The efficacy of the augmented board and care (ABC) system in reducing rehospitalization of identified "high end user" residents of San Bernardino County

Rowena Mateo

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THE EFFICACY OF THE AUGMENTED BOARD AND CARE (ABC) SYSTEM IN REDUCING REHOSPITALIZATION OF IDENTIFIED "HIGH END USER" RESIDENTS OF SAN BERNARDINO COUNTY

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Rowena Mateo
June 1996
THE EFFICACY OF THE AUGMENTED BOARD AND CARE (ABC) SYSTEM IN REDUCING REHOSPITALIZATION OF IDENTIFIED "HIGH END USER" RESIDENTS OF SAN BERNARDINO COUNTY

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June 1996
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6-12-96 Date
ABSTRACT

This is a descriptive study that measured the efficacy of an Augmented Board and Care (ABC) placement for clients identified as "high end users" in reducing frequent hospitalizations of Mental Health clients in San Bernardino County. Historically, "high end users" were placed in locked IMD facilities or State Hospitals. This practice was very costly for the San Bernardino County Department of Mental Health. Not only did these individuals fare poorly in these facilities but they also missed out on the opportunity of receiving services in a least restrictive environment. This study of the efficacy of the Augmented Board and Care measured any incidence of inpatient hospitalization that occurred during placement in ABC over a nine month period. The significance of the independent and dependent variables were measured using T-test and measurements of central tendencies. Results of the study showed a substantial decrease in the frequency of hospitalization as well as a decrease in the number of days spent in a hospital nine months into the residence.
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INTRODUCTION

In 1992, the San Bernardino County Department of Mental Health Adult Community Services Program (ACSP) reviewed its entire residential system. This review of residential system included the State Hospital, Institutions for Mental Disease (IMD), and the Supplemental Rate Payee (SRP) Board and Care Homes. ACSP deemed the review necessary as it believed that the system did not provide quality residential care in the least restrictive setting for the lowest possible cost. The review ascertained numerous problems which made the then existing community residential program less efficient and more costly.

The original SRP program was limited in many ways (Wirth, 1995). According to the proposal, SRP funds were given to care providers to further add additional programming to care for "hard to place" or "acting out" individuals. However, board and care providers viewed this fund as entitlement monies. Although most individuals diagnosed with a mental illness fit the SRP admission criteria, it did not identify individuals with a chronic and persistent mental illness at risk of hospitalization or in need of intense programming.

During the SRP era, board and care operators were allowed to dismiss clients whose behaviors were a problem or that required extra staff time. This did not enable the
department to place individuals that were discharged from IMDs, State Hospitals and Inpatient Units to place individuals into the SRP program. This also became costly as beds allotted for the department were not occupied but were being paid for by the Department under the SRP program. There were also inadequacies in the facilities for individuals being diverted from the Inpatient Unit who needed a stable environment with intensive linkage and advocacy needs in the community for services and interim assistance funding. Many of these clients did not need long term care, however, they were funneled into the IMD system and/or put into a regular board and care system where they often did not fare well. Some of the IMD and State Hospital beds were occupied by clients who could be treated in the community but due to specific problems such as assaultive behavior, AWOL (Absence Without Leave) risk, or behaviors that were frightening or seen as being unmanageable in the community system were placed in the IMD or State Hospital which was very costly for the department. Hence, the need for an augmented community residential system arose to serve the needs of these clients and divert them from the State Hospital and IMD system.

The Augmented Board and Care (ABC) system provides a quality residential board and care living environment for individuals with a chronic or persistent mental illness at
risk of hospitalization or in need of intense programming (Wirth, 1995). The ABC beds have allowed many consumers to receive treatment services at lower cost and less restrictive levels of care. The philosophy behind the ABC system is to provide a safe and controlled environment where individuals can receive treatment, life skills, and connection to other resources (Wirth, 1995). This was accomplished in the community without clients having to be in a locked setting. Many of the individuals who reside at these board and care homes have spent many years in locked IMD facilities or in a State Hospital. Staff in the ABC system are required to be more educated and better trained to manage chronically mentally ill individuals so that a program can be developed to alleviated problems and allow these persons to remain in the community rather than be placed in a higher cost and restrictive level of care. There are currently five ABC facilities in the County of San Bernardino with a total of 92 residents.

Adult Community Services Program (ACSP) staff designed the scope of services to be provided as well as the criteria for ABC placement (see Appendix I). Referral to ABC placement must first meet the criteria set forth for eligibility. Referrals usually come from IMDs, State Hospitals and Psychiatric Inpatient Hospitals. All referrals are made to ACSP through the Department’s approved
referral process which includes a Triage rating of 1 (see Appendix II). Referrals are then reviewed through case conferencing on the identified "high end user" client with the client's conservator, case manager, IMD staff and other individuals responsible for the delivery of services to the client. After the case conference it is determined whether the client would benefit from an ABC placement. Then it is determined which ABC facility the client is to reside in depending upon their need and a facility's immediate vacancy.

The purpose of this study was to determine whether identified "high end user" residents who were placed in an ABC system were hospitalized less frequently. This study evaluated the impact of ABC placement on inpatient hospitalizations. This study also measured which factors influenced, such as placement may have influenced re-hospitalization.

The impact that this study may have on social work practice includes direct practice and Administrative/Policy planning which relate to future funding. The study also indirectly impacts the community by possibly decreasing the number of homeless persons with criminal behavior who are arrested. Further results may have implications for future research.
LITERATURE REVIEW

In the words of Anthony, Cohen and Cohen (1983), "in the minds of many people, the nightmare of institutionalization has now been replaced by the horrors of deinstitutionalization". The laws of deinstitutionalization requires patients to be treated in the least restrictive environment within the Mental Health system. These laws reduce the number of mentally ill persons in state hospitals by transferring them to lower level community based facilities and assessing potential patients and providing services to prevent their hospitalization or re-hospitalization. The deinstitutionalization movement changed the primary responsibility for the provision of treatment of severely mentally ill individuals from state hospitals to the community. However, community based treatment facilities are often rejected by the community and by consumers referred to them. Such opposition usually stem from fear that property value will decrease, higher incidences of crime, and the misconceptions that mental illness is related to violence. Consumers usually oppose to the change in placement maybe to the degree of comfort that they have developed in their prior placement.

The community based placement era was the important step towards deinstitutionalization. The laws of deinstitutionalization requires patients to be treated in
the least restrictive environment in the community. Community placement of the mentally ill upon discharge from state hospitals or locked facilities have been the current trend in providing the least restrictive housing milieu for this population. The community based treatment approach was also engineered to transfer public treatment of the mentally ill to community facilities.

Individuals with mental illness have a variety of needs including residential, educational, vocational, and social. Some of these needs may not be met when an individual is committed to a state hospital. Throughout history, mentally ill persons have not been able to fully benefit from the services made available to them in the community and many of them eventually cycle back to state hospitals and other locked facilities. Lack of funds, poor staff to patient ratio, as well as minimal community resources, are the major causes of this problem.

With the passage of the Community Mental Health Centers Act of 1963, the government’s role was established as being the primary funding resource for public mental health services. Advocates of this movement reestablished local communities as primary care providers. However, Community Mental Health Centers (CMHC) and housing needs of chronic and severe mentally ill individuals were not adequate for individuals just released from state hospitals and locked
facilities. These individuals lacked the capacity to adjust to the community for many reasons. Regular board and care homes were not able to manage problems such as assaultive behavior, AWOL (Absence Without Leave) risk, or unmanageable behaviors in the community system due often to staffing limitations. Consequently, the Omnibus Budget and Reconciliation Act of 1981 (OBRA) seized all mental health funding. These monies were placed into a block grant and made available to all states for mental health services.

Environmental factors that contribute to rehospitalization were stressful living conditions, lack of community resources and social supports (Appleby & Desai, 1987; Caton & Goldstein, 1984; Harris, Bergman & Bachrach, 1986). Individuals that met this criteria were instead placed in a locked facility or state hospitals which were quite costly and less beneficial. In 1992, in a response to this dilemma, the San Bernardino County, Department of Mental Health, Adult Community Services Program reviewed its entire residential system. ACSP deemed the review necessary as it believed that the current system did not provide quality residential care in the least restrictive setting for the lowest possible cost for consumers assessed "high end users" of hospitalization admissions. Called the Augmented Board and Care (ABC) System, this program was designed to provide quality residential board and care
living for individuals with a chronic or persistent mental illness at risk of re-hospitalization or in need of intense programming.

Board and Care homes vary greatly in size, structure, and programming and individually exhibit a wide range of social environments (Coulton, Fitch & Holland, 1985). The program is designed to provide consumers with treatment services at lower, less restrictive levels of care. The philosophy behind the ABC system is to provide a safe controlled environment where individuals can receive treatment, life skills, and be hooked up with other resources. This is accomplished in a community setting without clients being in a locked treatment facility. In England, a similar program called the "ward-in-a-house" exists. It offers a model of institutional care that is small, homey and personal. The principles of care include: setting of goals in such a way as to reinforce small improvements; a focus on practical tasks and activities of daily living (ADLs); a de-emphasis on pathology, and a focus on functioning rather than symptoms (Shepherd, 1995).

Many of the individuals who reside at ABCs have spent many years in a locked Institute for Mental Disease (IMD) facility or a State Hospital. Two factors that contribute to the success of this program are staffing and the presence of a structured home. Staff at ABC homes are required to be
better educated and better trained so that they can develop and participate in a program to alleviate client problems and allow individuals to remain in the community rather than be placed in a higher and more costly level of care. In a study of 100 residents in 10 adult homes, Blake (1986) found that the key variable of community program utilization by board and care residents was the home operator’s attitude and philosophy of encouraging residents to participate in and reach out for community services and programs. Residents of an elaborately structured home become integrated more successfully into the community compared to residents of a less structured home.

Kruzich & Kruzich (1985), in assessing daily living skills, programs, rigidity of routines, number of residents per home, and social distance between staff and residents in adult homes, found that rigidity of routine and close social distance of staff were negatively associated with residents integration into the community. Residents usually found support by interacting with fellow residents and with individuals in the community. These studies suggest that there is a positive correlation between staff’s expectation and residents’ behavior and adaptive functioning of individuals living in an elaborately structured one compared to a less structured home.

One of the biggest problems in integrating
institutionalized individuals into the community is their rate of re-hospitalization. Data indicates that within one year after hospital discharge, 40% to 50% of psychiatric patients return to the hospital. The recidivism rate within 3 to 5 years increases to 75%. One of the causes of relapse is the individual’s inability to comply with a medication regimen. Since the majority of individuals in state hospitals are diagnosed with schizophrenia, anti-psychotic drugs are still the most effective means of treating patients placed at this, the highest level of care possible (Charlesworth, Sacks, Templer & Thackrey; 1993).

Another factor is the sudden change in the environment. Studies have found that in treating individuals with schizophrenia, the course of the illness is substantially affected by environmental events and that modification of the environment can have profound effects on an individual (Paul & Lentz, 1977; Hooley, 1985; Goldstein & Strachan, 1987).

RESEARCH DESIGN AND METHOD

This was a descriptive study of the efficacy of an ABC placement for "high end user" residents of San Bernardino County in reducing high institutionalization. This study was a single group pre and post test research design which measured the effectiveness of placing "high end user" individuals in an ABC. Outcomes were measured in terms of
the number of hospitalizations a client had within a nine month period of being placed in an ABC (post test) compared to the nine months prior to placement in an ABC (pre test). Other areas that may have influenced hospitalizations such as age, marital status, conservatorship status, prior placement (not considering acute care) and diagnosis were also considered.

This was a descriptive study utilizing a positivist paradigm. This study described the causal link between ABC community placement and hospitalization of "high end user" clients. The research question was: What is the effectiveness of ABC placement in reducing hospitalization for "high end user" clients? The hypotheses are: Placement of a "high user" client into an ABC reduces the risk of hospitalization and ABC reduces the number of days spent in a hospital.

DATA COLLECTION AND INSTRUMENTS

The sources of data for this study were derived from the sample population's individual "face sheet" (see Appendix III). This data was used to obtain demographics and to review the dates and duration of hospitalizations. For this study, only county (Ward B), DMH contracted IMDs and state hospitals were considered. Permission was not given for a review of other inpatient hospital records. The number of hospitalizations were tabulated over a total
period of eighteen months. The records were reviewed 9 months prior to ABC placement and 9 months into ABC residency. Nine months was used because this time frame allowed a broader pre and post ABC admission picture. Another factor that was also considered was the average stay at an ABC. The mean stay at an ABC was 9.22 months.

Once an individual entered into the County DMH system a number of forms were required for that individual’s case manager to complete as governed by the Department of Mental Health’s policy and procedures as well as the California state law. These forms were necessary to open a case as well as to continue providing services to the client. These forms contained the Client Episode Summary (CES) (see Appendix IV) and Community Functioning Evaluation (CFE) (Appendix V) which provided pertinent data and clinical information required for evaluation of the sample population. Data included on these forms were legal status, DSM IV diagnostic code, source of referral, and client’s reaction to current environment.

Data collection included information on an individual’s age, marital status, ethnicity, education level, diagnosis, previous placement (not considering acute care), number of inpatient hospitalization prior to ABC, total number of hospitalization days prior to ABC placement, mental health involvement prior to ABC placement, number of months in ABC
placement, number of hospitalization during ABC placement and total number of hospitalization days during ABC placement. Appendix VI provides a more elaborate description of the data collected.

This study did not impact the delivery of care as clients were unaware that the study was being conducted. Information collected were derived from secondary data using the "face sheet" (see Appendix III) and in no way interrupted the delivery of services.

**SAMPLING**

The population of interest for this study were mental health clients who are residents of San Bernardino county, aged 18 and older who currently reside at an Augmented Board and Care in the city of Rialto. All of the residents were male.

Of the thirty residents in the home three were excluded from the study because they had lived at ABC for one month or less. The sample study of twenty seven clients had an age range of 18-52 years with the mean age of 34 years. The average education level obtained was 10th grade with a range of no education to four years of college. In the sample 93% cases were never married. The racial composition of participants was 59% Caucasian, 18% Afro-American, and 11% Hispanic.

The majority of the sample was Public Conservateeess of
the county's Public Guardian's Office. Most of them were also receiving public funds such as Medicaid and/or Medicare. There was an even distribution of 33.3% of the sample study previously residing at IMDs or community residential facilities, 11% came from homeless shelters while 14% lived with their families prior to ABC. Acute care placement such as an inpatient hospital was not considered as placement prior to ABC.

The sample study was comprised of 77.8% of clients diagnosed with some type of Schizophrenia, followed by a diagnosis of a mood disorder at 7.4%. There was a total number of 24 inpatient hospitalizations and 10 IMD placements. These were combined to collect information on the number of hospitalizations prior to ABC placement (Table 1). Hospitalization days were 215 inpatient hospitalization and 2207 IMD days which totalled to 2422 (Table 2). The sample population included 44.4% with inpatient hospitalizations and 29.6% with IMD placement while the rest of the sample came from other community mental health centers.

DATA ANALYSIS

The dependent variable for this study was the acute inpatient re-hospitalization. The independent variable was the placement of a "high user" client in an Augmented Board and Care (ABC). A quantitative analysis was used to study
the strength of relationships between the independent and
dependent variables. Other variables, such as age and
diagnoses, which may influence re-hospitalization were
assigned ordinal or nominal variables. The dependent
variable were either ratio or interval variables.

All collected data were processed and analyzed through
SPSS+ using descriptive statistics. The independent
variables entered were analyzed by running frequencies for
the measure of central tendency. For the nominal variables
such as marital status, ethnicity, prior hospitalization,
etc., the mode is the most appropriate measure of central
tendency while for the ordinal variable such as education,
the mean is the most appropriate measure of central
tendency. The dependent variable (admission to acute
inpatient hospitalization) which were ratio and interval
variables were tested for central tendency distribution.

With bi-variate analysis of data, the t-test analysis
was used to measure the difference in means of acute
inpatient re-hospitalization. These tests measure whether
acute inpatient hospitalization occurred or not during the
eighteen month measurement period. The alpha was also used
to determine the significance of the other variables that
may influence the occurrence of hospitalization. The
results of these tests showed whether the relationship
between the dependent and the independent variables were
significant or not. The hypothesis that placement in an ABC reduces the risk of hospitalization of "high user" residents of San Bernardino County also needed to be tested to see whether a negative relationship exists between ABC placement during the nine month period was effective in reducing acute inpatient re-hospitalization of identified "high users".

RESULTS

The study showed the frequency of prior inpatient hospitalizations, including IMD placements, compared to hospitalizations during the nine month period of ABC placement. Most individuals in the sample had at least one episode of hospitalization or IMD placement prior to involvement to ABC system. During the nine month period measurement (after ABC placement), only 14% of the sample was hospitalized (Table 3) which equated to a 95% reduction in hospitalizations (Table 4). A comparison of the total number of hospital days pre versus post ABC admission showed a 95% reduction in hospitalization days (Tables 5 & 6). However, it needs to be taken into account that although this shows a highly significant result neither the values of hospitalization or hospitalization days were distributed normally.

Trends were observed for the remaining variables. The results showed only age was statistically significant. Using a cross sectional analysis of age, the results showed
that within this sample, older clients tended to have less hospitalizations prior and after ABC placement.

DISCUSSION

This study revealed and supported the effectiveness of the ABC system in reducing the frequency and number of days of hospitalization for "high end users" of mental health services. With the sample size being small it was highly possible that the independent variables used would have produced statistically significant effects on the outcome of this study. The age variable showed an inverse relationship with hospitalization. For this study, some aspect of maturation may have contributed to this effect which can be a strong implication for future research for looking at the onset of illness and its effect on individuals as they age.

A diagnosis of a major mental disability is one of the criteria in the scope of services provided by the ABC system (Appendix I). The majority of the sample involved in this study were diagnosed with some type of schizophrenia (Schizophrenia, Schizoaffective, Schizophreniform) a syndrome which often causes chronic deficiency in thought processing (which comprised 77.8% of the sample, 21 cases). Based on careful review of each of the sample’s Client Episode Summary (Appendix IV), a percentage of 29.6% (8 cases) was a coexisting diagnosis of substance abuse or dependence, and 3.7% (1 case) has a diagnosis of a
personality disorder. Despite the anonymity of the cases hospitalized nine months into the program, ABC placements appeared to be successful in deterring costly hospitalizations.

In comparing the frequency of hospitalization nine months prior to ABC placement and nine months into ABC placement, there was a dramatic decrease in hospitalization frequency (95%). (For purposes of this study IMD placement was considered "a hospitalization" because they are locked facilities that cater to a chronic population) There was a total of twenty combined frequency of hospitalization prior to ABC placement compared to only 4 during ABC placement.

The sample study also showed a reduction in hospital days. Applying the same concept used in assessing the frequency of hospitalization, a 95% reduction in hospital days was observed. There was an average of just 7 days of hospitalization compared to the average of 121 days nine months before ABC placement. Both the substantial reduction in hospitalization and hospital days showed the strength of ABC placement. This further supports the effectiveness of this type of community placement, not only as a therapeutic intervention, but also as a way of improving the quality of life for "high end users" of mental health services.

Almost all of those in the sample had never been married. This further substantiates the difficulty that
chronically mentally ill individuals have in obtaining and maintaining long term relationships. This may be due to their lack of social skills necessary for intimacy. A larger sample may have produced a more significant picture of this relationship.

The population distribution was the main obstacle in this study because of its small size. However, there was one variable that was almost evenly distributed. There was a nearly even split of voluntary clients at 40.7% versus clients on public conservatorship at 59.3%. Despite the smallness of the sample, this variable shows that the legal status of a client does not predict the likelihood of a person’s hospitalization.

One factor that was not measured in this study was the precipitating factor that rehospitalizes a client. For this study it was difficult to find a specific factor that may have caused hospitalization such as stress. There is literature that support that environmental factors do contribute to rehospitalization. In an article by McFarlane (1982), he writes that deinstitutionalized individuals need stability, continuity, and support and, by all means, a social network. The way an individual defines stress and reacts to it varies extremely. The goal of the ABC system is to provide a social environment that is safe and controlled to help alleviate stress by providing treatment
within the home and carefully providing case management in order to provide adequate community resources available for clients.

The ABC system is a fairly new program in our county. Since the cost of living in San Bernardino is less than other counties, the population receiving government relief continues to rise. Many new residents take advantage of what the county has to offer. The ABC system is a good transitional ground for the "high end user" so that they can benefit from a safe and controlled environment. The ABC system is least restrictive, safe and less costly than an IMD or state hospital and/or numerous acute hospitals.

RECOMMENDATION FOR FURTHER RESEARCH

The research project was an initial study used for measuring the effectiveness of the ABC system in reducing hospitalization for identified "high end users". A much larger sample study would provide a more meaningful statistical outcome. Another variable to consider would be adding a sample of females to the sample to identify whether there is a significant difference between sexes regarding who gets hospitalized more frequently.

Another recommendation for future research would be to study the factors that precipitate hospitalization during ABC placement. This would be very helpful in planning for the scope of services to be provided by the ABC placement as
well as the various community mental health centers involved in providing services to residents.

For this study, age showed a strong significance to hospitalization. Perhaps a research project designed to study how maturation becomes very important as clients deal with the symptoms of mental illness based on the duration of their illness as opposed to the onset of the illness would be helpful.

The county of San Bernardino has its share of the homeless mentally ill. Homelessness at times can drive an individual to participate in criminal behavior. Perhaps carefully housing this population, especially the ones needing a specialized and highly structured environment, can help alleviate or decrease criminal behavior in this population. Research on this subject could provide us with knowledge needed to determine the essential services necessary to reduce the number of the homeless mentally ill and forensic individuals needing these services to improve their quality of life.

All of these recommendations for further research could show the cost effectiveness of the ABC program. Because of fiscal hardships that counties experience every year, careful planning of the allocation of funds for programs such as the Augmented Board and Care System becomes very important if the effectiveness of the program can be shown.
Programs like this could provide valuable services to "high end users" instead of utilizing monies reserved for acute hospitalizations, IMD placements and state hospitals.

SUMMARY

The efficacy of the Augmented Board and Care system was reviewed to show the reduction in hospitalization for "high end users". The trends in this study support the hypotheses set forth in the initial proposal. Due to the sample size statistically significant findings were limited. Nevertheless, the study provides a framework for future research of the ABC system.
APPENDIX A

DEPARTMENT OF MENTAL HEALTH

AUGMENTED BOARD AND CARE SYSTEM
I. SCOPE OF SERVICES TO BE PROVIDED (CLIENT MUST MEET CRITERIA IN EITHER A OR B)

A. The population to be served (i.e., priority population) must meet appropriate criteria for mental health services. These criteria include: 1) A diagnosis of major mental disability which includes psychotic disorders, major affective disorders, or a disorder that may lead to a persistent disability such as borderline personality disorder, or; 2) The client must receive an SSI or SSDI entitlement obtained due to a mental disorder, (exceptions to this will be made on a case by case basis on approval from the ACSP Program Manager II, or designee).

And

To be included in the priority population, the client must have one of the following mental health service histories: 1) Two prior psychiatric hospitalizations within the past 3 years; 2) One psychiatric hospitalization lasting longer than 8 days; 3) One psychiatric hospitalization resulting from the first episode of a mental disorder with psychotic features; 4) Any previous stay in an IMD and/or State Hospital; or 5) A major functional impairment lasting more than two (2) years, resulting in utilization of mental health services on an intermittent and/or continuous basis.

And

In addition, to be included in the priority population, the client must have experienced two (2) of the following due to a mental disability on a continuing or intermittent basis or it is likely to occur: 1) Unemployment, sheltered employment, supportive work situation, or markedly limited skills and poor working history; and 2) Difficulty establishing/maintaining a personal social support system, requiring help in basic living skills such as hygiene, food preparation, money management, or obtaining shelter.

B. Persons who are involved in a natural disaster or emergency will be provided IMD services on an as needed basis as follows:

1. Adults or older adults who require, or are at risk of requiring, residential treatment, because of a mental disorder with symptoms of psychosis, suicidality, or violence.

2. Persons who need brief residential care as a result of a natural disaster or severe local emergency.

II. REQUIRED LINKAGE WITH COUNTY SYSTEM
APPENDIX B

DEPARTMENT OF MENTAL HEALTH

UNIVERSAL REFERRAL FORM
UNIVERSAL REFERRAL FORM

(Print legibly or type)

Date: ___________________________  Admission Date: ___________________________
Discharge Date: ___________________________

1. TRIAGE RATING (See back of page for instructions):

Patient Refused Services: Yes/No

Justification for Triage Rating: (Relevant Mental Health History, specific reason for referral):

Axis I  ________  Axis IV, Severity  ________
Axis II  ________  Axis V CGAF  ________  HGAF  ________
Axis III  ________

Diagnosis Provided By:  ___________________________

2. Patient Address and Phone:  ___________________________

Emergency Contact Person:  ___________________________

( ) Voluntary  ( ) Conservator  ( ) Ward/Dependent  ( ) Court Ordered

3. Substance Use Status:

( ) N/A

( ) Patient is currently substance free for # ______  ( ) Weeks  ( ) Months

( ) Patient is currently using:  ___________________________

on an ( ) intermittent  ( ) regular basis

Last day of use for any substance:  ___________________________

Medication Status: ( ) None  ( ) Patient currently/previous on:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOSAGE</th>
<th>AMOUNT</th>
<th>NAME</th>
<th>DOSAGE</th>
<th>AMOUNT</th>
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</tbody>
</table>

5. Program(s)  Appointment(s)  Code of Service

Referral To  Date  Time  Contact Person(s)  Phone #(s) Requested

_________________________  ___________________________  ___________________________
_________________________  ___________________________  ___________________________

Services Requested: (By Code)
a. Inpatient  d. Crisis Intervention  g. Drug/Alcohol Detox/Res
b. Outpatient  e. Medications  h. Drug/Alcohol Outpatient
c. Day Treatment  f. Case Management  i. Placement
j. Other

6. Did patient keep appointment?  Yes  No

If no, was patient rescheduled?  Yes  No

Rescheduled appointment date:  ___________________________

Did patient keep rescheduled appointment?  Yes  No

If no, disposition:  ___________________________

7. Originating Program  ___________________________

Contact Person  ___________________________

Phone  ___________________________

FAX Date:  ___________________________

Patient Name:  ___________________________

Chart No:  ___________________________

Date of Birth:  ___________________________

(Rev. 3/2/92)  CONFIDENTIAL PATIENT INFORMATION

DEPARTMENT OF MENTAL HEALTH

Recidivist  ________
# Triage Criteria

## Rating 5150/5585.5

**Patient to be seen within 2A Hours**

- **For Inpatient Referral:** Document all pertinent information relevant to your evaluation request (i.e. board and care operator name and phone number if appropriate, description of patient's deterioration process).

## Rating 1

**Patient to be seen within three calendar days**

- **For Stabilization Referral:** Patient does not meet 5150/5585.5 criteria but requests and needs stabilization due to severe, acute symptoms.

- **For CESR or OPD Psychiatrist Referral:** Patient extremely agitated and/or experiencing side effects.

- **For OADP Referral:** Patient wants/is in need of DETOX (late day of substance use within 72 hours). Please call for referrals to detox and/or residential.

- **For CCP Referral:** Patient in need of immediate placement and has ability to pay.

- **For Homeless Referral:** Patient in need of immediate shelter and has no resources.

## Rating 2

**Patient to be seen within twenteeen calendar days**

- **For CESR or OPD Psychiatrist Referral:** Patient needs medications ASAP, (e.g. to prevent decompensation, quantity limited due to suicidal risk, needs repeat injection).

- **For OPD Therapy Referral:** Patient seen at CESR or CCR needs follow up to continue stabilization.

- **For CCP Referral:** Patient has a history of multiple admissions and is in need of case management evaluation.

- **For Homeless Referral:** Patient in danger of eviction from place of residence.

- **For Enriched Youth Home Residents to OPD:** Child is at risk of higher level group home placement (Patient needs to be seen within five working days).

## Rating 3

**Patient to be seen within fourteen calendar days**

- **For OPD Therapy Referral:** Patient meets medical necessity and continues to need treatment to prevent serious role dysfunction.

- **For OPD Psychiatrist Referral:** Patient is on medication regimen and needs continued psychiatric treatment to prevent decompensation.

- **For OADP Referral:** Patient is in need of outpatient drug and alcohol services.

- **For CCP Referral:** Patient has functional impairment secondary to major mental illness. Patient needs ongoing case management.

## Rating 4

**Patient is referred to private or community resources.**
APPENDIX C

CLIENT INFORMATION FACE SHEET SAMPLE
CLIENT INFORMATION FACE SHEET SAMPLE

Report MHS 140

Run Date: 25-MAR-1996

************************************************************
Name: Number: Birthdate: Age
Address: SSN: Sex:
Other ID #: Language:
Phone: ( ) Marital: Education:
Staff: Disability: Ethnicity: Hispanic Origin:
Aliases:
RP Owes: Medicaid: Last Eligibility:
Insurance:

PERSON TO NOTIFY IN CASE OF EMERGENCY:
Name: ____________________________ Relationship: ______
Address: __________________________ Phone: ______

********************************************
CLINICAL HISTORY

<table>
<thead>
<tr>
<th>KU</th>
<th>Opening</th>
<th>Closing</th>
<th>Diagnosis</th>
<th>Primary</th>
<th>Clinician</th>
<th>MD</th>
<th>Total</th>
<th>Last</th>
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</tr>
</tbody>
</table>

-----OPEN EPISODES-----

-----CLOSED EPISODES-----

**************************
Total Episode Count =

**************************
Confidential Patient Information

**************************
APPENDIX D

COUNTY MENTAL HEALTH DEPARTMENT

CLIENT EPISODE SUMMARY
Episode Opening

Episode Opening Date: ___________ Referred From: ___________ Legal Status: _________

Axis I ________ ☐ Axis II ________ ☐ Axis III ________ ☐ Axis IV ☐ Axis V

Enter a "P" for Principal Diagnosis and an "S" for Secondary Diagnosis.

Additional Diagnoses: Axis I ________ ☐ Axis II ________ ☐ Axis III ________

Clinician __________________________  Physician ____________________________

Living Situation __________  Employment Status __________  Admission Hour __________

Legal Consent __________

Client Address___________________________

Phone: ___________________________  Completed by ___________  Date __________

Episode Closing

Episode Closing Date: ___________ Referred to: ___________  Reason for Discharge: _____________

Hour of Discharge ________  Legal Status: _________

☐ Check Box if the remaining Closing information is the same as the Opening information.

Axis I ________ ☐ Axis II ________ ☐ Axis III ________ ☐ Axis IV ☐ Axis V

Enter a "P" for Principal Diagnosis and an "S" for Secondary Diagnosis.

Additional Diagnoses: Axis I ________ ☐ Axis II ________ ☐ Axis III ________

Living Situation __________  Employment Status __________

Client Address___________________________

Phone: ___________________________  Completed by ___________  Date __________

Data Entry Initials __________

County Mental Health Department

Client Episode Summary

Confidential Patient Information

See Welfare & Institutions Code 5328

[Client ID: ___________]

[Client Name: ___________]
APPENDIX E

COMMUNITY FUNCTIONING EVALUATION SAMPLE
COMMUNITY FUNCTIONING EVALUATION SAMPLE

LIVING ARRANGEMENT (type, stability, safety, etc.):

DAILY ACTIVITIES (work, chores, school, parenting, recreation, legal problems, etc.):

SOCIAL RELATIONSHIPS AND SUPPORT SYSTEM (marital, family, friends, etc.):

HEALTH (hospitalization, untreated health problems, substance use, diet, etc.):

DATE AND EVALUATOR SIGNATURE

COMMUNITY FUNCTIONING EVALUATION

NAME:

CHART NO.:

DOB:

PROGRAM
APPENDIX F

DATA COLLECTION SHEET
DATA COLLECTION SHEET

1. ID#

2. AGE

3. MARITAL STATUS:  
   1. - NEVER MARRIED  
   2. - MARRIED  
   3. - SEPARATED  
   4. - DIVORCED  
   5. - WIDOWED  
   6. - UNKNOWN

4. ETHNICITY:  
   1. - CAUCASIAN  
   2. - AFRO-AMERICAN  
   3. - ASIAN  
   4. - HISPANIC  
   5. - NATIVE AMERICAN  
   6. - OTHER  
   7. - UNKNOWN

5. EDUCATION LEVEL:

6. LEGAL STATUS:  
   1. - VOLUNTARY  
   2. - PUBLIC CONSERVATEE  
   3. - PRIVATE CONSERVATEE

7. FINANCIAL STATUS:  
   1. - PUBLIC ASSISTANCE (MEDICAID, MEDICARE)  
   2. - NOT ELIGIBLE

8. PLACEMENT PRIOR TO ABC (NOT CONSIDERING ACUTE CARE):  
   1. - IMD  
   2. - STATE HOSPITAL  
   3. - COMMUNITY RESIDENTIAL  
   4. - HOMELESS SHELTER  
   5. - OWN HOME  
   6. - FAMILY

9. PSYCHIATRIC DIAGNOSIS (DSM IV, AXIS I):

10. NO. OF HOSPITALIZATION PRIOR TO ABC PLACEMENT:

11. NO. OF HOSPITALIZATION DAYS PRIOR TO ABC PLACEMENT:

12. NO. OF MONTHS IN ABC PLACEMENT

13. NO. OF HOSPITALIZATION DURING ABC PLACEMENT:

14. NO. OF HOSPITALIZATION DAYS DURING ABC PLACEMENT:
TABLE 1

Number of Inpatient Hospitalizations Prior to ABC

Number of inpatient hospitalizations prior to ABC
TABLE 2

Number of Inpatient Days Prior to ABC

Number of inpatient days prior to ABC
TABLE 3

Number of Inpatient Hospitalizations During ABC 1st Nine Months

Number of inpatient days during ABC 1st nine months
### TABLE 4

**Number of Inpatient Days During ABC 1st Nine Months**

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<thead>
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<th>Number of Inpatient Hospitalizations</th>
<th>Count</th>
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<td></td>
</tr>
<tr>
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<td></td>
</tr>
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<tr>
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<td></td>
</tr>
<tr>
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</tbody>
</table>

Number of inpatient hospitalizations during ABC 1st nine months.
TABLE 5

Hospitalization in Relation to Patient’s Age

![Hospitalization in Relation to Patient’s Age](image-url)
REFERENCES


