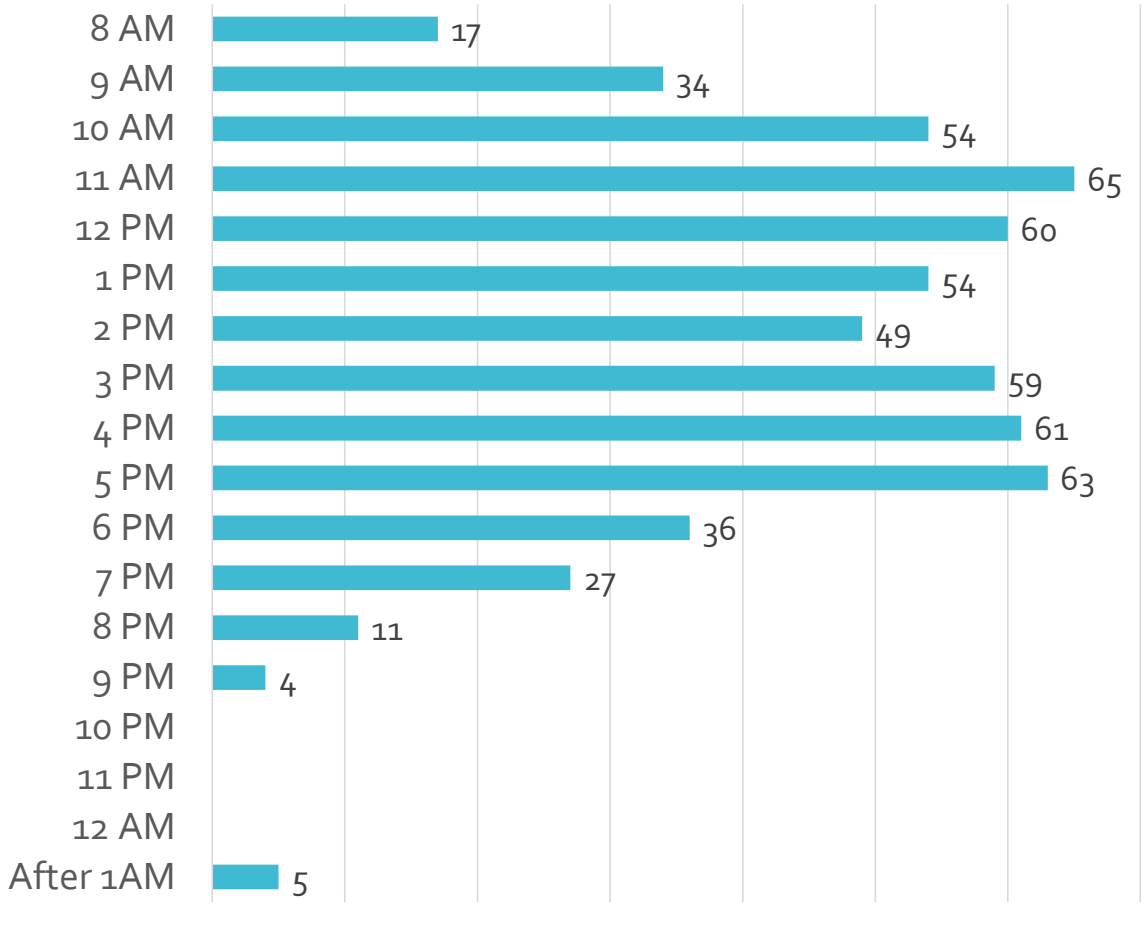
- 545 of 604 initial calls had referral type data available
- Half of initial calls came from community members



Call Times

June '24 – Aug '24

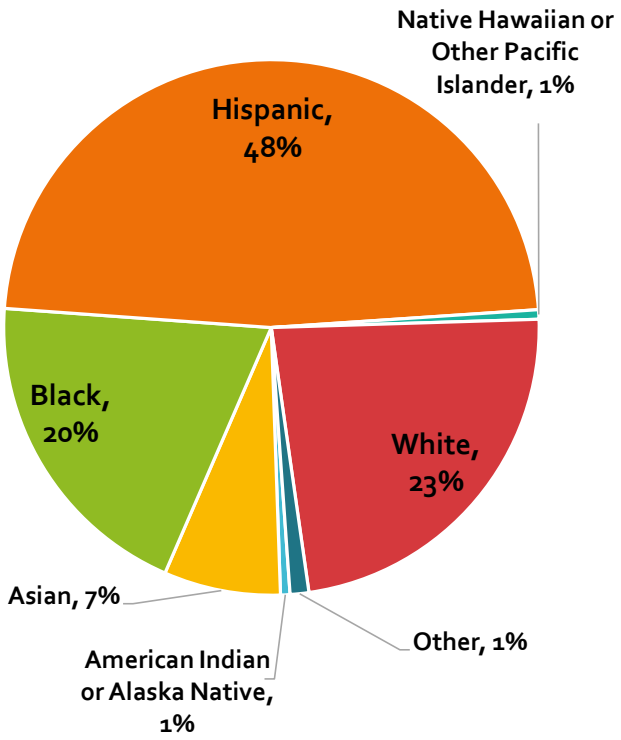
- Call time available for 599 of 604 initial calls
- 11am-1pm and 3pm-5pm accounted for around two-thirds of all calls
- Very few calls came in after 10pm

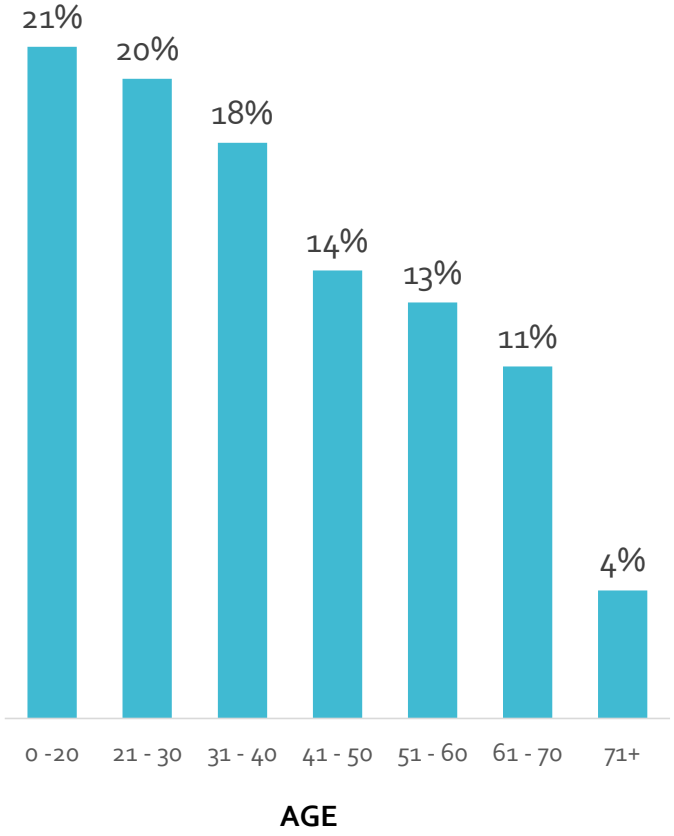


Race/Ethnicity & Age

June '24 – Aug '24

- Collection of race/ethnicity began in June 2023
  - Data available for 525 initial calls
- Caller average age was 38 years old

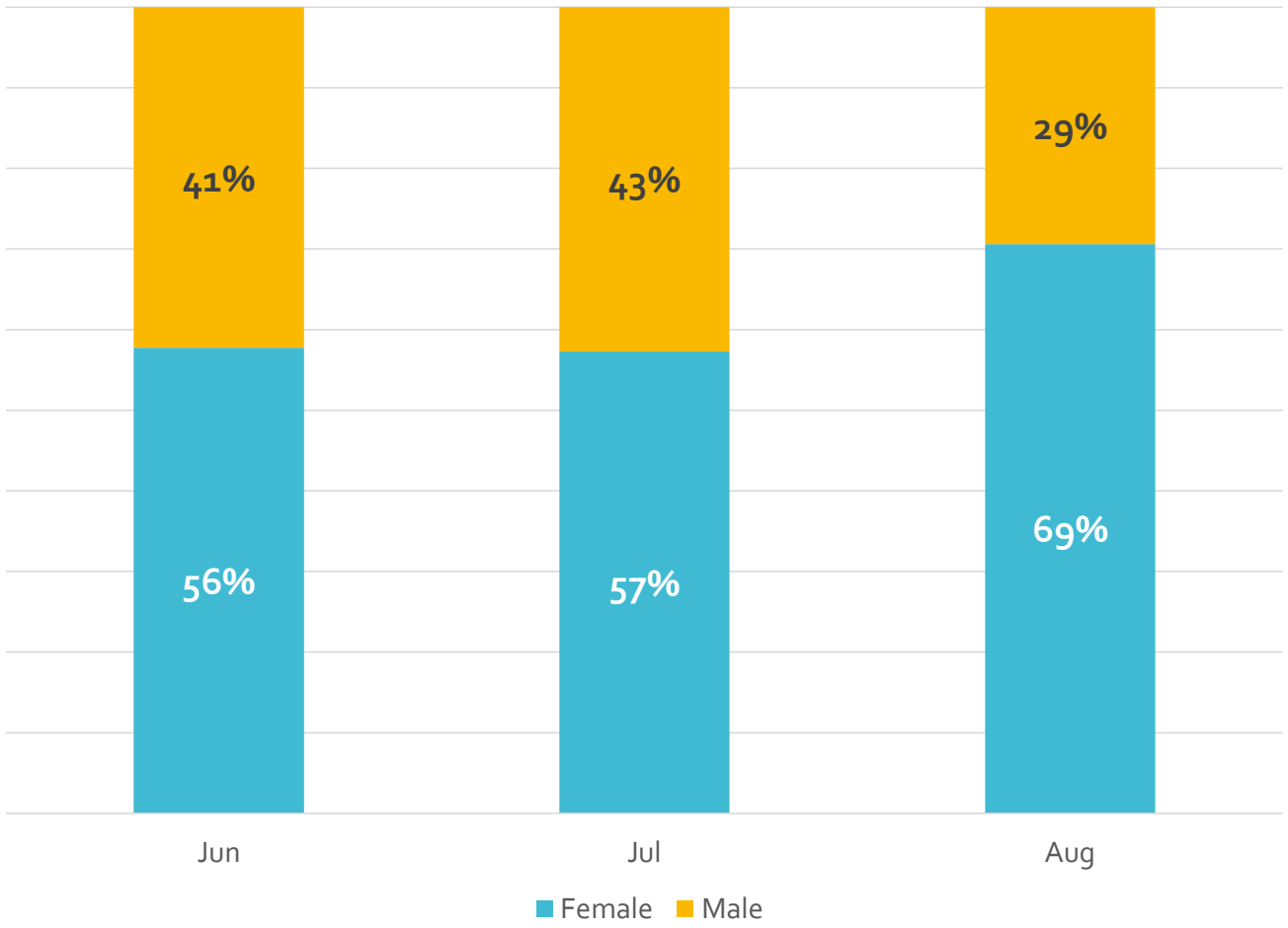




Gender

June '24 – Aug '24

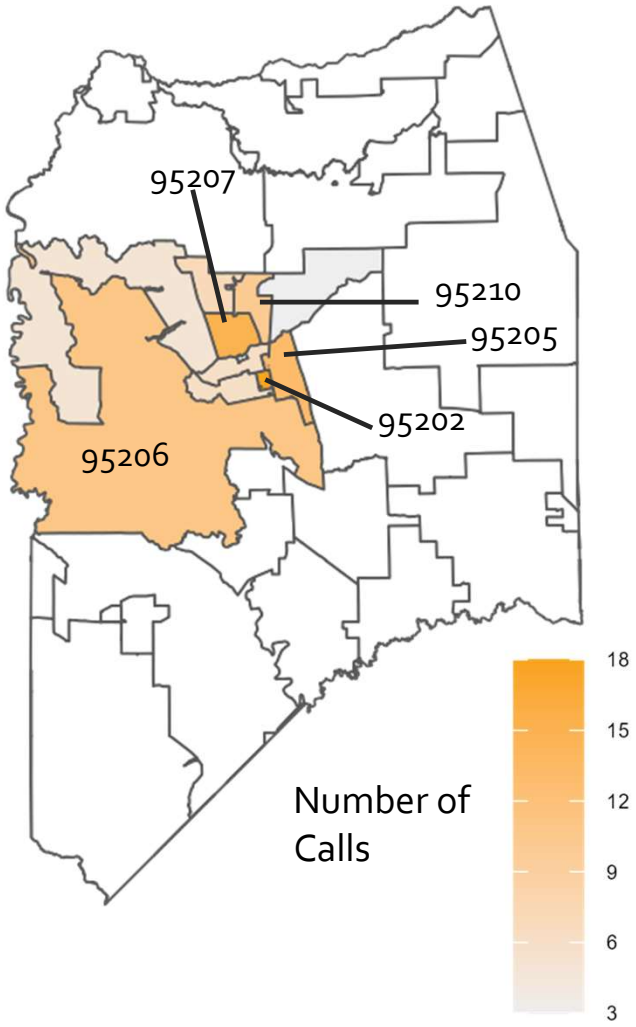
- MCRT began collecting patient gender in October 2023
- Available for 581 initial calls the past 3 months



MCRT Mobile Response by Zip Code

June '24 – Aug '24

- 98 calls had a mobile team response.
- 94 had available zip code information.

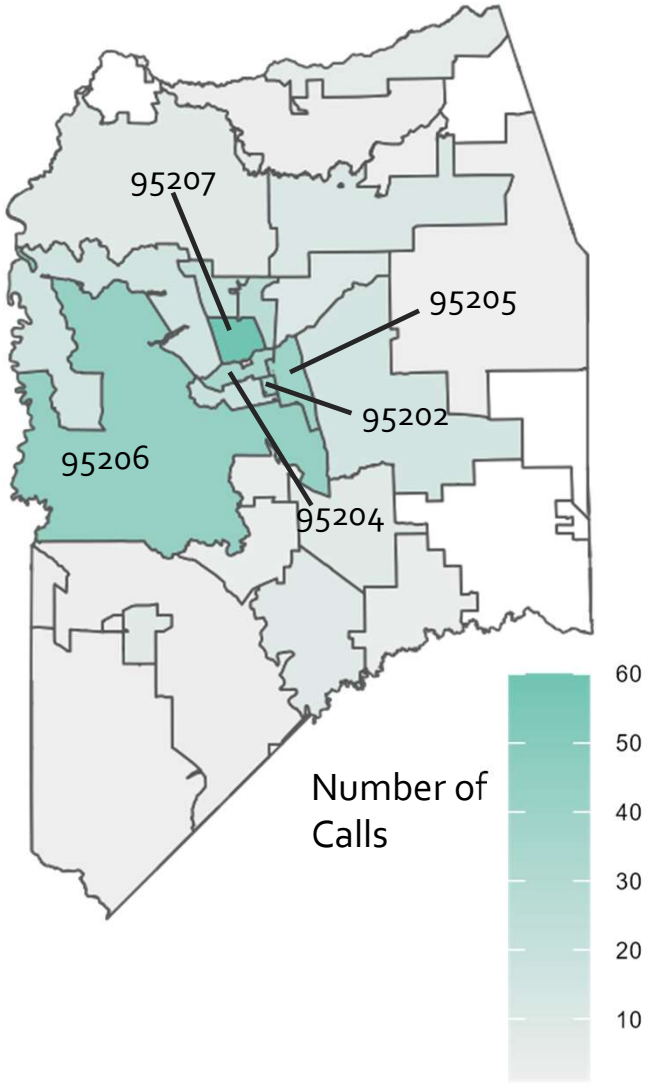


Zip Code	Count	Percent
95202	18	18%
95207	15	15%
95205	13	13%
95206	11	11%
95210	10	10%
95209	7	7%
95203	6	6%
95204	6	6%
95219	5	5%
95212	3	3%

MCRT Phone De-Escalation by Zip Code

Jun '24 – Aug '24

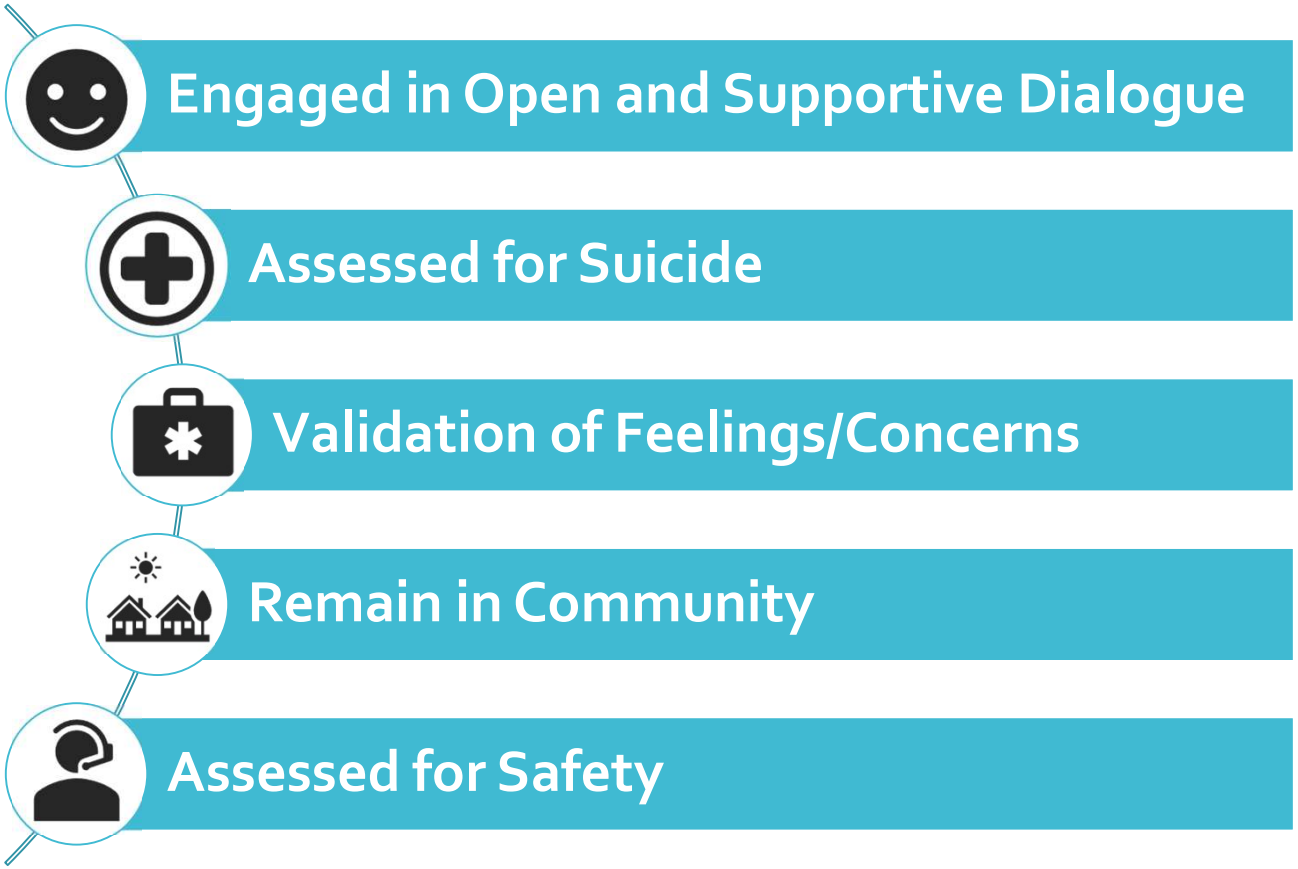
- 455 calls were deescalated over the phone.
- 398 had available zip code information.



Zip Code	Count	Percent
95207	60	13%
95206	44	10%
95205	40	9%
95202	36	8%
95204	34	7%
95210	26	6%
95209	21	5%
95203	19	4%
95219	15	3%
95215	14	3%

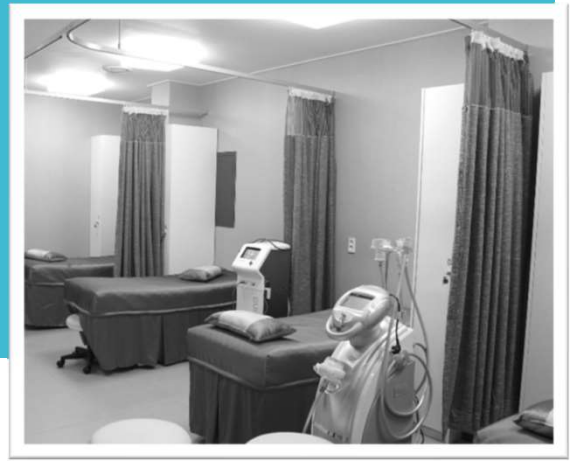
Clinical Resolutions

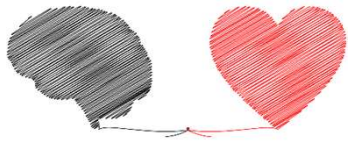
May '23 – Apr '24



CBO Collaborative Efforts in Public Safety and Supportive Services

Case Study 1





MCRT arrived at the trailer of a community member after receiving a call from SJ Cares Sheriff's Deputies, who provided information about the situation.

Community member was being displaced from her trailer as it was condemned.

SJC Sheriffs called SJC Animal Services who agreed to transport their dogs to their new location

Upon arrival, Animal Services asked pt and her partner to move the dogs, pt began to break down.

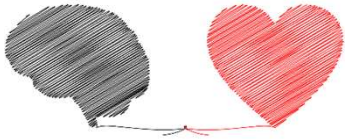
The team walked her to the MCRT van so that she could sit out of the heat and provided de-escalation techniques for pt to rest.

Ultimately, the Animal Services removed all of the patient's dogs, there ended up being 37 dogs.

LCSW helped process extreme hoarder of animals and Bipolar Schizophrenia and PTSD, exploring options and placed her in a motel for one night to find an opening at one of the shelters the following day.

Connecting to Substance Use Treatment

Case Study 2



Community member called the MCR line after experiencing depression and wanting to talk to someone.

Team went to his apartment, and he reported he is about to lose his place because he lost his temporary disability from work back in February and can't pay his rent anymore.

As follow-up work continued, the community member disclosed self-harm to his wrists and a substance use problem and extreme fear in seeking treatment for meth.

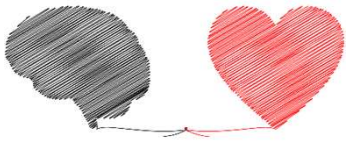
The process of working with him to get into substance use treatment at CMC's Respite began immediately to not lose momentum and he was encouraged by the support and elected to call on HIS OWN to seek treatment!

In the 30+ days of working with him, he was provided transportation, food stamps, linkage to SUD, follow-up and supportive service, connection to his TB test.

There were 7 (1:1) BH in person and over the phone visits with a clinician and 8 additional contacts with other CMC supportive staff and services.

Examples of MCRT Making a Difference

Case Study 3



On the evening of *National Night Out* MCR received a referral from our partners at OVP.

A 2-year-old child had been critically injured from a Gunshot Wound (GSW), due to a loaded gun being accessible and subsequently being shot by another child in the home .

MCR was able to be with the family during the extreme level of chaos and trauma erupting in the home and confusion over the many next steps for this child as he was rushed to UC Davis for life-threatening injuries and many surgeries ahead.

MCR provided 10 days of hotel stay and meal for the Mother and Aunt who were sleeping in their car across from the hospital without any money to pay for both rent at home and this new cost.

Clinically, MCR checked in with Mom and family as often as they needed and provided over five 1:1 visits to support while this was taking place.

The family had just lost another member of the immediate family due to gun violence weeks prior, and the connection between OVP and CMC to provide quality BH interventions and supportive services is critical when working with complex trauma cases.

COMMUNITY Medical Centers

NACHC 2024 CHI & EXPO | August 24, 2024

CMC spoke in Atlanta, GA on behalf of the collaborative work being done in our city and we received so much interest in this type of work!

Partnering to Create a 911 Alternative for the City of Stockton

COMMUNITY
Medical Centers

MOBILE
COMMUNITY
RESPONSE

Questions?

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COMMUNITY Medical Centers
IMPROVING HEALTH TOGETHER
45 YEARS

CMC Respite Data Report

City Council Meeting
October 1, 2024
Item #15.2

CMC Respite Center

201 N. Stanislaus Street, Stockton
(across the street from CMC Channel Clinic/Pharmacy)

RESIDENTIAL 24/7

Open 24 hours per day,
7 days a week

MEDICAL CLINIC

Monday–Friday, 8am–5pm

SITTING AREA
GROUP MEETING SPACE
COVERED PATIO

MEN'S DORM – 8 BEDS
WOMEN'S DORM – 5 BEDS
SPECIAL NEEDS – 1 ROOM

GROUP DINING AREA
KITCHEN FACILITY
LAUNDRY

CMC Respite Team + Services

COUNSELING
BH Clinician (LCSW)
Counselor (SUD Certified)

MEDICAL
X- Waiver Provider (MD/NP/PA)
Medical Assistant (MA)
Nurse (RN/LVN)

SUPPORT
Case Managers/ CHW
Patient Health Navigators
Peer Counselors

- 1-1 Behavioral and Substance Use Counseling
- Group Counseling
- Case Management
- Medication Assisted Treatment (MAT) for opioids and alcohol
- Monitored detox
- Sobering

- Serving individuals 18 and over
- 14-Day Transitional Respite Stay
- 24-hour monitoring
- Life skills classes and activities
- Community programs
- Presentations

CMC Respite Residential Bed Days Data

Total Individuals Seviced	
Men	31
Women	15
Total	46

Race/Ethnicity	
Afro American	6
Hispanic	14
Caucasian	18
American Indian	2
Multi Race	4
DECLINED	2

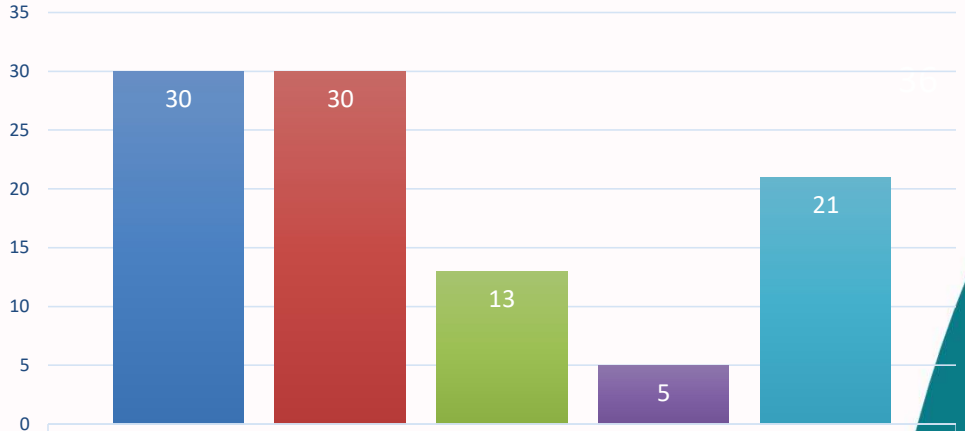
Report on Bed Occupancy for Respite Residential Bed Days

Pt. received 24-hour services:

- Case Management Services
- SUD Daily Programing 1-1/Groups
- Monitored Detox (as needed)
- Wrap Around Services –Med/BH Appt.
- Life Skills Programming
- 3 Meals & Snacks/Laundry

After Care Data
June to Aug 2024

After Care Services



	1
Out pt. Services	30
Case Management	30
MAT (Medical Asst. Treatment)	13
Long Term Recovery Program	5
Transportation	21

ALL Clients offered to be Connected with After Care :

- Case Management/Wrap Around Services –appt. w/SUD, BH & Medical (MAT)
- Transportation
- Next Level of Care transition
- Resources

Connections can Change Lives!

- **Audra Crocker - Peer Counselor Connection:** One of Community Medical Center Respite clients AC, who successfully completed our program, came in with personal and family challenges. He only knew how to cope by using alcohol and methamphetamine. After his successful completion at Respite, I was able to refer him to a sponsor with many years of sobriety. His sponsor meets with him weekly, and they talk or text daily. They work together with recovery workbooks and attend meetings together. He recently was hired as a Bakery Sous Chef locally and loves his job. He has over 4 months of sobriety. He had this to say about Respite:

"My stay at Respite was a discovering time that I will be grateful for the rest of my life. At respite I was guided towards new ways of thinking and behaving. With the help of the wonderful staff, I was able to begin seeing the possibilities of a life without substances. With over 4 months of sobriety, I continue to work on a positive, happier future which all began inside the walls of Respite." - AC

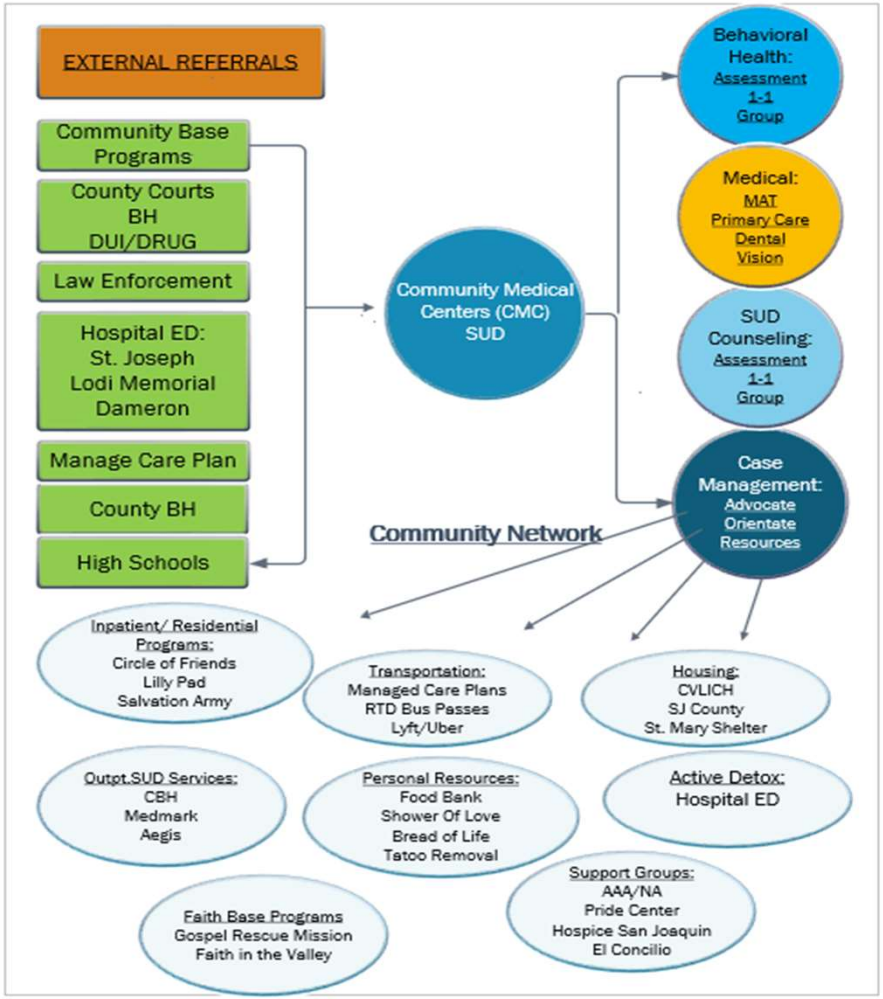
Connections can Change Lives!

- **Araceli Andrade- Case Manager Connection -** Patient connected to service due to Alcohol and Opioid use. Pt was referred to Case Management, SUD counseling and Behavioral Health. Patient has abstained from all substances for over 2 years now. Patient had a stroke several months ago and was unable to work. Due to being on a fixed income and no longer able to work, patient got behind on her rent and we were able to assist her for two months to allow her to get back on track. Patient is now doing great and continues to connect with all SUD services. Patient is grateful for all CMC Respite has done for her and her family.

- **Lavern Langford- SUD Counselor Connection-** This young lady was homeless at the time and would make sure she had a way to her appointments because she stated" I want to get better". I told her just keep coming to see me and rest of the team so you can get balanced out and stay clean. She would go on to see Psych NP, Behavioral Health & Case Management to help her find housing. Moving forward she is now still being seen by myself and the team. She has her own apartment, and she is also now active in NA, and the Wellness Center. This is what she wanted to share "it's because your team never gave up on me". This young lady is very active in the community. She is two and a half years clean from all substance and thriving.

  Laverne Langford " I must say this Community Medical Centers- Substance Use Program is where the "Phoenix rises from the ashes!" I'm so grateful to be part of miracles that happen every day within Community Medical Centers, all of our clinics strive to go the extra mile for our clients."

Community Collaboration



Networking Partnerships

CVLICH
Catholic Charities
Gospel Rescue Mission
El Concilio
St. Mary's Shelter
Hospital ED
Managed Care Plan (HPSJ)
CBH
SUSD
County Collaborative Courts
Lilly Pad
Salvation Army
Circle of Friends
Recovery House
Medmark
Aegis
Food Bank
Shower of Love
Bread of Life

THANK YOU

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IMPROVING HEALTH TOGETHER
45 YEARS