



## **Therapeutic Behavioral Services Accountability Structure Report to the Department of Mental Health**

**Purpose:** The goal of the Therapeutic Behavioral Services (TBS) Accountability Structure is to identify and develop a statewide practice and performance improvement structure. This structure will include outcome and utilization measures and a continuous quality improvement process that will allow the California State Department of Mental Health (CDMH) to effectively ensure that TBS are accessible, effective, and sustained for the Emily Q class members as outlined in the Court-approved TBS Plan.

The accountability structure, to be implemented by CDMH, will be accomplished through annual reports submitted by the county Mental Health Plans (MHPs). This new report utilizes a quality improvement process based on principles and accountability activities that focus on practice and service coordination, rather than compliance and disallowances. The report is designed to increase Emily Q class access to appropriate TBS services. This approach requires an interagency review of relevant data in response to four questions, utilizing a standard report format.

—Nine Point Plan, Appendix C

**Directions:** Please provide a brief summary of the answers to the following four questions as discussed in your local learning conversation (both Level I and Level II counties). Per the Nine Point Plan, it is the Mental Health Director's responsibility to submit the completed form. Please save this form to your computer then submit, along with a list of attendees, to [TBS@dmh.ca.gov](mailto:TBS@dmh.ca.gov).

**County MHP:** San Bernardino

**Date of Meeting:** October 14, 2009

**MHP Contact (name, phone, e-mail):** Timothy E. Hougen, Ph.D, Acting Program Manager II

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**Was this a Stakeholder or Decision-Maker meeting?** Stakeholders Meeting

### **1. Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?**

- Please see additional comments at end of document for review of presentation slides that were discussed prior to formally addressing each question. These slides taken in total show that TBS is still being underutilized in San Bernardino, but is increasing. Estimates of year-to-date usage for calendar year 2009 is 1.19% with an average unduplicated client count per month of 50 children. In sum, TBS usage is increasing, but still below expectations.
- One MH provider opines “No” in that they are receiving benefits “somewhere else”, like Success First Early Wraparound and SB 163 Wraparound.
- Unless the purpose is just to meet the numbers (i.e., TBS enrollments) set by the Bonta Court, then we must consider the impact and concomitant effects of TBS as a crisis intervention, including the overwhelming of parents and disruption of family life, family sentiment that TBS is “too intensive”, perceived requirement that a parent must be present during TBS, time scheduling problems/issues.
- DBH suggest that TBS providers become more flexible with concentration on “hospitalized” behavior and/or any behavior that would prejudice the child’s current placement.
- A CFS representative suggested (“what if”) that CFS social workers be marketed for referrals on the basis of “out-of-control kids” (e.g., ADHD, Bi-polar, etc.) with the potential for group home placement within the following year.

- TBS referrals continue to be delayed because of Release-of-Information and Consent-to-Treat issues at the CFS and Juvenile Court level.
- For the “unqualified” child, an initial referral to an Early Wrap program to qualify for EPSDT Case Management Services would facilitate a TBS referral.
- Start with a MH provider as support in DBH Continuum of Care SART 0-5 Yr/School-Based EPSDT → Children’s Intensive Services → Early Wraparound → Traditional SB 163 Wrap

**Note:** While the 9-Point Plan does address 30-days of TBS without “clear TBS class membership”, care should be exercised in that State Audit Protocol FY09-10 does not address this and audit disallowances may exist from State DMH.

## **2. Are the children and youth who get TBS experiencing the intended benefits?**

- “Yes” was general answer in this discussion.
- DBH data evidence decreases in psychiatric hospitalizations and crisis incidences. (Please see Appendix: “Slide Presentation & Comments”)
- RCL placement level information is not as readily available; however, TBS contractors reported positive results (this includes VCSS & MHS, Inc commenting that the TBS enrollees “remain at the same level of care” & do not lose current placement)

## **3. What alternatives to TBS are being provided in the county?**

- Discussion here as to the Bonta Special Master’s “Equivalency” submissions:
  - Very specific criteria is outlined in the SM’s protocols
  - Strict application of the criteria would appear to limit MH programs to those that are more “equivalent”... not “alternatives”
  - Providers comment that the child’s mental health needs are still being met by other services “as effectively as TBS” in some situations/programs.
  - Common theme was that individual rehab sessions accomplish the equivalent effects of TBS when provided within the context of an intensive program; however, the SM’s protocol of a “functional analysis of behavior” is not usually done as part of any MH service.
- TBS providers note that TBS interventions may be too much for the family, as in the example of TBS services brought in to augment Children’s Intensive Services... “at the convenience of the family”.
  - Solution (as proffered by TBS Providers): better coordination of TBS services as a utility for “problematic or crisis behavior” within the myriad of services provided (e.g., TBS in School-Based services vs. Family-setting Wraparound services)
  - Solution (as proffered by TBS Providers): use TBS when services would otherwise be billed as a “Rehab ADL” per specific issue as above and within context of the family (e.g., “behavioral coaching in family events”)
- Discussion here re: “parent present” requirement ... a TBS myth
  - This is really a “supervision” issue rather than a treatment protocol
  - Parental “involvement” is the issue, not physical presence
    - Liability issues are a different matter as where “caregiver” is required
  - No State requirement (i.e., disallowance) as to “parent present”

#### 4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?

- Outreach to Group Homes through CFS' Central Placement Unit
  - CFS' Central Placement Unit is now generating an email to all CFS Social Workers who receive a 7-day notice on children. This email provide brief TBS description & links for referrals and source of more information
  - Quarterly CFS Group Home Meeting (attended by private group homes) is now attended by one of the TBS providers on a rotating basis.
    - Goal is to increase referrals & working relationships
    - Some concern, expressed by TBS providers, that in current fiscal climate group homes may be less invested in moving children to lower level of care.
  - Hill View Acres (group home in South Western corner of SB County) was represented at meeting & was linked with MHS, Inc to develop more collaborative working relationships.
- Probation representative, recently assigned to placement division, asked if TBS is being utilized in Probation Group Homes
  - TBS is available where the Probation child has MH issues, and the Probation representative was referred to the TBS Providers in attendance
  - TBS service in the Juvenile Detention Assessments Centers (i.e., Juvenile Halls) requires that the child be on the Placement List to be Medi-Cal eligible
  - Dr. Hougen encouraged an internal Probation “screen” to prompt this consideration & will work with Probation supervisor of placement unit to develop this.
  - DBH's INFO program for recently-released Wards is also being utilized by Psychiatric staff
- Discussion/Suggestion here by a TBS Provider as to accessing the IPC (Interagency Placement Committee) process by attending and helping in preparing the referral paperwork on a per-child/per-referral basis.
  - The absence of parental releases/consents and Juvenile Court orders to initiate the referral are still barriers to CFS referrals.
  - All IPC is chaired by DBH Clinic Supervisor connected to TBS & all children presented are considered for TBS
  - Suggestion of DBH Forensic Adolescent Services Team (FAST) implementing a screening for TBS.
    - Approx 4,500 minors retained annually in SB County Juvenile Hall, all screened for mental health issues
    - Approx 3,500 of these minors seen by DBH FAST MH staff
    - TBS Providers have done presentations for the three FAST Units
    - Dr. Hougen to explore possibility of more formal TBS screening for minors with DBH manager of FAST
- TBS Providers discussed alternative methods of outreach to the various referring agencies:
  - Mini-Regional ACBO (Association of Community-Based Organizations) meetings with invitations to regional TBS providers for the purpose of explaining increased inclusion of TBS within existing MH services
  - Inviting regional TBS providers to “bagel day” informal meetings at CFS
  - Encouraging increased use of CFS' Uniform Referral Form (URF) that lists all MH service referral options, including TBS\
  - Penetration into AB 2726/SB 3632 Residential programs (if Medi-Cal eligible)
  - Access to Children's Psychiatric Hospital liaisons Canyon Ridge & Loma Linda Behavioral
    - Dr. Hougen to arrange in-service with this DBH staff
  - Style a flyer that differentiates between SBC geographical Regions and TBS providers.

- One community MH provider opined that this would be too confusing, and recommended that the current practice of using one central contact number with better “packaging” on a flyer.

Meeting Adjourned 4:10 P.M.

### **Additional Comments:**

The TBS Stakeholders’ Meeting started promptly at 2:00 PM. In attendance were the following individuals representing their respective agencies:

Matthew Fishler (Disability Rights), Rudy Cruz (DBH), Diane Terrones (DBH) Chailene Villegas (Hillview Acres), Candi Howard (EMQ), Kimberly Bartlett (MHS Inc.), Diane Waters (MHS Inc.), Cheryl Gardner (DMVCSS), Michael Oliver (DBH), Marcia Mathews (MHS Inc.), Paula Quijano (SBVCSS), Stephen Garrett (DMVCSS), Melissa Kalajian (CFS), Ralph Kuechle (SCCS), Glenn Low (Desert Mountain SELPA), Nicky Hackett (CFS), Danetra Wheeler (SBVCSS), Chike Nwokike (DMVCSS), Elaine Holzer (DBH) and Chuck Abajian (Probation).

Terms:

CFS refers to “Children & Family Services”, formerly known as the “Department of Children Services”

DBH refers to the “Department of Behavioral Health”, the MHP for San Bernardino County

SBC refers to “San Bernardino County”

Note: San Bernardino County has three TBS providers under contract: Mental Health Systems, Inc.

(hereinafter “MHS”); Pacific Clinics (hereinafter “Pacific”); and Victor Community Support Services,

Inc. (hereinafter, “VCSS”).

Slide Presentation and Comments followed with the following points of interest:

(1) Last Stakeholders’ Meeting (05/21/09) minutes, as well as the ensuing Departmental Decision Makers’ Meeting minutes, are posted on State DMH Website for TBS:

[http://www.dmh.ca.gov/Services\\_and\\_Programs/Children\\_and\\_Youth/Local\\_Meeting\\_Tools.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/Local_Meeting_Tools.asp)

(2) Unit Secretary is out on a family emergency; all phone inquiries should be directed to (909) 421-9300.

(3) DMH Notice 08-38 (copy) may be either accessed at

[http://www.dmh.ca.gov/DMHDocs/2008\\_Notices.asp](http://www.dmh.ca.gov/DMHDocs/2008_Notices.asp) or by calling the 421-9300 number above.

(4) APS Dashboard Review:

Salient aspects of the APS Dashboard were reviewed, these included the following:

a. Smaller than expected number of TBS recipients in CY2007 (i.e., 91 vs. 400)

b. Avg. No. of Contacts per TBS Episode = 28, which is within normal range

c. Average Number of Minutes. per TBS Contact = 258, which is approximately 100 minutes. over the “norm”

i. Given large size of SBC, travel time for TBS provided in past 6 months was calculated by providers. Average travel = 60 minutes, so TBS contacts are still 30-40 minutes longer than state average.

- (6) DBH Summary Data (Inasmuch as State data is Calendar-Year based, and DBH records data on the Fiscal-Year, DBH is attempting to “mimic” State data; slight variations exist: nonetheless, 0.90% for CY 2008 and 1.19% for YTD 2009 of Medi-Cal EPSDT kids (of an estimated 10,000 – 11,000) are receiving TBS services in San Bernardino County.
- (a) From Jan 2009- August 2009, data shows a strong upward trend in unduplicated TBS enrollments per month;
    - (i) Average Monthly Unduplicated client count is now approx 50.
  - (b) “Length of Average TBS Service” does replicate State data, but is also affected by travel time.
  - (c) “Third critical element of TBS delivery and accountability is the extent to which TBS reduces Child behavioral risk and institutional risk.”
    - (i) Finding: (Risk Reduction Q 1) Out of 367 kids, 1,197 total hospital days were logged by children 6 months immediately prior to TBS; only 278 hospital days were logged for children during TBS services.
    - (ii) Finding: (Risk Reduction Q 1) 18% of children who would eventually receive TBS were hospitalized in the immediate 6 months prior to the start of services, as compared to 6% during the regimen of TBS.
    - (iii) Re: Risk Reduction Q2: TBS and RCL Placements, having difficulty getting this data as RCL level is not listed in CMS database.
    - (iv) Re: Risk Reduction Q 3: TBS and Crisis Interventions, a drop in crisis services (from 44% 6-mos prior to TBS to 13% during TBS) was noted.

TH:sr