

**County of San Bernardino - Department of Behavioral Health
TBS Accountability Stakeholders Meeting
General Forum Open to the Public**

Children and Youth Collaborative Services

Date:	May 21, 2009
Location:	Behavioral Health Resource Center 850 E. Foothill Blvd., Rialto, CA
Facilitator/Recorder	Timothy E. Hougen/Sandy Rodriguez

In attendance: Stephen Garrett, VCSS Dst/Mtn; Monica Vega, San Gabriel Children’s Center; Marsha Mathews, MHS, Inc.; Sayaka Tada, VCSS-San Bernardino; Paula Quijano, VCSS-San Bernardino; Claire Karp, Pacific Clinics-TBS; Becky Heiple, VCSS-San Bernardino; Paola Machon, VCSS-San Bernardino; Corinna Garcia, VCSS-San Bernardino; Merida Saracho, DBH, Diane Terrones, DBH, Rudy Cruz, DBH; Yvonne Boudevin, VCSS-San Bernardino

Accountability Questions	Outcome of Discussion
Introductions	Around the table introductions.
<p>1. Are the children and youth in San Bernardino County\ who are Emily Q class members and who would benefit from TBS, getting TBS? Key Points:</p> <p>I. Referring Agencies use TBS as a “Last Resort” before hospitalization</p> <ul style="list-style-type: none"> • Need for more information to Referring Agencies re: criteria, process and benefits of early intervention <p>II. Foster Home & TAY populations are under-served</p> <ul style="list-style-type: none"> • Specialty Mental Health Provider” criteria is still a requirement and obstacle at times • Other Department’s Consent Process perceived as delaying TBS 	<p>I. Disagreement Amongst Providers: Problems with Referral Source:</p> <ul style="list-style-type: none"> • More info on TBS as an available resource with criteria, process, etc., needed • Referral Sources (e.g., Children & Family Services) are waiting too long to process a referral (e.g., delayed paperwork and follow-through) • “Last Resort” mentality resulting in TBS referral as a “last ditch” effort before hospitalization as compared to a recommended referral when behavior of child is indicative of being “at risk”.. waiting too long <p>II. Foster Home population is not being served.</p> <ul style="list-style-type: none"> • A barrier for CFS may result from new Consent protocols which require Treatment Consents from the biological parents and/or Court Order. • SMHP criteria requires Medi-Cal billing for specialty mental health services. <ul style="list-style-type: none"> ○ Not uncommon for a referral to fail as a result of the lack of a SMHP ○ For example, a LA County provider in attendance noted that LACO DMH requires DMH direct involvement by its LHPA SMHP to authorize TBS as an augmented service to mental health services; SB County DBH allows for contract agency/provider to function

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<p>III. Out-of-County Children also experience difficulties in getting TBS</p> <p>IV. Families decline TBS when they learn of high frequency of service.</p> <ul style="list-style-type: none"> • TAY population is underserved. <p>V. Verbatim comments of CFS Social Workers here</p> <ul style="list-style-type: none"> • Positive perception of effectiveness of TBS • Referral process too long to get TBS started • Perception that admission criteria is too strict 	<p>as SMHP, but SMHP is still requirement.</p> <p>III. Children placed out-of-county also experience difficulties in getting TBS services.</p> <ul style="list-style-type: none"> • Providers discussed from perspective of having children placed into SB County from other counties <p>IV. Families declining TBS is also a problem. This may be due to the high frequency and “intrusive” nature of services. A different Model of Services with less frequency may be required when family perceives TBS as too intrusive.</p> <ul style="list-style-type: none"> • Provider(s) suggests “Min to Max” guidance in terms of total service activities required under TBS Model • Problem may be definitional in that TBS is required to be unlike “Rehab ADL” and/or Therapy” • One Provider comments that Reduced Minutes Model may be more effective with Transitional Age Youth, ages 18-21; there is a need to increase outreach and access to the TAY population. • One provider reported evidence of a 2-Hour threshold for maximum learning that supports Reduced Minutes Model • However, one Provider notes that the non-Reduced Minutes Model allows time to address Family dynamics and “family systems learning”. <p>V. Comments from CFS Social Workers (Research & Evaluation Focus Group)</p> <ul style="list-style-type: none"> • “The ones getting TBS or who are eligible seem to benefit from it. The eligibility criteria excludes many.” • “Children do not fit criteria; need to have been hospitalized to get the services.” Comment: "Utilize TBS before child gets hospitalized." • "Services provided have been very good, once the long process of accessibility was completed." • “No, only a small number because Social Workers are not familiar with the referral.” Comment: "Work to improve communication with County Social Workers; continue to educate DCFS workers on available services.”

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<p>2. Are the children and youth who get TBS experiencing the intended benefits?</p> <p>I. Data confuses indicators of TBS efficacy (e.g., hospitalizations)</p> <ul style="list-style-type: none"> • Pre and Post test of client’s functioning is a better Indicator of TBS (ref: Riverside County’s Behavioral Assessment Functioning Index) <p>II. Use of TBS as “Last Resort” distorts TBS outcomes</p> <ul style="list-style-type: none"> • Limited levels of “collaborative coordination” • Early access would facilitate intended TBS benefits <p>III. Transition problems when TBS ends</p> <ul style="list-style-type: none"> • Parent’s/Family’s lack of maintaining TBS interventions an “inefficient passing of the baton” <p>IV. Comments from Social Workers’ here</p> <ul style="list-style-type: none"> • Multiple placements are obstacles to starting services • Benefits seen, but more kids should qualify (e.g., substance abuse) 	<p>I. Participants agree that Hospital data is confusing</p> <ul style="list-style-type: none"> • MHS, Inc. noted its success with pre- and post-testing of TBS applicant’s functioning; MHS found an increase in functioning level/improvement with TBS which “alone overshadows hospitalization failures” • Participants referenced the effectiveness of Riverside County’s Behavioral Assessment Functioning (BAF) tool:. • Observation was made that TBS was not “created” to help functioning, but to avoid hospitalization and to maintain current placement. <ul style="list-style-type: none"> ○ Participant commented that TBS effectiveness depended on its effect as a layered intervention over an existing “good mental health plan”... “true augmentation” .. “a level of coordination between core mental health services and TBS”. <p>II. Participants agree that points raised in Q1 apply here in that referrals are made only after the child is in crisis and placement change is already planned.</p> <ul style="list-style-type: none"> • Providers would like TBS to become involved at earlier signs of difficulties that put placement at risk; TBS to be used within context of ongoing treatment • Causing the inadvertent targeting of decompensating children/youth • Misuse of TBS as “primary intervention ” in response to crisis creating behavior • “Crisis oriented” referrals resulting in need for higher levels of care • Limited level of “high” or collaborative coordination • Therefore, more rapid access to TBS would facilitate intended benefits. <p>III. Participants also noted failure of parent/caregiver in not following up and/or maintaining TBS Interventions: “an inefficient passing of the baton”</p> <ul style="list-style-type: none"> • Follow-up issues related to SMHP not including focus on TBS interventions in ongoing care • Parent/caregiver not following through with ongoing care with SMHP also a problem. <p>IV. Comments from CFS Social Workers (Research & Evaluation Focus Group)</p> <ul style="list-style-type: none"> • "Cannot access services because child is constantly having different placement(s)" • "Yes, those who receive do benefit". Comments: " Expand criteria to include Dual-Diagnosis Children" • "Yes- the child received excellent services from TBS. The counselor worked very well with her, and worked with her behavioral challenges." Comment: " Better referral process, perhaps". • "Yes, but not for a long (time),2 teens due to AWOL" Comment: "Less paper work."

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<p>3. What alternatives to TBS are being provided in the County?</p> <p>I. Wraparound, Children’s Intensive Services, TAY & Success First Contracts noted</p> <p>II. Participants want TBS to be available as well.</p> <ul style="list-style-type: none"> • Are there too many options? • TBS may augment any of these services 	<p>I. Participants mentioned:</p> <ul style="list-style-type: none"> • SB163 Wraparound Programs • Children’s Intensive Programs • Success First Programs <ul style="list-style-type: none"> ○ Participants noted that Success First Programs have not been marketed to CFS Social Workers, and believe this may account for a lesser response to TBS at lower levels of care. ○ Success First was defined as a Full-Service Partnership that is: <ul style="list-style-type: none"> ○ Available to Medi-Cal & non-Medi-Cal children ○ Provided to children not in group home placement ○ Short-term ○ Analogous Outpatient programs were mentioned: Day Tx Intensive (>4.5 Hrs), Day Rehab in RCL-14’s and TAY FSP’s. ○ Emphasis made that TBS is available to qualified children across entire continuum of care <p>II. Participants agreed that TBS must be an adjunct to all treatment... “children in other programs”.</p> <ul style="list-style-type: none"> ○ Some Families would participate in TBS if these other types of intensive services were not available ○ “Intrusiveness” of TBS into home is exacerbated when offered in conjunction to these other intensive in-home programs ○ Point made that TBS may help children in these programs as well
<p>4. What can be done to improve the use of TBS and/or alternative behavioral support services in the County?</p> <p>Key Points summarized at right.</p>	<p>I. Participants noted/proposed most efficacious avenues as:</p> <ul style="list-style-type: none"> • Outreach • Networking • TBS Coordinators <p>II. Issues here are:</p> <ul style="list-style-type: none"> • Easier Access (as in Q1) • Streamlined Coordination of Care processes <ul style="list-style-type: none"> ○ Comment: CFS SW’s may be concerned as to the amount of time required to facilitate a TBS referral only to be met with denials or delays in service, as a result of their unfamiliarity with TBS criteria... “a lack of understanding as to the TBS Provider’s role” ○ Suggestion: CFS Social Workers’s need a “cheat sheet” (“when and when not to refer for TBS”, with underscored emphasis not to wait till TBS is only a “safety valve”).

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<p>Other Comments:</p> <p>Key Points summarized at right.</p> <p>Other Comments: Continued:</p> <p>Key Points summarized at right.</p>	<p>I. How can we say that TBS is an augmented service when it is started from the start of treatment regimen with other mental health services?</p> <p>II. How long should TBS last?</p> <p>III. Issue as to 9-Pt Plan's reference to 30 day window for unplanned contact during which TBS may be provided.:</p> <ul style="list-style-type: none"> • Plan states that MHP may authorize TBS up to 30 days when class membership cannot be established: <ul style="list-style-type: none"> • Do services need to be stopped as soon as class membership is ruled out? • Could there be disallowances if auditor felt that class membership could have been ruled out from onset of treatment? • How much uncertainty of class membership is permissible? • Concern regarding providing services for children who are then determined to not have Medi-Cal. <ul style="list-style-type: none"> ○ Possible scenarios discussed: <ul style="list-style-type: none"> • Medi-Cal dropped and reinstated • Clinical assessment that Outpatient services will not be enough and how to substantiate that conclusion? ○ Problem: While 9-Pt Plan opens/suggests new avenues of service, State Medi-Cal Auditing Standards remain untouched with possibility of large disallowance. <p>IV. CFS Social Worker Observations (to DBH Research & Evaluation)</p> <ul style="list-style-type: none"> • "Children move due to different placement and it is hard to pin down issues and access Mental Health services." • "Wraparound services have been helpful." • "Education of services and how to apply for services would be helpful." • "The approval process time needs to be quicker, by the time approvals are received, clients are gone; AWOL." • "Children receiving TBS services who are eligible seem to benefit from the service but the eligibility criteria excludes many. It would be nice to expand criteria to include Dual-Diagnosis children." • "Crisis Response Team for children who are not in placement. How to identify the children who are qualified at intake before placement. Can the process be started early as possible." • "CFS Staff needs to be education (sp) services, and how to apply for services; it would be helpful if we had a liaison. I think the referral process needs to be much quicker. My boys are "runners" (AWOL) and by the time they are approved, the boys were gone."

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	<p>V. Survey Responses from Parents:</p> <ul style="list-style-type: none"> • “Keep doing what you are doing. You do a great job.” • “Helping all that is involvedHaving Male counselors to service young men. Mentoring, budding, tutors, support groups for family members. • I am very please with the services we get. • Programs need to last longer. • You all are doing a good job keep up the good work.