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**SUBMITTAL TO THE BOARD OF SUPERVISORS
 COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**



FROM: Executive Office

SUBMITTAL DATE:
 August 15, 2006

SUBJECT: Response to the Grand Jury Report: Riverside County Department of Mental Health Western Region Older Adult and Adult Services

RECOMMENDED MOTION: That the Board of Supervisors:

- 1) Approve with or without modifications, the attached response to the Grand Jury's recommendations regarding Riverside County Department of Mental Health Western Region Older Adult and Adult Services.
- 2) Direct the Clerk of the Board to immediately forward the Board's finalized response to the Grand Jury, to the Presiding Judge, and the County Clerk-Recorder (for mandatory filing with the State).

BACKGROUND: On June 20, 2006, the Board directed staff to prepare a draft of the Board's response to the Grand Jury's report regarding the Riverside County Department of Mental Health Western Region Older Adult and Adult Services.

Section 933 (c) of the Penal Code requires that the Board of Supervisors comment on the Grand Jury's recommendations pertaining to the matters under the control of the Board, and that a response be provided to the Presiding Judge of the Superior Court within 90 days.

Gary M. Christmas

GARY CHRISTMAS
 Deputy County Executive Officer

FINANCIAL DATA

Current F.Y. Total Cost:	\$ N/A	In Current Year Budget:
Current F.Y. Net County Cost:	\$	Budget Adjustment:
Annual Net County Cost:	\$	For Fiscal Year:

SOURCE OF FUNDS:

Positions To Be Deleted Per A-30	<input type="checkbox"/>
Requires 4/5 Vote	<input type="checkbox"/>

C.E.O. RECOMMENDATION: APPROVE.

County Executive Office Signature

[Handwritten Signature]

Dep't Recomm.: Consent Policy
 Per Exec. Ofc.: Consent Policy

Prev. Agn. Ref.: 3.9- 7/12/05

District:

Agenda Number:

3.52

**RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
WESTERN REGION OLDER ADULT AND ADULT SERVICES**

FINDINGS:

Finding Number 1:

Staff morale is dangerously low for an effective working environment. Major causes include, but are not limited to:

- 1.a. Frequent relocation or transfer of personnel.

Response:

Respondent disagrees partially with the finding.

It has been over a year since Western Regional Adult Services and Older Adult Services relocated, and staff morale is stabilizing. Western Region Adult services underwent both program reorganization and facility relocation in 2004-2005. Facility relocation was due to a combination of loss of lease and relocation of a second program site. These two events reduced programs to three program locations and less space. A second program relocation was related to adjusting the location of Older Adult Services to improve a more centralized access to Western Region Older Adults and to integrate specialized homeless services in a manner more consistent with state funding guidelines. These adjustments were done primarily in two phases, August 2004 and March 2005.

One program, Older Adult Services moved three times. The number of moves was stressful for staff. The Older Adult moves were as follows:

- *Spring 2004: Mold and a pattern of respiratory illnesses among the work group required a temporary relocation to Atlanta Avenue in order to address staff concerns about work environment. The move was planned to be temporary as the new program location at Blaine was under construction.*
- *August 2004: Relocated from Atlanta to new Blaine Street facility.*
- *March 2005: Based on staff and supervisor feedback, the program was relocated to Riverside Avenue. This is more centralized to the region. The justification was to improve client access and decrease the time and distance required to transport clients to program.*

- 1.b. Reorganization of clinics without seeking and considering staff input.

Response:

Respondent disagrees wholly with the finding.

Organizational changes in 2004-2005 were driven by the loss of staff and facility resources. These programs had insufficient staff remaining to maintain timely access to care and were also reporting significant operational difficulties. Supervisors were provided opportunities to participate in the re-organizational planning. Western Region managers met with staff at each program location to explain the primary need and the goals of reorganization. While managers did recognize and consider staff input, the abrupt timing and severity of operational challenges limited re-organizational alternatives. Recognizing that the department had limited options, there was a deliberate effort to incorporate suggestions whenever possible and to provide all staff an opportunity to request their preferred work assignment. Managers were able to honor most of staff work preferences.

- 1.c. Pervasive lack of communication among senior management, supervisors and staff.

Response:

Respondent disagrees wholly with the finding.

Although there are challenges to communication within a geographically widespread workforce, lack of communication is not pervasive. Regional managers meet regularly with supervisors to communicate developments and solicit feedback. Supervisors are responsible for communicating information to line staff at weekly staff meetings. Supervisors have also been encouraged to attend monthly department supervisor's meetings to receive, discuss and share information. Senior managers have attended these meetings to discuss supervisory issues and concerns. Regional managers have attended program staff meetings to provide updates on both department and regional issues, to answer questions and to solicit feedback. The Mental Health Services Act planning process conducted during 2005 included information sharing meetings with staff in each region. Additionally, dedicated employee focus groups were conducted to solicit input from any interested staff regarding program planning. These focus groups were followed by presentations about the plan which was developed as a result of the planning process. All employees were given another opportunity to provide feedback. All employees were invited to attend multiple sessions that were conducted to maximize access by date and time.

- 1.d. Inconsistent and unclear opportunities for promotion.

Response:

Respondent disagrees wholly with the finding.

The department consistently adheres to county hiring policies and standards. As hiring opportunities become available, regional managers communicate

through supervisor meetings and at program meetings – encouraging staff interested in promotions to submit their resumes to the county's Resumix system and to make sure any existing applications are still active.

- 1.e. Senior management not monitoring morale indicators such as stress leave, frequent unscheduled time off, unexpected resignations or retirements, and transfer requests.

Response:

Respondent disagrees wholly with the finding.

Managers review each leave of absence request, and monitor worker's compensation claims and excess time off. Patterns of leave are discussed with both program supervisors and Human Resources on an individual basis. In several cases, program supervisors adjusted workloads in order to reduce the workload stress on staff. In addition, staff were asked if they wanted to take leave time in order to relieve the stress. Managers monitor resignations, leaves of absence, unplanned time off and transfer requests. As a result, in several cases, managers have been able to identify patterns of leave requests and/or time off that are related to supervisory efforts to improve the employees' work performance to standard. Resignations not linked to performance concerns have usually been associated with employees' decisions to relocate out of the area, promotional opportunities, and/or career changes. Following county personnel practices and policies, the department has terminated some employees. For privacy reasons, management does not report employee terminations to the work force and recognizes that they may have been perceived as unexpected resignations.

Finding Number 2:

Personnel in some clinics denied knowing, or were unaware of, the existence of written safety protocols for their clinics.

- 2.a. Safety inspection reports were not uniformly followed.

Response:

Respondent disagrees partially with the finding.

The department responds to all safety reports and develops plans of correction. If the department does not plan to act on a recommended change, the decision is communicated to the Safety Office. The Safety Office and the department work toward consensus to resolve any outstanding safety concerns. The department recognizes that due to staff shortages, implementation of safety recommendations have, at times, exceeded the planned implementation timeline.

- 2.b. The reception areas do not provide full visibility to clinic staff. This is important

as the clinics deal with mentally ill persons.

Response:

Respondent disagrees partially with the finding.

Three of four facilities have reception areas with full visibility. The department has attempted to improve visibility as part of an ongoing effort to provide a more welcoming environment for consumers. Visibility improves overall safety for any business operation, not just those serving persons with a mental illness. The department plans to evaluate redesign options for the fourth facility as part of the program expansion and reorganization related to new Mental Health Services Act programs.

2.c. Not all clinics are equipped with panic buttons. Some buttons are not operational or staff members were unaware of their location and use.

Response:

Respondent agrees with the finding.

The department has provided alarms when clinics requested them. In clinics which are not equipped, alternative safety protocols are being developed.

Finding Number 3:

3.a. Clinics do not have designated training officers.

Response:

Respondent disagrees partially with the finding.

The department has a designated training officer; however, there is no policy that each clinic have a training officer. The training officer receives regular input regarding training needs from managers, supervisors and program staff.

3.b. In some clinics, proper documentation in a client's chart, in terms of assessment, case notes and other actions (including appropriate reimbursement billing notations), is handled by untrained clerical personnel.

- Clerical staff is unable to handle workloads due to their personal injuries.
- Clinics are unable to secure replacement staffing through the county's Temporary Assistance Program (TAP).

Response:

Respondent disagrees partially with the finding.

Proper documentation, including appropriate billing notations is solely the responsibility of clinical provider staff, not clerical personnel.

- *Two clerical staff at one program location were on temporary medical leave for several weeks in November-December, 2005. Operational issues have been linked to their absence, to program operational procedures, and individual performance concerns for a number of staff at the facility.*
- *The program has been able to secure replacement staff via TAP whenever funding was available for such staffing.*

3.c. There was no evidence that each clinic regularly scheduled and participated in drill procedures for fire or other emergency situations.

Response:

Respondent disagrees wholly with the finding.

A review of emergency drills found that all programs have conducted and recorded dates for emergency drills. Records of safety meetings were also found. The department also found that due to recent staff vacancies, replacement safety officers scheduled to attending training were unable to attend due to class cancellation or personnel issues. The transition impacted recent drill schedules.

Finding Number 4:

4.a. The Regional Mental Health Services Manager volunteered for and assumed additional duties, thus resulting in dilution of overall effectiveness.

Response:

Respondent disagrees partially with the finding.

The regional manager assumed additional duties to provide temporary coverage while a new manager was recruited. The assumption of temporary extra duties is standard procedure used to minimize disruption to program operations during the recruitment process. During the past year, all members of the management team assumed and received additional assignments in order to assist with the Mental Health Services Act planning process. This required a restructuring of workload priorities.

4.b. Employee performance evaluations are not accomplished in a timely manner. Some employees have not received written evaluations for as long as seven years.

Response:

Respondent disagrees partially with the finding.

The department acknowledges that some employee evaluations have not been provided in a timely manner. A performance evaluation training module is being developed by our HR Team, and this will be implemented in January 2007.

- 4.c. Senior management has displayed an indifferent attitude toward staff input in clinic reorganization.

Response:

Respondent disagrees wholly with the finding.

The department acknowledges that not everyone agreed with the need or decision to reorganize programs. Feedback was solicited. The director, at the time of the reorganization, met with supervisory staff. The Western Region Manager met with direct service staff. The reorganization was necessary for the department to meet service delivery needs with resources available and performance outcomes established by state funding standards. The implementation is still in process because hiring staff is still in process.

- 4.d. There is a perception of managerial indifference toward staff recommendations, requirements and needs.

Response:

Respondent disagrees partially with the finding.

It is possible that program changes may be perceived by some as proceeding without regard to staff recommendations, requirements and needs. The reported perception is not consistent with manager's efforts to train staff, meet with staff, include their input and make adjustments based on their feedback whenever possible. Consistent with the Mental Health Services Act vision of system transformation, the department has been actively providing training, soliciting input, and actively working to increase employee participation, understanding and readiness for pending changes. Staff are in meetings each week. They receive training opportunities and each received department newsletters bi-monthly.

- 4.e. Underperforming employees are transferred without remedial action being taken by the transferring supervisor. This practice "infects" the receiving clinic, increases the tasks of already overworked supervisors, and reduces clinic productivity.

Response:

Respondent disagrees wholly with the finding.

The expected practice for all supervisors is to address performance deficiencies in place and not "transfer the problem." In the event that a

substandard performance cannot be remedied in the current assignment, both the manager and supervisors involved in the programs have consulted with Human Resources and collaborated on reassignment planning. Any such action is taken only after a determination was made that the employee(s) in question required individualized support and attention that was not available at his or her current assignment and that his or her needs could not be met through standard performance resolution strategies.

- 4.f. Some supervisors isolate themselves, often managing by e-mail or written directive rather than personal contact.

Response:

Respondent disagrees partially with the finding.

The nature of client services and clinic operations require daily interaction by supervisors with both staff and clients, making isolation very difficult. All supervisors conduct regular staff meetings. Management addresses performance concerns with supervisors who isolate or overuse e-mail, demonstrate ineffective leadership and direction of staff and operations.

Finding Number 5:

- 5.a. Based on available information, failure to document fees for services correctly, or not document at all, cost the County approximately \$250,000.

Response:

Respondent disagrees partially with the finding.

The state mental health department has a system for reversing inappropriate charges to Medi-Cal and expects each county to use this system. Riverside's reversals (or disallowances) have been very small (less than 5%). Documentation of non-compliance with Medi-Cal requirements has been identified in one clinic. The amount of services not eligible for reimbursement has not yet been determined.

- 5.b. Medi-Cal billing was disallowed due to incomplete charting.

Response:

Respondent agrees with the finding.

The department conducts regular program audits. Some billing disallowances are routinely found during program audits and reviews.

- 5.c. Charts audited were selected by the supervisor, rather than randomly chosen, thus allowing any audit effort to be easily manipulated.

Response:

Respondent disagrees partially with the finding.

Historically, supervisor selection was used. The department converted to random audits last year (2005).

- 5.d. The twenty-year-old computer system currently in use is outdated and cannot keep up with government accounting and billing requirements.

Response:

Respondent disagrees partially with the finding.

The computer system is not the state-of-the-art available and a Request for Proposals (RFP) for a replacement will be sent out in August. The current system meets all the government billing and reporting requirements.

Finding 6:

- 6.a. The office structure of the clinics is not conducive to meeting the physical and emotional needs of the majority of the clients.

Response:

Respondent disagrees partially with the finding.

Two locations are faced with significant space challenges. The department is planning to relocate all or part of the staff from these locations. In the interim, program supervisors have worked to organize available office space in a manner that is respectful of client needs. All programs meet ADA requirements in accordance with state and federal requirements.

- 6.b. The Corona/Norco area, with a population of nearly 200,000, has no locally available multipurpose mental health service clinic, so clients must travel to Riverside.

Response:

Respondent agrees with the finding.

The department requested and received Board of Supervisor approval in November 2005 to identify a new location for West Clinic Adult in Riverside to relocate to the Corona/Norco area. In order to improve access for clients, the department adopted the goal of establishing services in the Corona/Norco area in 2004. Relocation has been delayed due to shortage of space available for lease; however, several tentative locations have been identified.

- 6.c. There is inadequate office space to assure client confidentiality.

Response:

Respondent disagrees wholly with the finding.

Every program location provides confidential offices for client meetings. In programs with limited or shared worker space, private interview offices are set aside for client meetings. Additionally, the workforce is routinely out in the field. Their offices are also available for confidential interviews should the need arise.

- 6.d.** There are insufficient personnel trained to deal effectively with dual diagnosis (mental illness plus alcohol and/or drug addiction) that afflict seventy to eighty percent of service consumers.

Response:

Respondent disagrees partially with the finding.

Programs in Western Region do have a number of providers trained and providing treatment of co-occurring mental health and substance abuse disorders. The department recognizes the need to improve the skills of all providers to assist clients with dual disorders and has recently trained 27 mental health staff in a best practice model of intervention. A standardized model of intervention is being developed for introduction to all provider staff working with clients with co-occurring disorders.

- 6.e.** Reception personnel are not trained to deal with the clinics' difficult mental health service clients.

Response:

Respondent disagrees wholly with the finding.

The department has sponsored training for office support staff in dealing with consumers. The most recent was in May 2006. Additional training for the clerical staff is being planned.

- 6.f.** The City of Riverside has initiated eminent domain proceedings, with condemnation of two facilities currently contracted by the county to provide housing for Department of Mental Health clients. This action will exacerbate the shortage of bed space for these clients.

Response:

Respondent agrees with the finding.

The City of Riverside initiated eminent domain proceedings on one licensed residential care facility; the property owner then sold it to a developer prior to eminent domain action. The City of Riverside is pursuing eminent domain on a second similar facility as part of ongoing redevelopment efforts. These

facilities are not under contract with the county, but are used on a referral basis. Combined, these two private facilities provide housing for 108 clients. This represents 25% (of 435 beds) of countywide capacity for adults ages 18-59. The department is working with prospective vendors and State Social Services-Community Care Licensing to encourage new facilities in the county. If this effort is not successful, clients will be staying longer at higher cost facilities or being sent to facilities in other surrounding counties.

Finding Number 7:

7.a. Quality Improvement audits of clinics are not conducted quarterly as the procedure manual dictates.

Response:

Respondent disagrees wholly with the finding.

The Quality Improvement Manual does not require quarterly reviews. Reviews are generally conducted quarterly but no less often than every six months.

7.b. A function of Quality Improvement is to collect data for Medi-Cal disallowances. This data is used in discussions with clinic supervisors, but is not disseminated to senior management.

Response:

Respondent disagrees wholly with the finding.

Quality Improvement initiated the practice of providing audit results to managers of program services last year.

7.c. Adequate information regarding billing procedures is not collected. There are no indicators to alert management to billing deficiencies.

Response:

Respondent disagrees wholly with the finding.

The existing database tracks and reports unclaimed services on a monthly basis. Additionally, within the last year, the department developed new audit policies, procedures and audit tools for supervisors to use during chart reviews. The policy includes forms and procedures for supervisors to report their findings to management.

7.d. Information collected is not always reported to the department program manager, assistant director or director.

Response:

Respondent disagrees partially with the finding.

As indicated in 7b above, Quality Improvement reports all audit findings to regional managers. Senior management receives audit results related to significant or re-occurring findings.

RECOMMENDATIONS:

Recommendation Number 1:

1.a. Develop a system that allows senior management to evaluate morale indicators including, but not limited to:

- Stress leave;
- Transfer requests;
- Excessive absenteeism (particularly on Mondays and Fridays);
- Unplanned resignations or retirements; and
- Worker's compensation claims.

Response:

The recommendation has been implemented.

The department currently monitors indicators as recommended.

1.b. Take action to avoid the perception that staff input is of little or no value. Senior management should solicit participation of line staff and supervisors in decisions affecting the clinic environment.

Response:

The recommendation has been implemented.

The department will continue to solicit and consider input from all levels of employees. As part of the department's commitment to transform provision of mental health services, the department has been aggressively providing training to management, supervisors and program staff. The department recognizes that in order to effectively implement system transformation, workforce inclusion and participation in the transformation process will be essential.

1.c. Increase employee awareness of educational and other requirements for promotional opportunities. In appropriate circumstances, communicate the requirement for degreed or certificated applicants.

Response:

The recommendation has been implemented.

Job qualification requirements will remain consistent with those specified by Human Resources. Western Region will continue the practice of announcing job opportunities during staff meetings and encouraging/reminding employees interested in promotional opportunities to maintain an active resume through the Resumix system.

Recommendation Number 2:

2.a. Implement guidelines from the Safety Division with respect to location, installation, and maintenance of panic buttons and alarm systems.

Response:

The recommendation has not yet been implemented but will be implemented in the future.

Currently, guidelines related to location, installation and maintenance of panic buttons and alarms are not available. The department will implement a schedule of functional tests for facilities that are equipped with panic alarm systems.

2.b. Prepare written protocols for emergency actions and evacuations. Assure that all personnel are aware of emergency procedures. Conduct frequent training with various emergency scenarios.

Response:

The recommendation has not yet been implemented, but will be implemented in the future.

Western Region will review and update existing emergency plans. A schedule of training to review plans with employees will be developed.

2.c. Make all reception areas fully observable by staff.

Response:

The recommendation has not yet been implemented, but will be implemented in the future.

Three of four Western Region facilities provide full visibility. The department has pre-existing plans to improve the remaining facility as part of the ongoing effort to improve consumer service environments.

Recommendation Number 3:

3.a. Each clinic supervisor appoint a clinic training officer.

Response:

The recommendation will not be implemented because it is not warranted or is not reasonable.

Training officers at the clinic level will diminish the resources available to serve clients and would increase the likelihood of inconsistent training methodology. The department, through funding opportunities anticipated through the Mental Health Services Act, will improve its centralized training capacity and effectiveness.

- 3.b. Position descriptions and duties be explained to each employee.

Response:

The recommendation will not be implemented because it is not warranted.

Position descriptions and minimum requirements are posted by Human Resources. The department assists staff with promotional opportunities. Job duties are currently explained to each employee by the supervisor either as a new employee or whenever their job duties have changed. This practice will continue.

- 3.c. Explain to each employee and contract professional the importance of prompt and proper chart documentation, and require compliance.

Response:

The recommendation has been implemented.

Chart documentation has been an ongoing area of focus by QI and supervisors. The department initiated revision of the documentation guidelines and chart compliance procedures in 2005. These revisions will be finalized in July 2006. Training to the revised standards will commence in August 2006 with a target completion date by November 1, 2006.

- 3.d. In the case of contract personnel, make documentation of client records a specific contractual requirement.

Response:

The recommendation will not be implemented because it is not warranted.

Accurate and compliant service documentation is an expectation of all provider staff, including contract personnel. Failure to meet expectations is cause to terminate contract personnel which is specified in our contract.

- 3.e. Recognize quality performance promptly and publicly.

Response:

The recommendation has not yet been implemented, but will be implemented in the future.

The initiative described in Response 1b includes the commitment to develop strategies that demonstrate employees are valued and utilizes methods of employee support through strength based recognition.

- 3.f. Develop positions consistent with client profiles.

Response:

The recommendation requires further analysis.

The department requires clarification of this recommendation before a response is possible.

Recommendation Number 4:

- 4.a. Require written performance evaluations at all levels on employee anniversary dates. Failure to comply be a mandatory notation on the evaluator's performance report.

Response:

The recommendation has been implemented.

The department is reviewing the on-line Employee Performance Manager to monitor the compliance of completing timely performance evaluations.

- 4.b. After removal of employees from progressive discipline (Progressive Performance Improvement, or PPI), require written reports on employees until performance has been at a satisfactory level for six months.

Response:

The recommendation has not been implemented because it is not warranted.

The department will continue to adhere to Human Resource policies, procedures and standards of practice that relate to progressive discipline.

- 4.c. Transfer of under-performing employees be prohibited unless both transferring and receiving supervisors agree. Employees being transferred under these circumstances should have already been under PPI for a reasonable period.

Response:

The recommendation has not been implemented because it is not

reasonable.

Transfer of under-performing employees will continue to be in consultation with supervisors, Human Resources, and pursuant to provisions provided by all applicable policies and procedures. Employee transfers will also be in response to identified program need(s) in order to insure effective and appropriate services.

Recommendation Number 5:

- 5.a. Require the Auditor-Controller to audit the Western Region.

Response:

The recommendation has not yet been implemented, but will be implemented in the future. Provide a time frame for implementation.

The Auditor-Controller has included an audit of Mental Health Western-Region in the fiscal year 2006-07 Internal Audit Plan. This audit will focus on fees for service and medical billing. This will be implemented during FY 2006/07.

- 5.b. Standardize policies and procedures throughout the system to maximize reimbursement for authorized services.

Response:

The recommendation has been implemented.

The department has consistently focused on meeting requirements for reimbursements. The department initiated the revision of documentation guidelines and chart compliance procedures in 2005. These revisions were finalized in July 2006. Training to the revised standards will commence in August 2006 with a target completion date by November 1, 2006.

- 5.c. Review financial records regularly to assure that appropriate reimbursements are received.

Response:

The recommendation has been implemented.

Revenues and costs continue to be reviewed monthly.

- 5.e. Develop a comprehensive system of electronic record keeping, to include the replacement of the twenty-year-old computer system.

Response:

The recommendation has not yet been implemented, but will be implemented in the future.

The Request for Proposals for the replacement is scheduled for release by early August 2006.

(Grand Jury Report did not include a recommendation #6 or #7)

Recommendation Number 8:

8.a. Educate transportation and reception personnel to deal appropriately with clientele displaying significant physical or emotional problems.

Response:

The recommendation has not yet been implemented, but will be implemented in the future.

The department provided training to office support staff regarding working with challenging behaviors in May 2006. This training was part of the ongoing initiative to improve workforce skills and customer service. The department will continue to evaluate training needs for all staff, including transportation employees, in order to enhance their skills in working with consumers of department services.

8.b. Initiate fast-track efforts to establish a full-service clinic in the Corona/ Norco area.

Response:

The recommendation has been implemented.

The department received Board approval in-principle to identify a Corona-Norco service location in November 2005. This request was initiated by an urgent need to relocate an existing service site and a pre-existing goal to provide services to the Corona-Norco area. Facilities Management has been actively assisting the department in achieving this relocation goal as quickly as possible.

8.c. Provide clinicians and behavioral health specialists private offices to guarantee client confidentiality.

Response:

The recommendation will not be implemented because it is not warranted.

The department will continue to make private client interview areas available to all staff so that they are able to protect client confidentiality.

8.d. Increase staff resources to deal with dual diagnosis (mental illness plus alcohol and/or addiction drug) clients.

Response:

The recommendation has been implemented.

The department initiated a Co-Occurring Disorder Work Group in 2004. The goal was to increase standardized services to clients with co-occurring (mental health and substance abuse) disorders. The Work Group has been working to develop a standardized training to develop the skills of all staff in providing services to consumers with co-occurring disorders. As part of this effort, 27 mental health providers received training in a best-practice model of co-occurring disorder treatment intervention on June 8-9, 2006. Ten of these providers have joined the Work Group developing the standardized training that will be provided system-wide. Additionally, standardized assessment and treatment protocols have been implemented on a pilot basis. The Mental Health Services Act will provide additional staff that will also receive standardized training in the treatment of co-occurring disorders.

- 8.e. Coordinate county and city efforts to provide facilities to replace the loss of client beds caused by property condemnations.

Response:

The recommendation has been implemented.

The department recognizes that local municipalities will endeavor to improve their respective communities through the re-development process. The department will continue to partner with local jurisdictions, state community care licensing and facility operators to restore and expand housing capacity.

- 8.f. Urge county and city governments to locate multipurpose facilities for client convenience.

Response:

The recommendation has been implemented.

The department will continue to partner with local jurisdictions to site programs and services consistent with community needs.

Recommendation Number 9:

- 9.a. Develop a statistically valid protocol to provide accuracy of records, and to monitor revenue.

Response:

The recommendation will not be implemented because it is not warranted.

As indicated in Finding 7 (a through d), the department has established policies and procedures that include routine quality improvement and supervisory reviews. Audit results are reported to regional and senior

management. Unbilled services will continue to be reviewed on a monthly basis. Furthermore, the Quality Improvement Committee meets monthly and reviews results of the quality improvement chart reviews.

- 9.b. Provide review and audit results to senior management on a quarterly basis.

Response:

The recommendation has been implemented.

Currently, senior management routinely receives information on audits with significant problems and those where less serious problems continue despite Quality Improvement training and intervention. Every provider's audit is reviewed no less than once every two years. The department concurs with this recommendation and all audit results will be received and reviewed on a quarterly basis.