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July 20, 2005

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

Dear Ms. Bird,

Enclosed is a copy of the San Bernardino County Mental Health Plan (MHP) Focused Review of Evaluation of Services to Emily Q. Class Members. This report reflects the findings and recommendations of the Department of Mental Health's (DMH) TBS Focused Review Team that conducted the focused review between the dates of May 16, 2005 and May 20, 2005. This report is being sent to Plaintiffs on July 20, 2005, within the sixty-day time frame agreed to by the parties for the completion of the report.

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

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

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

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

Sincerely,

Rita McCabe

RITA MCCABE, LCSW
Acting Chief
Medi-Cal Policy Branch

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

# Qualitative Focused Review Report

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| **County MHP:** | San Bernardino County Department of Behavioral Health Services |
| **Review Dates:** | May 16-20, 2005 |
| **Review Team Members:** | Troy Konarski, MSW, DMH, County Operations<br>Connie Lira, RN, DMH, Medi-Cal Oversight<br>Anne Murray, LCSW, DMH, Medi-Cal Policy & Support<br>Cynthia Rutledge, DMH, Medi-Cal Policy & Support<br>Ivor Groves, PhD, Special Master for Emily Q |

## I. Purpose

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

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

**Review Team Comments:**
In the specific case of San Bernardino County Department of Behavioral Health (SBCDBH), your county was selected for TBS focused review based on the following observations from September 2003- December 2003 data from DMH: 8 unduplicated TBS clients, 205,122 average monthly EPSDT eligibles,

6,743 unduplicated EPSDT clients, .12% utilization rate for TBS, .00039% penetration rate for TBS; and .01% increase in RCL 12-14 placement rate, -2.29% decrease in hospital readmission rate, and -.37% change in the state hospitalization rate.

## II. Procedure/Methods of Qualitative Focused Review

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

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

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

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

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

1. Carol Hughes, Assistant Director, SBDBH
2. Terri Franklin, Director of Clinical Programs, SBDBH
3. Carol Sakai, Quality Management, SBDBH
4. Lisa McGinnis, TBS Supervising Clinician, SBDBH
5. Margarita Bermudez, Clinician, SBDBH
6. Andrew Grunchy, Clinic Supervisor, SBDBH
7. Marilyn Ashton, Children Clinical Supervisor, SBDBH
8. Charolette Lewis, Clinical Supervisor, SBDBH
9. Alexa Christensen, Mental Health Specialist, SBDBH

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

1. *Administrative Staff*
2. *TBS Coaches within Behavioral Health in San Bernardino*
3. *Clinical Staff*
4. *Child Welfare Social Workers*
5. *Probation and Social Service Departments*

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

1. *Clinicians/Case Managers*
2. *Clients*
3. *Parents*
4. *TBS Provider (Coaches from County Mental Health)*

## III. Comprehensive System Findings

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

***Review Team Comments:***
The San Bernardino County has experienced multiple challenges in the last several years that have impacted the provision of EPSDT and specifically TBS to class members.

This report will address the challenges and recommend actions to be taken by the SBDBH. Issues identified by the team to be addressed at the county level and between agencies include: lack of communication within SBDBH and with other county departments, lack of vision EPSDT and TBS services as an important component of the service system to class members, and lack of tracking mental health case outcomes to seek improvement in the mental health system in San Bernardino.

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

1) The SBDBH has experienced ongoing instability at the management level within SBDBH.

2) As identified through case reviews, SBDBH is providing a minimum amount of intensive services to its EPSDT population, including TBS.

SBDBH does have a contract with East Ming Quan (EMQ) to provide "wrap around" for approximately 30 children; however, the amount of availability of this service was determined to insufficient given the number of potential eligibles.

3) During the individual case interviews, the review team found that SBDBH staff understood the authorization system process; however, staff does not refer TBS class members because of the lack of capacity. (see Appendix 1 for analyses of the individual case reviews)

4) San Bernardino County has an Interagency Placement Council (IPC), which represents Probation, Child Welfare and Mental Health agencies in the county and works to place children in the most appropriate level of care. The IPC has not provided a referral for TBS services. The structure for efficient inter-agency collaboration with high needs children is in place; however, the Council is not utilizing their full potential in assessing eligible class members for TBS or other intensive services because of the lack of capacity to provide TBS.

*5)* Training is needed to improve awareness, proper utilization, assessment and referrals for TBS. The absence of training has resulted in the SBDBH not regarding as valued service resulting in restricted capacity and limited efficiency in providing TBS.

## IV. Specific Findings of the Case Reviews

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

*Review Team Comments:*
The review team identified a sample of 10 cases to be reviewed during the focused review: 2 cases in which TBS had been or is being provided, and 8 cases of which were eligible class members, but did not received TBS. In each of these 8 cases the children are currently residing in an RCL 12 or above.

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

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

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

## V. Specific/Distinct Findings

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

**Review Team Comments:**
The review team found that there were three identified areas within the SBDBH system that generated concern, and warrant additional follow-up. SBDBH and other agencies that provide services to class members will need to address: increasing capacity for TBS, providing extensive follow-up and monitoring of cases by case managers, and increasing understanding and use of TBS to class members.

1. ***Develop additional TBS capacity***
   SBDBH will need to increase capacity to provide TBS services to class members. At the present time, SBDBH staff act as the TBS coaches and have the current capacity to serve up to 9 individuals. SBDBH does provide approximately 30 service units for EQR (wraparound services). The DMH team assessed the TBS and EQR capacity, and concluded that it is inadequate considering San Bernardino County has approximately 207,000 children that are eligible to receive EPSDT services.

2. ***Tracking and monitoring of TBS utilization (i.e. referrals, authorizations, denials, and reductions) is based on inconclusive data.***
   The lack of clarity around SBDBH referral and authorization processes, coupled with the lack of data reported to DMH around denials, modifications, and reductions in the provision of TBS, indicates that the ambiguity in these processes creates a misperception as to the functional assessment of the system. Specifically SBDBH does not have the capability to accurately assess TBS authorization and/or utilization within their system. The 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 SBDBH administrative and clinical staff, the individual case reviews, and external stakeholder focus groups, authorizations for TBS have been used to prevent placements into higher levels of care, but were not being routinely considered as a method for transitioning children into lower levels, or back into their homes. 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. The SBDBH is underutilizing TBS.

## 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 San Bernardino County.

***Review Team Comments:***

1) SBDBH has had an impaired ability to provide TBS. Several issues were identified as contributing factors including lack of sufficient provider capacity from EPSDT services and TBS, and several management leadership changes at SBDBH.
2) SBDBH will need to improve system to accurately track and monitor TBS utilization (i.e. data). This is a result of inappropriate funding levels in SBDBH and current program practices.
3) TBS is not being considered for class members as a service to enable transitions to lower levels of care, and is only used in trying to reduce a higher level of residential service. Thus, eligible class members are not considered for TBS.
4) SBDBH will need to improve communication and coordination of referrals with other service agencies in San Bernardino County programs, and agencies outside the county system that provide services to this population. This increased communication will assure appropriate service levels to the class members.
5) SBDBH will need to establish stable management to provide leadership and support to SBDBH staff to assure staff improve in their capacity to provide appropriate TBS and mental health services to class members and other clients using the mental health system.

## 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 to San Bernardino County MHP. 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) **Increased TBS Capacity:**
SBDBH must expand medically necessary and appropriate TBS services to class members. At the time of the review by DMH, SBDBH was in the process of issuing a Request for Proposals (RFP) to acquire a contractor to provide TBS. DMH strongly supports this action and would encourage SBDBH to carefully monitor and maintain the awarded TBS contract to confirm that services provided are sufficient to the class members.

2) **Establish Referral and Authorization Policies and Procedures:**
The SBDBH should develop referral and authorization policies and procedures regarding TBS that are consistent with their MHP contractual responsibilities with 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. The county's policies and procedures should delineate clear lines of responsibility and definition around the point at which TBS referrals are made.

3) **Establish a Tracking System for TBS:**
The SBDBH 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 are dependant on the county's policies and procedures being clear.

4) **Establish a TBS Training Program:**
SBDBH will need to establish a TBS training program for agencies, professionals and possible class members. This training should include, but should not be limited to: class membership, appropriate uses for TBS, including using TBS as a "step down", proper referrals, techniques on providing TBS and proper documentation and tracking of TBS.

***Strategic Improvement Recommendations***

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

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

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

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

In addition, SBDBH should contact the California Institute for Mental Health (CIMH) for additional technical assistance and participate in all TBS training opportunities provided by CIMH. In addition, requesting support and assistance from DMH to assure full implementation of their strategic improvement plan.

## 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)

San Bernardino County Behavioral Health Services

Dates of review: May 16 – May 20, 2005

# Appendix 1 – Individual Case Review Analyses

**San Bernardino County Behavioral Health Services**

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

# Case Review #1

**Case Review Team:** Cynthia Rutledge, DMH Policy
Ann Murray, LCSW, DMH Policy

**Facts:** The information on this child was gathered from the review of the child's chart(s) and interviews with the client and her foster mother. The client is a 10-year-old African American female. She is not currently receiving TBS but did receive these services in the past. She recently moved from an RCL 12 group home into foster care in Rialto, CA. located a short distance from the San Bernardino county offices. Her two siblings are placed in the same home and also a fourth unrelated child. It was difficult to gain a complete picture of this case because the number of reviews and the information in the client's chart was limited.

The client was placed in the foster care system at a young age. Her biological mother is incarcerated and her father's whereabouts are unknown. The child was abused and neglected and the client and her siblings were removed from the care of their biological mother and placed in the foster care system. The child has an open file with Department of Children's Services (DCS) in San Bernardino County. The chart included a number of diagnoses for the client: intermittent explosive disorder, posttraumatic stress disorder and oppositional defiant disorder.

**Summary:** Neither the client's case manager nor the former TBS workers were available to be interviewed by the review team. The reviewers were able to meet briefly with the foster mother and the child. The client did not respond to specific questions about TBS and the foster mother had limited knowledge about these services.

**Conclusions:**

a) *Adequacy of access to services, including TBS.* The client was identified as a child who needed TBS and case management services. The evaluation occurred and the necessary referral was completed.

b) *Adequacy of capacity to provide service.* The capacity appears to be very limited in the county as evidenced by the number currently receiving TBS services and the total FTE committed to providing the services. The capacity is reported to be lower in the high desert region in the Barstow area of the county.

c) *Accountability.* There was coordination in the case as evidenced by the review team notes in the file and that the child was considered for a lower level of care

when her behavior had improved to an adequate degree. The foster mother was displeased with some of the transition efforts. There was a transition period in which the client spent lengthy periods of time in the foster home prior to her discharge from the RCL 12 group home. The foster mom did not want the client to feel left out so she paid for her to be included when she took the other children in her home out for dinner, to a movie or when she distributed allowances. There was no financial compensation for these activities during the transition period resulting in numerous out-of-pocket expenses for the foster mother.

d) *Evidence that TBS or other services are working*. There is evidence that the child benefited from receiving TBS. Her dangerous behaviors decreased and she displayed progress in school. She was able to move from an RCL 12 group home to a foster home and this made it possible for her to be reunited with her siblings.

e) *Quality of TBS, if TBS was provided*. The starting date for TBS was October 21, 2004 and the service was approved for 14 hours over 12 weeks. The third authorization for TBS was completed. Case review meetings were documented in the client chart that included the participation of the client, the client's therapist, DCS worker, TBS advisor, TBS coach and the house manager.

f) *Appropriateness of services to kids placed out of county (if applicable)*.
The child is not placed out of San Bernardino County. The foster care placement was in the county.

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# Case Review #2

**Case Review Team:** R. Connie Lira, DMH Compliance

**Facts:** Client is a 13-year-old white male. Currently residing in an RCL 14 placed through the San Bernardino County Social Services. His Axis I diagnosis' are Cognitive Disorder, due to a medical condition and Impulse Control Disorder. He carries an Axis III Grand Mal Seizures, Encephilitis, and Ataxia, status post Herpes virus. His current GAF= 30.

Through the chart review, I found information that this child had been first referred to services 8/99 by his biological Mother because of difficulties at home. Mother reported that he was experiencing severe temper tantrums and including head banging, rages and impulse control issues. Client was acting out and had issues with aggression at school; he was eventually suspended from school after stabbing a classmate (1/27/00). It appears that his initial assessment was done 9/99 and he did meet class for TBS and could benefit from services, but by the time the assessment was finished the family had fallen apart and he was living outside the service area. The Department of Children's Services (DCS) the crisis response team stepped in and placed the three children in foster care except this child who was placed at Childhelp USA (2/9/00) an RCL 12 which houses 80 children (60 males & 20 females). This facility is set out along the border of Riverside/San Bernardino Counties. He will be turning 13 and has aged out of this program. The DCS caseworker he has already started the transition to a therapeutic foster home known to her for their good care in 6 months. He currently is involved in individual, group and a strong behavior modification program which he likes but still longs for going to a home and being closer to his siblings. His parents are not involved in treatment. Father's continued disruption at the Childhelp has jeopardized his placement at this facility making it necessary for the court to issue a restraining order. Father now needs the permission of DCS caseworker to request visitation but has not requested such. Mother has since moved out of the area and started another family and is no longer available to him and his two other siblings. The caseworker from DCS is very involved and appears to care for the child's well being. He appears well nourished and well groomed. The facility was well equipped and spacious having many recreational activities available for the children.

**Summary:** Except for assessment, med support and case management there is no evidence that the child received other services. It appears that DCS has taken over the case without asking for much input from Mental Health. She reports not having a working relationship with SBBH. There are no collaborative meetings for planning or sharing of services for this child.

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## Conclusions:

a) *Adequacy of access to services, including TBS.* TBS is limited by the use of MHP staff, which has been cut severely. They are misconceptions of "turf" that if DCS is working on placement then MHP is not to step in with any services.

b) *Adequacy of capacity to provide service.* TBS is limited and the MHP is hopeful that they will be able to contract services to a provider who can increase capacity.

c) *Accountability*: It is hard to assess because it seems that the MHP is glad for other social service agencies to take over the case in it's entirety.

d) *Evidence that TBS or other services are not working for this child.* The client was eligible and appeared to have been able to benefit from services including TBS, but was not offered due to other barriers.

**San Bernardino County Behavioral Health Services**

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

# Case Review #3

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

**Facts:** The information on this child was gathered from the review of the child's chart(s), interviews with the child and his mother, and the child's clinician.

The male child is 11 years of age and is diagnosis is Attention Deficit, Hyperactivity, and Disorder (ADHD). In November 2004 until April, 2005 he received TBS. According to the chart and interviewing the TBS coach, the main goal was to address difficulty in transitions and to address anger and self-injuries behavior. The majority of the TBS sessions included working with the client during basketball practice.

The client was certified for TBS services in 2002 and didn't receive services until 2004. The delay in TBS occurred because of the lack of capacity. He was in a level 12 group home and has transitioned to his biological mother and grandmother's home. Education has continued to be a struggle and he is performing below grade level, mostly because of his behavioral issues.

The chart included a diagnosis for the child that includes Attention-deficit hyperactivity disorder (ADHD), and Axis III overweight. The child has received services that include case management, psychiatry, individual therapy, group therapy and TBS services provided by a behavior coach. He has also had an inpatient psychiatric hospitalization.

**Summary:**
The client is an 11-year boy who is living with his mother and grandmother in a small home. The team assessed that the child would have benefited from additional TBS in the home to assist the mother and grandmother in providing behavioral techniques to de-escalate aggression in the home.

**Conclusions:**

a) *Adequacy of access to services, including TBS.* TBS was beneficial when the child was receiving the services, however, it is difficult to access if basketball practice is the most beneficial environment to provide the service.

b) *Adequacy of capacity to provide service.* The child's TBS was discontinued because of a "lack of coaches". San Bernardino has minimum capacity to provide TBS to children.

c) *Accountability.* The case manager remains in regular contact with the client, the group home and the client. She attends the child's IEP meetings and quarterly reviews. She is actively working on addressing the needs of the child and family members.

d) *Evidence that TBS or other services are working.* He is at home, and is reported to be doing pretty well. He attends a non-public school associated with the group home parent company. He is in the grade, which is appropriate for his age, but he is not doing that grade level of work.

e) *Quality of TBS, if TBS was provided.* TBS was provided in a basketball setting, it is difficult to assess if this is the most appropriate place to provide behavioral interventions. In addition, the family environment seems to be very difficult with the grandmother, mother and client all in a small home.

f) *Appropriateness of services to kids placed out of county (if applicable).* This is not an issue, because the child is at home.

**San Bernardino County Behavioral Health Services**

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

# Case Review #4

**Case Review Team:** Anne Murray and Cynthia Rutledge

**Facts:** The information on this child was gathered from the review of the child's chart(s) and interviews with the client's aunt who is her legal guardian and three workers employed by the contract provider. There was an attempt by the review team to interview the client by telephone but there was no answer at the home at the agreed upon time. The client is a 10-year-old Caucasian female who, along with her younger brother, is residing with her legal guardian in Barstow, CA. She has not received TBS.

The client was placed into the foster care system at a young age. Her biological mother was manufacturing amphetamine in the home. The client and her sibling were severely neglected. Their biological father who, in turn brought the children to his sister removed the children from the home. Both children were subsequently placed in the foster care system under the guardianship of their aunt. There continues to be an open Department of Children's Services (DCS) case on the client. The chart included a number of DSM diagnoses for the client: adjustment disorder with mixed emotions and conduct, neglected child and oppositional defiant disorder.

**Summary:** The client's aunt has been her legal guardian for seven years. She has requested mental health services for the client since she was five years of age. The aunt's first request was made when she noticed a significant change in client's behavior with the reappearance of the biological mother. The aunt reported that she received very little support from county agencies, including mental health, social services and child protective services, during the two years the biological mother continued to disrupt the stability of the children. The court did not deny parental visitation until the client was nine years of age. Since September 2004, there have been three hospitalizations for this client, the most recent in February 2005.

The aunt reports that the mental health counseling services the client has received have seemed fine once the client has established a relationship with the counselor; however, she has had to travel long distances for her niece to receive those services. The aunt also reports feeling overwhelmed with the continued aggressive and dangerous behaviors of her niece. The aunt reported that the client recently ran into the highway when she was angry, strikes her brother without warning and destroys property in the house.

When asked by the team, the aunt stated that she had never heard of TBS. The child's chart indicates that she is currently receiving "wraparound" services;

however, in the team's interview with the current provider, Desert FICS, the provider stated that they do not provide wrap services and are not licensed to do so.

## Conclusions:

*a) Adequacy of access to services, including TBS.* Discussions with the client's aunt indicate difficulty getting approval for services, having to drive long distances for services, lack of information on services available and misinformation on what services will be provided.

b) *Adequacy of capacity to provide service.* Access to county services is reported to be lower in the high desert region (Barstow area) where the family resides.

c) *Accountability.* There was some coordination in the case as evidenced by the review team notes in the file, but there have been some gaps in the service and placement coordination for the client and her family. The child's aunt and her husband paid for the child's therapy out-of-pocket for a period of time since the judge had ordered counseling. There was difficulty getting the necessary services in place and little information given to the family regarding services for which the client could be eligible.

d) *Evidence that TBS or other services are working.* According to the client's guardian, the client's behaviors are not diminishing. Although the client's chart indicates that wrap services are being provided to this family, the provider is not approved to provide those services. TBS has not been offered or provided.

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

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

San Bernardino County Behavioral Health Services

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# Case Review #5

Review Team: R. Connie Lira, DMH Compliance

Facts: This 17 year old black, conserved male he was removed from his home after reports of sexual abuse by his Grandfather who turns out to also be his Father. He carries the following diagnosis' Axis I Schizo-affective Disorder; PTSD and Rule out borderline intellectual functioning. Axis II Rule out Mental Retardation. Axis III Hypothyroidism; Tardive Dyskinesia, which made his speech difficult to understand. He continues to receive a combination of medications some of the same class. He had a current GAF of 55. He has been in placements since the age of 6 when he was removed from his biological home due to his Mother failing to keep him safe from a family member who sexually abused him. He was again molested in Foster placement. The records report the child has had many hospitalizations and multiple crises due to his aggression he was unable to be maintained in an RCL 14 he was then placed at Metropolitan State Hospital. He had been assessed for Mental Health services including TBS on 8/20/02 but TBS was not being considered because services " would solely be to ensure the child's physical safety and the safety of others." He was assessed for medical necessity for services again 5/28/03 with no recommendation for TBS because he was going to placed at Metropolitan State Hospital while there he was assessed 9/9/2003 to assist in transition back into the community again to a level 14 treatment facility services were again denied "due to state hospital placement he is not eligible for TBS". He was placed in an RCL 14 where he is doing well upon interview he appeared sedate, slow moving and showed evident signs of tardive dyskinesia. There was no evident plan to address the fact that this young man will be turning 18 in less than a year and there is no plan for transition to a lower level of care and he will not be able to stay in this facility once that occurs. He is assigned a Case manager through the MHP but when interviewed she was relatively new to this case and was not very knowledgeable about this case, she did not know of any transition plan or in general what services would be required to allow this young man to live in the least restrictive level of care when he "ages out".

Summary: The client was clean, large for his age, and had obvious psycho-motor retardation he had difficulty annunciating which made him a brunt of others teasing (a precursor identified to his becoming agitated / assaultive). He was proud to report that he was learning to control his anger, and had not been in restraints recently. He was taking several medications and his physical health was being monitored. He is receiving school services on site (non-public school) and the staff reported him doing well at or just below grade level.

**San Bernardino County Behavioral Health Services**

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

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

a) *Adequacy of access to services, including TBS.* This child's services were limited to medication support, case management and placement in a state hospital. He was assessed for but never received TBS due to placement in a state hospital.

b) *Adequacy* of capacity to provide service at the time of our visit the capacity of the MHP to provide TBS was very limited and the MHP was working on getting a contract for TBS services in place.

c) *Accountability*: The MHP staff appeared to not take an active role in providing TBS and other mental services to this client. For example, if another agency was involved with a client SBDBH should enhance services that are provided to the client; however, it seems that the case manager and SBDBH withdrew from providing services.

d) *Evidence that TBS or other services are working:* the focus for this young person was geared towards placement providing him with a place that would accept him.

e) TBS was not provided for this youngster on three different occasions that medical necessity was assessed for TBS due to lack of capacity.

f) N/A although it was reported by the cm that he would be moving to Texas upon his 18 BD but the facility staff report that he doesn't have any supports in Texas.

San Bernardino County Behavioral Health Services

Dates of review: May 16 – May 20, 2005

# Case Review #6

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

**Facts:** The information on this child was gathered from the review of the child's chart(s), interviews with the child and the San Bernardino County case manager. The client is a 17 year-old Asian and Hispanic male. He has not received TBS. He is currently placed in a RCL 14 group home.

The client was placed into the foster care system at age 9. The client has a long history of loss, with a several immediate family member that have died from killing other family members, suicide or from AIDS. The client started to display more behavioral problems at the age of 6 with fire starting. There were problems with running away (5 AWOLs in 03-04); he has had 15 placements in the last 6 years. Client has affiliated with gangs and has a history of drug use. The client's only living relative is an aunt that is unable to provide a resident for the client at this time. Client was denied TBS services and has only received mental health services in the last few months.

He was hospitalized due to high-risk behavior and the family did not feel safe with a plan for the client to return to the home.

The chart included a number of diagnoses for the client: conduct disorder, depression disorder and cannabis abuse and PCP use. The IQ was 85-91 at the time of her county psychosocial assessment.

**Summary:** The child's case manager was well informed about the client and expressed a thoughtful consideration of the placement and treatment options for the client and his transitional options as he ages out of the system. The case manager indicated that TBS and wraparound services were not considered when the client moves to a lower level of care because of the lack of capacity. Independent living is currently being considered for the client and also, an application to Job Corp is in process.

**Conclusions:**

*a) Adequacy of access to services, including TBS.* The client is residing in an RCL 14 group home in San Bernardino, CA. He was placed there directly from the psychiatric hospital. He is currently receiving individual therapy, group therapy, and case management services. The client is a smart child and outgoing since he has been in the structured residential placement. He

has run for a leadership role and won the designation of "Chairperson" of the home. He has not received TBS from San Bernardino.

b) *Adequacy of capacity to provide service*. It does not appear that the youth received the appropriate services after his hospitalization became known to the county mental health plan (MHP). There is a minimal plan to assist in the transition to independent living in July 2005.

c) *Accountability*. The case manager is a master's level county worker who remains in regular contact with the client, and the group home. He is actively working on placement options for transitioning the child down to an independent living.

d) *Evidence that TBS or other services are working*. The client is maintaining in his current placement. He is progressing in his schoolwork and receiving average grades. He wants to move into independent living in July when he turns 18. An independent living program associated with his group home is being considered as well as an apartment on his own. However, this client will have a difficult time adjusting an independent setting. He has history of drug use and gang affiliation. This client will need a strong support network to be successful in his placement as he ages out of the youth residential system.

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). Does not apply.*

**San Bernardino County Behavioral Health Services**

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

# Case Review #7

**Case Review Team:** Cynthia Rutledge, DHM Medi-Cal Policy
Ann Murray, LCSW, DMH Policy

**Facts:** The information on this child were gathered from the review of the child's chart(s) and interviews with the client's foster mother and Department of Children's Services (DCS) worker and conservator. There was an attempt by the review team to interview the client by telephone but she chose not to speak with the reviewers. The client is a 15-year-old Filipino/Caucasian female residing in an RCL 12 group home located in Lancaster, CA. She has been in this placement for eight months. The client was previously hospitalized at Metropolitan State Hospital and she is on conservatorship. She has received Therapeutic Behavioral Services (TBS) in the past but not at this time.

The client was placed into the foster care system at a young age and there is currently an open DCS case. The chart included a number of DSM diagnoses for the client: bipolar disorder with psychotic features, attachment disorder and attention deficit hyperactivity disorder. Her global assessment of functioning (GAF) is 38. Her psychotropic medications include Paxil, Seriquel and Depokote.

**Summary:** The client has had significant mental health needs for a long time and she has been known to DCS for many years. She was placed in a group home at the age of 5 and remained there for five years. The child was later remanded to the custody of her mother. The placement was interrupted when the client set a fire in her mother's apartment. She has been placed in a variety of locked facilities and group homes: Metropolitan State Hospital, Child Help, Shandin Hills Adolescent Center, and Care Providers. The client has demonstrated violent outbursts, dangerousness to self and others, threatening behavior toward peers and staff, poor hygiene, non-compliance with medication and poor school performance. The chart indicated a history of self-mutilation and assaultive behavior toward her mother. The client's history of danger to self and others and fire setting has resulted in difficulty with placements options.

The client is currently doing quite well according to the DCS worker. There has been a decrease in her problem behaviors but she continues to have difficulty at school due to her behavior. There has been no TBS provided while the current worker has been assigned to the case. The client also has issues of abandonment, loneliness and unresolved grief. The worker reported that the client sees a therapist on a weekly basis at her placement. A psychiatrist prescribes and monitors her medication.

**Conclusions:**

**San Bernardino County Behavioral Health Services**

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

*a) Adequacy of access to services, including TBS.* The services have been coordinated through the DCS worker/conservator. The child received TBS in the past and she is in need of a lot of services at this time. This worker believes the child is not appropriately placed in school. She has an Individual Education Plan and she attends a regular public school. The worker believes the client would be more successful in a non-public school and the worker is attempting to facilitate this change. The client functions better if she works on projects independently due to deficits in her interpersonal skills. There are behavioral problems when coordination with her peers is required.

b) *Adequacy of capacity to provide service.* TBS is rarely being provided in the county as evidenced by the data reported by the county and interviews with staff and family members of the children. There was also some confusion about how other services for children are provided such as some discrepancy about the services provided by the contracted agencies as specified in lack of information in the case file.

c) *Accountability.* There was coordination in the case as evidenced by the review of the team notes in the file and by the report of the DCS worker.

d) *Evidence that TBS or other services are working.* This was difficult to fully assess. The therapist did not respond to the MHP requests to participate in the focused review interviews and the child refused to speak with the reviewers.

e) *Quality of TBS, if TBS was provided.* The child is now in a lower level of care but it was difficult to determine what impact TBS had on the change in placement. The child's behavior continues to cause difficulties with peers in the school setting and in the group home and could benefit from additional TBS.

f) *Appropriateness of services to kids placed out of county (if applicable).*
The child is placed in a group home that is fairly close but is outside of San Bernardino County. The child is receiving mental health services that include psychotherapy and medication services from SBDBH. The DCS worker sees her on a regular basis to coordinate the care and treatment.

**San Bernardino County Behavioral Health Services**

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

# Case Review #8

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

**Facts:** The information on this child was gathered from the review of the child's chart and an interview with the client and the client's case manager and therapist employed by the group home provider, East Valley Charlee. The client is a 10-year-old Caucasian male who is residing at a rate classification level 12 group home. He has not received TBS.

The client and his sister were placed into the foster care system once the biological mother was unable to continue to care for the children due to their behaviors. The client's father resides in Arizona, but has been denied custody due to his criminal record. The client has had multiple placements. The chart recorded a history of major depression in the family. The current DSM diagnoses for the client includes: Bi-Polar disorder, major depression, and problems with primary social support and education.

**Summary:** He has had numerous placements due to behaviors that include antagonizing peers, yelling, assaultive to staff, and throwing rocks at windows. The client has a history of fire setting and shows very little empathy for his actions. The client has numerous hospitalizations. The child does receive visits from his mother and he is very upset with his mother. The father does occasionally visit but the visits are unannounced and disruptive since he promises the child that he will be able to live with him.

Although a TBS assessment was done prior to the current placement, TBS was never provided due to the lack of capacity to provide TBS. The client has shown progress in his current placement. He has been at the current placement since June 2004. The client states that he would like to live with his father. The client's current case manager and therapist report that this child is showing some progress.

**Conclusions:**

*a) Adequacy of access to services, including TBS.* Discussions with the client's case manager and therapist indicate difficulty in getting approval for TBS services due to the lack of coaches available.

b) *Adequacy of capacity to provide service.* The client's therapist stated that he was a TBS coach for San Bernardino County at one time, but the pay was poor and there were no benefits offered. Both the case manager and the therapist

stated that TBS was not asked for since there never seemed to be an available TBS coach.

c) *Accountability.* The progress notes also indicate coordination between the provider and the case manager. The chart also indicates the assessment and initiation was requested for TBS, but was not available.

d) *Evidence that TBS or other services are working.* According to the client's case manager and therapist, the behaviors that are being addressed for this client are about the same. This appears to be largely due to the efforts of the therapist. TBS has not been provided.

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

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

**San Bernardino County Behavioral Health Services**

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

# Case Review #9

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

**Facts:** This child did not receive TBS services. This 14 year old conserved male (DOB 10/22/90) carries the following diagnosis Axis I Bipolar Disorder with psychotic features in partial remission. No Axis II diagnosis, and Axis III Drug exposure (In utero). He is reported to have a current GAF of 60. This child receives a combination of medications: Risperdal, Lithium, Wellbutrin Depakote, Tenex, Cogentin, DDAVP and Synthroid. The clinical record for this child was very sketchy and contained several gaps in time. He was first assessed for medical necessity for mental health services on 1/6/03 and again on 1/20/04. He met class for TBS services each time but did not receive services. On 1/6/03 he did not receive TBS because he was going to be admitted to Metropolitan State Hospital. A note was found dated 3/17/03 stating that the client possibly could return to East Valley Charlie (EVC) with a TBS coach. He was placed at Metropolitan State Hospital on 4/17/03.The assessment of 1/20/04 stated that TBS was not appropriate because "client currently at highest level of care". A bed at East Valley Charlie became available at on 6/17/04 and he was placed on 7/30/04 from the state hospital there were not any notes stating that TBS were considered for transition to the community or to explain why TBS was not being provided. His conservatorship was renewed 4/22/2005. Interview with this child revealed an appropriately groomed, well nourished, happy individual who stated he was glad to be a EVC he described the home as clean and fed them well. He described a safe environment that provided good food and plenty of recreational activities, He reported doing OK in school he attends a non-public school run by EVC and is doing well.

**Summary:** The interviews for this child were limited to himself, and the group home staff. This child is open to only case management from the MHP and EVC provides individual, group therapies and medication support services. During staff interviews they reported that this child had transitioned from State hospital to group home living with some difficulties and TBS would have benefited him in the transition, but to their knowledge it was not an option considered. His current plan is for him to receive therapeutic services and to transition to a lower level of care, as he must leave the program by December, as this is an 18-month program. He still requires a high level of behavior modification techniques to allow him to remain in this group home, but he has made great improvement.

**Conclusions:**

a) *Adequacy of access to services, including TBS.* This child received multiple assessments for services and he was found to meet the qualifications for class membership for TBS but for various reasons (in and around placement) he

did not receive TBS.

b) *Adequacy of capacity to provide service*. The MHP admitted they were having a difficult time finding and keeping TBS coaches to serve their county residents and are in the process of awarding a contract in hopes to increase the availability to TBS. SBDBH does not have the capacity to fulfill the need for TBS in San Bernardino.

c) *Accountability*. With a new contractor coming on board the contract should address oversight and accountability. SBDBH will need to monitor cases and contracts regarding TBS to class members.

d) *Evidence that TBS or other services are working.* TBS was not used for this child and most likely would have been helpful but the use of other services appeared to be appropriate.

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

f) *Appropriateness of services to kids placed out of county (if applicable)*. Does not apply.

**San Bernardino County Behavioral Health Services**

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

# Case Review #10

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

**Facts:** The information on this child was gathered from the review of the child's chart and an interview with the client and the client's case manager and therapist employed by the group home provider, East Valley Charlee (EVC). The client is a 12-year-old Caucasian male who is residing at a rate classification level 12 group home. He and his sister are dependents of the court. He has not received TBS.

The client and his sister were placed into the foster care system once the biological mother was unable to continue to care for the children due to their behaviors. The client's father resides in Nevada, but has been denied custody due to his criminal record. The client has had multiple placements and hospitalizations. The chart recorded a history of schizophrenia in the family. The current DSM diagnoses for the client includes: depression and anxiety disorder.

**Summary:** The client has significant mental and emotional problems. He has had numerous placements due to behaviors that include antagonizing peers, yelling, kicking holes in walls, and throwing rocks at windows and staff. The client has been hospitalized twice. The child does not receive visits from his mother. The father does occasionally visit but the visits are unannounced and disruptive since he promises the child that he will be able to live with him. The child's aunt used to visit but visits are now rare.

Although a TBS assessment was done prior to the current placement, TBS was never provided. The client has shown progress in his current placement and states that he "likes it better than the last place." He has been at the current placement since March 2004. The client states that he would like to live with his father. He also states that he is working hard to control his behaviors so that he can be transitioned to a foster home. The client's current case manager and therapist report that this child is showing progress and they will continue to work on a transition to a lower level of placement.

**Conclusions:**

*a) Adequacy of access to services, including TBS.* Discussions with the client's case manager and therapist indicate difficulty in getting approval for TBS services due to the lack of coaches available.

b) *Adequacy of capacity to provide service.* The client's therapist stated that he was a TBS coach for San Bernardino County at one time, but the pay was poor and there were no benefits offered. Both the case manager and the therapist stated that TBS was not asked for since there never seemed to be an available TBS coach.

c) *Accountability.* The client's chart contains a clear chronology of the placements for this child. The progress notes also indicate coordination between the provider and the case manager. The chart also indicates the assessment and initiation of TBS; however, TBS was never provided.

d) *Evidence that TBS or other services are working.* According to the client's case manager and therapist, the behaviors that are being addressed for this client are diminishing. This appears to be largely due to the efforts of the therapist. During the client interview, the child said that he liked his current placement but was anxious to be moved to a lower level of care and was working hard to control his temper and "do the right thing". TBS has not been provided.

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

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

# Appendix 2 – External Stakeholder Focus Group Analysis

**DMH Focused Review of services to Emily Q. Class Members**

**San Bernardino County Behavioral Health Services**

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

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

The Qualitative Focused Review consisted of 5 Focus Groups performed on May 17- May 19, 2005. The external stakeholder focus groups for San Bernardino County Mental Health Plan (MHP) included TBS coaches, Interagency Placement Council (IPC), Contracted Providers (Group Homes), Parent Partners and SBDBH clinical staff.

The TBS coaches focus group understood the criteria for TBS services. They explained the procedure in providing TBS services (i.e. establishing replacement behavior and reward systems). However, most of the members in other focus groups (group home providers, probation department and parent partner) had a vague idea of what TBS is and how is it is properly used for class members. For example, a person from the Probation Department stated, "I came to the Interagency Placement Council (IPC) for a whole year and I just heard about TBS in the last two weeks." The majority of the members in the other focus groups did not understand the criteria and the most effective way to use TBS.

Another major issue for San Bernardino County regarding the provision of TBS is the lack of capacity throughout the entire county, especially in desert regions. The City of San Bernardino is where most of the TBS is provided in the county. . The number of coaches in San Bernardino is approximately 2.5 FTE. One participant from the groups stated, "There are not enough resources in San Bernardino, we could use 5-6 coaches in each service area (there are 4 regions in San Bernardino)...the wait is too long (for TBS)."

In addition, San Bernardino County has a relatively limited referral process since capacity is restrictive. One member of the focus groups explained, "referrals only come from San Bernardino Behavioral Health staff and not from family members or providers that need to implement services." This situation limits access for the referral process and in turn reduces the number of TBS units provided.

The MHP is not routinely using TBS to transition children and youth to a lower level of residential care. From the cases that the DMH team reviewed, TBS is being used as a last option to prevent a higher level of care. In addition, TBS has been inadequate for prevention of a higher level of residential care.

The MHP does not have adequate data to substantiate access, capacity or quality. The focus group members have not seen any indication that SBDBH is providing reports or tracking services regarding TBS cases or outcomes of services provided.

Interviews with child welfare staff indicated substantial out-of-county placement issues. The issues discussed are not specific to San Bernardino County, but are part of the complex statewide issues being discussed by several workgroups whose focus is the many difficulties for children who need services and are placed out of their county of origin.

**Conclusions and Issues specific to the San Bernardino County MHP include:**

- There is a lack of a data system to track children, services and outcomes;
- There is a need for technical assistance and training in providing TBS more expansively, (i.e. the use of TBS to children/youth needing extended TBS authorization, children/youth transitioning to a lower level of care and children/youth needing mental health services and placed out-of-county);
- There is a need for a written and more comprehensive authorization/certification process;
- There is a need for training and assistance in collaborative techniques with other county agencies.
- There is a need to expand the capacity and provide TBS resources to all regions of the county.
- Finally, eliminate service waiting lists for mental health services including TBS.

# Attachment

# A

# San Bernardino County

## 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:**

## 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:** | 27 |

| | |
|---|---|
| *0* | -TBS has been provided and the placement is still required.<br>*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:

| | |
|---|---|
| 27 | -TBS services will not resolve the child/youth's transition issues or prevent the child/youth from moving to a higher level of care.<br>*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.<br>*Cultural issues? Involvement in the planning process?* |
| *0* | TBS is appropriate but:<br># ___ - Was refused by family/caregiver or the child/youth (when appropriate).<br>*Cultural issues? Involvement in the planning process?* |
| 0 | # ___ -Is not available because...other<br>*What criteria was used in this decision?* |

Qualitative Focused Review – Data & Information

**SAN BERNARDINO 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:** | **6 unduplicated clients (6 notifications received)** |

**Initial Information – Class Membership**

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

*1* - Being considered for RCL 12 or above

*2* - One psychiatric hospitalization in preceding 24 months

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

| Gender | |
|---|---|
| 4 Boys | 2 Girl |

| Age | |
|---|---|
| 6 ages 0-17 | 0 age 18-20 |

**Ethnicity**

| | | |
|---|---|---|
| 4 White | 1 African-American | 1 Hispanic |
| 0 Native American | 0 Asian/Pacific Islander | 0 Other |

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

| | | |
|---|---|---|
| 3 Family Home | 0 Foster Home | 0 Foster Family Agency |
| 0 Children's Shelter | 3 Group Home | 0 CTF |
| 0 Other | 3 (RCL 12) | |

Qualitative Focused Review – Data & Information

**SAN BERNARDINO County**

**Therapeutic Behavioral Services (TBS)**

**Notifications Quarterly Summary**

| **Service Need:** | |
|---|---|
| 6 - To prevent placement in higher level of care | 0 - To enable transition to a lower level of care |

Analysis (Identify trends, questions, etc.)

# Attachment

# B

# San Bernardino County

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

### DATA SUMMARY
### September 2003-December 2003

Open TBS Cases (as reported by the county)- 8
TBS Notifications – 6
TBS Certifications –27
TBS NOAs – 0
TBS 4th Authorizations – 0

RCL Rate -.11%  Readmit Rate -2.29%  SH Rate -.37%

San Bernardino county has the TBS coordinator participate on a multi-agency assessment team, the Interagency Placement Council (IPC) with juvenile justice, social services, schools, public health, and probation. The IPC appears to be a well-coordinated system for interagency collaboration and a good opportunity to place TBS class members.

San Bernardino county relies on referrals to come from contract providers. This could cause a restriction on access to TBS if contract providers do not want TBS in their facilities, or do not see the benefit of TBS for their clients in an RCL 12 or 14 placement.

San Bernardino county has an authorization process, 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.

San Bernardino county does not have a method for monitoring TBS cases, when it is provided to class members.

San Bernardino county does have a mechanism for outreach and education to agencies and families regarding the availability of TBS as well as information about the referral process. SBDBH has provided information at an Annual Children's Network Conference. In addition, SBDBH provides informational material at the psychiatric inpatient hospitals, but it appears that TBS is not strongly pursued for class members, once the client is discharged for the inpatient setting. Finally, it appears that training to other agencies and families is at a minimal level in San Bernardino county.

Information provided by SBDBH regarding the -2.29% decrease in re-hospitalization are the result of hospital aftercare services resulting in a decreased of the re-hospitalization rate.

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

Coordination of the TBS treatment plan does not appear to involve a behavior team and support counselor from SBDBH.

The review team has additional questions around the following:

1. The Interagency Placement Council (IPC) is established; however, it appears the IPC is not fully used to access TBS for class members.
2. SBDBH has a Home and Hospital Program for TAY that provides assessment, and intensive case management; however, it is difficult to assess the proficiency of the program.

# Attachment

# C

# San Bernardino County

State Department of Mental Health
Name of MHP: **San Bernardino County Dept. of Behavioral Health**

## Focused Review of Services to Emily Q. Class Members
### MHP Pre-Visit Questionnaire

Thank you for taking the time to complete this questionnaire. The questionnaire is one component of the preliminary analysis that the review team will be conducting prior to the upcoming focused review scheduled in your MHP. The information you return to us will assist the review team in developing a picture of Therapeutic Behavioral Services (TBS) in your mental health system prior to the review.

Be sure to answer these questions as thoroughly as possible. Any additional information that you feel is relevant to understand TBS in your MHP is appreciated, however we ask that you hold onto any additional printed materials for discussion when we arrive for the on-site review. You can anticipate that the review team will spend some time during the on-site visit discussing the information contained in this questionnaire.

Please return the completed MHP Pre-Visit Questionnaire no later than 2 weeks prior to the scheduled on-site review, to facilitate the review team's preliminary analysis. Thanks.

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

Lisa McGinnis, LMFT, Mental Health Clinic Supervisor, coordinates TBS responsibilities in our MHP. Yes, her other responsibilities include coordinating the AB2726 Program.

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

Provider submits a Treatment Authorization Request (TAR) form (for both initial authorization and reauthorizations) along with the assessment and treatment plan to Department of Behavioral Health ACCESS Unit. ACCESS reviews these documents, then approves, modifies or denies the request for services. When there is a modification or denial or services ACCESS will issue an NOA.

## Focused Review of Services to Emily Q. Class Members
**MHP Pre-Visit Questionnaire**

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

In the past year twenty (20) initial TBS authorization requests have been received.

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

In the past year nineteen (19) requests were received and authorized as submitted, and one (1) request was modified before authorization.

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

San Bernardino County, Department of Behavioral Health is currently the primary provider for most of the TBS cases. NOAs have been issued during the referral and screening process for clients, who do not meet eligibility, class or need criteria. Only one NOA-B has been issued in the past year for an initial authorization request based on a reduction in the number of TBS hours initially requested by the provider.

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

In our MHP TBS providers/coaches received initial training using State DMH training material. The TBS Unit also receives weekly supervision where cases are discussed in detail. In addition TBS staff receive ongoing training and updates provided by State DMH materials and through monthly TBS conference calls.

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

TBS Training was provided at the Annual Children's Network Conference and also to the Department of Children's Services (DCS), Public Health, and Probation. Quality Management staff provided TBS training to contract and non-contract psychiatric

hospitals.

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?

TBS Certifications and informational materials are distributed to psychiatric inpatient hospitals in English and Spanish.

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 currently have one TBS coach who is Spanish-speaking but to date we have not received a request for non-English speaking providers for TBS. For fiscal year 2005-2006 our TBS contracts will require Spanish-speaking staff.

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).

To date we have not received any grievances in regards to access to TBS, satisfaction with TBS or from a TBS provider.

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

Parents or caregivers are present at all TBS treatment planning meetings. TBS is explained to the family members before the assessment process, during service treatment planning meetings and ongoing during the coaching sessions.

## Focused Review of Services to Emily Q. Class Members
**MHP Pre-Visit Questionnaire**

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

TBS is included in the quality improvements efforts through thirty-day reviews with peers, client/caregiver satisfaction surveys as well as the State DBH Performance Outcome surveys. A section on TBS is included in the current Quality Improvement Plan.

13. What is the county MHP's process for ensuring that Transitional Age Youth (TAY) is assessed for TBS?

TAY clients in State hospitals and RCL-12 and 14 group homes are provided with TBS informational materials. TAY issues are discussed in the weekly Interagency Placement Council where Wraparound and TBS services are potential tools for addressing the treatment needs of this population.

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

Transitional Age Youth in foster care are assessed for TBS through the Healthy Homes Assessments provided to foster care children. TAY and foster care issues are discussed in the weekly Interagency Placement Council, where both Wraparound and TBS is included in the treatment planning process.

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

The Interagency Placement Council reviews the cases of all minors placed out of county, including TAY, to discuss eligibility for TBS services.

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

## Focused Review of Services to Emily Q. Class Members
**MHP Pre-Visit Questionnaire**

The Department has a Home and Hospital Program that provides assessment, and intensive case management services to TAY along with referrals to TBS for those who are eligible. In addition the MHP participates in monthly multi-agency team meetings where resources and case needs are discussed for clients with multiple hospitalization.

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

The MHP currently does not utilize CTFs. Monitoring of TAY in IMDs is provided by our Adult Case Management Unit, which has received TBS training and materials. At every State Hospital treatment team meetings TBS is considered as part of discharge planning. TBS treatment is also discussed with our contracted Mental Health Rehabilitation Center and is included as part of the discharge planning process for all clients, including TAY.

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

Yes, during the past year there have been four children placed out of County who have been authorized to receive TBS services

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.

The treatment, staff for both DBH and its contract providers, are routinely involved in treatment planning meetings and the TBS coaches regularly meet and consult with clients' primary provider. TBS coaches meet weekly for group consultation with an LPHA as well as weekly treatment oversight meetings.

16. Looking at the data below, generated from data available to DMH from your county, the State Department of Social

## Focused Review of Services to Emily Q. Class Members
**MHP Pre-Visit Questionnaire**

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) .011% increase/decrease in RCL Level 12 or higher rate.

Our Probation Department contracted with a provider for 75 beds with a stay of 6 months

b) -2.29% increase/decrease in re-hospitalization rate.
There has been an increase in hospital aftercare services, development of outpatient clinics' walk-in and triage programs as well as in-home intensive case management program for children with multiple hospitalizations.

c) -0.37% increase/decrease in State hospitalization rate.
The Department of Behavioral Health contracted to increase their RCL-14 beds. In addition, specialized residential care wraparound services became available in this County in 2003.

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More detailed information on the rates cited above is available on the DMH website at http://www.dmh.ca.gov/SADA/SDA-OtherRpts.asp. Thank you for completing this survey. Please be sure to return it at least 2 weeks in advance of your review date to the address below to the County Operations liaison at:

Department of Mental Health
Attn: INSERT NAME HERE
1600 9th St., Room 100
Sacramento, CA 95814

or via email to:

First.Last@dmh.ca.gov