PROGRAM INFORMATION:

Program Title:	TEAMMATES Wraparound	**Provider:**	Central Star Behavioral Health
Program Description:	Comprehensive, individualized services designed to address and resolve multiple child and family needs among children and families with socially and ecologically complex and challenging life circumstances	**MHP Work Plan:**	2-Wellness, recovery, and resiliency support
Age Group Served 1:	CHILDREN	**Dates Of Operation:**	June 2018 to present
Age Group Served 2:	ADULT	**Reporting Period:**	July 1, 2018 – June 30, 2019
Funding Source 1:	Medical FFP	**Funding Source 3:**	Other, please specify below
Funding Source 2:	EPSDT	**Other Funding:**	County SB 163 Funds

FISCAL INFORMATION:

Program Budget Amount:	$4,500,000	**Program Actual Amount:**	$3,392,839.36 (including both Medi-Cal and SB163 non Medi-Cal services)

Number of Unique Clients Served During Time Period: 197
Number of Services Rendered During Time Period: 15,723 services (1,234,471 units of service)
Actual Cost Per Client: $17,222.53

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	WRAP
Contract Term:	06/01/2018 – 06/30/2023 (06/01/2018 – 06/30/2021 plus two optional twelve-month periods)	**For Other:**	
		Renewal Date:	06/30/2023

Level of Care Information Age 18 & Over: Medium Intensity Treatment (caseload 1:22)

Level of Care Information Age 0- 17: Intensive Outpatient (TBS, Wrap)

TARGET POPULATION INFORMATION:

Target Population: Children/youth, ages birth through 18 and their families who typically have a history of multi-system involvements and/or out-of-home placements with a need for support to sort out and address issues while building on strengths to achieve safe, stable and positive family life or alternative permanency arrangements for children.

CORE CONCEPTS:

- **Community collaboration:** individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural competence:** adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
- **Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services**: adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Access to underserved communities:** Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services.
- **Integrated service experiences:** services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

Please select core concepts embedded in services/ program: *(All apply)*	**Please describe how the selected concept(s) embedded**:
Access to underserved communities	
Integrated service experiences	Communitiies served include foster youth in fulfillment of Katie A. requirements.
Community collaboration	From the outset, enrolled clients are assisted by an interdisciplinary team of staff whom work closely together with the child/youth and family to coordinate, communicate, and focus services as needed. This includes screening, assessments, referral, and linkages to primary health care and to a wide range of community-based resources, services and supports; it also includes much in-vivo work with young adults so they are accompanied and supported during varied aspects of community life functioning.
Cultural Competency	Central Stars' Bi-Annual Cultural Attunement Plan addresses staff training needs; policies, procedures, and protcols; and, elective projects to meet the needs of the service population.
Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services	All services are focused per the client's Child and Family Team (CFT) process and the collaboratively authored individualized service plan that taps into the program's generous array of interventionists (staff types), mental health treatment, family-focused services, and wellness practices.

PROGRAM OUTCOME & GOALS
- **Must include each of these areas/domains: (1)** Effectiveness, **(2)** Efficiency, **(3)** Access, **(4)** Satisfaction & Feedback Of Persons Served & Stakeholder
- **Include the following components for documenting each goal: (1)** Indicator, **(2)** Who Applied, **(3)** Time of Measure, **(4)** Data Source, **(5)** Target Goal Expectancy

NOTE: Reader will see three sections: **Measurement Protocols**; **Synopses** (highlights of outcomes); and, **Details** (full details of outcomes).

Measurement Protocols:

Tool	Rationale(s)	Status
Varied screening & assessment tools (e.g., ACES, CSSRS, PHN, SBIRT)* and service delivery tracking. Screenings & assessments are completed during intake, and also later during services when needed. Service entries occur continuously as services are provided.	Required by county, SBHG and/or SBHG for Joint Commission (JC) accreditation. Guides service planning for resolution of needs and risks.	Implemented. Completed in SBHG electronic health record (EHR).
Varied TQM/QA and program/practice fidelity tracking (IRs, QI projects, JC Tracers, staff training, cultural attunement plans, wraparound fidelity, etc.). TQM data collection timetables are driven largely by a published CQI calendar and QI project dates. Wraparound fidelity protocols will be completed on an ongoing basis to obtain a valid annual sample of observations.	Information to monitor quality of care, practice fidelity and cultural attunement for quality assurance and improvement. Wraparound fidelity tools: • Team Observation Measure (TOM) • Wraparound Fidelity Index (WFI-EZ) • SBHG Four Truths Survey**	Most tracking systems are implemented at this time. CQI review (quality council) is scheduled Oct 2019. First available data from “Four Truths” surveys are reported (see analyses section).
Performance Outcome System (POS) – Child Adolescent Needs Scale (CANS-50) and Pediatric Symptom Checklist (PSC-35). These tools are completed at intake, every six months through discharge.	State DHCS mandate for children’s services, applied to Children ages 4 to 18 at time of program enrollment.	Staff trained, protocols provided. Team completed N= 81 CANS-50 and N=83 PSC-35 this year. Baseline profiles are provided; there are too few matched sets to report treatment results at this time.

	PSC meets SBHG's JC requirement for use of one standardized tool per age group served.	
Ages & Stages Questionnaire (ASQ). ASQ is completed at intake, every six months and discharge.	Tool for small children up to age 5 that assesses developmental milestones and pre-school functioning (meets JC requirement).	Recently implemented. No data to report so far.
SBHG EHR Child Outcomes Report (COR) and DC Status Form. COR is completed at intake and discharge; DC Status Form at discharge.	Used SBHG-wide to capture varied categorical statuses at intake and at discharge, incl. referrals/linkages provided for aftercare.	Implemented. Matched (pre to post) Child COR avail on N=42 (58%) discharges; DC Status on N=52 (72%) discharges.
Client, Family & Agency Partner Surveys (state MHSIP surveys, SBHG Agency Partner Surveys). Mandated state surveys collected twice a year from persons seen during a 1-week window (fall, spring).	Agency Partner Surveys required by SBHG. Scheduling TBD.	Team participated in state MHSIP data collection during fall 2018 (N=48 caregiver and 13 youth respondents) and spring 2019 (91 caregiver, 19 youth) cycles. Spring report pending***. Agency Partner Surveys will be gathered this coming year.

Synopses:

ACCESS:

- The Katie A. subclass is well served. A majority (84%) of all clients participated in Intensive Care Coordination (ICC) and 80% with Intensive In-Home Services (IIHBS), modalities specific to this subclass.
- The program participated, along with all of Central Star, in the creation of their first bi-annual Cultural Attunement plan, completed June 2019. It is available upon request.
- CS is working in tandem with SBHG to assure data collection for monitoring performance to new state DHCS timeliness of care standards (e.g., 10 days from referral to first MH appointment; 15 days for psychiatry appointment). So far: the average days from referral to enrollment (EHR date/time stamps) is 24 days (median =5, range 0 to 261). There were a few (N=19) that took over 90

days, driving up this statistic. These will be examined to understand the barriers to overcome for operational quality improvement. Overall, 75% were enrolled within 10 days (0 thru 9 days) of referral.

- The team commenced required data log submissions of the Network Adequacy Certification Tool (NACT).

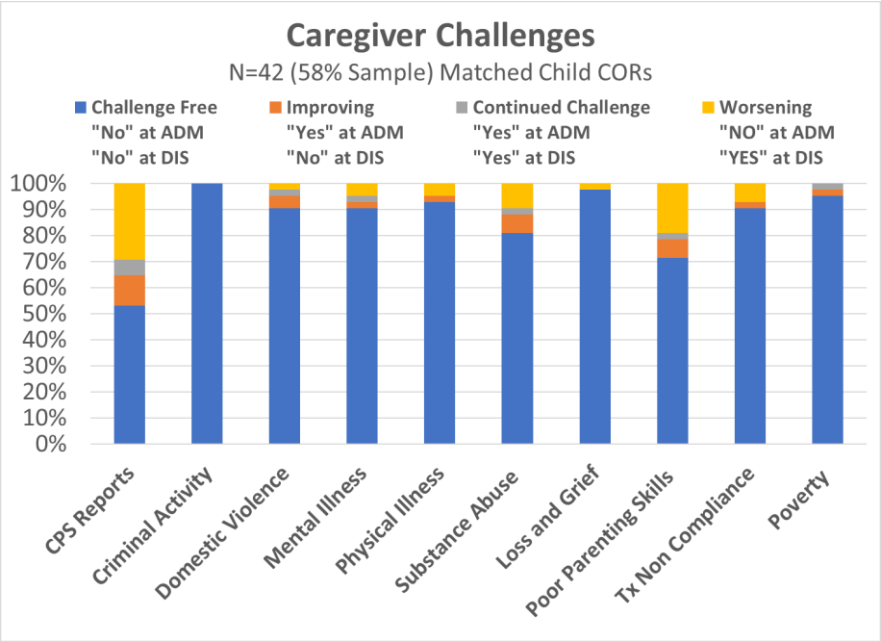
EFFECTIVENESS:

- Based on SBHG EHR Child Outcome Report (COR) data, improvement or stability in a living situation was achieved by many (67%): close to 36% successfully maintained in a family home, 10% transitioned from foster home to family home; 17% maintained in foster home, and 5% maintained in a group home.

- Tabled data in Form C details progress with family reunification at enrollment (ADM) to discharge (DIS), pertinent to children on this track at some point during CS Wraparound (57% of population). Close to 25% of children/youth had parents able to resume legal status (child custody) from the courts by discharge (CWS case closure).

- Roughly 41% of the children/youth served were well along with permanency when they enrolled – that is, they had a prospective family identified, a permanent foster home, or had been adopted. Importantly, 19% joined this status by discharge; and another 14% were seeing some progress toward potential permanency*.

- Clinicians rate (“Yes” or “No”) whether caregivers’ challenges “impact the child’s mental health functioning and/or treatment prognoses”. Below shows the distribution for 10 challenges where each was either never an issue (“challenge free”), ceased being an issue (“improving”), persisted as an issue during services (“continued”) or newly appeared as an issue (“worsened”). We note that a process of discovery – clinicians’ recognizing more issues as they work with families over time – can shape these data. Newly detecting issues, even if discovered well along in services, is important and is considered for aftercare planning.



- 42% met all, most or some of their mental health treatment goals by discharge.

- The team administered 81 Child and Adolescent Need and Strengths (CANS-50) forms regarding 81 unduplicated clients thru June 2019. They also administered 83 Pediatric Symptom Checklist (PCS-35) forms with 73 unduplicated clients. While samples are insufficient at this juncture for pre-post analyses, a baseline profile of the service population is provided from both these tools.

- For example, Wraparound clients have extreme difficulties (70% and more with “actionable ratings”) with their cultural identity, community life, and spirituality. These areas with the highest level of needs or insufficient strengths symptoms are the priority foci for the program’s wellness, recovery and rehabilitative practices, and for clinicians to address in individual therapy. Addressing these areas may also eventually and positively contribute to improving youth’s school performance.

- On the PCS-35 highest rated items (indicating greater impairment) are “distracted easily”, “irritable, angry”, “trouble sleeping”, “does not listen to rules”, and “does not understand other people’s feelings”. These are priority areas for intervention. Importantly, the total score average for these clients is greater than the cutoff of 28, indicating that, on average, the children/youth are need of an intensive level of treatment, such as they have with wraparound.

- The SBHG EHR DC Status Form captures information about the types of services and supports, behavioral health and community resources tracked separately, that are part of aftercare plans for those leaving Wraparound. For the discharge cohort thru June with available records, 90% were linked to one or more aftercare services of each broad type (behavioral health, community resources). Details are tabled on Form C.

EFFICIENCY

- Central Star's training department maintains detailed logs of staff trainings, which are a mix of classroom and on-line trainings, and are available for inspection. Many staff hired into Wraparound from other SBHG programs, and the transferred staffs along with new hires have participated, on average, in 51 trainings each (range 15 to 156) anchored to their date of hire and scope of practice. They have, on average, 152 hours of training (range 50 to 315) with CS, SBHG and some externally provided by county.

- The program's supervisors received training from SBHG's Fidelity Specialist on administering standardized wraparound fidelity tools (TOMs, WFI) and they have an implementation plan at this time, which starts soon. A contract for anonymous, secure database entries and reporting is in place with the University of Washington.

- Facilitators have begun to provide structured feedback on the CFT process, pertaining to the participation of allied professionals. This data will be shared at their coming Quality Council.

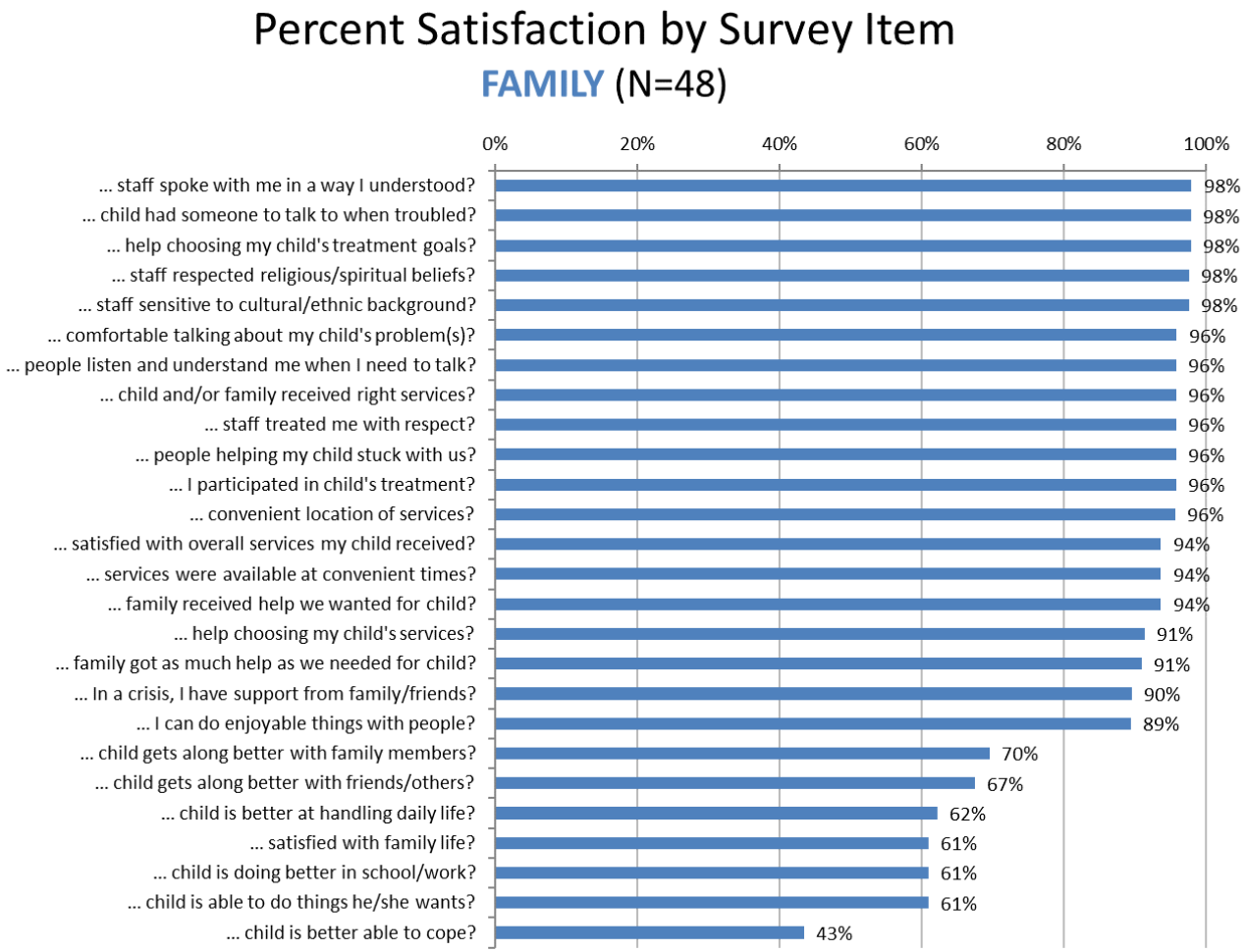
- The fidelity data described above will yield information helpful to assuring that CS Wraparound program services are community-based, comprehensive, coordinated and individualized. Meanwhile, services are being delivered primarily at home (37%), field, incl. schools (31%), program offices (18%) or on the phone (7%). Staff also travel to the youth's group homes, treatment settings, and other locations as needed to provide services in an efficient way from the client/caregiver perspective.

- The central tendencies of service delivery per client enrollment, for all N=72 closed cases, are tabled on Form C. Overall, 85% of the service units involve direct client/caregiver contact (vs. 'other' time for documentation, travel, etc.).

- The average length of stay among discharged youth was 138 days; median 123 days, range 14 to 350. Majority (70%) were discharged within 6 mos.

SATISFACTION

- During fall 2018 survey cycle, a majority (87%) of caregiver's endorsed the program, as did many youth (76%). Caregiver responses to survey items are shown below.



- The items falling below company benchmark (85% or better results expected) pertain to perception of outcomes; they were not prioritized for quality improvement at the time. This is because the MHSIP surveying process is cross-sectional (persons seen during a 1 week window), program was under six months in operation, and many respondents were not far along to report gains.

Details:

- Each section starts with a list of contract KPIs for the reporting area: Access, Effectiveness, Efficiency and Satisfaction.

ACCESS:

- Mental health services for Katie A. subclass members, among others, are provided.
- Population trends, demography, cultural & linguistic needs are addressed.
- Timeliness of care standards are met (referral to first service, etc.).
- Barriers to access and to effective care are identified and addressed.

- The Katie A. subclass is well served. A majority (84%) of all clients participated in Intensive Care Coordination (ICC) and 80% with Intensive In-Home Services (IHBS), modalities specific to this subclass. During the FY, each client with these services (whether active or closed cases), participated, on average, in 64 discrete ICC service dates encompassing 3,196 units/minutes (median 2,464 range 1 to 12,520); and, in 26 discrete IHBS service dates encompassing 2,054 units/minutes (median 1,490 range 39 to 8.8.11).
- The program participated, along with all of Central Star, in the creation of their first bi-annual Cultural Attunement plan, completed June 2019. It is available upon request. The plan follows CLAS topics and addresses staff training; policies, procedures and protocols; and, elective projects designed to boost awareness, competencies, and responsiveness to Central Star's (CS) service populations.
- CS is working in tandem with Stars Behavioral Health Group (SBHG) to assure data collection for monitoring performance to new state DHCS timeliness of care standards (e.g., 10 days from referral to first MH appointment; 15 days for psychiatry appointment). So far:
  - The average days from referral to enrollment (EHR date/time stamps) is 24 days (median =5, range 0 to 261). There were a few (N=19) that took over 90 days, driving up this statistic. These will be examined to understand the barriers to overcome for operational quality improvement. Overall, 75% were enrolled within 10 days (0 thru 9 days) of referral. Referrals have not yet been coded in the EHR for urgency, but they will be.
  - Preliminary data also indicates a team member sees a client within 5 days on average (median =0, range 0 to 84 days) from the date of enrollment/intake to first service, which typically involves further screening and assessment (35%), wraparound activity (22%), treatment planning (15%) or case management (12%). About 10% of the time the first session results in a "No Contact" note (cancelled/missed appointments). Overall, first service is occurring within 10 days (0 thru 9 days) from enrollment for 86% of those enrolled.
  - Company-wide, SBHG is revising Business Analytic (BA) Dashboards to provide teams with real-time monitoring of access to care milestones. The team commenced required data log submissions of the Network Adequacy Certification Tool (NACT).
- Barriers to access and to the full range of needed, effective services will be assessed soon, and reviewed at the team's fall Quality Council (aka CQI).

EFFECTIVENESS:

- Effectiveness of treatment interventions
- Improved family involvement (parents, siblings, child client, etc.)
- Safely and stably maintain children in least restrictive placements (or step down)
- Effectiveness of discharge planning

Child Outcomes Report (COR) Data. The information below reflects analysis of N=42 (58%) of discharged clients' matched Child Outcome Report (COR) records for FY 18-19.

- In aggregate, the children and youth did not experience significant gains with regards to schooling: from enrollment to discharge (→), similar proportions (26% → 29%) had one or more disciplinary issues (truancies, suspensions, etc.), although the average count of such events decreased slightly (.43 → .33). Moreover, based on the available sample, in aggregate, attendance did not improve (55% → 45% attending 4+ days per week), neither did course grades (24% → 21% achieving "C" grades or better).

- Improvement or stability in a living situation was achieved by many (67%): close to 36% successfully maintained in a family home, 10% transitioned from foster home to family home; 17% maintained in foster home, and 5% maintained in a group home.

- Less desirable shifts occurred when youth moved from a family/foster home to a group home (14%), detention facility (14%), homeless shelter (2%) or unknown by discharge (2+%).

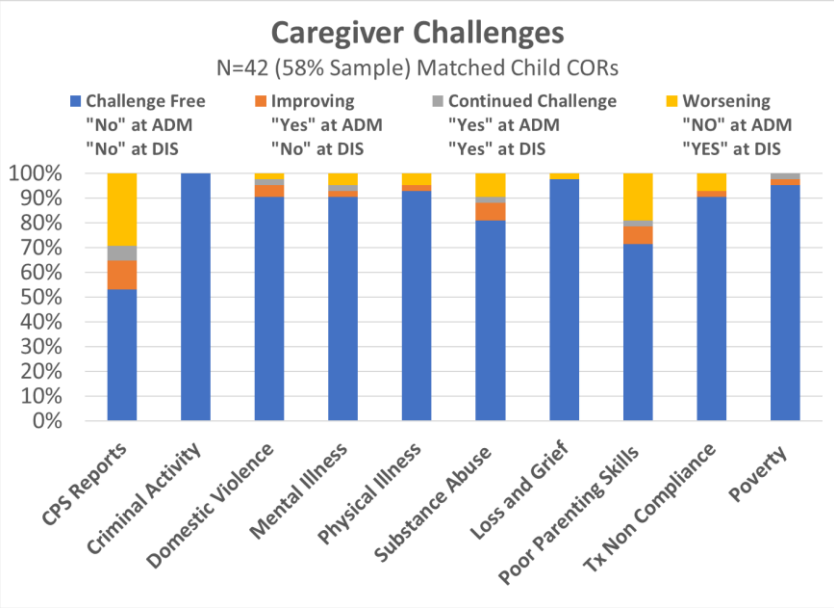
- The following table details progress with family reunification at enrollment (ADM) to discharge (DIS), pertinent to children on this track at some point during CS Wraparound (57% of population). Close to 25% of children/youth had parents able to resume legal status (child custody) from the courts by discharge (CWS case closure).

Family Reunification:	
Reunification Achieved by Discharge:	**26.1%**
Reunification Achieved at ADM	7.1%
In Progress at ADM, Achieved by DIS	11.9%
Unknown at ADM, Achieved by DIS	7.1%

Reunification in Progress by Discharge:	**16.7%**
In Progress at ADM, In Progress by DIS	11.9%
Unknown at ADM, in Progress by DIS	0.0%
Achieved at ADM, in Progress by DIS	4.8%
Reunification Failed by Discharge:	**14.3%**
In Progress at ADM, Failed by DIS	2.4%
Failed at ADM	7.1%
Unknown at ADM, Failed by DIS	4.8%

- Roughly 41% of the children youth served were well along with permanency when they enrolled – that is, they had a prospective family identified, a permanent foster home, or had been adopted. Importantly 19% joined this status by discharge; and another 14% were seeing some progress toward potential permanency*.

- Clinicians rate ("Yes" or "No") whether caregivers' challenges "impact the child's mental health functioning and/or treatment prognoses". Below shows the distribution over time of the proportions for 10 challenges where each was either never an issue ("challenge free"), ceased being an issue ("improving"), persisted as an issue throughout services ("continued") or newly appeared as an issue ("worsened"). We note that a process of discovery – clinicians' recognizing more issues as they work with families over time – can shape these data. Newly detecting issues, even if discovered well along in services, is important and considered for aftercare planning.



- 42% met all, most or some of their mental health treatment goals by discharge.

*Please note youth/families may be multi-tracked in the child welfare system: working on both reunification and permanency simultaneously; thus, proportions across tables do not add to 100%.

CANS-50 Baseline Profile. The team administered 81 Child and Adolescent Need and Strengths (CANS-50) forms regarding 81 unduplicated clients thru June 2019. At this juncture, there are insufficient matched pairs for pre- post- analyses; improving completion rates of the CANS and other tools -- especially as youth exit the program -- is a QI focus.

- So far, the data provides a CANS-50 profile (N=60) of clients at program enrollment. The available sample are of residents with an average age of 12.5 yrs. who are 40% female and 50% Latinx/Hispanic. Generally, the CANS-50 sample mirrors the overall service population to date, except it includes a few more Latinx/Hispanic clients.

- CANS-50 ratings are numeric, i.e., 0 = No evidence; 1 = History, mild, suspicion; 2 = Moderate, action needed; 3 = Severe, disabling, dangerous, immediate action needed. Ratings of “2” or “3” indicate a need for action that helps to focus the service team and/or the MH clinician. It is desirable to have lower ratings (less difficulties, less frequent symptoms) and smaller proportions with 2+ ratings.

CANS-50 Baseline Profile

Item	N	Mean	Std. Deviation	Actionable ("2" or "3")
Psychosis	60	0.20	0.576	8.3%
Impulsivity/Hyperactivity	60	1.17	0.806	38.3%
Depression	60	1.37	0.758	50.0%
Anxiety	60	1.12	0.666	28.0%
Oppositional	60	1.43	0.890	53.3%
Conduct	60	0.65	0.880	16.7%
Anger Control	60	1.57	0.767	63.3%
Substance Use	60	0.72	0.904	23.3%
Adjustment to Trauma	60	1.25	0.628	25.0%
Family Functioning	60	0.53	0.676	10.0%
Living Situation	60	0.40	0.694	8.3%
Social Functioning	60	0.60	0.616	6.7%
Development/Intellectual	60	0.23	0.465	1.7%
Decision-Making	60	1.40	0.741	41.7%
School Behavior	60	0.90	0.681	18.3%
School Achievement	60	0.93	0.733	23.3%
School Attendance	60	0.62	0.715	13.3%
Medical/Physical	60	0.08	0.279	0.0%
Sexual Development	60	0.15	0.481	1.7%
Sleep	60	0.52	0.813	16.7%
Suicide Risk	60	0.58	0.766	13.3%
Non-Suicidal Self-Injury	60	0.48	0.725	13.3%
Other Self-Harm	60	0.67	0.795	16.7%
Danger to Others	60	0.75	0.816	20.0%
Sexual Aggression	60	0.10	0.440	1.7%
Delinquent Behavior	60	0.62	0.865	15.0%
Runaway	60	0.88	0.940	28.3%

Intentional Misbehavior	60	0.90	1.374	13.3%
Language	60	0.02	0.129	0.0%
Traditions and Rituals	60	0.02	0.129	0.0%
Cultural Stress	60	0.00	0.000	0.0%
Family Strengths	60	1.35	0.860	36.7%
Interpersonal	60	1.37	0.736	31.7%
Educational Setting	60	1.55	1.126	38.3%
Talents/Interests	60	1.15	0.954	26.7%
Spiritual/Religious	60	2.25	1.019	71.7%
Cultural Identity	60	2.37	0.901	75.0%
Community life	60	2.37	0.843	76.7%
Natural Supports	60	1.57	1.031	46.7%
Resiliency	60	1.20	0.777	25.0%
Supervision	60	0.23	0.563	6.7%
Involvement with Care	60	0.18	0.431	1.7%
Knowledge	60	0.42	0.591	5.0%
Social Resources	60	0.28	0.490	1.7%
Residential Stability	60	0.10	0.354	1.7%
Medical/Physical	60	0.12	0.415	3.3%
Mental Health	60	0.15	0.404	1.7%
Substance Use	60	0.15	0.404	1.7%
Developmental	60	0.02	0.129	0.0%
Safety	60	0.05	0.220	0.0%

- The data indicate that high percentages (50% or more with “actionable ratings”) of incoming Wraparound clients have significant difficulties in the area of ‘Behavioral/Emotional Needs’. Specifically, depression, oppositional behaviors and anger control are top concerns.

- Wraparound clients also have extreme difficulties (70% and more with “actionable ratings”) with their cultural identity, community life, and spirituality. These areas with the highest level of needs or insufficient strengths symptoms are the priority foci for the program’s wellness, recovery and rehabilitative practices, and for clinicians to address in individual therapy. Addressing these areas may also eventually and positively contribute to improving school performance.

PCS-35 Baseline Profile. The team administered 83 Pediatric Symptom Checklist (PCS-35) forms with 73 unduplicated clients thru June 2019. As with CANS-50, there are currently insufficient matched pairs for pre-post- analyses; completion rates are a current QI focus.

- The available sample of clients have an average age of 13.3 yrs. The PCS-35 consists of 35 items rated by the child's caregiver, and distinguishes between clients aged 4-5 and 6-18, with the latter having higher cutoff scores to indicate psychological impairment. Due to the current sample having only 1 client aged 4-5, we can only provide a baseline profile for clients aged 6-18 (Baseline N=59).

- PSC-35 ratings are numeric, i.e., 0 = Never; 1 = Sometimes, and 2 = Often; with lower ratings being desirable. For each client, a total score is computed by adding together the scores of the 35 items. For clients aged 6-18, a total score greater than 28 indicates psychological impairment; for clients aged 4-5, a total score greater than 24 indicates psychological impartment.

PSC-35 Baseline Profile

Item	N	Mean	Std. Dev.
1. Complains of aches/pains	59	0.640	0.660
2. Spends more time alone	59	1.000	0.740
3. Tires easily, has little energy	59	0.680	0.730
4. Fidgety, unable to sit still	59	0.930	0.740
5. Has trouble with a teacher	59	0.920	0.750
6. Less interested in school	58	0.900	0.740
7. Acts as if driven by a motor	58	0.710	0.770
8. Daydreams too much	59	0.630	0.760
9. Distracted easily	59	1.190	0.680
10. Is afraid of new situations	59	1.020	0.710
11. Feels sad, unhappy	59	1.000	0.670
12. Is irritable, angry	59	1.310	0.590
13. Feels hopeless	59	0.760	0.650
14. Has trouble concentrating	59	0.970	0.610
15. Less interest in friends	58	0.520	0.660
16. Fights with others	59	0.970	0.740
17. Absent from school	59	0.610	0.770
18. School grades dropping	59	0.850	0.780

19. Is down on him or herself	59	0.810	0.750
20. Visits doctor, finding nothing wrong	59	0.360	0.610
21. Has trouble sleeping	58	1.050	0.850
22. Worries a lot	59	0.970	0.720
23. Wants to be with you more than before	59	0.590	0.750
24. Feels he or she is bad	59	0.640	0.690
25. Takes unnecessary risks	59	0.630	0.740
26. Gets hurt frequently	59	0.370	0.610
27. Seems to be having less fun	58	0.480	0.630
28. Acts younger than children his or her age	59	0.750	0.780
29. Does not listen to rules	59	1.200	0.740
30. Does not show feelings	59	1.000	0.690
31. Does not understand other's feelings	59	1.070	0.740
32. Teases others	59	0.780	0.740
33. Blames others for his or her troubles	59	0.980	0.780
34. Takes things that do not belong self	59	0.660	0.780
35. Refuses to share	59	0.530	0.750

- In this sample, the PCS-35 highest rated items (indicating greater impairment) are “distracted easily”, “irritable, angry”, “trouble sleeping”, “does not listen to rules”, and “does not understand other people’s feelings”. These are priority areas for intervention. Importantly, the total score average for these clients is greater than the cutoff of 28, indicating that, on average, the children/youth are need of an intensive level of treatment, such as they have with wraparound.

Status at Discharge (SBHG EMR DC Status Form):

- The following tabled information derives from staff’s recording varied aspects of each discharged client’s status, results, and aftercare plans in the SBHG EMR. The DC Status Form was implemented this past spring, and data are available on N=52/72 (72%) closed cases through the end of the FY. Form completion is now routine: since the end of the FY there are N=18/18 (100%) additional discharges with reports available (not included in FY tables).

DC Reason		Count	Percent
	Client/Caregiver Refused Services	9	17.3%
	Client/Family Completed Program	13	25.0%
	Move Out of Area	8	15.4%
	No Longer Meet Eligibility	4	7.7%
	Other	11	21.2%
	Services Discontinued	7	13.5%
	Total	52	100.0%

- If the available sample is representative, and 'no longer meeting eligibility' is removed from denominator, the completion rate is 13/(52-4) or 27% for the start-up period.

DC Living Situation		Count	Percent
	Congregate Care Settings	0	0.0%
	Family Home	23	44.2%
	Foster Family Home	17	32.7%
	Independent Living	0	0.0%
	Tx/Incarcerative Settings (Covered Elsewhere)	8	15.4%
	Shelter, Homeless	0	0.0%
	Unknown	4	7.7%
	Total	52	100.0%

- The DC Status Form also captures information about the types of services and supports, behavioral health and community resources tracked separately, that are part of aftercare plans for those leaving Wraparound. For the discharge cohort thru June with available records, 90% were linked to one or more aftercare services of each broad type (behavioral health, community resources). Details shown below.

Types of Post DC Bx Health Referrals & Linkages	Count	Percent
School-Based Counseling	6	12%
Outpatient Counseling	8	15%
Psychiatry Incl. Medication Services	3	6%
County Case Management	2	4%
Family Therapy or Rehab	9	17%
Group Therapy or Rehab	1	2%
Outpatient ATOD Counseling	0	0%
Intensive Outpatient Program	0	0%
Treatment Foster Care Program	2	4%
Day Treatment	0	0%
Adult Full Service Partnership	0	0%
Wraparound	4	8%
Other	12	23%

Types of Post DC Community Resource Referrals & Linkages	Count	Percent
AA Type Groups	0	0%
Domestic Violence Interventions	4	8%
Faith-Based Entitites	0	0%
Supported Housing	3	6%
Legal Resources	4	8%
Life Skills Classes	13	25%
Mentoring Programs	15	29%
NAMI Type Groups	5	10%
Parenting Skills Classes	6	12%
Peer to Peer Supports	16	31%
Advocacy Organizations	0	0%
Public Benefit Programs	5	10%
Recreational Programs	14	27%
Special Education Services	5	10%
Supported Education	2	4%
Volunteer Activities	3	6%
Other	5	10%

EFFICIENCY

- Effectiveness of training care providers
- Services are community-based, comprehensive, coordinated and individualized.
- Favorable central tendencies re: length of stay, units and costs per client/episode.
- Cost neutrality – there were no requests for additional funding (no further information about this below).
- Information and reports are shared with a defined distribution list (no futher information about this below).

- Central Star's training department maintains detailed logs of staff trainings, which are a mix of classroom and on-line trainings, and are available for inspection. Many staff hired into Wraparound from other SBHG programs, and the transferred staffs along with new hires have participated, on average, in 51 trainings each (range 15 to 156) anchored to their date of hire and scope of

practice. They have, on average, 152 hours of training (range 50 to 315) with CS, SBHG and some externally provided by county. Examples of topics are:

AF-CBT Training Day (1-3) and Consultation Conferences (1-5)
Ages and Stages Questionnaire (ASQ)
Aggression Replacement Training (ART) (All Staff)
Assessment and Treatment of Oppositional Defiant Disorder
California CANS 50, Trainings, Recertifications
CBT for Psychosis - Introduction
Ceridian Training
Child Abuse Assessment and Reporting (AATBS), Mandated Reporting (CDSS)
Child Abuse Prevention Conference
Child Sexual Abuse and TF-CBT Related Approaches to Therapy
Civil Rights Act Training (All Staff)
Clinical Case Consultation (CS)
Clinical Supervision (Supervisors)
Clinical Supervision Training (ALL)
Columbia Suicide Severity Rating Scale
Community Resource (CS)
Core Practices: Alcohol Tobacco and Other Drugs (ATOD)
Core Practices: Externalizing Conditions
Core Practices: Internalizing Conditions
Core Practices: Motivational Interviewing
Core Practices: The Clinical Picture from Assessment to Discharge
Core Practices: Trauma 101
CS Targeted Documentation Training
Cultural Competence: Current Multicultural Issues in Research and Therapy
Department Specific Training Checklist (All Staff) 0922
Distractions While Driving
Documentation Refresher (All Staff)
Documentation and Billing/General Compliance Training
Documentation Training Part I (CS)
Drug Awareness & Drug Trafficking

Effects of Domestic Violence on Children
Emergency Preparedness: Fire Safety & Disaster Annual Refresher
EMR Training (All Staff)
Exceptional Parents Unlimited 0-5 Training
Family Therapy Training
Fresno County Documentation and Billing
Fresno County HEMCDT & SBHG HEMCDT
Fresno Gang Awareness
General Compliance
Group Facilitation Training (CS)
Guidelines for Writing Tx Plan Objectives
HIPAA
HR Management Academy Overview
HR New Hire Benefits Overview
HR Wage and Hour Training
Human Sexuality
ICC Coordinator Training (Wrap)
Islamic Culture Awareness Training
IT Security: Password Security
IT Security: Spearphishing Attacks
Judge's Report Training
Katie A. and Trauma Stewardship
Katie A. Training (CS)
Law and Ethics for Marriage and Family Therapists (CA) (AATBS)
Management Academy (All Staff)
Mandated Reporting
Mental Health: Culture, Race, and Ethnicity
NAMI's Services, Multiculturalism and Mental Health (CS and PHF)
NEO Condensed
NEO Days 1 - 5
New Hire Benefits Overview
Online Incident Reporting (CS)4
Overview of the Child Welfare Process (CS)

Overview of the Child Welfare System
Parent Child Interaction Therapy (PCIT)
Patients' Rights Annual Refresher
Pediatric Symptom Checklist (PSC)
Peer Support
Performance Management Trainings
Primer for Working with Psychosis
Pro-ACT for CS
Psychological Evaluation Overview
QPR Training
Safety, Emergencies, and Infection Control
SBHG Child COR Training
SBHG Law and Ethics
Seeking Safety
Sexual Harassment Trainings (Staff, Supervisors)
Specific Compliance
Burnout Prevention
TF-CBT Overview
The Great Shake Out (All Staff)
The Impact of Child Abuse on Brain Development (CS)
The Joint Commission (TJC) Safety Training
Theraplay (CS)
Time Management Training
TJC Tracers (CS)
Total Quality Management TQM
Transgender 101
Transition to Independence (TIP)
Trilogy Training for Staff and Supervisors (CS)
Understanding Trauma Informed Care: Interventions for Child Welfare
Workplace Bullying & Violence Prevention
WRAP and Wellness Education (Staff, Supervisors)
Wraparound CFT Facilitation
Wraparound Fidelity

Wraparound Service Process and Protocols

- The program's supervisors received training from SBHG's Fidelity Specialist on administering standardized wraparound fidelity tools (TOMs, WFI) and they have an implementation plan at this time, which starts soon. A contract for anonymous, secure database entries and reporting is in place with the University of Washington.

- Facilitators have begun to provide structured feedback on the CFT process, pertaining to the participation of allied professionals. This data will be shared at their coming Quality Council.

- The fidelity data described above will yield information helpful to assuring that CS Wraparound program services are community-based, comprehensive, coordinated and individualized. Meanwhile, services are being delivered primarily at home (37%), field, incl. schools (31%), program offices (18%) or on the phone (7%). Staff also travel to the youth's group homes, treatment settings, and other locations as needed to provide services in an efficient way from the client/caregiver perspective.

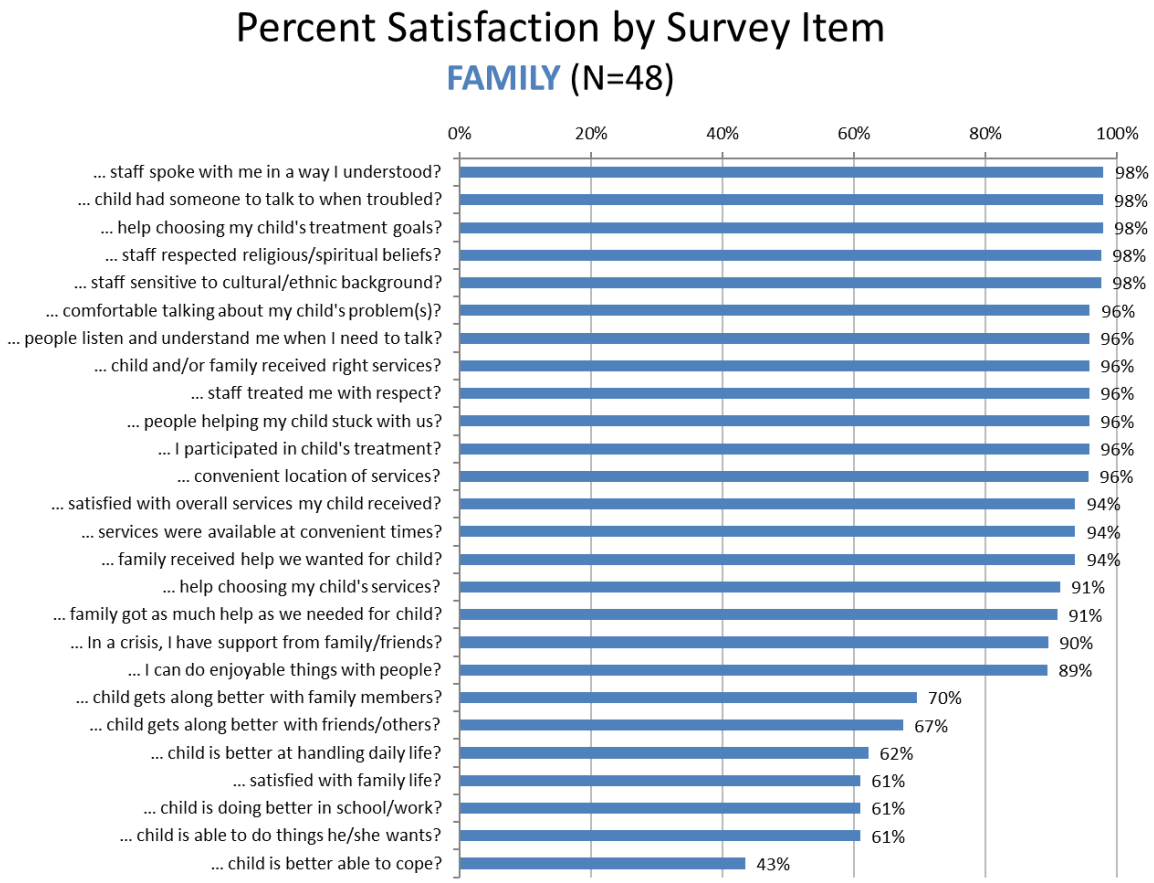
- The central tendencies of service delivery per client enrollment, for all N=72 closed cases, are shown below. Overall, 85% of the service units involve direct client/caregiver contact (vs. 'other' time for documentation, travel, etc.).

	Clients	Average Units	Median Units	St. Dev	Range	Avg. Srv. Date Entries
Wraparound Activity Notes	72	771	478	810	0 to 4,462	11
Case Management*	69	2003	1601	2030	0 to 8,934	41
Crisis Interventions	6	88	28	115	0 to 294	2
Family Rehab or Therapy**	50	1518	992	1703	39 to 8,811	18
Individual Rehab or Therapy	39	445	270	609	41 to 208	5
Psychiatry Services Referrals	37	6	0	14	0 to 64	1
Screenings & Assessments	72	89	47	105	0 to 660	3
Plan of Care & Updates	72	47	48	17	4 to 105	2

- The average length of stay among discharged youth was 138 days; median 123 days, range 14 to 350. Majority (70%) were discharged within 6 mos.
- Additional funding was not sought during the FY.
- The team follows county guidelines and instructions for reporting.

SATISFACTION

- During fall 2018 survey cycle, a majority (87%) of caregiver's endorsed the program, as did many youth (76%). Caregiver responses to survey items are shown below.



- The items falling below company benchmark (85% or better results expected) pertain to perception of outcomes; they were not prioritized for quality improvement at the time. This is because the MHSIP surveying process is cross-sectional (persons seen during a 1 week window), program was under six months in operation, and many respondents were not far along in services to report treatment gains.

- A small sampling of comments:
  - Caregiver of female youth – “[Staff] are very accommodating and understanding of our schedules. When a crisis comes up they are there to help myself as well as my child deal with it.”
  - Caregiver of female youth -- “They have helped improve her coping skills and anger management and social skills/relationships.”
  - Male, age 17 yrs. – [I like] “Having someone to talk to.”
  - Male, age 13. – [I like] “Seeing my family helping me.”

DEPARTMENT RECOMMENDATION(S):

Click here to enter text.