CALIFORNIA DEPARTMENT OF
Mental Health

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August 3, 2005

Melinda Bird
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RE: *Emily Q. v. Bonta*, U.S. Dist. Ct., C.D. Cal. Case No. CV 98-4181 AHM (AJWx)

Dear Ms. Bird,

Enclosed is a copy of the Contra Costa County Mental Health Plan (MHP) Focused Review of Evaluation of Services to Emily Q. Class Members. This report reflects the findings and recommendations of the Department of Mental Health's (DMH) TBS Focused Review Team that conducted the focused review between the dates of May 29, 2005 and June 2, 2005. This report is being sent to Plaintiffs on August 3, 2005, within the sixty-day time frame agreed to by the parties for the completion of the report.

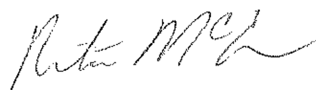
This report is the third of five reviews that will be completed by DMH in accordance with the Court Order in the Emily Q. et al., v. Diana Bonta case, No. CV 98-4181 AHM (AJWx). Pursuant to the Order, Topic A, AGREEMENTS RE: TBS DATA AND MONITORING, Item 4, "Focused Reviews", DMH agreed " it shall perform focused reviews of mental health services provided to class members by MHPs. The focused reviews will examine quality of care and adequacy of services provided." Under this same area, Topic A, Item 5 "Protocol for Focused Reviews", DMH consulted with Plaintiffs in the development of the protocol for the focused reviews prior to commencing the reviews and incorporated the recommendations of the Special Master concerning the content and implementation of the review protocol; in addition, under Items 6, 7 and 8 of the same Topic area,

DMH is now entering into a collaborative process to work with the MHP through the existing contractual arrangement and utilizing the training available through the California Institute for Mental Health (CIMH) to develop a Corrective action Plan and plan for DMH to provide any necessary technical assistance and training.

This report is a significant part of an assessment effort by DMH to provide the county with a comprehensive evaluation of TBS utilization. Additionally, DMH intends for this report to establish a foundation for counties and DMH to work towards promoting maximal levels of appropriate TBS utilization. The development of the protocol, the process of conducting the focused reviews, the reporting methodology, and the follow-up improvement plans are consistent in addressing provisions of the court order.

Please let me know if I can be of additional assistance.

Sincerely,



RITA MCCABE, LCSW
Acting Chief
Medi-Cal Policy Branch

cc: Mateo Munoz
John Krause
Norm Black
Dr. Ivor Groves

# Qualitative Focused Review Report

**County MHP:** Contra Costa Department of Mental Health (CCDMH)

**Review Dates:** May 31- June 3, 2005

**Review Team Members:**
Eddie Gabriel, DMH, County Operations
Lori Hokerson, MA, DMH, County Operations
Troy Konarski, MSW, DMH, County Operations
Connie Lira, RN, DMH, Medi-Cal Oversight
Anne Murray, LCSW, DMH, Medi-Cal Policy & Support
Ruth Walz, DMH, County Operations
Ivor Groves, PhD, Special Master for Emily Q

## I. Purpose

The overarching purpose of the Qualitative Focused Review Report is to capture, in one comprehensive document, all the evaluation efforts that have occurred, and to synthesize the relevant information that has been collected from the focused review for evaluation of services to Emily Q. class members. The following report represents a documented comprehensive assessment that will provide a foundation for supporting county Mental Health Plans (MHPs) in development of their strategic improvement efforts. County MHPs and the State Department of Mental Health (DMH) will need solid, relevant and comprehensive data and information in order to proceed with making well-informed recommendations and decisions regarding services to eligible class members and to advance potential strategic improvement initiatives to ensure appropriate access to those services.

During the focused reviews, the specific purpose of reviewing the selected counties is to quickly and comprehensively gain an informed understanding of the dynamics of Therapeutic Behavioral Services (TBS) utilization in a select group of MHPs. Only after such an evaluation can DMH and county MHPs begin to logically and intelligently strategize a collaborative set of initiatives to improve TBS utilization and outcome measures. The primary data sources used in selecting the MHPs this year included the county's number of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligibles, the TBS utilization rate, the Rate Classification Level (RCL) placement rate, the re-hospitalization rate, and the MHP's state hospitalization rate.

***Review Team Comments:***
*In the specific case of CCDMH County Department of Mental Health (CCDMH), your county was selected for TBS focused review based on the following observations from 2002-2003 data:* ***46,987 average monthly Early Periodic Screening Diagnosis and Treatment (EPSDT) eligibles; 8.22 % penetration rate; 4.92% decrease in RCL 12-14 placement rate; 7.68% decrease in hospital readmission rate; and no change in the state hospitalization rate.***

## II. Procedure/Methods of Qualitative Focused Review

The procedure used by DMH during this comprehensive review included four main components, listed below. Steps 1 and 2 were completed as part of an initial information gathering and preliminary analysis stage, while steps 3 and 4 were completed as the elements of the on-site system review. The four components of the qualitative focused review include:

1) Quantitative data review
2) MHP Pre-Review Questionnaire
3) Qualitative Focused Review Protocol
4) External Stakeholder Focus Groups

With respect to the performance of the comprehensive review--collecting information from a variety of sources, arriving at the findings, interpreting and contextualizing the findings, and providing conclusions, recommendations and technical assistance to the counties--it is very important to note that no single person at DMH is solely responsible for production of this report. The entire qualitative focused review process, including the reporting component, is based on a team approach with input from a wide variety of sources. For reference and completeness, the completed review tools used in the comprehensive evaluation are provided as appendices to this report.

***Review Team Comments:***
*The following persons, agencies, or groups participated during the focused review and contributed to the information documented in this report.*

*A)* *MHP staff that participated during the on-site focused review:*

1. Donna Wigand, Mental Health Director
2. Larry Hanover, TBS Program Manager
3. Christine Bohorquez, UR Coordinator
4. Sharon Cuthbertson, TBS Team Lead
5. Grace Marlar, Provider Relations/Compliance Officer
6. Sherry Burke, County Behavioral Consultant

*B)* *Stakeholders that participated in the external stakeholder focus groups:*

1. *Administrative Staff*
2. *TBS Coaches*
3. *Clinical Staff*
4. *Child Welfare Social Workers*
5. *Probation and Social Service Departments*

*C)* *Stakeholders that participated in the individual case review interviews:*

1. *Clinicians/Case Managers*

2. *Clients*
3. *Parents*
4. *TBS Contract Providers*

# III. Comprehensive System Findings

This section of the report is intended to reflect the review team's observations and analysis from the broader perspective (e.g. systems and service/agency integration/coordination). This perspective considers all of the review tools collectively and all the elements involved in the provision of services to eligible class members taken in concert. The emphasis here is on interrelatedness, interdependence, cooperation and communication between individuals, agencies, systems, and processes.

***Review Team Comments:***
CCDMH has implemented a comprehensive TBS program in the last several years with providing EPSDT and specifically TBS to class members. This report will address the strengthens and challenges and recommend actions to be taken by CCDMH. Issues to be addressed at the county level and between agencies include: need for stronger communication within other county departments, a need to increase capacity and to track mental health case outcomes in trying to improve the mental health system in CCDMH.

The review team highlighted the following items during the on-site focused review with CCDMH staff and participating stakeholders:

1) The CCDMH has had a strong commitment from CCDMH County Board of Supervisors and at the management level in providing TBS to class members.

2) As evidenced by the case reviews, CCDMH is providing a significant amount of intensive services to its EPSDT population including TBS. CCDMH does provide wrap around services provided by the CCDMH County Department of Social Services and TBS to class members.

3) CCDMH does a very good job of screening all foster care children for mental health services. The structure for efficient inter-agency collaboration with high needs children is in place; however, the review team emphasis would support efforts to increase access to class members for TBS or other intensive services.

4) CCDMH has a strong training program; however more intensive skill training is needed to TBS coaches regarding proper usage, assessment and referrals for TBS.

## IV. Specific Findings of the Case Reviews

This section addresses the findings of the review team from the case reviews that were conducted during the on-site review.

***Review Team Comments:***
The review team identified a sample of 10 cases to be reviewed during the focused review: 4 cases in which TBS had been or is being provided, and 6 cases of which were eligible class members, but did not received TBS.

Each case was assigned a 2 person review team. Each case review analysis draws conclusions from the information gathered during the chart review and stakeholder interviews, and is presented as conclusions on each of the following dimensions:

a) Adequacy of access to services, including TBS.
b) Adequacy of capacity to provide service.
c) Accountability.
d) Evidence that TBS or other services are working.
e) Quality of TBS, when applicable.
f) Appropriateness of services to kids placed out of county, if applicable.

A summary of each case is included as Appendix 1 to this report.

## V. Specific/Distinct Findings

Turning from the global to the specific, the following section will discuss individual findings that surfaced during the various stages of the comprehensive qualitative review process, and that were considered significant enough by the DMH review team to warrant specific mention.

**Review Team Comments:**
The review team found that there were three identified areas within the CCDMH system that generated concern, and warrant additional development and follow-up. CCDMH and other agencies under contract to CCDDMH to provide TBS will need to address: increase capacity for delivery of TBS, provide more extensive follow-up and monitoring of cases by case managers, and increase understanding of potential uses of TBS.

1. ***Increase TBS capacity***
   CCDMH is providing an adequate amount of TBS; however, CCDMH will need to increase TBS capacity to provide services to eligible class members who demonstrate medical necessity for TBS. CCDMH should review policies that may impede access to TBS members.

DMH should support MHPs efforts in increasing access through the State policy requiring authorization of TBS and through additional technical assistance.

2. ***Tracking and monitoring of TBS utilization should be improved to track outcomes for TBS Class Members.***
CCDMH does collect aggregate data of TBS; however, individual outcomes are not tracked. The CCDMH may want to consider a more detailed system that can track individual outcomes. This would provide the necessary data to revise program disparities and could improve service outcomes.

3. ***TBS is considered for class members to enable transition to lower levels of care, or back into their homes.***
CCDMH is providing a significant amount of TBS to class members but there is not a current emphasis on providing TBS at lower levels of care (RCL 12 or at risk). Increasing emphasis on using TBS, or a "step down" could improve service outcomes.

## VI. Conclusions

The DMH Review Team, in light of a thorough and objective analysis of the findings mentioned above, has developed the following conclusions related to the infrastructure, process, and access and outcome issues connected to the evaluation of services to eligible class members in CCDMH County.

***Review Team Comments:***

1) CCDMH is providing TBS to class members. A slight emphasis change from oversight to improving access for class members should be supported by DMH.

2) CCDMH should develop means to enhance tracking and monitoring of TBS utilization. CCDMH would be better served to track individual outcomes for class members instead of aggregate data and analyze data to make service revisions to improve service outcomes.

3) TBS is being considered for class members as a service to enable transitions to lower levels of care, and is used in trying to reduce a higher level of residential service. However, more of an emphasis is placed on reducing a higher level of care.

4) CCDMH should improve communication and referrals with other service agencies in Contra Costa County programs, and agencies outside the CCDMH system that provide services to this population. This increased

communication will improve access and appropriate service levels to the class members.

## VII. Recommendations

After carefully analyzing and evaluating the variety of information gained through the Focused Review process, the DMH review team has arrived at consensus regarding the primary recommendations we would like to present for the CCDMH's consideration. The intent of these recommendations is that they not be viewed as prescriptive or definitively exhaustive of all options, but as an informative source of consultation that will provide high value to the county's own quality improvement and strategic improvement efforts. Ideally, we hope that your county's decision-makers and external stakeholders will find our recommendations to flow logically and reasonably from the results achieved through the comprehensive review.

The review team's recommendations are described below on two levels with consideration given to the likely time horizon (i.e. what can be done immediately or in the short run, and what may need to be approached from a longer-run strategic perspective), and also with awareness of the resource/scope intensity issues connected to a recommendation.

***Review Team Comments:***
***Tactical/Operational Recommendations***

1) **Enhance TBS Capacity:**
CCDMH should sustain efforts to provide the significant amount of TBS to class members. However, a shift from oversight to access and improving quality assurance should improve outcomes for class members that receive TBS.

2) **Enhanced Tracking System for TBS:**
The CCDMH should incorporate a system for tracking of TBS utilization and other appropriate services by eligible class members into their quality improvement activities, including monitoring access, denials, modifications, and reductions in TBS. Effective quality improvement efforts show a comprehensive array of services to class members. Enhancing the tracking system in CCDMH will provide information to program revisions that will better meet the mental health service needs of class members.

3) **Enhance a Comprehensive TBS Training Program:**
CCDMH should enhance the TBS training program for agencies, professionals and possible class members. This training should include, but should not be limited to: class membership, appropriate uses for TBS,

proper referrals, techniques on providing TBS and proper documentation and tracking of TBS.

***Strategic Improvement Recommendations***

The DMH review team recommends that the county implement a strategic improvement plan that addresses each of the recommendations above. DMH sees these recommendations as short-term, intermediate, and long-term goals.

In the short-term, recommendations 1 & 2 are essential for DMH and CCDMH to improve access to and availability of appropriate services to eligible class members.

In the intermediate, recommendation 3 reflects DMH's desire for CCDMH to develop a mechanism to track and monitor services to these beneficiaries, but recognizes that this recommendation is dependent upon reconciliation of the first 2 recommendations. Thus the review team anticipates that recommendation 3 would be implemented as part of CCDMH' second stage of its strategic improvement plan.

In the long-term, recommendation 4 acknowledges a need to establish a CCDMH training program and to improve county awareness of the availability of TBS.

## VII. Appendices/Attachments

**Review Team Comments:** Ensure inclusion of all supporting documents, protocols, and forms with the formal report to the county. Included are tools used during the on-site review and completed by the DMH review team:

Appendix 1 – Individual Case Review Analyses
Appendix 2 – External Stakeholder Focus Group Analysis

Attachment A – Data Reports
Attachment B – Preliminary Analysis
Attachment C – Qualitative Focused Review Protocol (with MHP responses)

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# Appendix 1 – Individual Case Review Analyses

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #1

**Case Review Team:** Eddie Gabriel, DMH, County Operations
Lori Hokerson, DMH, County Operations

**Facts:** The information for this child was gathered from the review of the child's chart, interviews with the Social Worker, parent, client TBS Provider and Case Manager. The client is an 18 year-old Caucasian male. He had received TBS in the past. He is currently placed in level RCL 11 group home.

The client has been in placement RCL 11 since 2000. The client's most recent diagnoses are major depressive disorder, severe with psychotic features and attention deficit hyperactivity disorder. The medications regime last found in the chart were Adderol, Paxil, Risperdal and Serzone. The client exhibited problems with expressive language difficulties, explosive behaviors, obsessive-compulsive disorder behaviors, and boundaries issues (inappropriate physical touching). The client was also described as having primitive social skills with regards to hygiene and socialization with peers.

**Summary:** The client's social worker and case manager were both well informed in this case. TBS was authorized because the client was at-risk of losing his previous placement in a level RCL 12 group home due to his behavior. The social worker expressed that the client will need some level of care throughout his life, but placement will be made when he can function appropriately and at a higher level. Although this case is closed with the MHP (strictly a Social Services case) the case manager checks in quarterly and TBS will be proposed when the next placement occurs, probably to a Board and Care facility closer to his family.

**Conclusions:**

*a) Adequacy of access to services, including TBS.* The client has been in various residential placements since 2000. TBS was authorized and provided when the client's behavior put him "at risk" of losing his placement in a level 12 group home. The client is currently in a RCL 11 group home. Due to his age and current functioning level, his next placement is in question. It is anticipated that he will require some level of care throughout his life and that TBS will be proposed when the placement ultimately occurs (although the case is officially closed with the MHP).

*b) Adequacy of capacity to provide service.* It appears the client has received adequate and appropriate services. There is a plan to provide TBS when the next placement is made.

*c) Accountability.* The parent has indicated that she is not involved in the client's current treatment planning (client is 18), but would like to be more involved. She has been involved in the client's Individual Education Plan via telephone. The parent indicated she had more frequent involvement when the client was placed in Alameda County, but the parent is currently residing in Napa County. However, it was indicated that the parent is also addressing her issues. The group home staff is attempting to coach her on how to interact with the client in order to move him forward with his progress.

*d) Evidence that TBS or other services are working.* The chart review showed that the client is extremely impaired, but has made progress in the current placement. The client has not had outbursts in his current placement for at least 3 months and has improved with his social skills. Although he is functioning at a 3rd to 4th grade level, he reads at a high school or college level and is likes science.

*e) Quality of TBS, if TBS was provided.* TBS was provided when the client was at-risk for losing placement at a RCL12 group home. He was successfully placed in the current level 11-group home in January of this year.

*f) Appropriateness of services to kids placed out of county, if applicable).* Due to the client's age, it appears that numerous resources have expended to provide all necessary and appropriate services. The client must show evidence that he can function appropriately and at a higher level before being placed back in the county and closer to his family. MHP staff continues to make quarterly checks, although the case is officially closed, and TBS services are offered as part of the transition services upon placement back to the county.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #2

**Case Review Team:** Connie Lira, RN, DMH, Program Compliance

**Facts:** 17 year-old (DOB 6/23/88) white female who identifies self as Native American is currently resides in a CTF/RCL 14. It should be noted that her cultural needs were identified and were being addressed by both the facility staff and the TBS coach. She carries on her Axis I Depressive disorder, not otherwise specified and Post Traumatic Stress Disorder, Chronic. She has lived in Foster care the majority of her life as both parents suffer from mental illness and are dependent on paternal mother. The paternal Grandmother is involved with this child's treatment but is unable to keep her at home (she reported having her hands full with the parents of this child). She has received anti-depressants in the past but due to the serious liver damage that she sustained after overdosing she is currently on no medications and is having her health monitored closely. This is her second admission to this facility. She was first open to services 11/12/02 to date she has received TBS services three times. Her first course of TBS began 12/02 to stabilize her behavior, in order to stay in Foster Care that resulted in her first CTF placement. Then in 2003, she was given TB services at the CTF to assist her in transitioning from a non-public school to a neighboring public (mainstream) high school, where she did very well. She transitioned into Foster care 1/3/05 and into public school both out of the area known to her. She returned to the CTF 2/05, TBS was considered to maintain her placement, but the foster family was opposed to having TBS in their home. The child was overwhelmed and began displaying maladaptive behaviors (running away placing self in danger was sexually molested then made a serious suicide attempt which has left her with liver damage). Most recently she had been receiving TBS to assist her return to the CTF. When interviewed she reported that it was her last day in TBS, the client felt that having a TBS coach enhance her ability to communicate. She is looking forward to possibly returning to public school available close to the facility, graduating and going to college.

**Summary:** All individuals interviewed knew about TBS, when and how services could be requested. All felt that the services had proved beneficial for this child. There was only one concern and that was the change in a TBS coach if services were extended or for return beneficiaries the same coach was not re-assigned. I later found out that each case is assessed prior to assignment and all situations are considered and the assignment of TBS coaches is made in a very systematic way.

**Conclusions:**

**a)** *Adequacy of access to services, including* TBS for children of this county. CCDMH appears to thoroughly assess each class member's needs and

refer them to the most appropriate services. There is evidence that the MHP provides quality assessments.

**b)** *Adequacy of capacity to provide service* CCDMH is limited to the extent that they have had a waiting list. The waiting time is reported to be less than 2 weeks. There is a schedule to triage the list, so that the most severe can be bumped up for immediate services.

**c)** *Accountability* is evident in that the MHP provides a behavioral analyst who looks over all the plans, gives clinicians feed back, and is available for consultation.

**d)** This MHP has been collecting data that allows them to assess services and the aggregate outcomes for services including TBS.

**e)** *Quality of TBS, if TBS* was provided the contractors that this county uses have TBS coaches whose qualifications includes bachelor's degree, they are supervised by licensed clinicians who provide training regularly. The contractors report the turn over of coaches is about 2 years and most leave to return to graduate school.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #3

**Review Team:** R. Connie Lira, RN, DMH, Program Compliance

**Facts:** This 7year old (DOB 9/29/97) female who was removed from her biological home by Emergency Child Protective Services. She carries the following diagnosis' Axis I Oppositional Defiant, No Axis II, Axis III Asthma, Obesity and Constipation (etiology unknown) Axis IV blank Axis V GAF-60. She is not receiving psychotropic medications. She was open to MHP services when she was removed from her home. She did not begin receiving TBS until she re-united with her mother to ensure her to maintain her home placement. The child received TBS (the particulars of exact dates, duration and schedule were not very clear from the chart review). Mother reported that the TBS coach worked with the family approximately 15-20 hours weekly and that she terminated services 2 weeks early due to her opinion the progress had been made.

**Summary:** The following people were interviewed Mother, the child, staff from the MHP (case manager) and Department of children's services (emergency foster care division). All reported being able to access services including TBS easily, finding staff approachable and that the TBS coach included training for parents about how to appropriately deal with the maladaptive behaviors and replace them with appropriate behaviors. Mother reported learning parenting skills that have helped tremendously in all aspect of their lives all were happier and increased their capacity to make plans for the future.

**Conclusions:** (Here are the key points that each analysis should ultimately answer:

a) For this case the access to MHP services were easy to address. There do not seem to be barriers to services.

b) Adequacy of capacity to provide service for this client appears adequate. The MHP has established a waiting list they report no longer than a 2-week wait has occurred.

c) Accountability is evident in the multi layers of oversight and feedback to their providers but yet the MHP was viewed to be very accessible, provide training and outreach for other agencies. In general the process from referral to services being delivered appeared seamless with all disciplines working together for the good of the beneficiaries of the county.

d) Evidence that TBS or other services are working was evident in the presentation provided by the MHP, interviews with clinicians of other agencies, families involved, individuals who received services and

contractors of those services. The documentation provided a good understanding of the process as it was presented.

e) Quality of TBS, if TBS was provided: TBS appears to be more than appropriate with evidence that it was driven by need and discontinued when the goals were met.

The MHP takes responsibility their beneficiaries that are placed out of county, but they report that they are not always successful in being able to find contractors for services.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #4

**Case Review Team:** Lori Hokerson, MA, DMH, County Operations

**Facts:** The information on this child was gathered from the review of the child's chart(s) and interviews with the client's therapist. An interview with the child was not scheduled. The client is a 15-year-old Caucasian male residing in a RCL 12 facility. He was referred and approved for TBS, but the client was placed in a facility prior to start of the services.

The chart included a number of DSM diagnoses for the client: bipolar disorder not otherwise specified, depression and oppositional defiant disorder. The client has a number of behaviors that cause problems in his living situation and in the school classroom.

**Summary:** The therapist reported that the client if very bright and engaging. The client has an excellent chance to have some successes in the future if he can make better decisions for himself and be in the most appropriate placement. The therapist and the client's mothers both believe this facility is the most appropriate placement for the client.

**Conclusions:**

a) *Adequacy of access to services, including TBS*. The child was not interviewed. The therapist indicated that services were adequate. The client was maintaining the current placement and DMH team observed access to TBS to be adequate.

b) *Adequacy of capacity to provide service*. The county MHP has a good capacity to provide services to children. There do not appear to be significant barriers to children receiving TBS or other children's services in CCDMH County.

c) *Accountability*. There was evidence of coordination in the case as described in the interviews and documentation of such in the client's file. The therapist was very familiar with the client and with the other components of the client's care and treatment that are provided by other agencies.

d) *Evidence that TBS or other services are working*. He is now in a facility and the therapist is hoping that he will be able to turn things around and be placed in a lower level of care in the future.

e) *Quality of TBS, if TBS was provided*. The client has not received TBS. He required a higher level of placement before TBS could be implemented. The

therapist was very familiar with TBS and believes it's an important option when the client moves to a lower level of care.

f) *Appropriateness of services to kids placed out of county (if applicable).*
The child is not placed outside the county.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #5

**Case Review Team:** Anne Murray, LCSW, DMH

**Facts:** The information on this child was gathered from the review of the child's chart(s) and interviews with the client's social worker/legal guardian and the case manager. An interview with the child was not scheduled. The client is a 10-year-old Caucasian male residing in an RCL 12 group home in Oakland, California, the Lincoln Child Center, and has been in this placement for several years. He is has not received TBS.

The child's biological mother was an amphetamine addict and the child was exposed to the drug in utero. He was removed from the custody of his biological mother at the age of 18 months due to neglect associated with his mother's drug use. He was adopted at age 2 and came to the home of the adoptive parents directly from the crisis nursery. He has been taking psychotropic medication from an early age. A physician currently prescribes Depakote and Seroquel. The client was residing with his adoptive parents prior to his placement in the group home. The chart included a number of DSM diagnoses for the client: psychotic disorder not otherwise specified, seizure disorder, and oppositional defiant disorder. He has a history of encopresis and eneuresis.

**Summary:** The client is reported to be a very likeable child who has made excellent progress in the group home placement. He has gender identity issues and this sometimes make it difficult in his interactions with his peers. The adoptive family rarely visits the child and they have expressed no interest in the child returning home in the future. The client views the RCL 12 as his home and the staff and peers as his family.

**Conclusions:**

a) *Adequacy of access to services, including TBS*. The child has received services that appear to be very helpful to him. There has been a significant improvement in functioning since his placement in the RCL 12 group home.

b) *Adequacy of capacity to provide service*. The county MHP has a good capacity to provide services to children. There do not appear to be barriers to children receiving TBS in CCDMH County.

c) *Accountability*. There was coordination in the case as evidenced by the review team notes in the file. There has been service and placement coordination for the client and his family. The supervision and oversight of the TBS contractors are done in a structured, clear and timely manner. The consultant on contract

with the MHP reviews the treatment plans. There is tracking and data collection of the children in treatment.

d) *Evidence that TBS or other services are working.* The adoptive parents communicated to the court that their son cannot return home but they were not always forthcoming with the child about this fact. The social worker intervened and scheduled a meeting with the adoptive parents and the child. Once the parents communicated that he could not return home, the child began to do much better in his placement and to have more realistic goals for the future. Prior to the meeting, he saw other children moving on to foster care and he knew his behavior was better than the children that were moving. The child is now more trusting of the group home staff. He is very engaging and is doing well in school. A foster home placement is now being considered for the client and visits to a foster home have been arranged for the client.

e) *Quality of TBS, if TBS was provided.* TBS has not been provided, but the services were offered while the child was still in the adoptive parents. According to the chart, TBS never began because the child needed residential treatment quickly and the adoptive parents no longer wanted the child to return home.

f) *Appropriateness of services to kids placed out of county (if applicable).* The child is placed outside of CCDMH County. The services are coordinated through the Department of Child Services social worker. The services are provided through the group home placement or contract agencies in Alameda County. An MHP case manager continues to be assigned to the child and the worker makes periodic visits.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #6

**Case Review Team**: Lori Hokerson, DMH, County Operations
Eddie Gabriel, DMH, County Operations

**Facts:** The information on this child was gathered from review of the child's chart, interviews with the maternal grandmother, case manager and client. The client is an 11 year old male. He has not received TBS and is currently placed in a RCL 14 group home.

The client was initially referred to mental health as an AB 3632 referral by the mother and school. He was hospitalized in May 2003 and due to his mother's problems with drugs and homelessness was placed in an RCL 14 upon discharge in the group home. The chart included several diagnoses: attention deficit hyperactivity disorder, mood disorder depressive no other symptom, and posttraumatic stress disorder rule out bipolar. There were several medications prescribed: Depakote, Risperdal, Concerta, and Paxil.

**Summary:** The maternal grandmother recently obtained legal custody of the client. She had nothing but praise for the case manager and the group home. She stated that the placement saved the client's life. The staff is very supportive and available via telephone during the client's home visits, which occur every other weekend.

**Conclusions:**

*a) Adequacy of access to services, including TBS.* Due to the circumstances of the client's placement he appears to be receiving adequate and appropriate services. Although he occasionally struggles and can be disruptive, the client was described as "high functioning". All parties indicate that the client has made tremendous progress.

*b) Adequacy of capacity to provide service.* It appears that the client is receiving all necessary services.

*c) Accountability.* All parties are actively engaged in the client's care, including treatment planning. All are in agreement that the next placement would be a foster care home close to the client's maternal grandmother.

*d) Evidence that TBS or other services are working.* The client is doing very well in his current placement. He is doing very well in school; however, he is behind by approximately 2 grade levels below. The case manager indicated that the client does not need a residential placement and foster care would be

appropriate. The case manager indicated some concern that the current Individualized Education Plan was ending in July and he could not place the client in Foster Care.

*e) Quality of TBS, if TBS was provided.* TBS has not been provided, but was considered. However, the client was placed in a residential placement.

f) Appropriateness of services to kids placed out of county, if applicable). The maternal grandmother is very pleased with both the group home and case manager.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #7

**Case Review Team:** Troy Konarski, DMH County Operations
Ivor Groves, PhD, Special Master Emily Q

**Facts:** The information on this child was gathered from the review of the child's chart and an interview with the client's case manager from the Department of Child Services in Contra Costa County.

The client is a 15-year-old Asian male who ran, or went Absent Without Leave (AWOL) approximately 3 month before the review from a rate classification level (RCL) 12-group home. The foster care worker in CCDMH has not had contact with the client since he went AWOL. The client did not receive TBS.

The client has had multiple placements. The chart recorded a cross gender issues that may have contributed to his running away from the current placement, because of possible lack of sensitivity to the clients service needs. The current DSM diagnoses for the client includes: adjustment disorder, cross gender and primary social support.

**Summary:** He has had several placements due to his gender identify issues and family members that do not support or were unwilling to accept his issues. TBS was not provided. The Focus Review team does not have sufficient evidence to properly assess if this case was appropriate for TBS.

**Conclusions:**
*a) Adequacy of access to services, including TBS.* The client went AWOL approximately 3 months prior to the review, and it is impossible for the review team to assess the appropriate level of mental health services provided, including TBS.

b) *Adequacy of capacity to provide service.* Team is unable to review due to lack of data.

c) Accountability. Team is unable to review due to lack of data.

d) *Evidence that TBS or other services are working.* Team is unable to review due to lack of data.

e) *Quality of TBS, if TBS was provided.* TBS was not been provided.

f) *Appropriateness of services to kids placed out of county (if applicable).* The child is not placed out of CCDMH County.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #8

**Case Review Team:** Anne Murray, LCSW, DMH Policy

**Facts:** The information on this child was gathered from the review of the child's chart(s) and interviews with the client's foster mother and the case manager. The case manager works on the team that evaluates every child who comes into emergency foster care. There is a weekly placement coordination meeting with the department of social services. An interview with the child was not scheduled. The client is a 5 year-old African American male residing in a small family foster home in Richmond, CA. This is the second time the child and his biological sister have been placed in the foster home. The two siblings reside in the foster home with one other unrelated child. The client has not received TBS. The child has received case management, wraparound services from DSS and contacts through the mobile crisis team based on the open episode sites documented in the child's chart.

The child's biological mother was reportedly a drug addict and the child's father is incarcerated. There is a history of abuse and neglect. The child was placed in foster care with the current foster mom from June 2002 until March of 2003. The foster mom is very fond of the client and his sister and she had considered legally adopting them. The child and his sister were later removed from the foster mom's home when a distant relative was willing to provide care for them in Nevada. This was not a good placement due to drug use in the home of the relative and allegations of physical abuse. The children were then returned to California.

**Summary:** The child is very active and often fights with his sister, sometimes with hitting and biting. Sexual play between the client and his sister was observed when the two were in county foster care. Based on the chart review, the client is defiant; uses foul language, wets the bed and yells at others in a high-pitched scream. He is old enough to be in kindergarten but he did not start because he was emotionally unprepared for kindergarten. The child is taking psychotropic medication and he is seeing a therapist in a private agency. He attends an early childhood daycare with a goal of becoming more prepared for kindergarten. He has been tested and is eligible for special education.

**Conclusions:**

a) *Adequacy of access to services, including TBS.* The child is at risk of losing the foster care placement and of requiring a higher level of care. The services may not have been adequate at the time the children returned from Nevada,

which indicates some of the challenges in coordinating the cases that have the involvement of multiple agencies. There is a question of whether the MHP was immediately notified of the child's return to CA. after the failure of the relative placement in another state. The worker in emergency foster care reported the coordination with the department of social services is generally very good.

b) *Adequacy of capacity to provide service.* The county MHP has a good capacity to provide services to children. There do not appear to be any barriers to children receiving TBS in CCDMH County but this child may have benefited greatly from TBS if the services had started in a timely manner after his return to CA. It may still be possible to save the placement if the foster mother receives interventions and strategies on how to handle the child in the home.

c) *Accountability.* There was coordination in the cases in CCDMH as evidenced by the review team notes in some of the client charts. The supervision and oversight of the TBS contractors regularly occurs. The consultant on contract with the MHP reviews the treatment plans. The case manager, who was interviewed by this reviewer, works on the team that evaluates every child who comes into emergency foster care. There is a weekly coordination meeting with social services to discuss the children entering emergency foster care and the service needs of these children.

Though there has been some coordination of the child's care and treatment, TBS may have benefited the child if it had been offered when the child and his sister were returned to the foster home following their out-of-state placement. The foster mom reports that she thinks the client needs to have his medications adjusted. She reports that the child fidgets a lot and frequently cries and screams. The foster mother said the physician does not return her calls in a timely manner. She believes the current interventions at the daycare and the work of the behavior specialist at the private agency have decreased his high-pitched screaming but she does not see improvement in the client in some of the other problem behaviors.

d) *Evidence that TBS or other services are working.* The foster mother reports that the child and his sister are very difficult to handle. She said she receives six hours of respite per week that is provided by a private agency, Westwind. The child is receiving services but there appears to be some gaps in the coordination of the case. The emergency foster care worker from Contra Costa County was very aware of TBS but indicated there needed to be time for the child to settle into his placement before a referral would be made. The child has been back in CA. for several months.

e) *Quality of TBS, if TBS was provided.* TBS has not been provided and the foster mother did not know about TBS.

*f) Appropriateness of services to kids placed out of county (if applicable*

The child is not placed outside of CCDMH County. The services are coordinated through the DCS social worker and MHP office in the Richmond area of the county.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #9

**Case Review Team:** Anne Murray, LCSW, Medi-Cal Policy

**Facts:** The information on this child was gathered from the review of the child's chart(s) and interviews with the client's therapist and her biological mother. An interview with the child was not scheduled. The client is a 15-year-old Caucasian/Chicano female residing in a facility, Thunder Road, for clients with dual diagnosis issues. She was referred and approved for TBS but the client was placed in a facility prior to start of the services.

The chart included a number of DSM diagnoses for the client: bipolar disorder not otherwise specified depression and oppositional defiant disorder. The client has a number of behaviors that cause problems in her living situation and in the school classroom. She has trouble sleeping, drug use, excessive worry, fears of being alone, risk-taking behavior, poor boundaries and impulsiveness that sometimes puts her in physical danger.

**Summary:** The client's mother was no longer able to care for her due to her own chemical dependency issues. The client went to live with her father and stepmother in another state. A CPS report was filed due to the stepmother's neglect of the client and the father no longer wanted the client after this. The client was later returned to CA. to live with her mother who had gotten into recovery by this time. It was at this time that the client reported having been sexually abused by her stepbrother for a number of years. Her behavior was more troubled upon her return to CA. to live with her mother and brother. She was promiscuous, impulsive, angry, and labile and she sometimes ran away from home. She has been admitted to an inpatient psychiatric hospital after she cut her wrists and later to juvenile hall for assaulting her mother.

The therapist reported that the client if very bright and engaging. She is interested in attending college and pursuing a career in the medical field. The client has an excellent chance to have some successes in the future if she can make better decisions for herself and be in the most appropriate placement. The therapist thinks Thunder Road is adequate, but that Chris Adams Residential Girl's Center has more of a family therapy component that would benefit the client and her family. The juvenile court judge ordered the client to Chris Adams Residential Girl's Center. The therapist and the client's mothers both believe this facility is the most appropriate placement for the client. The departments of the mental health and probation jointly operate Chris Adams. However, the facility is on the chopping block due to county budget cuts and may have to close. Chris Adams is not accepting any referrals at this time.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

## Conclusions:

a) *Adequacy of access to services, including TBS*. The child was not interviewed but the child's mother was very pleased with the services. She indicated that the mobile response team was very helpful when her daughter was still living in the home. The TBS authorization occurred within a short period of time but TBS never started (Focus Team members were unable to determine why TBS was not provided). The client's mother was very disappointed when her daughter's behavior resulted in her juvenile probation placement. The client's mother reported feeling rather amazed about how much help she received from the MHP. The client's mom now has many years of sobriety and she is very supportive of her daughter.

b) *Adequacy of capacity to provide service*. The county MHP has a good capacity to provide services to children. There do not appear to be significant barriers to children receiving TBS or other children's services in CCDMH County.

c) *Accountability*. There was evidence of coordination in the case as described in the interviews and documentation of such in the client's file. The therapist was very familiar with the client and with the other components of the client's care and treatment that are provided by other agencies.

d) *Evidence that TBS or other services are working*. The client recently returned to CA. after residing in a different state. She had not been in a very supportive environment and she was not very accepting of treatment upon her return. She is now on probation and in a facility that specializes in dual diagnosis issues. It is hoped that she will be able to turn things around and be placed in a lower level of care in the future.

e) *Quality of TBS, if TBS was provided*. The client has not received TBS. She required a higher level of placement before TBS could be implemented. The therapist was very familiar with TBS and believes it's an important option when the client moves to a lower level of care.

f) *Appropriateness of services to kids placed out of county (if applicable).*
The child is placed outside the county in Alameda. The services are coordinated through the MHP and the department of juvenile probation. Most of the services are now being provided through her placement at this time and it has a large drug and alcohol treatment component.

**CCDMH County Behavioral Health Services**

**Dates of review:** May 31 – June 3, 2005

# Case Review #10

**Case Review Team:** Troy Konarski, DMH County Operations
Ivor Groves, PhD, Special Master Emily Q

**Facts:** The information on this child was gathered from the review of the child's chart and an interview with the client and the client's case manager and therapist. The client is a 15-year-old Hispanic female who is residing at a rate classification level 14 group home. She has not received TBS.

The client was placed into the foster care system after several AWOLs, illegal drug use and gang activity. The client has had multiple placements. The current DSM diagnoses for the client includes: Post-traumatic stress disorder (PTSD), poly substance abuse, and operant defiant. The client has a strong relationship with the worker from Ugima Family Services from CCDMH Human Services (CASA), Fatima. The Ugima or CASA worker and client spend approximately 3 hours a week by going to movies or spending time together. The client reports doing very well in school and the plan is to transition into public school in the fall. The case manager from mental health is working with the mother to re-connect and is in the process of acquiring TBS for the transition period. Currently, there is a wait of approximately 2-3 weeks and the case manager is trying to minimize any delay in services.

**Summary:** She has had numerous placements due to running away and poly drug use. The client has shown progress in her current placement. She has been at the current placement since June 2004. The client states that she will need to stay away from Oakland the people that got her into trouble in the past. The client's current case manager and therapist report that this child is showing progress and hope to move the client to a lower level of care in August 2005.

**Conclusions:**

a) *Adequacy of access to services, including TBS.* There is adequate access to TBS and a minimal wait for this youth.

b) *Adequacy of capacity to provide service.* CCDMH seems to provide adequate capacity regarding this case.

c) *Accountability.* The progress notes also indicate coordination between the provider and the case manager. In addition, the client is progressing and the provider and CCDMH caseworker seem to be providing access and accountable mental health services.

d) *Evidence that TBS or other services are working.* According to the client's case manager and therapist, the child is progressing and it is recommended that TBS would be appropriate to assist in the transit to a lower level of placement and into a regular school environment.

e) *Quality of TBS, if TBS was provided.* TBS has not been provided at the time of review.

f) *Appropriateness of services to kids placed out of county (if applicable).* The child is not placed out of CCDMH County.

# Appendix 2 – External Stakeholder Focus Group Analysis

**CCDMH County Behavioral Health Services**

**Dates of review:** May 16 – May 20, 2005

**Focus Group Facilitators:** Troy Konarski, DMH County Operations
Ivor Groves, PhD, Special Master Emily Q

The Qualitative Focused Review consisted of 5 Focus Groups performed on May 31- June 2, 2005. The external stakeholder focus groups for CCDMH County Mental Health Plan (MHP) included: Child Welfare from CCDMH county, TBS providers, Contracted providers (Group Homes), CCDMH clinical staff and family members.

The DMH Focus Review Team found that CCDMH is providing a significant amount of TBS to class members. CCDMH County has an excellent referral process some of the focus group members' call the process "seamless". This process seems to increase TBS utilization to class members. The MHP is using TBS to transition children and youth to a lower level of residential care. From the cases that the DMH team reviewed, TBS is being used to prevent a higher level of care and to maintain a lower level of care. In addition, TBS was adequate in preventing the escalation to a higher level of residential care.

The DMH team review team would recommend the follow minor revisions to the TBS program in CCDMH. The revisions to the TBS program would include: provide additional quality assurance by tracking outcomes and progress on the service continuum. Focus group members found the service to be effective and would like to more flexibility in providing it.

The TBS coach's focus group understood the criteria for TBS services. They explained the procedure in providing TBS services (i.e. establishing replacement behavior and reward systems). However, in another focus group some of the members recommended that TBS Coaches have minimal qualifications to provide TBS and it should be regulated by DMH, at the state level. Focus Team members identify this issue as a training issue for TBS coaches to provide appropriate services to class members.

**Conclusions and Issues specific to the CCDMH County MHP include:**

- Increase proficiency for data systems to track children, services and outcomes;
- The need for training and assistance in collaborative techniques with other county agencies.
- A need to provide additional TBS to eliminate waiting lists for TBS.

## Therapeutic Behavioral Services (TBS)
## Notice of Action Quarterly Summary

MHPs are required to submit copies of Notices of Action issued to beneficiaries when the MHP denies an MHP payment authorization for TBS. The preliminary analysis of this data will focus on identifying the reasons the MHP payment authorizations were denied. The analysis may indicate the need to focus on specific issues in the review of the MHP's authorization system.

**Data Collection Period:** Sep. – Dec. 2004

**Total # of Notices of Action:** 0

**Summary of reasons for issuance of Notices of Action:**

**Preliminary Analysis:**

**Therapeutic Behavioral Services (TBS)**
**Notifications Quarterly Summary**

The TBS notification form indicates the provision of TBS to a beneficiary. Analysis is below.

**Data Collection period:** **Sep.– Dec. 2004**

**Total # of TBS Notification forms:** **79 unduplicated clients (83 notifications received)**

**Initial Information – Class Membership**
**54 forms for initial information; one form had 2 responses; 29 forms were quarterly updates which do not ask this question*

*19* - In Rate Classification Level (RCL) 12 or above

*22* - Being considered for RCL 12 or above

*9* - One psychiatric hospitalization in preceding 24 months

*5* - Previously received TBS while Class Member and otherwise would not be eligible

**Gender**

45 Boys 34 Girl

**Age**

69 ages 0-17 10 age 18-20

**Ethnicity**

35 White 29 African-American 11 Hispanic

2 Native American 1 Asian/PacificIslander 1 Other

**Primary residence for child/youth while receiving TBS as indicated on notification forms:**

17 Family Home 14 Foster Home 0 Foster Family Agency

0 Children's Shelter 41 Group Home 5 CTF

## Therapeutic Behavioral Services (TBS)
## 4th Authorizations Quarterly Summary

MHPs are required to submit a 4th authorization letter to the Department of Mental Health (DMH) upon a 4th TBS authorization approval. Analysis of this data will focus on identifying those circumstances that warrant authorizations beyond the established authorization timelines and reported in the 4th authorization letters.

**Data Collection Period:** **Sep. – Dec. 2004**

**Total # of TBS 4th Authorization Letters:** **0**

**Summary of circumstances that warrant authorizations beyond established timelines:**

**Preliminary Analysis:**

**Therapeutic Behavioral Services (TBS)**
**Notifications Quarterly Summary**

| | |
|---|---|
| 6 Other | 11 (RCL 12)<br>12 (RCL 14) |

**Service Need:**

| | | | |
|---|---|---|---|
| 57 | - To prevent placement in higher level of care | 26 | - To enable transition to a lower level of care |

Analysis (Identify trends, questions, etc.) ______________________

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WILLIAM B. WALKER, M.D.
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Focused Review of Services to Emily Q. Class Members
MHP Pre-Visit Questionnaire

1. ***Who is responsible for coordinating TBS in your MHP? Does this person have other responsibilities outside of TBS?***

   ***Larry Hanover, PhD, TBS Program Manager/Oversight***
   Dr. Hanover, in addition to his TBS responsibilities, is the Program Manager of CCMHP's Hospital and Residential Unit. Supervision of 7 FTE's who oversee placements for children placed in out of county residential homes and children who have been hospitalized.

   ***Sharon Cuthbertson, MFT, TBS Team Leader***
   Sharon Cuthbertson, in addition to her TBS responsibilities, is a clinician with the Emergency Foster Care Unit. She is also responsible for performing mental health assessments on children referred by Department of Social Services.

   ***Christine Bohorquez, RN, UR Coordinator***
   Christine Bohorquez, in addition to her TBS responsibilities, oversees the authorization process for a variety of CCMHP's Community Support and Services programs, e.g., Regional Clinics/Community Based Organizations (CBOS)'s, Day Treatment.

2. ***How are TBS authorized in you MHP? (Be sure to explain the authorization processes for initial requests, reauthorization requests and approval).***

   CCMHP has outlined the authorization process for TBS in the attached Policy and Procedure, Number 706.

3. ***In the past year, how many initial TBS authorization requests have been received?***

   For the time period of January 1, 2004 – December 31, 2004, CCMHP TBS program has received 174 initial TBS authorization requests.

   On average, CCMHP TBS program has on average 65 open cases per month.

4. ***In the past year, how many initial TBS authorization requests have been approved.***

   During the past calendar year, 1/1/04 – 12/31/04, CCMHP TBS has granted initial authorization for 173 consumers.

5. ***In the past year, how many initial TBS authorization requests have been certified to not meet the eligibility, class, or need criteria?***

   As outlined in CCMHP TBS policy and procedure, requests for TBS services are initially reviewed by Regional Clinic Managers prior to review by the TBS authorization committee.

   Due to this initial review, consumers who do not meet eligibility, class or need criteria are not submitted to the TBS unit that results in a minimal number of TBS denials.

   During the past calendar year, 1/1/04 – 12/31/04, only one (1) TBS authorization requests did not meet eligibility, class or need criteria. The consumer in question was not a Medi-Cal beneficiary.

6. ***How are your TBS providers trained/educated regarding the principles and practices of TBS in your MHP?***

   CCMHP does not directly provide TBS services. CCMHP contracts with several agencies that provide the direct TBS service with our consumers.

   Each TBS provider must complete the state mandated training, "Applying Principles/Practices of Functional Behavior Analysis to Therapeutic Behavioral Services (TBS). Upon completion of the training, CCMHP will issue a certificate of completion to the TBS provider.

   Each provider agency has developed its own initial training for TBS providers.

   CCMHP provides ongoing documentation training for TBS providers.

   TBS Unit conducts monthly case conference meetings with TBS providers/supervisors.

7. ***At what level of participation have other county agencies been educated about the principles and practices of TBS in your MHP? (Identify those agencies in which training has been provided, including frequency.)***

   TBS team has several ongoing meetings with the following county agencies:

| | |
|---|---|
| County Regional Clinics/CBOs | monthly meeting |
| Department of Social Services | monthly meeting |
| SELPA (Special Education Local Planning Areas) | monthly meeting |
| County Unified School Districts | monthly meeting |

CCMHP initially provided training at the inception of TBS and currently on request to the following county agencies/employees:

Child Welfare
Juvenile Hall and Probation
Presiding Judge, Juvenile Court Referee
Juvenile Bar Association

8. ***What community outreach has been done for clients and family members regarding the availability of TBS as a specialty mental health service?***

TBS Unit has developed information fliers, which are available to consumers upon request and are displayed prominently at our regional clinics.

***Was outreach done to non-English speaking communities?***

TBS Unit has met with and developed a relationship with two CBOs whose population are primarily monolingual, non-English speaking.

Asian Pacific Psychological Services (APPS)
Familias Unidas

In addition, our regional clinics have bi-lingual/multi-lingual clinicians who ensure that their consumers are informed of services available to them (TBS).

9. ***Do you have any TBS providers that have the capability to provide TBS in a language other than English?***

TBS providers have the following language capabilities:

American Sign Language
Arabic
Chinese (Cantonese)
French
Hebrew
Hindi
Laotian
Punjabi
Spanish
Tagalog

***Has there been a need for non-English speaking providers for TBS?***

There has been a need for non-English speaking providers. During the past year, 1/1/04 – 12/31/04, TBS Unit has utilized the services of TBS providers who have the following language capabilities:

Spanish
American Sign Language
Cantonese
Laotian

10. ***Has a grievance (or formerly a complaint) ever been received regarding access to TBS, satisfaction with TBS, or from a TBS provider? If so, please summarize the nature of the complaint(s) and resolution(s).***

CCMHP has not received a grievance regarding access to TBS, satisfaction with TBS or from a TBS provider.

11. ***How are clients and family members involved in the treatment planning of TBS?***

CCMHP requires that Partnership Plans (treatment plans) are completed with input from the consumer and involved family members. Partnership Plan are signed by the CCMHP service provider, the consumer and the legal responsible party (should the consumer be under the age of 12).

The CCMHP clinician (point person) must interview and obtain information from the parent/legal responsibility during their initial assessment.

The assessment and partnership plan are part of the TBS referral packet.

Once the consumer has been authorized for TBS services and a referral to a TBS provider agency has been made, further collaboration is necessary between the parent/legal responsible party, TBS provider and the CCMHP point person to ensure TBS is successful.

The client and family members are invited to attend the TBS planning meetings (also attended by CCMHP point person, TBS provider) and are expected to give input regarding target/replacement behaviors and plan of care (TBS plan). Once the TBS plan is completed, the parent/legal responsible party must sign so that the plan can be executed and direct services provided.

12. ***How does your county include TBS in its quality improvement efforts?***

CCMHP conducts on-going chart review (Centralized UR) for all open TBS cases. TBS charts are reviewed to ensure compliance with CCMHP documentation standards, all claims are supported by documentation and to ensure that progress notes match monthly summaries and that continued authorization is appropriate.

TBS activities are reported to the Utilization Management meeting as outlined in the CCMHP Quality Improvement Plan. Any problem items identified at the Utilization Management meeting are brought to the quarterly Quality Improvement Committee meeting for discussion.

13. ***What is the county MHP's process for ensuring that transition age youth (TAY) are assessed for TBS?***

Transition Age Youth are assessed for TBS.

Key Young Adult and Children staffs meet to discuss TAY and the appropriateness of TBS for these clients. Key staff meet with Child Welfare/Probation to ensure TBS is considered for at-risk clients.

Children's Lead Staff meeting, one week per month is dedicated to TAY and at-risk TAY are identified and preliminary treatment planning commences.

At the weekly Adult Hospital Review Committee meeting, at-risk TAY are identified and TBS, if appropriate, is considered as part of discharge planning.

a. ***Specifically what is the process for ensuring TAY in foster care are assessed for TBS?***

The Placement Review Team (comprised of representatives from the Department of Social Services, CCMHP Hospital & Residential and CCMHP Emergency Foster Care clinicians) meet weekly to discuss at-risk TAY in foster care and assessment is made for appropriateness for TBS.

b. ***Specifically, what is the process for ensuring TAY place "out of county" are assessed for TBS?***

Identified TAY who have been placed "out of county" are also reviewed/considered for TBS during the Placement Review Team meetings.

In addition, any child/TAY who has been hospitalized in an "out of county" contract hospital is also discussed at the weekly Adult Hospital Review Committee meeting.

c. ***Specifically, what is the process for ensuring that TAY with multiple hospitalizations are assessed for TBS?***

Consumers who have been hospitalized multiple times are reviewed at the weekly Hospital Bed Review Committee meeting. Appropriateness of TBS is reviewed on a case-by-case basis.

d. ***Specifically, what is the process for ensuring TAY placed in CTF's, IMD's or State Hospitals are assessed for TBS?***

***CTF:*** TAY placed in CTF are assessed for TBS at a monthly meeting attended by key Seneca CTF staff and Hospital and Residential clinicians/program managers.

***IMD:*** TAY who are currently hospitalized or in the community are assessed for need for TBS or continued placement in the community or at a IMDs. If an IMD

placement is warranted, the IMD liaison and UR Coordinator confer and complete the TBS Prior to Placement form.

***State Hospital:*** CCMHP does not currently have TAY placed in State Hospitals.

14. ***Has the MHP ever authorized TBS for children placed out of county? If so, for how many children?***

CCMHP has authorized TBS for children placed out of county.

A total of 18 children who have been placed out of county have been authorized for TBS for the period of 1/1/04 through 12/31/04. The breakdown by county is as follows:

| | |
|---|---|
| San Francisco | 2 |
| Alameda | 6 |
| Solano | 3 |
| Yolo | 7 |

15. ***An essential component to TBS is the communication between the TBS coach/aide and the clinician. How is this achieved in your system? If this process varies by TBS provider, please identify the different methods of integration for a representative number of providers.***

CCMHP refers to the "clinician" as the county point person.

The county point person is responsible for completing the initial referral packet for TBS. The initial referral packet includes a clinical assessment and partnership plan that includes the need for TBS.

Once the referral has been made to a TBS provider. The TBS provider is responsible for contacting the county point person to introduce self and set up planning meeting. The TBS provider and the point person are key players in the TBS treatment planning meetings. Once TBS services have commenced, the TBS provider is required to contact the county point person, at a minimum, once a month to update the point person on the consumer's course of treatment and progress towards the goal. Both the point person and the TBS provider are required to document the interaction.

16. ***Looking at the data below, generated from data available to DMH from your county, the State Department of Social Services and from DMH records for calendar years 2002 and 2003, please provide some context or explanation as to what is happening in your mental health system that might explain the trends below:***

    a. **4.92% decrease** in RCL Level 12 or higher rate
    b. **7.68% decrease** in re-hospitalization rate.

The 4.92% decrease in RCL Level 12 or higher rate and the 7.68 % decrease can be attributed to several factors. TBS decreasing the need for repeat episodes, helping the

RCL12+ to move to lower levels, and decreasing all emergency follow up services. CCMHP also utilizes the services of Seneca Programs' Mobile Response Team (MRT) and provides Wraparound Services both of which have played a crucial role and have been the main thrust of our Spirit of Caring grant and instrumental in changing the face of CCMHP Childrens MH service delivery. This shift in "how we do business" as a system has led to these interventions becoming more available for youngsters both earlier in their intervention histories and as they transition to lower levels of care.

The programs CCMHP has in place have been long evolving towards decreasing placement levels. CCMHP has made efforts to decrease the number of AB3632 placement and since most of the youngsters served do not have full scope Medi-Cal we cannot attribute them to TBS alone.

In addition, changes in both Child Welfare practice and Probation placement practice have also affected the numbers.

Clearly this is an extremely valuable service, especially viewed within the context of a more comprehensive overall plan for placement reduction.

c. 0% change in State Hospitalization rate.

CCMHP does not current have children/TAY placed in State Hospitals.