CALIFORNIA DEPARTMENT OF
Mental Health

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August 31, 2005

Ivor Groves, PhD
2107 Delta Way
Tallahassee, Florida
32303

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

Dear Dr. Groves;

Enclosed is a copy of the Napa 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 June 27, 2005 and July 1, 2005 This report is being sent to Plaintiffs on August 31, 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 have been 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,

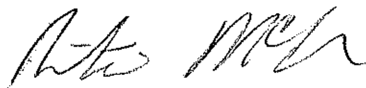
DMH is now entering into a collaborative process to work with the MHP through the existing contractual arrangement and utilizing the training available through the California Institute for Mental Health (CIMH) to develop a Corrective action Plan and plan for DMH to provide any necessary technical assistance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

Qualitative Focused Review Report

County MHP: Napa County Department of Mental Health Services

Review Dates: June 27– July 1, 2005

Review Team Members: Eddie Gabriel, DMH, County Operations
Troy Konarski, DMH, County Operations
Connie Lira, RN, DMH, Medi-Cal Oversight
Anne Murray, LCSW, DMH, Medi-Cal Policy & Support
Dr. Ivor Groves, Special Master

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 of TBS services through a Focused Reviewed performed by DMH during the week of June 27-July 1, 2005, 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 this first year of 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/assessment can the DMH and county MHPs begin to logically and intelligently strategize a collaborative set of initiatives to improve TBS utilization and outcome measures. County MHPs were selected based on several factors including, but not limited to, penetration rates for TBS compared to other counties of similar EPSDT population. Another factor was a county was selected based on region, i.e. Southern, Central, Bay or Northern sections of California. Finally, the size of the county was taken into consideration when counties were selected, i.e. Yolo is considered a smaller northern county, and Los Angeles is considered by DMH to be a larger county from the Southern region of California. Another major 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. All of the above

factors were considered when selecting Yolo, Contra Costa, San Bernardino, Napa and Los Angeles for the initial TBS Focused Reviews by DMH.

Review Team Comments:

In the specific case of Napa County Department of Mental Health Services (NCDMHS), your county as a small rural county in the Bay region was selected for TBS focused review based on the following observations; 2 unduplicated TBS clients; 5,608 average monthly Early Periodic Screening Diagnosis and Treatment (EPSDT) eligibles; .04% penetration rate; 4.50% increase in RCL 12-14 placement rate; 5.19% decrease in hospital readmission rate; and 17.31% decrease in the state hospitalization rate from Fiscal Year (FY) 2002-03.

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 (See Attachment A)
2) MHP Pre-Review Questionnaire (See Attachment B)
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) <u>MHP staff and providers that participated during the on-site focused review:</u>

1. Suzanne Tavano, NCDMHS, Mental Health Director
2. Doug Hawker, NCDMHS, Deputy Director of Clinical Programs

3. Sherrie Pitman, NCDMHS, Quality Management
4. Mary Flett, NCDMHS
5. Barbara Reynolds, NCDMHS, TBS Supervisor

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

1. NCDMHS Administrative Staff
2. TBS Contract Providers (Aldea and Behavioral Solutions)
3. NCDMHS Clinical Staff
4. Child Protective Services (CPS) case managers
5. Parent/Care giver of children receiving services.

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

1. NCDADMHS Clinicians/Case Managers
2. Clients
3. Parents
4. TBS Provider (Behavioral Solutions)

III. Comprehensive System Findings

This section of the report is intended to reflect the review team's observations and analysis from the broader (e.g. systems and service/agency integration/coordination) perspective. 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:

The DMH review team found NCDMHS staff and provider agencies that participated during the focused review demonstrated a dedication toward their clients and providing the appropriate level of services to meet the individuals' needs. Dedication was evidenced by a professional atmosphere at the county, and responsiveness to DMH requests for information.

Communication between NCDMHS and its TBS provider (as well as county agencies) will need to improve and collaborate between contract providers and Napa MHP. This collaboration is essential in a smaller rural county such as Napa and would be an asset to the county in providing mental health services.

The efforts and cooperation of the TBS coordinator are acknowledged and appreciated by the review team. The TBS coordinator had prepared in advance written responses to Part 1 of the qualitative focused review protocol- the

systems evaluation- that was helpful for the review team when they arrived on-site.

The review team highlighted the following items during the on-site focused review as a result of the discussions with NCDMHS staff and participating stakeholders:

The NCDMHS has assigned primary responsibility for managing and monitoring TBS utilization, referral, and authorization to their county TBS Coordinator and have established policies and procedures (P&Ps) around TBS referral, authorization, and provision. The P&Ps do not reflect actual county practices related to TBS. During the individual case review interviews, the review team found that NCMHS staff follows a more informal authorization process than is outlined in the P&Ps. This is consistently reported throughout the individual case review analyses (Appendix 1)

1) The review team also found through the initial discussion with the TBS coordinator and other staff, when asked about staff training on the county P&Ps related to TBS, that higher-level clinical staff were trained only once in TBS services by the California Institute for Mental Health. The absence of further training may have contributed to the ambiguity of the P&Ps around TBS referral and authorization practices in the county, and could present a potential barrier to clearly understanding how to access TBS and/or contribute to utilization issues in Napa County.

2) NCDMHS contracts with Behavioral Solutions to provide intensive services to its EPSDT population, including TBS. They are the only contracted provider of TBS in the county.

3) Discussions about the section of the protocol that addressed assessment, access, and utilization of TBS (Section B) revealed that TBS referrals are sent to the county TBS Coordinator, who reviews the referrals for eligibility and class membership prior to sending them to the behavior analyst at Behavioral Solutions for a need assessment.

4) The issue around access and capacity for TBS seemed restrictive for class members. The MHP seeks to exhaust other mental health services prior to pursuing TBS. In addition, there is only one TBS provider. The data available to assess the number of referrals for TBS was not well documented. Currently, the TBS provider (Behavioral Solutions) is providing TBS for four (4) TBS members, and two (2) are waiting for the assessment period to be completed. However, the preliminary analysis yielded no certifications, Notices of Action (NOAs), or 4th authorizations had been completed during the Sep.-Dec. 2004 quarterly period, which led the team to believe that no services had been denied, modified, terminated, or extended beyond the authorization timelines.

5) Although it was indicated in the county's responses to the protocol that TBS can be accessed through the family, DESS staff, providers, and clinicians, the point at which the referral becomes a TBS referral was ambiguous. In addition an interagency coordination team (MARP) exists; however, no referrals were documented as being received from the multi-agency team within Napa County. The structure for efficient inter-agency collaboration with these high needs children is in place; however, this team may not be utilized to its full potential in assessing eligible class members for TBS or other intensive services. It is unclear why this coordination team does not refer eligible children for TBS services. It is possible that further training would result in increased referrals.

6) The issue of services provided to children in out-of-county placements also presented itself during the focused review. The extent to which NCMHS is assessing children placed out-of-county for TBS is difficult to determine because of a lack of documentation in the case records reviewed. Other issues were identified by NCDMHS, such as the group home's lack of willingness to have an outside TBS provider on their site, which confounded the issue of providing TBS to these children. The review team did not conclude that this issue was unique to NCMHS, rather that it was perceived by the team as a statewide, systemic issue. It should be noted that group homes are under the jurisdiction of CDSS, not DMH or the MHPs.

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- 3 cases in which TBS had been or is being provided; 7 cases of which are eligible class members but did not received TBS. Here is a description of those cases that were reviewed- 3 of which TBS had been provided; 7 of which are eligible class members but had never received TBS. Of those cases that had not received TBS, 2 were instances in which the parent refused the service; 4 of the cases were currently residing in an RCL 12 or above; 1 case was currently incarcerated in juvenile hall.

Each case was assigned a 1 person, or a 2-person team to review. 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 and the case review team's conclusions 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 four identified areas within the NCMHS system that generated concern and warrant additional development and follow-up.

1. Policies and procedures related to TBS need to be strengthened.

As described in Sections III (Comprehensive System Findings) and IV (Specific Findings of the Case Reviews) of this report, the NCMHS system does not have updated policies and procedures that reflect current practice related to authorization requirements and timelines consistent with their MHP contractual obligations. The current practices of referrals within NCMHS system are ambiguous and informal, presenting concern for the review team that current practices are not maximizing access to TBS or other appropriate services for eligible class members.

2. Tracking and monitoring of TBS utilization (i.e. referrals, authorizations, denials, and reductions) are minimal.

The lack of clarity around NCMHS referral and authorization processes, coupled with the lack of data reported to DMH around denials, modifications, and reductions in the provision of TBS, make an assessment of the system difficult. Specifically NCMHS does not have the capability to accurately assess TBS authorization and/or utilization within their system. The DMH review team was not able to conclude whether or not eligible class members have access to appropriate levels of services, including TBS, because of the lack of information.

3. TBS is not being considered for class members to enable transition to lower levels of care, or back into their homes.

As evidenced through the discussions with NCMHS administrative and clinical staff, the individual case reviews, and external stakeholder focus groups, authorizations for TBS had been used to prevent placements into higher levels of care, but were not being considered as a method for transitioning children into lower levels, or back into their homes. However, throughout the review there were no indications that TBS was being considered to transition children placed out-of-county or in group homes into lower levels of care.

4. Develop an additional TBS Provider

Napa County Mental Health should consider establishing either an additional TBS provider to class members in Napa County or other means to increase access for TBS. For example, if Behavioral Solutions does not have the capacity to accept a TBS case, or a family doesn't communicate with this provider, then TBS will not be provided to the class member. The review team understands the fiscal restraints in a small county; however, more than one provider should be acquired by Napa County.

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, access and outcome issues connected to the evaluation of services to eligible class members in Napa County.

Review Team Comments:

1) NCDMHS has policies and procedures related to TBS that are ambiguous and do not reflect current practice within the county. In addition, the system as is exists is incapable of accurately measuring access and availability of services, including TBS, to eligible class members.

2) NCDMHS does not currently have a system to accurately track and monitor TBS utilization (i.e. data.

3) TBS is not routinely being considered for class members as a service to enable transitions to lower levels of care, or back into their homes. Thus, eligible class members do not appear to be considered for TBS under its full range of therapeutic application.

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 Napa County MHP'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) The NCMHS should develop referral and authorization policies and procedures regarding TBS that are consistent with their MHP contractual responsibilities with the State DMH and with effective current practices. Further, these policies and procedures should enable the county to clearly track all referrals, authorizations, denials, modifications, or reductions for TBS that are processed in the county. The county's policies and procedures should delineate clear lines of responsibility and definition around the point at which TBS referrals are made.

2) The NCMHS should incorporate 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 require that the county's policies and procedures be clear.

3) The NCMHS should incorporate and promote, as part of their training efforts, a broader application of TBS as a method for transitioning children, youth, adolescents into lower levels of care, in addition to the other "need" criteria. These training efforts should be targeted at and made available to their provider network and organizational providers, and families, routinely. The interagency coordination team (MARP) should especially be provided with training on TBS services.

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, recommendation 1 is essential for DMH and NCMHS to accurately measure and assess access to and availability of appropriate services to eligible class members.

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

In the long-term, recommendation 3 acknowledges a need to expand NCMHS and its complete network providers' awareness of the availability of TBS in its full therapeutic capacity.

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)

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Appendix 1 – Individual Case Review Analyses

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #1

Case Review Team: Eddie Gabriel

Facts: The information on this child was gathered from the review of the child's chart, interviews with Children Protective Services (CPS), clinician, and client. The client is a 16 year-old Caucasian male who has received TBS. He is currently placed in a level 12 group home.

The client has been in placement for approximately two years. The client has problems with difficulty adapting coping skills when stressed, physical aggression, and verbal threats of harm when angered or hurt, and self-mutilating.

The chart included a number of diagnoses for the client: bipolar, most recent manic moderate; and, attention deficit hyperactivity disorder, combined type. The global assessment of functioning (GAF) was 55. His medications include lithium, Risperdal, Trileptal, and Allegra.

Summary: The client has a great deal of support from his mother, foster family, and service providers. He has a good connection with his therapist, and is currently in family therapy to strengthen bond with his mother and brother. He has not been hospitalized for almost one year, and has not been restrained for months. The client is motivated to control anger and express feelings more constructively. He has developed insights regarding perception of events, demonstrated improved control of negative emotions on occasion, and can be redirected more readily. Both the CPS and clinician indicated that the client transitions out-of-placement to either foster care or mother before he turns 18 years old.

Conclusions:

a) Adequacy of access to services, including TBS. The client appears to be progressing. Both the mother and foster family want to be reunited with the client. It was difficult to gauge the effectiveness of TBS since a previous contract provider delivered it in 2001.

b) Adequacy of capacity to provide service. At the current time, it appears that services provided to date have addressed the client's need. The client will be transitioning from the children's program to adult program. Both DESS "wrap around" and mental health TBS are being considered during this transitional period.

c) Accountability. The CPS and clinician are both in agreement with the next transitional placement.

d) Evidence that TBS or other services are working. The client is progressing well in his current placement. He is performing at, or close to, grade level with the exception of math. The client will require supportive services and medication support in the future. Both the mother and foster family are willing to be designated as his next placement.

e) Quality of TBS, if TBS was provided. As mentioned previously, it was difficult to gauge the effectiveness of TBS since a previous contract provider delivered it in 2001 and no interview was conducted with that provider.

f) Appropriateness of services to kids placed out of county, if applicable). The client has been brought back into the county and has weekend visits with the mother and foster family on an alternative basis, which has contributed to his overall progress.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #2

Case Review Team: Anne Murray, LCSW and R. Connie Lira, RN

Stakeholders Interviewed: client, TBS clinician and client's mother

Facts: The client is a 17-year-old Caucasian male who is currently placed in an out-of-state group home. The group home is the equivalent to a RCL 14 in California. He is not receiving therapeutic behavioral services (TBS) at this time but had received TBS in the past. The client was interviewed on the telephone but it was difficult to understand him at times. His speech was quite slurred but he appeared to be fairly candid about his feelings regarding his placement and his options for the future.

The child has been known in the mental health system since elementary school. He had his first inpatient psychiatric hospitalization in the third or fourth grade. The chart included a number of diagnoses for the youth that include attention deficit hyperactivity disorder (ADHD), bipolar disorder, oppositional defiant disorder and major depression. The global assessment of functioning (GAF) was generally determined to be in the range between 35 and 40. The child has received services that include case management, psychiatry, individual therapy, group therapy and TBS services provided by a contract provider of the MHP. The client reports his current medications include Abillify, Lithium and Seroquel. He has had a number of inpatient psychiatric hospitalizations and school suspensions. The most current hospitalizations took place at California Specialty Hospital (CSH) in Vallejo 2/99, 11/02 and 8/04. He was evaluated and found seriously emotionally disturbed (SED) and he has a school individual education plan (IEP). He began receiving TBS on10/04/04 along with other services from multiple agencies.

Summary: The family was overwhelmed with the child's escalating acting out in the home. The child has a long history of mental illness and difficulties in school. He eventually got into legal trouble and was placed on probation resulting in his current placement out of state. He is receiving mental health services at the group home but his legal status has resulted in juvenile probation being the lead in the case. He will be at the group home for only five months and will apparently remain on probation when he returns to California.

Conclusions:

a) Adequacy of access to services, including TBS. Once TBS services were in place, TBS was beneficial while the child was receiving them; however his unsafe behavior still resulted in a need for placement in a group home. The TBS

clinician reported that only two children have received TBS through Behavioral Solutions, the only provider of TBS for Napa County for the past six months.

b) *Adequacy of capacity to provide service.* Overall, there is a limited capacity to provide TBS services, and there are delays in receiving approval for TBS. It is difficult to draw a conclusion on whether the child could have been maintained in the home for a longer period of time if additional hours of TBS and other services had been provided. Some of the individual interviews raised the question of whether the child's legal trouble might have been avoided if services had been started at an earlier stage of the client's difficulties. The case manager reports there is a plan to provide TBS to assist in the transition to a lower level of care.

c) *Accountability.* No one agency was initially accountable for the referral to TBS. Eventually, Behavioral Solutions provided the TBS services after approval by NCDMH The client's mother first heard about TBS from another parent while she was in a hospital waiting room. She said she had never been told about the service. Two years prior to this hospitalization, her son had become violent and he was having significant difficulties in school. The client's mother said he has always been teased a lot in the school setting. She believes her son should have received TBS at age 15 when he was at risk of out-of-home placement. The client's mother reported that her son's probation officer is very competent and caring.

d) *Evidence that TBS or other services are working.* The child's behavior continued to escalate while he was in the home and TBS was eventually authorized. The MHP approval process for TBS was reported to be slow. It appeared from interviews that once the service was approved, TBS was started quickly by the contract agency that provides all TBS. There were multiple services in place for the client by the time TBS was initiated. The client's mother and the TBS clinician reported that there were so many workers involved in the case at this point that it was overwhelming for the client. The description of this time period was one of limited services for a significant period of time and it was overkill later on. The child is now in an RCL 14 group home in Utah and is reported to be doing well with the additional structure provided at the group home and the on-site school.

e) *Quality of TBS, if TBS was provided.* The TBS worker was very competent according to the client's mother. Both the client and his mother liked the TBS coach and appreciated the service provided. TBS was initiated shortly before the client got into legal trouble for assaulting school staff. The client's file indicates that the TBS request was made on October 20, 2004. The judge's juvenile court order was made for conditions of release and on-going probation on January 24, 2005. The client said things might not have gotten so bad if he had received

additional help earlier. Many of the challenges in this case appear to be due to the involvement of multiple agencies.

f) *Appropriateness of services to kids placed out of county (if applicable).* The child is placed outside of California, and is under the purview of Juvenile Probation. The DMH review team did not have access to information regarding services provided to the child.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #3

Case Review Team: Anne Murray, LCSW & R. Connie Lira, RN

Stakeholders Interviewed: Client, Mother, TBS Clinician/ Supervisor.

Facts: This 6 year-old (DOB 11/27/98) who live in his biological home with his three older siblings, mother (sister and twin brothers), and the child were receiving TBS when this review took place. The child's diagnosis were as follows: Axis I Mood disorder, NOS; and Post Traumatic Stress Disorder (PTSD) (witness to domestic violence). Axis II N/A. Axis III Rule Out possible temporal lobe or Neurological disorder. Axis IV included primary support group, educational, housing, economic and psychosocial difficulties. Axis V Global Assessment of Functioning (GAF) of 50. The child was prescribed Zoloft 25 mg/AM and Seroquel 50 mg/2 times a day. The family is involved with another social agency where they receive individual and group/family therapy. The child was referred to Napa's MHP for a TBS assessment and medication support by the hospital liaison upon discharge after an acute inpatient stay in 3/2004.There appeared to be some difficulty in getting this child into services and required an emergency appointment when his medications ran out. Both the child's mother and the TBS supervisor stated that there had been problems with this child's medication and that it was very difficult for them to contact the MHP's psychiatrist or to get him to respond. The first note found in this child's chart that TBS was discussed with the mother was made on August 18, 2004. He was not referred to TBS provider for assessment until October then began receiving TBS 10/20/04. He was authorized to receive TBS for 30 days /60 hours. The first re-authorized 11/26/04 for another 60 days 120 hours; the second re-authorization was on 2/3/05 for 3 hrs/daily or 21 hrs/week; the third/current re-authorization was 6/7/05 with a plan to terminate decreasing the services from 5 to 4 days weekly.

Summary: The persons interviewed agreed that TBS was a valued service. The mother felt that although the services helped she felt that it would have been better all the way around had they been started as soon as the child left the hospital (at his best) instead of waiting until the child's behavior had regressed to the point where he needed hospitalization again. Mother was very concerned that TBS was coming to an end and she was not being taught interventions to sustain appropriate behavior. These issues were not disputed but were justified because the TBS supervisor did not feel mother was emotionally equip to follow through with the interventions. The TBS supervisor reported that since they did not provide the family overall services that they were only concerned was with the child being served, even though the mother was asking for skills to use once TBS was terminated. Since the mother recently had another child in the home who was hospitalized and also meets class for TBS she verbalized frustration on

being given conflicting information from the MHP and the TBS provider on the appropriate avenue to pursuit getting TBS for him. The mother did not know where to take her concerns, i.e., did not know who the responsible party was.

Conclusions:

a) *Adequacy of access to services, including TBS.* Services were slow in being authorized taking several months to get an appointment for medication support, requiring an emergency re-fill before being set up with a doctor. When there was any difficulty with the medications there was difficulty being able to access the MHP's MD.

b) *Adequacy of capacity to provide service.* It was felt by all who were interviewed that the capacity for the only contract provider needed to be enhanced. There is only one contract provider of TBS and there were many more children who qualified for TBS who were able to be evaluated for or receive service. It is not known if the limited capacity was a factor in this case.

c) *Accountability.* Behavioral Solutions provided TBS services. There is some question over the quality of supervision provided to the TBS coaches (e.g., mother reported different time spent from what was recorded in the client's chart, mother felt that the TBS coaches, while in the home, over stepped their (TBS) boundaries, and the mother reported feeling like the provider was placing her in a position where she was labeled uncooperative).

d) *Evidence that TBS or other services are working.* While mother was very appreciative of the services she did verbalize some dissatisfaction with the amount of time it took for services to be provided.

e) *Quality of TBS, if TBS was provided.* Mother reported that she felt she was not being taught skills she would soon need to be able to handle target behaviors once TBS services were discontinued.

f) *Appropriateness of services to kids placed out of county (if applicable).* N/A

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #4

Case Review Team: Eddie Gabriel

Facts: The information on this child was gathered from the review of the child's chart, interviews with the client, Children's Protective Services (CPS) and clinician. The client is a 13 year-old Caucasian male who has not received TBS. He is currently placed in a level 12 group home.

The client became a dependent of the court in January 2003. The client was physically/sexually abused and neglected as a younger child. He is aggressive to his brothers and molested his younger brothers. CPS agreed that residential treatment was appropriate due to safety issues. The client makes silent threats under his breath when angry. There are issues with clinical depression, poor coping skills, and withdrawn behavior.

The client is diagnosed with post-traumatic stress disorder and is not on any medications.

Summary: Both the CPS and clinician were well informed about the client. They are in agreement that the client's next placement will be back into the county to foster care then ultimately with his family. The foster care placement is scheduled in the next few months. TBS will be requested when this placement occurs.

Conclusions:

a) Adequacy of access to services, including TBS. The client has made tremendous progress. He is no longer violent and explosive, self mutilating, and damaging property. His hygiene and behavior have improved.

b) Adequacy of capacity to provide service. It appears that the child received the appropriate services and has done well in a structured environment of the RCL 12. There is a plan to request TBS when he is return to the county for foster care placement.

c) Accountability. The CPS, clinician, and family are actively involved with the client's plan of treatment and decision-making. The family is looking for a bigger home in anticipation of reunification.

d) Evidence that TBS or other services are working. The client is doing very well in his current placement. He is progressing in his schoolwork and is about one

grade behind. The client will be returned to county in a few months for foster care placement and ultimately reunification with his family.

e) Quality of TBS, if TBS was provided. The client has not received TBS.

f) Appropriateness of services to kids placed out of county, if applicable). As indicated above, the client has made significant progress and improvement in his current placement. He will return to the county in the next few months.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #5

Case Review Team: R. Connie Lira, RN and Anne Murray, LCSW

Stakeholders Interviewed: Client, Father (currently living with), Mother (had been living with her when met class), and previous DCF caseworker.

Facts: This16 year old white male is currently receiving Medication support, case management, family therapy and qualifies as SED. He has the following diagnosis: Axis I: Bipolar disorder, NOS. Disruptive behavior disorder, NOS with some elements of Oppositional Defiant disorder. ADHD – Combined and AXIS III: Phonologic disorder. This child was caught up in a lot of family dysfunction. His parents are divorced but supportive of the child. Prior to being placed out of county, he was having difficulty following rules at his grandmother's house where he and his mother were living after the parents separated. He was not going to school and became aggressive by hitting grandmother when she attempted to get him up to go to school. The client's mother was feeling overwhelmed, unable to work and keep him in school. She quit her job of 17 years and drew out her retirement in an attempt to care for her son's needs. The child was placed at California Specialty Hospital in March 2004 at which time residential placement was the only service suggested by MHP. He continued to have difficulties and finally was sent out of county to a placement for approximately one year. The family reported the out of county placement was good because it helped him mature and gain new coping skills. At the time of this interview, he was returning to live with his father and new stepmother and was quite excited about starting anew in Vallejo. He has been referred to Solano County Mental Health. The client and his parents were very grateful with the services that were received but felt that TBS services would have been helpful when the mother was struggling to take care of him and his needs as a single parent.

Conclusions: This family was not assessed, referred or offered TBS.

a) Adequacy of access to services, including TBS. The family reported being grateful for all the services provided but felt MHP was slow in responding to the needs of the child especially during a crisis. The family was not informed about TBS.

b) Adequacy of capacity to provide service. As noted in other case reviews, the one service provider had limited capacity to provide services. It is not known if the limited capacity of the provider was an issue in this case.

c) Accountability. The MHP was providing services for the child other than TBS. TBS was not assessed for, referred, or offered.

d) *Evidence that TBS or other services are working.* MHP provided other mental health services, but the child was eventually placed in a residential setting out of county. No TBS was provided. The child was stabilized in the residential setting and returned home.

e) *Quality of TBS if TBS was provided.* N/A

f) *Appropriateness of services to kids placed out of county (if applicable).* No TBS was provided for this child in or out of county.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #6

Case Review Team: Troy Konarski and Dr. Ivor Groves, PhD

Facts: The information on this child was gathered from the review of the child's chart, interviews with the client, Children's Protective Services (CPS) and clinician at River Oaks (RCL 14). The client is a 12 year-old Caucasian female who has not received TBS. She is currently placed at River Oaks, a level 14 group home in Sacramento, California.

The client became a dependent of the court in 1994, at 2 years old. The client was physically/sexually abused and neglected as a younger child. She is aggressive to her younger sister. CPS agreed that residential treatment was appropriate due to safety issues. The client has had several residential placements. For example in 2002, client was placed in 7 foster homes in an 11-month period. There are issues with attachment and sexual acting out behaviors.

The client is diagnosed with Post-Traumatic Stress Disorder (PTSD), Reactive Attachment Disorder, Sexually Abused and Borderline Intellectual Functioning. Client is on the following medications: Zoloft, Risperdol, Seroquel and Depokate.

Summary: Both the CPS worker and staff at the residential facility were well informed about the client. They were not in agreement about the client's next placement. The facility staff thought a foster care setting with the proper supports would be beneficial for the client, and the CPS worker thought a RCL 12 was more appropriate for the clients needs. The facility and the CPS case manager will need to establish a transition plan for this client to a lower level of care, and TBS may be appropriate as this transition occurs.

Conclusions:

a) Adequacy of access to services, including TBS. The client has made progress at the current placement RCL 14. She has reduced her sexual acting out behaviors.

b) Adequacy of capacity to provide service. It appears that the child received the appropriate services and has done well in a structured environment of the RCL 14. There needs to be a plan to request TBS when she is moved to a lower level of care.

c) Accountability. The CPS case manager and clinician are actively involved with the client's plan of treatment and decision-making. Currently, there is no plan for reunification with the biological mother, as she is planning on moving out of state.

d) Evidence that TBS or other services are working. The client is doing well in her current placement. She progressed in her schoolwork; however, her progress has slowed in the last year.

e) Quality of TBS, if TBS was provided. The client has not received TBS.

f) Appropriateness of services to kids placed out of county (if applicable). As indicated above, the client has made progress and improvement in her current placement. In addition, there was discussion of difficulty finding a foster care home in Napa that will be able to meet the clients needs.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #7

Case Review Team: Anne Murray, LCSW and R. Connie Lira, RN

Stakeholders Interviewed: the client, the client's clinician, CPS worker and the group home administrator

Facts: The client is a15 year-old Puerto Rican/American Indian female. She has not received TBS and is currently placed in an RCL 14 group home. The child was taken into protective custody by Napa County after the client's mother was detained for driving under the influence with her children in the car. The children reported being molested by their stepfather when they were interviewed. There is a history of physical and sexual abuse, neglect and exposure to domestic violence in the home.

Summary: The client has demonstrated behaviors such as physical aggression, head banging and rocking. Her history of abuse has resulted in feelings of anger, demanding attention and difficulty trusting others. The client was placed in a foster home and she reports very fond feelings for her foster mother. However the foster mother could not handle her behavior after a period of time. She was placed in a group home in Sacramento and this was not a successful placement for the child. She needed a more structured program and was then placed in the RCL 14 group home out of the county. She attends a non-public school and has an Individual Education Plan (IEP). The DSM diagnoses listed in the client's file include: oppositional defiant disorder, attention deficit hyperactivity disorder, post traumatic stress disorder and depression.

Conclusions:

a) Adequacy of access to services, including TBS. There is no evidence in the records that the client was considered for TBS services, and it is not known if she would have benefited from TBS services if they had been implemented when she was in the foster home. The client is currently receiving multiple services; she is residing in a RCL 14 group home outside the county where she is receiving psychotherapy, medication services and family therapy services. The client is acting out far less since she has been in the structured residential placement. The group is a six bed for seriously emotionally disturbed females. The client reports that it is a beautiful setting, animals to take care of, good food and staff that care about her.

b) Adequacy of capacity to provide service. One professional worker reported that she has tried to access TBS for several of her clients but was unable to get the approval for the service. She indicated she is now reluctant to make the

request. She has been told by the county mental health plan (MHP) that if a client already has a therapist or psychologist, TBS is not needed. The MHP reported that the child has to be hospitalized before TBS can be approved.

c) Accountability. The case manager was well informed about the client. The case manager remains in regular contact with the family, group home and the client. The client is nearly 16 years old and the case manager and the group home administrator reported that the client would probably remain in her current RCL 14 placement until she ages out of the program.

d) Evidence that TBS or other services are working. It appears that the client has received appropriate services after her current RCL 14 placement. She is making good progress according to the progress notes in the file, the reports of the client and the client's clinician. Some of the child's most destructive behaviors have either been extinguished or greatly decreased. The client is doing very well in her current placement. She is progressing well in her schoolwork and her negative behaviors have been reduced since she has been in the placement. She still experiences intense rage when she misreads the indentions of others. The most significant change appears to be that she is no longer banging her head. There has not been an instance of this behavior for approximately one year.

e) Quality of TBS, if TBS was provided. The client has not received TBS. There is no evidence in the client's chart that TBS was considered at any time, although the client appeared to be appropriate for TBS services. The client reported that even though she likes her group home, she wishes more could have been done to maintain her foster home placement.

f) Appropriateness of services to kids placed out of county, (if applicable). The client is placed out of county. The case manager sees the client in order to coordinate the services. The client's mental health services are either provided or arranged through the group home due to the client' placement out of Napa County.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #8

Case Review Team: Eddie Gabriel

Facts: The information on this child was gathered from the review of the child's chart and interviews with the client, mother and clinician. The client is a 12 year-old Hispanic/Caucasian male currently placed in Juvenile Hall and a ward of the court. He was placed in Juvenile Hall for violation of probation – assaulting his mother with an ax and destruction of property.

The client is diagnosed with bipolar disorder, no other symptoms, and attention deficit hyperactivity disorder, combined type. His current medications are Concerta and Strattera.

Summary: The child is in a difficult circumstance. The clinician has attempted to assist the family with receiving services for the client either through AB 3632 or Medi-Cal. The mother did not follow-up on an AB 3632 referral and the client's Medi-Cal eligibility "turns on and off". The parents, more specifically the mother, is committed to doing whatever it takes, but has acknowledged that they need help in order to help her son.

Conclusions:

a) Adequacy of access to services, including TBS. Due to the client's institutional status, he is not eligible for any Medi-Cal services including TBS. The client has been provided wrap around services (SB 163) while in Juvenile Hall.

b) Adequacy of capacity to provide service. The current plan is for the client to be placed in a residential treatment center upon discharge from Juvenile Hall. It is unclear whether he will be eligible for Medi-Cal services at that time.

c) Accountability. Since the client is a ward of the court, all decisions will be made by the Probation Department over the next one and one-half years.

d) Evidence that TBS or other services are working. All mental health services are currently being provided by Juvenile Hall.

e) Quality of TBS, if TBS was provided. The client has not received TBS. TBS is being considered when the client becomes eligible for Medi-Cal.

f) Appropriateness of services to kids placed out of county, if applicable). The client is not placed out of county.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #9

Case Review Team: Troy Konarski and Dr. Ivor Groves, PhD

Facts: The information on this child was gathered from the review of the child's chart, interviews with the Children's Protective Services (CPS) and clinician. The client is an 11 year-old Caucasian male who has not received TBS. He is currently placed in a foster care home in American Canyon.

The client was physically abused and neglected as a younger child. It was reported in the chart that his father would beat the client after his father would get intoxicated from alcohol. Also, chart indicated sleeping in the same bed as mother and siblings. The client is aggressive to peers and has been fighting on a regular basis at school. Child Protective Services (CPS) agreed that residential treatment was appropriate due to safety issues. There are issues with fighting, poor coping skills, and threats, feces smearing and suicidal ideation.

The client is diagnosed with Post-Traumatic Stress Disorder (PTSD), Adjustment Disorder, and Attention Deficit Disorder with Hyper-Activity (ADHD). Client is taking the following medications: Abilify, Prozac, Wellbutrin and Concerta.

Summary: Both the CPS and clinician were well informed about the client. They are in agreement that the client's placement in foster care working for the client. The mother doesn't want the child back in the home because she can't handle his behaviors. The foster care placement could benefit from a TBS referral, if the client's behaviors become unmanageable.

Conclusions:

a) Adequacy of access to services, including TBS. The client has made progress in the current foster home with the extra attention that the foster family has provided. According to the chart, the client is not receiving mental health services and the client doesn't have a case manager. Napa County is currently trying to obtain a therapist. His hygiene and behavior have improved.

b) Adequacy of capacity to provide service. It appears that the child is not receiving the appropriate mental health services. However, is doing well in a structured environment of his current foster home placement. There is no plan for TBS; however, when Napa County Mental Health acquires a therapist. Then, a top priority should be to assist the current foster family in providing appropriate mental health services to the client.

c) Accountability. The CPS worker is involved with the client. However, as stated above additional follow-up will need to occur with mental health services.

d) Evidence that TBS or other services are working. The client is not receiving mental health services at the time of the review.

e) Quality of TBS, if TBS was provided. The client did not receive TBS.

f) Appropriateness of services to kids placed out of county, if applicable). The client is not placed out of county.

Napa County Department of Mental Health Services

Dates of review: June 27- July 1, 2005

Case Review #10

Case Review Team: Eddie Gabriel

Facts: The information on this child was gathered from the review of the child's chart and interviews with the county psychiatrist, group home, and Children's Protective Services (CPS). The client was placed on a 5150 hold after threatening to kill himself with a knife while in foster care placement. The client is an eight (8) year old African American/Hispanic male. He has not received TBS and is currently placed in a level 12 group home.

The client has been in 2-3 foster care placements. He has been physically abused and neglected by his mother, thus leading to his CPS assignment. The client has problems with assaultive behaviors.

The inpatient psychiatric hospitalization diagnosed the client with adjustment disorder, unspecified. His current diagnoses are: mood disorder, no other symptoms; rule out post-traumatic stress disorder; and, rule out reactive attachment disorder. Upon discharge from the hospital, he was prescribed Risperdal, Benzatropine, Effexor, and DDAVP. The Benzatropine was later removed. A court order was also obtained to get medications changed on a trial basis, but the client was placed out of county. He is currently prescribed Risperdal only.

Summary: After his hospitalization, the client was placed in an out of county foster care agency. It was thought that he would be receiving intensive case management, but a therapist did not see him for six (6) months. This led to his current out of county placement in Ukiah. The current plan is to terminate the reunification rights of his mother and to obtain rights for his father. The client would be placed in a foster care home somewhere closer to his father (Sonoma County) and then transition to his father in a 9 to 12 month period.

Conclusions:

a) Adequacy of access to services, including TBS. It is difficult to ascertain whether the services were adequate since CPS is responsible for arranging the necessary services. The only service provided by the county was the medication management.

b) Adequacy of capacity to provide service. It is unknown when the county will become responsible for the client's mental health needs under the Medi-Cal program.

c) Accountability. CPS is the responsible agency. Due to the client's circumstances, he does not have an assigned county clinician. The MHP should coordinate with the CPS worker regarding the need for additional services, including TBS.

d) Evidence that TBS or other services are working. Not applicable.

e) Quality of TBS, if TBS was provided. The client has not received TBS.

f) Appropriateness of services to kids placed out of county, if applicable). The client is progressing, although slowly. He is currently receiving individual therapy, family therapy (with his father and stepmother), substance abuse program (group therapy for kids who's families are substance abusers – mother), and anger management. CPS has indicated that he is responding to medication and therapy, and talking about his feelings. The client has exercised some self-control, has not gone "AWOL" (Absent Without Leave), and coming to terms with not being reunited with his mother. The client is working at grade level and has above average intelligence.

Appendix 2 – External Stakeholder Focus Group Analysis

DMH Focused Review of services to Emily Q. Class Members

Napa County Mental Health Services

Dates of review: June 27, 2005 – July 1, 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 June 27- July 1, 2005 in Napa County. The external stakeholder focus groups for Napa County Mental Health Plan (MHP) included: Child Welfare workers from Napa county, TBS providers, contract providers (not providing TBS), and NCDMH clinical staff and family members.

The DMH Focus Review Team found that Napa Mental Health is providing a minimal amount of TBS to class members. For example in 2002-03, Napa County provided TBS to 2 unduplicated class members. Several factors have contributed to a less than optimal amount of TBS provided in the county. Napa County Mental Health has had a difficult time in establishing and maintaining an effective and efficient TBS provider in the county. The DMH team discovered that Napa contracted with Bayberry for TBS. Bayberry is a provider that works with developmental disabilities and mental health clients. In the focus group with contract providers, it was stated that Bayberry did not have a strong tracking mechanism and was unable to provide TBS to the satisfaction of Napa County and the contract was terminated. After the Bayberry contract was dissolved, Napa did not have a contract provider for TBS for approximately 6 months in 2004. Currently, Napa has established another contract with Behavioral Solutions to provide TBS. This contract was established approximately 6 months prior to the DMH Focused Review. (Jan. 2005)

Napa County has a TBS referral process that may provide an informal denial of TBS services. For example, in a focus group with child welfare workers it was stated that the referral packet needed to written in a certain manner, or the referral was denied. Also, several of the child welfare workers felt that the access to TBS is limited. One member of the child welfare group stated, "I have quit trying to get it (TBS)." In addition, the child welfare case managers focus group, three (3) case managers have tried to acquire TBS for children on their caseload and one (1) has successfully obtained the service. (It could not be determined if all the referrals met the class membership for TBS). Napa County Mental Health's informal TBS referral process may result in decreased TBS utilization to class members. It appears from the focus groups and case reviews that the MHP is not using TBS to transition children and youth to a lower level of residential care. In addition, it also appears that TBS was not used to prevent a higher level of care, or to maintain a lower level of care.

Napa County does possess several areas of strengths to improve TBS to class members. For example, all children that enter the foster care system are accessed for mental health services. This mental health assessment could be strengthened to assist in providing an appropriate level of services to the foster

care population to a) receive mental services, and b) assist in a referral to TBS for appropriate class members that meet criteria and would benefit from the service.

The DMH review team would recommend the follow revisions to the TBS program in Napa County.

Conclusions and Issues specific to the Napa County MHP include:

- The need to make the referral process transparent and simple for those who are outside the mental health system,
- Increase capacity by establishing another provider to contract to provide TBS to class members,
- Increase proficiency for data systems to track children, services and outcomes to class members,
- The need for training and assistance in collaborative techniques with other county agencies in providing TBS to class members,
- Training for contact providers of TBS, Napa Mental Health staff, care givers and family members regarding benefits and effective uses of TBS to class members,
- A need to provide additional TBS to eliminate waiting lists for TBS to class members.

Attachment

A

Therapeutic Behavioral Services (TBS)
Certification Quarterly Summary

The TBS certification form indicates that TBS was considered for a beneficiary but not provided. Analysis of the data reported to DMH will focus on identifying trends in the denial of TBS as reported on the TBS certification forms. Analysis is below.

Data Collection period:	**September – December 2004**
Total # of TBS Certification forms:	**0**

0	-TBS has been provided and the placement is still required. *Why? Did the services fail (e.g. timeliness in providing TBS, duration/frequency of TBS services) Were client symptoms too acute to be treated by TBS? Who makes this decision?*

TBS has been considered and has been determined inappropriate because:

0	-TBS services will not resolve the child/youth's transition issues or prevent the child/youth from moving to a higher level of care. *Who makes this determination?*

0	-The child/youth/family refuses to participate in the full range of services specified in the treatment plan as necessary to address the child/youth's mental illness. *Cultural issues? Involvement in the planning process?*

0	TBS is appropriate but: # ___ - Was refused by family/caregiver or the child/youth (when appropriate). *Cultural issues? Involvement in the planning process?*

0	# ___ -Is not available because…other *What criteria was used in this decision?*

NAPA County

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: **0 unduplicated clients (0) notifications received)**

Initial Information – Class Membership
PLEASE REFER TO PAGE 2 FOR A NOTE REGARDING DATA SUBMITTED BY NAPA TO DMH.

0 - In Rate Classification Level (RCL) 12 or above

0 - Being considered for RCL 12 or above

0 - One psychiatric hospitalization in preceding 24 months

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

Gender

0 Boys 0 Female

Age

0 ages 0-17 **0** age 18-20

Ethnicity

0 White	**0** African-American	**0** Hispanic
0 Native American	**0** Asian/PacificIslander	**0** Other

Primary residence for child/youth while receiving TBS as indicated on notification forms: (8 in RCL lower than 12)

0 Family Home	**0** Foster Home	0 Foster Family Agency
0 Children's Shelter	**0** Group Home	**0** CTF

NAPA County

Therapeutic Behavioral Services (TBS)
Notifications Quarterly Summary

0 Other	**0** (RCL 12) **0** (RCL 14)

Service Need:

0 - To prevent placement in higher level of care	**0** - To enable transition to a lower level of care

Analysis (Identify trends, questions, etc.)

NOTE ON DATA REPORTING:

Summary of TBS notification form data submitted by Napa County since the program inception in July 1999:

13 unduplicated clients
21 forms (some were quarterly updates)

Ethnic Groups
10 White
1 African-American
1 Asian/Pacific Islander
1 Other

All 13 unduplicated clients were in the 0-17 age group. The age was calculated based on the form date. If a client had more than one form, the earliest one was used.

11 males, 2 females

Napa County was pretty good in submitting forms for a while. Then there's a big gap between 7/29/03 and 3/2/05 where there are no forms. According to the SD/MC approved claims data, Napa had one client in FY 03-04 and two clients so far in FY 04-05.

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)
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:

Napa have not provided any 4th authorizations during this quarter.

Attachment

B

Focused Review for Services to Emily Q. Class Member
Preliminary Analysis Summary

DATA SUMMARY

Open TBS Cases (as reported by the county) – 0;
TBS Notifications – 0– all provided in the home; all used to prevent placement in higher level of care
TBS Certifications – 0
TBS NOAs – 0
TBS 4th Authorizations – 0

RCL Rate - +4.50% Readmit Rate - -5.19% SH Rate – -17.31%

Napa county's TBS coordinator is one of two supervisors for the Child and Family Behavioral Health Unit, is supervisor for Mental Health Clinicians in Juvenile Hall and Children's Emergency Response, a contract monitor for a school mental health program, and a Mental Health liaison to MARP (the county Multi-Disciplinary Assessment, Review, and Placement Team), CRT (Children's Review Team), and the Safe Schools/Healthy Students Initiative. Additional duties include participation in the County's Coordination Committee and Compliance Trainings.

Napa county has an authorization set up such that all initial requests for assessment for TBS are approved via the TBS Coordinator. Subsequent re-authorization requests are also approved (or denied) by the TBS Coordinator; to date

Napa county has provided a 5.19% decrease in re-hospitalization for children's re-hospitalization rate. However, the decrease was due to a reduction in N of the sample size and was statically significant.

Coordination of the TBS treatment plan clearly involves participation of the behavior analyst. It is unclear how the primary mental health clinician is involved in coordinating this service with the child/youth's overall treatment plan.

The review team has additional questions around the following:

1. Origination of authorization requests for TBS
2. Requests for re-authorizations – criteria used to determine ongoing TBS
3. Coordination of TBS with mental health clinician
4. Data reporting over the last few years is sporadic.

Napa has a reduced population and DMH team will need to investigate that class members are provide access to TBS services.

Attachment

C

COUNT OF NAPA
HEALTH AND HUMAN SERVICES
2261 Elm Street
Napa, CA 94559-3721
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RANDOLPH F. SNOWDEN, DIRECTOR
SUZANNE T*, MENTAL HEALTH DIRECTOR
BARBARA REYNOLDS, TBS COORDINATOR

Napa County Health & Human Services
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?***

Barbara Reynolds, MFT, TBS Coordinator

Barbara Reynolds, in addition to her TBS responsibilities is one of two supervisors for the Child and Family Behavioral Health Unit, is supervisor for Mental Health Clinicians in Juvenile Hall and Children's Emergency Response, a contract monitor for a school mental health program, and a Mental Health liaison to MARP (the county Multi-Disciplinary Assessment, Review, and Placement Team), CRT (Children's Review Team), and the Safe Schools/Healthy Students Initiative. Additional duties include participation in the County's Coordination Committee and Compliance Trainings.

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

Currently, requests for TBS are reviewed by the TBS Coordinator for eligibility and when eligibility is met, requests are forwarded along with a copy of the primary Mental Health Clinicians' most recent assessment and plan to the TBS Provider for supplemental

assessment and plan development based on behavioral analysis. The target time frame for completion of the supplemental assessment and plan is 30 days, sooner if possible.

Initial requests for authorization of TBS services are made by the TBS Provider upon completion of their assessment and plan. Requests, accompanied by the assessment and plan may be made by paper copy or fax to the TBS Coordinator.

Authorization for services is made upon review of the assessment and plan for necessary elements, and in timeframes that are in accordance with DMH Information Notice Number 99-03, Number 04-03, and the Napa County Mental Health Plan. Requests not requiring additional information are authorized within fourteen working days, three working days for expedited requests.

Reauthorization requests are made by the TBS Provider by fax or paper copy, accompanied by a current Monitoring Report providing information on the progress of the case. Reauthorization requests are to come to the TBS coordinator in enough time to allow for review and approval with no unnecessary disruption of service to the client. Currently requests not requiring additional information are authorized within five working days.

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

From June 1, 2004 through May 31, 2005 four initial authorization requests have been received by the Napa County TBS Coordinator.

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

From June 1, 2004 through May31, 2005 four initial authorization requests have been approved.

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

In the past year no initial TBS authorization requests have been certified to not meet the eligibility, class, or need criteria.

Napa is a small county and the TBS Coordinator has maintained an "open door" policy to help educate anyone interested in obtaining TBS services regarding the nature of the services and the eligibility criteria for TBS. The TBS service request form also helps delineate the eligibility criteria resulting in few referrals that do not meet eligibility, class, or need criteria.

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

The TBS providers in Napa County are contract providers. The foundation of the current provider agency's clinical services are based on the practice of Applied Behavioral Analysis. They have intensive training in their new employee orientation in the principles of ABA. When employees become TBS coaches, they receive the state mandated training, "Applying Principles/Practices of Functional Behavior Analysis to Therapeutic Behavioral Services." They also receive agency training provided by the Executive Director and Clinical Director who is a licensed psychologist and certified behavior analyst.

The County provides mandatory annual Provider Compliance Training for all Medi-Cal providers. The TBS Provider Compliance Training reviews the principles and practices of TBS as well as issues pertaining to ethics, NOA's and grievance procedures and TBS documentation standards.

The TBS Coordinator is available on request to provide additional training and support at Providers staff meetings.

The TBS Coordinator is available by appointment or by phone to answer any further questions regarding the principles and practices of TBS in Napa's MHP.

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)?***

Information regarding TBS services was initially made available to Juvenile Judges, Juvenile Probation, Child Welfare, and Child and Family Behavioral Health (Children's Mental Health Case Management). Information currently remains available at the CFBH office. Ongoing conversations regarding TBS services and eligibility are entertained at MARP, the County's Multi-Disciplinary Assessment, Review and Placement meeting which includes representatives from Child Welfare, Probation, SELPA, Mental Health, and the County's only level 12 RTC.

This year's annual Provider Compliance Training provided basic information regarding TBS practices and eligibility to:
The TBS Provider
EPSDT Providers
Managed Care Providers
A variety of other providers likely to serve the TAY population

More in-depth training is being planned for the fall to review TBS practices and principles with the following agencies that have experienced a turnover in personnel and to allow all staff time to ask questions regarding their understanding of the service or of eligibility:
Child Welfare
Juvenile Probation/Juvenile Hall
EPSDT contract agency

8. ***What community outreach has been done for clients and family members regarding the availability of TBS as a specialty mental health service? Was outreach done to non-English speaking communities?***

A TBS handout is available upon request at the CFBH office. Currently, information regarding TBS is being distributed at intake to all new clients in CFBH as part of their informing materials.

No specific outreach has been made to non-English speaking communities other than information provided to families on a case by case basis by case managers or EPSDT providers.

9. ***Do you have any TBS providers that have the capability to provide TBS in a language other than English? Has there been a need for non-English speaking providers for TBS?***

We do not have any TBS providers that have the capability to provide TBS in a language other than English at this time. Our provider is currently trying to replace a bi-lingual staff member who left the agency in February.

A bi-lingual English/Spanish TBS provider would help maximize the effectiveness of TBS services in this community, particularly in the family collateral work.

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).***

Has a grievance ever been received regarding access to TBS, satisfaction with TBS, or from a TBS provider?

Yes. A single, verbal grievance was made (11/13/03) and a proposed solution negotiated 11/19/03. This turned out to be unacceptable to the grievant, and a State Fair Hearing was scheduled for 12/08/03. The grievant requested a postponement (12/01/03), and the grievance was subsequently resolved without need to complete the Fair Hearing process.

This grievance arose when the grievant received a Notice of Action discontinuing services. The NOA was issued based on the provider's

assessment that progress was not being made. In response to the NOA, the client requested services be re-started. A period of two months had elapsed since services had been provided, but the grievant did not request services be re-started until after receiving the NOA. During that interim, the beneficiary experienced a closed-head injury due to a skateboarding accident. The grievant requested that the beneficiary be re-assessed for TBS services, however, it was determined that wrap-around services would be more appropriate. Accordingly these were offered. Wrap-around services were provided until the beneficiary moved out of State.

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

CFBH Case Management Client Plans are completed with involvement from the client and their family. As TBS becomes a service possibility for a client, the client and family are engaged in the process of making the decision and the clinician gets client and parent/caregiver signatures on their revised client plan that includes TBS as an intervention.

The TBS Provider involves clients and family members (parents/caregivers primarily) in the planning of all stages of treatment planning by home-visits and direct client interview by the supervising clinician assigned to the case at least two times per month.

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

As part of our annual work plan and in collaboration with the TBS coordinator, QI undertook a quality improvement project (QIP) during FY 2003-2004 to collect data and analyze how TBS notifications are provided to eligible beneficiaries or their families. We identified several access points (Emergency Response staff, Hospital Liaison) where TBS information was either required to be shared or could be shared effectively. We then identified a protocol for gathering information. The QIP is currently collecting

the following data on a monthly basis: how many requests for TBS were made to the TBS coordinator, what is the total number of children hospitalized monthly, and did the hospital liaison offer and document TBS during discharge planning. Additionally, QI is assessing the utility of documenting offering of TBS through a checklist developed by Emergency Response (24-hour unit) staff. QI is monitoring inclusion of this checklist in each chart during its periodic chart reviews.

Once the data are gathered and analyzed, preliminary conclusions will be considered and shared among staff, consumers, and other stakeholders. Where trends are identifiable, they will be used as part of the on-going program development.

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

TAY who will be returning from RTC's are discussed at MARP and agencies serving the youth are encouraged to make referrals to TBS as appropriate. TAY receive information regarding TBS at the time of hospitalization. Napa County Hospital Liaison is available to promote TBS as part of discharge planning considerations.

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

The TBS Coordinator has provided information regarding TBS to the County ILP Coordinator who has primary access to TAY in foster care. MARP provides a forum for agencies to present client needs including those of TAY who might be referred for TBS services.

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

MARP or individual case worker referrals are the primary vehicles for ensuring that TAY placed out of county are assessed for TBS.

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

Information regarding TBS services are given to TAY at the time of hospitalization.

d. Specifically, what is the process for ensuring TAY placed in *CTFs, IMDs, or State Hospitals* are assessed for TBS?

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

TBS has authorized TBS for one child placed out of county. Napa county has had few requests for TBS for children placed out of county. However, the County is working on expediting the contracting process to make TBS more readily available should it receive requests.

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.***

Currently Napa County has only one TBS Provider. They have internal TBS meetings two times per month with their clinicians and all coaches assigned to cases for grand rounds review of cases with Clinical Director of the Agency. In addition, each clinician meets with TBS coaches for individual case review, plan development and supervision two times per month. Plan development notes are documented by the clinician as applicable.

In interagency terms, the primary clinician is the person providing the primary EPSDT services to the client and who has the initial client plan listing TBS as an intervention. When a referral has been made to the TBS Provider, the TBS provider is responsible for contacting the primary clinician to begin the TBS planning process. Once TBS services begin, the TBS coach is responsible for contacting the primary clinician on a regular basis to review the progress and status of TBS. The TBS coach is also responsible to bring any case

management needs encountered in the course of their service to the attention of the primary clinician.

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) ***4.50 % increase in RCL Level 12 or higher rate.***

Overall, the percentages cited in the pre-visit questionnaire are somewhat misleading, as our N is very small. An increase or decrease of 4% or 5% may reflect a single individual. For example, while data included in the pre-visit questionnaire shows an increase of 4.5% in placement of beneficiaries in a RCL12 or higher, we were unable to duplicate those numbers. According to our records, in 2002 a total of 51 children were placed compared with 2003, when 68 children were placed. These children were predominantly Probation and/or Child Welfare cases. Conversations with individuals making placement decisions at that time recalled not a change in philosophy for placement of probation children, but an increase in the numbers of children on probation, along with a shift in funding (patch) sources. The County's probation placements remain higher than either Child Welfare or 3632 and the County is hoping to address this issue with the imminent opening of a new Juvenile Hall facility that will afford the implementation of additional Mental Health treatment intended to maximize the County's commitment to serving children/youth in their local environment and reduce the need for placements.

b) ***5.19% decrease in re-hospitalization rate.***

The decrease noted in the re-hospitalization rate (5.19%) actually reflects a change in N from six children in 2002 to five children in 2003. Total hospitalizations for children in 2002 were 27 but only 18 for 2003. This is a more remarkable finding, statistically speaking. Our Fiscal unit produces a monthly hospitalization report that is used at the management and supervisory level to determine the need for intervention or diversion and the

appropriate assignment of personnel. The philosophy of the Agency is to keep the children in the home, in the least restrictive level possible, with as much support service provided as needed.

Increased collaborative efforts between the hospital liaison, the children's medication unit, and the children's case management units have contributed to the relatively stable numbers of children being hospitalized and as shown in the chart below.

	2002	**2003**	**2004**
Hospitalized	27	18	27
Re-Admitted	6	5	5

c) *<u>17.31</u> % decrease in State hospitalization rate.*
We were unable to confirm the 17.31% decrease in State hospitalization rate. Our records indicate that we did not have any children in a State facility during 2002-2003. We were able to determine that Metropolitan Hospital was the only State hospital were Napa County beneficiaries were admitted during 2002-2003 (n=3). According to our records, the three cases were all adults, and the only child admitted to this facility was admitted (as a conservatee) in June, 1999 and discharged to an Adult Forensic Facility when he attained age 18.

While the numbers are too small to conclusively suggest trending, we can and do individually track services for each child who was hospitalized or re-hospitalized. Data are available in aggregate form regarding the number and type of services provided (e.g., therapy, medication clinic, day treatment, crisis intervention, targeted case management, collateral, assessment, and plan development). The following chart demonstrates one such report.

			Claims by program (2002-2003)							
Client	***Age***	***Gender***	***Crisis***	***Out-patient Medication Management***	***Case Mgmt***	***TBS***	***RCL/Day Tx/ School-based program***	***Therapy***	***Other***	***Hosp Liaison***
1	9	M	5	9	7	9				8
2	7	M	4	5	15			2		
3	8	M	4	72	146	78		9		
4	14	F	4	23	74			18		
5 *	17	M	1	1	124	25	58		3	
6	6	M	5	36	70		16**	150	6	6
7	11	M	5	14	205	165	146	237	43	8
8	15	M	2	18	152	141	118	48	31	4
9	15	F	4	33	129			10		
10	6	M	18	94	81		326***			5

* Client was in placement during this period, where he received psychotherapy and medication management

** Services included a 1:1 aide under Chapter 26.5 services

*** Services included psychotherapy and medication management while in placement.

NAPA MHP TBS QUALITATIVE FOCUSED REVIEW PROTOCOL
PART I

A. TBS Policies and Procedures

1. Review of county's policies and procedures for TBS program (authorization requirements, notifications, referrals, access, certifications, NOA, etc.).

The Mental Health Plan (MHP) policies and procedures for the TBS program include those addressing access and qualifying criteria, information regarding service delivery and documentation requirements as well as those addressing TBS Notices at the time of Emergency Psychiatric Admission to MHP Hospitals.

2. What's working well with these established P&P's?

The policies give a general overview of the purpose of and eligibility for TBS services as well as specifically identifying class membership and limitations on service.

3. What's not working with the P&P's?

The P&P's have been found to be not detailed enough and are under revision in order to provide more specificity.

4. What is the county's process for review and modification of the TBS P&Ps?

The MHP has a Mental Health Coordination Committee comprised of county stakeholders that reviews and recommends revisions to policies and procedures to the Mental Health Director.

5. Are TBS roles/functions clearly defined in P&Ps? Who is accountable for TBS referrals, authorizations, notifications, certifications, NOA, etc?

TBS P&Ps are scheduled for revision to more clearly define roles/functions.

6. How are staff trained on TBS P&Ps?

All mental health staff are trained on P&Ps at annual mandated compliance trainings. New employees are provided training and copies of the policies and procedures within 30 days of the date of hire. Additionally, unit supervisors distribute new or revised P&Ps to staff or review them at unit staff meetings.

7. What P&P changes have been implemented in the past, and what changes are being considered in the future, to promote increased county TBS utilization?

P&P changes being considered for the future include adding specificity in defining roles/functions. We have identified areas that can be addressed through additional policies and procedures regarding notification and to promote utilization of TBS services (e.g. RCL 12 or higher placements made by child welfare or juvenile probation staff.

B. TBS Assessment, Access, and Utilization/Service Processes

1. How does assessment for TBS happen in the county? Is it part of the overall mental health assessment or a separate stand-alone assessment?

All children when referred for mental health services are given a bio psycho social assessment. Findings are used to determine service array, one component of which is TBS. During the initial and ongoing assessment and treatment process, if the client is found to meet eligibility and need criteria for TBS they are referred for TBS services.

2. How are eligibility, class membership, and need identified and what are the specific criteria used in the determination of each?

Napa County requires referrals for TBS to include a primary mental health provider's most recent assessment and client plan as well as the Napa County Children's Behavioral Health Initial Screening Criteria for TBS Eligibility Form to assist in the determination of eligibility, class membership and identified need. Current Medi-Cal eligibility is determined through the Medi-Cal Eligibility Determination System (MEDS). Specific Criteria used in these determinations are:

A. *Eligibility:*
   - *The child/youth has full-scope Medi-Cal with Napa County*
   - *The child/youth meets medical/service necessity criteria*
   - *The child/youth is under 21 years of age.*

B. *Class Membership:*
   1. *The Child/youth is placed in a group home facility of RCL 12 or above or locked treatment facility for the treatment of mental health needs; or*
   2. *The child/youth is being considered by the county for placement in a facility described above; or*
   3. *The child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months; or*
   4. *The child/youth has previously received TBS services while a member of the class.*

C. *Needs:*
   1. *The child/youth is receiving other Specialty mental Health Services, and*

2. It is highly likely in the clinical judgment of the mental health provider that without additional short term support of TBS the child/youth

a.) will need to be placed in a higher level of residential care, including acute care, because of changes in the child/youth's behaviors or symptoms, or

b.) will need this additional support to transition to a lower level of residential placement

3. Discuss with us the county's infrastructure components; the department, systems and cross-agency integration related to children's mental health and TBS; and processes associated with clients gaining access to TBS.

Napa County Health and Human Services Agency is an integrated human services agency with 6 major program divisions: mental health, social services, child welfare services, public health, alcohol and drug, and comprehensive services for older adults. Approximately 400 staff are employed within the agency. An operations division, a compliance division, and a fiscal/contracts division support program divisions. The Agency Director reports to the office of the County's Chief Executive Office and to the Board of Supervisors. Key management level staff from the 6 major program divisions, along with the Director, Assistant Director, Chief Fiscal Officer, Compliance Officer, Chief Operations Officer and County CEO Analyst comprises the central Management Team.

The mental health division of the agency is administered by the Mental Health Director, Assistant Manager, and a Psychiatric Medical Director. Staff in the division provide a variety of mental health services including: case management, medication support services, outpatient therapy, psychiatric emergency response, inpatient hospitalization, and residential services to children, adults, and older adults. Seven program supervisors provide first line supervision to these units, and a mental health program analyst provides additional support across the division. The mental health division employs approximately 70 staff and serves approximately 1200 individuals annually. The MHP contracts with a number of community based organizations and individual providers. Approximately 50% of the MHP's annual budget is for contracted mental health services.

Cross agency integration in regard to the delivery of mental health services and TBS occurs in a number of ways. Children's mental health services and child welfare services are functionally co-located in two wings of the same building. This co-location and other more formal mechanisms result in frequent collaboration on mutual cases between staff in Child Protective Services, Family Preservation, Children's Medication Clinic, and Children's Case Management units. An "all staff" meeting for all children's mental health and child protective service staff is held monthly for the purpose of facilitating integration, discussing program and staff changes, and other business. Additional cross agency integration in overall policy planning is further described in Section I, Question 1.

4. What is the specific process for securing a TBS provider?

Local agencies were surveyed regarding interest and capacity to provide TBS services. Only one contract proposal was received by the county and the agency was evaluated, proposal accepted and contract developed. Where there is an anticipated need for TBS for a client in an out-of-county placement, the host county is contacted for information regarding local TBS providers and contracts with those agencies are pursued. The MHP's contractor is approached to determine their ability to serve a client in an out of county placement.

5. Describe the manner and characteristics of how clients and their families are currently accessing and utilizing TBS services.

Most clients and their families are currently accessing TBS services via a referral from their primary mental health provider who also takes time to explain and help coordinate the service as an intervention addressing specific behavioral problems addressed in their client plan.

6. How does the county handle access and provide TBS for difficult-to-place clients? For example, children who present significant behavioral challenges? How about children who are placed out of county? Children in foster care and adoptive assistance?

The MHP provides access to TBS for all eligible referrals. Our provider has successfully provided services to difficult-to-place children, and children in foster care. This provider has provided services to all referred clients. Most children who receive TBS present significant behavioral problems. Napa has provided TBS for one child placed out of county and has received only one other inquiry regarding TBS for a child placed out of county. That case was resolved during the contracting process by other means, so TBS became unnecessary.

7. How does the county provide TBS for children placed in group homes?

Napa has only had one inquiry since the inception of the program, regarding the possibility of need for TBS for a child in a group home. As stated above, the contracting process was started, but the behavior was resolved by other means, so TBS was not required.

C. Agency, Client, Family, and Community Coordination, Collaboration, and Integration

1. Within county mental health, describe coordination efforts and processes that integrate TBS service provision between Medi-Cal/EPSDT, Children's SOC, TBS coordinator, case managers, QI Coordinators, and MHP service authorization staff.

County case managers play an integral role in coordinating TBS service provision with other care providers either by phone collateral contacts or by coordinating treatment team meetings. The TBS Coordinator is available to field questions regarding access and eligibility. The MHP is currently studying how to build capacity in order to further maximize utilization of TBS services.

2. What is the role of such coordination in maximizing utilization of TBS by class members?

Coordination efforts to date have succeeded in generating TBS referrals through case management and child welfare providers. Support in understanding TBS contributes to increased buy-in by all service providers and works toward maximizing utilization by increasing likelihood of referrals.

3. External to the county mental health program, describe the structure and processes in place to promote stakeholder coordination and collaboration with schools, teachers, school counselors, social service agencies, foster care, and the juvenile justice system.

A Multi-Disciplinary Assessment Review and placement team (MARP) is the primary coordination forum involving representatives from Child Welfare, Juvenile Justice, SELPA, Mental Health, and RTC. The County's current Chief Probation Officer previously held the position of Behavioral Health Care Manager and was instrumental in setting up TBS services in Napa County.

4. What communications channels exist for promoting feedback loops from TBS Coaches, providers, clients, and other stakeholders to county MHP management and clinical TBS program decision-makers?

Feedback is welcomed from providers, clients or stakeholders via any route or means. TBS coordinator is available to MHP Provider staff meetings on request, and available for feedback by phone. Client feedback generally is made via the case manager or TBS coach and has been relayed to management by the TBS Coordinator. Clients and their families have also given feedback to the TBS Coordinator by phone. MHP QI staff provide training to TBS Providers on the MHP Beneficiary Problem Resolution process and all clients are provided information on this process at intake and annually.

5. What communication vehicles/methods are utilized by county mental health to promote identification and outreach to potential clients and families who may benefit from TBS services?

1. *Case managers and social workers are encouraged to discuss TBS with clients and caretakers who may benefit from TBS services. TBS informational brochures are made available at intake for all clients and upon request. Staff in Napa County Emergency Response Units shall provide copies of the notices to the beneficiary and his/her representative upon notification of acceptance for admission to a contract psychiatric hospital.*

6. What systems, procedures, practices and training are established and used by the county MHP to ensure that cultural, ethnicity and language issues are addressed effectively throughout the entire TBS process?

A variety of cultural competency trainings are offered to staff each year. Both the county and the TBS Provider make every effort to attract bi-lingual, bi-cultural staff. County staff also makes use of translators or the ATT language line when necessary.

D. Organizational Culture

1. How committed is the county mental health program's executive staff to TBS in general, and specifically to maximizing appropriate TBS utilization? What circumstances or conditions (e.g., resource considerations/funding) limit commitment?

At the executive level, there is a clear intention to provide a complete range of mental health services, including TBS, to Napa County eligibles. It is the philosophy of county leadership and staff to keep our children in the community to the degree that is clinically indicated and safe. Resource considerations range from staffing issues, to finding and retaining therapeutic foster homes for CPS referrals, as well as the availability, capacity, and training of potential TBS providers.

2. What specific methods have been and are currently being used to communicate and convey to MHP staff and external stakeholders the executive staff commitment to TBS services in general? To maximizing TBS utilization in particular?

Trainings and staff meetings are the primary means of communicating executive staff commitment. For example, the Acting Mental Health Director provided information at the annual organizational provider and out-patient provider network staff training.

3. Describe qualitatively how, and to what degree, county mental health staff (and other executive management) has demonstrated "buy-in" to the provision and maximization of TBS services?

At the service delivery level, case managers have incorporated TBS into their assessment and referral activities. Staff buy-in is growing with demonstrated successes. Administrative buy-in has been hampered with changes in executive management.

4. What organizational culture components support/promote TBS?

There is a clear dedication to client care and welfare by staff at all levels. Providing TBS is a component of that dedication.

5. What organizational culture components inhibit or create resistance to TBS (e.g., philosophical differences, clinical practice differences?)

It is a challenge to meet increasing administrative responsibility associated with effective service delivery.

E Staff and Provider Training on TBS

1. Describe county mental health TBS training/education efforts (orientation of new employees, annual updates, in-service ad hoc training).

The Mental Health Plan (MHP) provides mandatory annual Provider Compliance Training for all Medi-Cal providers. The TBS Provider Compliance Training reviews the principles and practices of TBS as well as issues pertaining to ethics, NOA's and grievance procedures and TBS documentation standards. All new employees are trained on these materials which include TBS within 30-days of hiring.

TBS provider staff must receive one hour of general compliance training and three hours or documentation and billing training within 30 days of the date of hire and annually thereafter. All Contractors are screened through the National Provider Databank to ensure that staff are practicing in good standing. Ongoing monitoring of compliance to documentation and billing standards is determined through regular quality assurance reviews conducted by county staff. Monitoring of the contract and ongoing consultation with the contractor is provided by the TBS coordinator as needed for ongoing evaluation of provider capacity and service delivery.

Behavioral Solutions, our TBS contractor, provides training to its staff. Training is provided by the Executive Director/Clinical Director, who is a certified behavioral analyst and a licensed psychologist.

On-going individualized training is provided by the TBS coordinator on an ad hoc basis to management, staff, contract, and individual providers as requested.

2. What specific training has been provided in the past?

All Children's case management staff took part in the initial teletraining on TBS offered by CIMH. They also took part in the tele-conference training Applying Applied Behavioral Analysis to Therapeutic Behavioral Services, the training currently used to train all new TBS Providers. This year a contract provision is included in the TBS provider's contract to provide children's staff with specific training on approaches to behavioral approaches to treatment.

3. Is there evidence to support that training has occurred on the subject of TBS access for class members, determination of eligibility, need, assessment, certification, authorization, and the objective of maximizing utilization?

This year's annual compliance trainings for outpatient network providers and organizational mental health providers included specific training on TBS with handouts. Sign in sheets were obtained and can be provided.

4. What specific training is planned for the near future?

All county mental health staff will receive training on TBS in July as part of Annual Compliance Training.

5. Who does the training?

Mental Health Assistant Manager, Mental Health Supervisors, QI Specialists, and TBS Coordinator

6. Are there other training or communications channels through which county staff, providers, and external stakeholders receive education on TBS service provision?

Individually, on an ad hoc basis, the TBS coordinator provides training and communications to all. These are augmented by distribution of state promulgated materials, and locally generated forms that include required information.

F. Performance and Quality Improvement

1. What performance improvement or quality improvement efforts are currently underway by county mental health to improve TBS processes, access, outcomes, and utilization?

QI staff began a Quality Improvement Project (QIP) last July (2004) regarding the notification of TBS-eligible beneficiaries at one point-of-service. Data is being gathered on a monthly basis as to who has been hospitalized, whether the hospital liaison position and the children's emergency response worker have been successful in offering TBS services to the family, and cross-referencing that information with all requests for TBS services received by the TBS coordinator. Data is being gathered through June, 2005. These data will be analyzed, and findings presented at the Quality Improvement Committee, and included in the annual QI report to the Mental Health Director and the Mental Health Coordination Committee. Preliminary findings indicate that the hospital liaison is well situated to inform beneficiaries of the service; however, access to the service has not been utilized at high levels.

2. How is TBS integrated into the county's annual QI Work Plan?

As noted above, TBS has been incorporated into the county QI work plan specifically addressing beneficiary access. TBS will continue to be included in the work plan for 2005-2006 utilizing the data gathered this year as a benchmark to identify outcomes.

3. Are any studies currently underway related to TBS access for class members, utilization, or other factors?

Yes, please see the answer to Q.1 above. Additionally, we will be conducting a case study of each child who received TBS services that will include a retrospective analysis of pre-hospitalization service utilization, post-hospitalization (discharge) outcomes, and effectiveness of TBS services.

4. Has the MHP (or can it now) identified any trends related to TBS access, utilization, class member client outcomes, etc.?

Trends analysis has not been conducted at this time, as the QIP was established to determine baseline data. Trending will be part of the overall analysis to be completed in July, 2006. Since the numbers in Napa are smaller than in other counties, it will be possible to do a qualitative case study for users of this service as part of that analysis that will include factors of access, utilization, and outcomes.

5. Has the county explored or implemented any practice guidelines, best practices, or evidenced-based practices related to administrative or clinical processes of TBS service provision.

Practice guidelines are based on the Applied Principles/Practices of Functional Behavioral Analysis to Therapeutic Behavioral Services. Similarly, evidence-based practices fall within the general approaches outlined in this training. It is anticipated that best practices will come out of the on-going chart reviews of the TBS provider along with information shared by other Counties at Bay Area TBS meetings.

6. What kind of TBS case review process exists in the county MHP? How does it work?

The TBS Coordinator reviews progress towards meeting goals as documented in the monitoring report necessary to determine ongoing authorization of TBS services. This review occurs concurrently.

Currently TBS services are reviewed bi-annually by Quality Improvement, using a 100% sample and a six-month retrospective review. A monitoring report from the TBS provider is required to be sent every 60-days to the TBS Coordinator to determine progress and readiness for transition of services. [Review tool will be made available at the site visit]. QI chart reviews include both quality assurance and quality improvement elements as well as recoupment issues provided by DMH. These additional areas provide the means of identifying clinical and program issues for follow-up.

QI reviews are shared with the Mental Health Director and the TBS Coordinator. The TBS Coordinator shares results with the provider and staff as appropriate. Where there are findings requiring corrective action plans (CAPs), these CAPs are worked out with mental health staff, the TBS Coordinator and the TBS provider. To date no corrective actions have been required.

The TBS provider conducts on-going internal reviews (twice monthly), overseen by the Clinical Director and clinical staff.

7. How does information related to the quality, access, challenges, and utilization of TBS get fed into the county's QI framework?

At present this is an informal process which includes the audit process and regular contact with the TBS Coordinator. We anticipate formalizing this process and expanding input to include stakeholders, program, and consumers based on the findings from the QIP noted previously. Additionally, further QIPs or PIPs may arise from the benchmark data gathered.

G. Outcomes and Clinical Standards

1. How does the county measure and report client and family/caregiver satisfaction related to TBS access, service quality, and outcomes? What happens with this information once it is obtained?

A pilot satisfaction survey [to be made available at the site visit] was recently distributed and results analyzed. Findings indicate that the survey is successful in gathering information related to access, satisfaction, outcomes, and treatment experience. These findings were shared with the Quality Improvement Committee and with the Mental Health Coordination Committee (comprised of MHP supervisors and administrative staff). The sample used in the pilot did not capture significant numbers of class members or those potentially eligible for TBS. We will remedy that with the distribution of the survey in the next few months specifically sampling this group.

2. Has the county formulated any client outcome, service quality or utilization goals/objectives related to TBS?

No. However, based on the findings of the QIP noted above and this review, these items will be addressed in the QI Work Plan for next year.

3. Has the county developed any clinical standards related to TBS service quality?

The TBS provider (Behavioral Solutions) has developed clinical standards. [to be made available at the site visit].

4. How is progress (or challenges to progress) related to these client outcomes and meeting clinical standards monitored and communicated to appropriate stakeholders?

Progress with regard to outcomes has not yet been analyzed, but will be part of the findings based on the benchmark data currently being gathered. These findings will be shared with the Mental Health Director, the Quality Improvement Committee, and

stakeholders. On-going monitoring of services is done by the TBS coordinator with the 60-day monitoring reports and the six-month retrospective chart review done by QI.

5. How can the county MHP demonstrate that TBS is being considered for all EPSDT children? How does the county evaluate or ensure confidence that all denials of TBS (certifications) were error-free?

The TBS Coordinator reviews all certifications to ensure that any denials comply with TBS regulatory requirements.

6. How does the county MHP monitor their contracted TBS providers with respect to outcomes and clinical standards?

TBS Coordinator does concurrent review and monitors progress in meeting treatment goals and objectives. As noted above, based on findings of the benchmark data and information gathered from the satisfaction survey to be distributed in the near future, these data points will be incorporated into the QI work plan and reviewed by TBS Coordinator and Mental Health administrative staff.

H. Data Management and Information Systems Capability

1. At a general level, how does the county collect relevant data and information related to TBS? What is done with this information?

On the direct service level, all mental health services, including TBS service information is recorded in the agency's electronic documentation and billing database system. Service data is utilized to generate Medi-Cal billing through the fiscal billing portion of this database. The database generates specific reports by program, by service activity, and/or by staff. Service reporting is generated along a number of other variables.

From a system perspective, any Department of Mental Health or other State information notices and letters related to TBS (or other mental health services) are copies upon arrival and distributed in a Mental Health Coordination Committee weekly meeting. Participants in this meeting include: the Mental Health Director, Assistant Director, all mental health Program Supervisors, the mental health Analyst, and representatives from the agency's Fiscal, Quality Management, and Compliance units. This group reviews each notice/letter to determine if policy or program changes are required, assigns these tasks and tracks completion. New or revised policies and procedures are approved by the MH Coordination Committee, distributed to staff via e-mail, with follow-up by each program supervisor in unit level meetings. Policies and procedures are maintained by the mental health Analyst and a copy is placed on the agency's policy and procedure intranet site. Additionally, the county's TBS coordinator attends regional meetings with other TBS coordinators to share county practices, forms, and quality of services among shared providers. In addition, they discuss new developments in TBS.

2. How is TBS utilization measured, stored, and analyzed at the county level separate from, or complementary to, what is provided at TBS data from the state?

The TBS coordinator maintains files in a locked drawer with referrals, authorizations, certifications, and notifications.

The TBS programs are building capacity to collect data on Medi-cal hospital and CTF admission, and RCL 12 and above placements. This information will be used to create procedural changes with the intention of maximizing TBS utilization.

All TBS direct service data from the county's TBS provider is input into the county's electronic documentation and billing system. The TBS coordinator receives service notes for all TBS services and then forwards the header portion (with billing information) of the notes to the fiscal department for input into the electronic system. The fiscal department receives billing invoices direct from the TBS provider and ensures that each service noted on the invoice has been documented on a progress note. Fiscal and program staff are able to print reports at any time to determine amounts and types of services provided, service dates, etc. In the upcoming fiscal year, the county plans to analyze TBS services use and to compare that use to other mental health service utilization in regard the overall effectiveness of services in preventing higher level placement and/or hospitalization.

3. What information systems capability is employed to facilitate the actions in #1 above?

The agency utilizes ECHO, an electronic documentation and billing database system to record client demographics and other administrative information, clinical documentation and billing to Medi-Cal and/or other payer sources.

4. How is county TBS provider capacity measured and evaluated?

The county TBS coordinator evaluates TBS provider's capacity to provide TBS services. The TBS coordinator and the agency's Quality Management staff set and measure compliance to program certification standards. Total number of staff, staff qualifications and level of expertise, operating policies and procedures and overall administrative oversight are reviewed. The provider must meet the agency's Medi-cal contract requirements regarding documentation and billing standards. Furthermore, this provider has never refused to provide services to referred clients.

I. TBS Service Planning

1. Describe the county's comprehensive children's service planning process and how TBS specifically fits into this process.

The county utilizes a number of different children's services planning processes to ensure adequate system services and the coordination of these service systems. A monthly

children's policy committee is convened that includes the Chief Probation Officer of the county, the county Child Protective Services Manager, the Mental Health Director (or her designee), the Napa County Office of Education SELPA Director, and a management level representative from a child and family advocate contract agency. This committee was developed as part of the implementation of the children's system of care and has continued to meet to collaboratively address important policy decisions impacting multiple services, including TBS services to children across different agencies. Additional planning occurs in a regularly scheduled meeting, Multi-Agency Residential Planning meeting with representatives from juvenile justice, child welfare, and mental health. The purpose of the meeting is to identify children who are at risk of out of home placement and to develop service strategies to mitigate this risk. Children already in placement, but changing placements or returning to the community are also staffed in these meetings. The TBS coordinator attends this meeting and provides consultation regarding TBS qualifying criteria and possible TBS referrals. The Children's Review Team meets two times a month to review and authorize children's therapy services for CPS and mental health cases. Although most of the services are provided to children who do not receive Medi-Cal, the TBS coordinator also attends this meeting and provides consultation as needed on the appropriateness of TBS services for those clients who may qualify for Medi-Cal.

Children's service plans are developed in conjunction with the client and family, based on a Comprehensive Assessment by case management assessors or psychiatric nurse. TBS services are included as an intervention for targeted behavioral goals. The TBS Provider client plan, also developed in conjunction with the client and family, address the targeted behaviors with more specificity and goals are developed based on behavioral analysis. Client and parent signatures are required on both plans.

2. Are children/youth and the parent(s)/caregiver(s) invited to participate in the TBS case planning conferences?

It is a requirement of the county that they be invited to participate. It is also a clinical practice of the TBS provider to invite participation, not only in the initial phases, but on an ongoing basis.

3. Is there evidence to support that client/family input is being taken into account in the TBS service plan development?

Client/family member signatures serve as evidence supporting client/family input.

4. Is there evidence to support that the individualized service plans are strengths-based and outcome-oriented?

Plans build on strengths and promote positive replacement behaviors with specific outcome objectives.

5. Does the county have the client and family sign the service plan and indicate their agreement with the plan?

Yes, the signature serves as indication of agreement with the plan.

6. Does the county have a process for evaluating how clients and their families feel about the overall TBS service planning process and/or that their needs are being met during planning?

Not as a specific program function, however, our beneficiary satisfaction survey includes questions on overall satisfaction, treatment, outcomes, and access. Additionally this information is gathered in the State Performance Outcomes Measures. These are shared with the QIC and the Mental Health Director, and reviewed by the Mental Health Board.

7. Is there any evidence that can substantiate other stakeholders (e.g. school staff) are considered, invited, and participated in service planning when appropriate?

Other stakeholders may sign the client plan along with the client, family and TBS clinician. While not specifically documented in the client plan, it is common practice of the TBS provider to routinely include stakeholders, as appropriate, in the on-going treatment planning and implementation of services to beneficiaries.