PROGRAM INFORMATION:

Program Title:	Community Services	**Provider:**	Central Star Behavioral Health
Program Description:	Outpatient Mental Health Services and court specific services for children and youth in Fresno County's child welfare system, and their families	**MHP Work Plan:**	4-Behavioral health clinical care
Age Group Served 1:	CHILDREN	**Dates Of Operation:**	July 29, 2014 - present
Age Group Served 2:	ADULT	**Reporting Period:**	July 1, 2020 - June 30, 2021
Funding Source 1:	Medical FFP	**Funding Source 3:**	Other, please specify below
Funding Source 2:	EPSDT	**Other Funding:**	DSS

FISCAL INFORMATION:

Program Budget Amount: $4,750,000 **Program Actual Amount:** $3,983,853

Number of Unique Persons Served During Time Period: 1,116

Number of Services Rendered During Time Period: 23,203

Actual Cost Per Person Served: $3,569.76

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	Outpatient
Contract Term:	07/01/2019 – 06/30/2022 plus two optional one-year extensions)	**For Other:**	
		Renewal Date:	7/1/2021

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

Level of Care Information Age 0- 17: Outpatient Treatment

TARGET POPULATION INFORMATION:

Target Population: All referred children, youth, parents, guardians, and foster parents involved with a child's child welfare case.

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:
(May select more than one)

Community collaboration

Cultural Competency

Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services

Access to underserved communities

Integrated service experiences

Please describe how the selected concept (s) embedded :

All of these concepts are well expressed in there being funding for this kind of program and throughout service delivery. Central Star mental health staff collaborate with child welfare, courts, and/or behavioral healthcare staff for referrals, on CFTs, in court, and for case management activities. Our staff master and apply Evidence Informed Practices, Evidence-Based Practices and community best practice standards selected specifically for their attunement to the needs of the service population; and, we employ a multi-culturally diverse staff familiar with the Fresno communities being served. All of our services are anchored to principles of individualized care, and include explicit wellness/recovery and resiliency-promoting rehabilitative skills, therapeutic interventions and connections into community resources. Integrated psychological testing and psychiatry services are available, as needed. By definition, the provision of speciality mental health services helps to meet the needs of Katie A child welfare/foster care individuals whom have been historically unserved, underserved and/or poorly served and we abide the CAPP and KatieA Core Practice models as well as Stars Behavioral Health Group (SBHG) standards for collaboration and service integration.

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

Outcome Measures Being Used

Outcome Measures	Notes
Access to Care:	
Referrals	Data is captured in SBHG's Electronic Medical Record (EMR) & displays on Business Analytics (BA) Dashboards. BA Dashboard focused on Timely Access to Care, state/county standards.
Timely Access	
Client Profiles	
Effectiveness:	
Child & Adolescent Needs & Strengths (CANS)	State Department of Health Care Services (DHCS) Performance Outcome System (POS) mandates, completed with youth ages 4 to 18, at intake, every 6 months, and discharge. SBHG's Treat to Target (T2T) PSC Dashboard provides real time data on the youth's progress, fulfills JC accreditation standards.
Pediatric Symptom Checklist (PSC)	
Behavioral and Symptom Identification Scale (BASIS)	Brief 24-item scale completed by adult at enrollment, every 6 months, & discharge. The BASIS-24® is a McLean Hospital licensed product. SBHG's T2T BASIS-24 Dashboard provides real time data on the individual's progress, fulfills JC accreditation standards.

Ages & Stages Questionnaire (ASQ)	Tool for children up to age 5 that assesses developmental milestones and pre-school functioning. Staff enter scores into a HIPAA secure, proprietary on-line database reporting system. ASQ meets our JC requirements for young children.
SBHG Client Outcome Report (Child COR)*	Child COR is administered at intake, every 6-months, & discharge
DC Status Form	DC Status Form augments data collected at discharge. Tools capture categorical status on life domains, system of care, & aftercare referral & linkage
Efficiency:	
Aspects of Program Design	Program leverages a collaborative process between mental health and the CWS system.
Utilization: Service Volumes & Mixes, incl. Screenings, Evaluations	Sustainment of collaborative structures and processes; separate service tracks for psychiatric services, psychological evaluations, and adult caregivers. Utilization data is captured in SBHG's Electronic Medical Record (EMR) & displays on Business Analytics (BA) Dashboards.
Length of Stay (LOS)	
Stakeholder Satisfaction:	

Agency Partnership Survey	SBHG Agency Partner Survey administered to one or more programs within Central Star annually. NOTE: Surveys administered this year with the partners of the Community Services program, data available and presented in this report.
Consumer Perception Survey (CPS)	Mandated cross-sectional state survey collected from youth and caregivers twice a year (unless cancelled by the state/county) during a 1-week period. NOTE: Recent CPS spring 2021 data are not yet available for provider agency and program review
Quality Management:	
Training	Trainings managed by Central Star 's Training Department, staff training data are tracked in SBHG's training database.
Cultural Attunement	Bi-Annual Cultural Attunement Plan updated for FY 21-22 & FY 22-23. Actionable items address staff trainings, policies & procedures, and elective projects. Plan available upon request; progress reported at SBHG's CQI Councils.
Rapid Cycle Improvement Process (RCIP)	Ongoing data tracking with monthly reports on: Incident Reporting (IRs), grievances/complaints, Rapid Cycle Improvement Projects (RCIPs), along with traditional quality assurance and compliance monitoring. Highlights for the year, incl. support activities during COVID, are summarized in this report, also presented at SBHG's CQI Councils.
Quality Assurance & Compliance	
Covid Response	SBHG's Infection Control Plan (ICP) in response to COVID-19 Pandemic

Telehealth Services	Abiding SBHG practice standards, the agency continues to offer telehealth services along with in-person care.

** The SBHG Child Client Outcomes Form was recently discontinued. To close out our use of the tool, we provide a separate report on COR data, with just a few selections included in this report.*

Outcome Analysis

Access to Care

Katie A Subclass members

Katie A subclass members received Intensive Care Coordination (ICC) or Intensive Home-Based Services (IHBS). The Community Services program delivered 2,238 ICC services and 2,196 IHBS services to 111 Katie A Subclass youth in the 2020-21 Fiscal Year. Katie A Subclass youth accounted for 10% (n = 111 / 1,133) of persons served.

Referrals

During the 2020-21 Fiscal Year, Community Services received 930 referrals and admitted 75% of them (N = 695). Fourteen percent of the referrals were re-admissions (N = 129). Some (15%) admissions were for Voluntary Family Maintenance (VFM).

Timely Access to Care

During the 2020-21 Fiscal Year, the Community Services program admitted 695 referrals with data available on 100% of admissions. The average time from referral to program enrollment was 19 days (median = 14 days, range = 0 minutes – 148 days). Most (85%) of persons served were enrolled within 32 days of their referral. Refer to Table 1 for timely access to program enrollment for each population served. While caregivers have the greatest range of time from referral to enrollment, the average and 85th percentile for each group is approximately the same.

Table 1 - Timely Enrollments by Service Populations

Service Populations N = 695	Average	Median	Min	Max	85th Percentile
Psychological Evaluation n=9	19	17	6	38	34
Caregivers n=195	19	13	0	148	32
Children n=282	19	14	1	89	32
Not Recorded n=197	19	15	0	66	30

** Time measured in days*

Data was available to calculate time from referral to first service for 653 of 695 enrollments (94%). The average time from referral to first service was 19 days (median = 14 days, range = 0 days to 148 days). Most (85%) of persons served were first seen within 33 days of their referral. Please see Table 2 below for timely access to services for each population served. Caregivers have the greatest delay from referral to service.

Table 2 - Timely Services by Service Populations

Service Populations N = 695	Valid	Average	Median	Min	Max	85th Percentile
Psych Eval & Medication Sup. n=9	100%	19	17	6	38	34
Caregivers n=195	96%	19	13	1	148	34
Children n=282	95%	20	14	1	89	33
Not Recorded n=197	88%	19	15	0	66	31

** Time measured in days*

Client Profiles

During the 2020-21 Fiscal Year, the Community Services program served 1,117 active persons served, persons enrolled during the year, or continuing from the prior year. Table 3 below shows counts by the three service populations: (1) Children, (2) Adult Caregivers, and (3) Persons Receiving Psychological Evaluations and Medication Supports. (i.e. referred specifically for this service only).

Table 3 - Service Populations

Service Populations	Count	Percent
Children	762	67%
Adult Caregivers	356	31%
Psych Eval & Medication Sup.	15	1%
TOTAL	**1,133**	**100%**

* Note: the number of persons served differs from the number of referrals or enrollments in a year as some as some individuals enrolled in a previous year and continued into services during the fiscal year being reported on.

Table 4, Table 5, and Table 6, show the respective race & ethnicity by gender demographics for the three service populations (children, adult caregivers, and those receiving psychological evaluations). Hispanic/Latinx heritages were the most represented ethnicity for children and caregivers receiving services. Two-thirds of the caregiver population was female while the children were equally male and female.

Table 4 - Child Race & Ethnicity by Gender

Child Demographics N = 762	Female	Male	Trans-gender	Grand Total
American Indian	1%	1%	-	3%
Asian	1%	2%	-	4%
Black	10%	10%	-	19%
Hispanic	20%	21%	-	41%
Mixed	1%	2%	0%	3%
Other	0%	-	-	0%
Unknown	1%	1%	-	2%
White	14%	14%	-	28%
Grand Total	**49%**	**51%**	**0%**	**100%**

* The average age of a child at enrollment was 7.96 years old.

Table 5 – Adult Caregiver Race & Ethnicity by Gender

Caregiver Demographics N = 356	Female	Male	Grand Total
American Indian	1%	0%	1%
Asian	2%	1%	3%
Black	9%	4%	14%
Hispanic	24%	17%	41%
Mixed	2%	1%	3%
Other	0%	0%	1%
Unknown	0%	2%	2%
White	25%	9%	34%
Grand Total	**64%**	**36%**	**100%**

* The average age of a caregiver at enrollment was 33.54 years old.

Table 6 - Psychological Evaluation - Race & Ethnicity by Gender

Psych Eval Demos N = 15	Female	Male	Grand Total
American Indian	7%	-	7%
Black	13%	7%	20%
Hispanic	20%	7%	27%
Unknown	-	7%	7%
White	27%	13%	40%
Grand Total	67%	33%	100%

* The average age of an individual receiving psychological services at admittance was 29.87 years old.

Table 7, Table 8, and Table 9 array primary diagnosis the three service populations (children, adult caregivers, and those receiving psychological evaluations).

Of the 762 unduplicated child/youth, there was more than one primary diagnosis reported among 14% (N = 107 of 762). The most common clinical pathways (areas in need of treatment) were internalizing disorders (58%) such as mood and anxiety disorders.

Table 7 - Child Primary Diagnosis

Child Diagnosis N = 762	%
Externalizing	11%
Internalizing	58%
No Dx at Intake	27%
Other Conditions	11%
Grand Total	**108%**

Of the 356 adult caregivers, there was more than one primary diagnosis reported in 8% of enrollments in the sample (N =25 of 356). The most common clinical pathways (areas in need of treatment) were internalizing disorders (60%) such as anxiety and mood disorders.

Table 8 – Adult Caregiver Primary Diagnosis

Caregiver Diagnosis N = 356	%
Internalizing	60%
Major Mental Illness	1%
No Dx at Intake	32%
Other Conditions	9%
Substance Related	1%
Grand Total	**103%**

Of the 15 referrals for psychological evaluations only, the most common clinical pathways (areas in need of treatment) were internalizing disorders (68.8%) such as anxiety and mood disorders.

Table 9 - Psychological Evaluation - Primary Diagnosis

Psych Eval Diagnosis N = 15	%
Externalizing	7%
Internalizing	53%
Substance Related	13%
Grand Total	**73%**

Effectiveness

KPIs related to program effectiveness are as follow. Different measurement tools, described in the measurement table on page 2 of this report, are used to illuminate results for these indicators

1. Improved Child and Family Functioning
2. Reduced Caregiver Challenges & Strain
3. Reduced Child Maltreatment (Child Welfare Recidivism)
4. Connections Made with Community Resources, Services and Supports
5. Reduced Out-of-Home Placements and High-End Service Utilization
6. Increased Endurance of Permanency Placements
7. Improved Schooling Outcomes (Child/Youth & Young Adults)
8. Improved Vocational and Employment Outcomes (Older Youth & Young Adults)

Analysis addresses two populations (children/youth and adult caregivers), indicators from among the above per population as relevant.

Child & Adolescent Needs & Strengths (CANS-50)

The Child & Adolescent Needs & Strengths (CANS-50) is a multi-purpose tool to support decision making with children. The tool contains 50 items rated on a 4-point Likert scale, where 0 = lowest and 3 = highest. An actionable level of clinical concern is defined as a rating of 2 – 3. CANS implementations can vary and typically have 5+ domains, including: (1) Life Functioning, (2) Child Behavioral/Emotional Needs, (3) Risk Behaviors, (4) Caregivers Resources & Needs, and (5) Cultural Factors. The CANS is administered at intake, every 6 months, and at discharge. This analysis uses matched pairs; only children with an intake score and a later subsequent score are analyzed. This CANS analysis includes all Central Star data in SBHG's BA database.

For this CANS analysis, only items with an average of 0.25 or more in the initial assessment were analyzed. The figures below shows the percentage of persons served with an actionable score in the initial and latest assessment. The percentage in the label denotes the percentage of persons served with an actionable score in the initial assessment. Please note that the Asterix, (*), and the green bars indicate that the difference between initial and latest assessment was statistically significant at 0.05 alpha level. The caregiver needs & strengths and child behavior/emotional needs domains require the most attention in this population.

Figure 1 - Child & Behavioral Emotional Needs Domain - Proportions with Actionable CANS Scores Over Time in Treatment

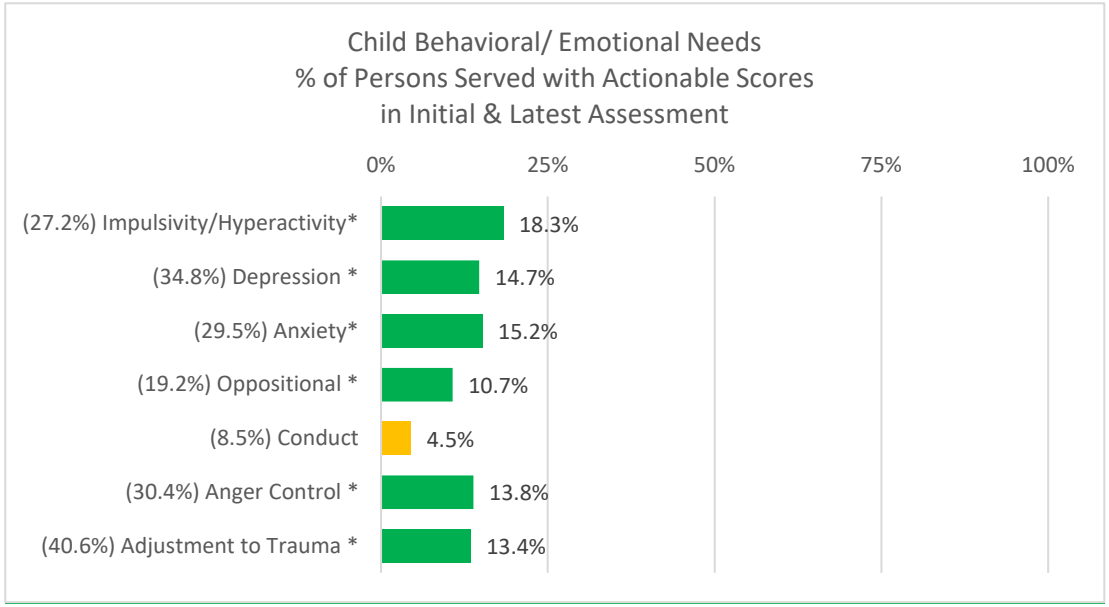


Figure 2 – Life Functioning Domain - Proportions with Actionable CANS Scores Over Time in Treatment

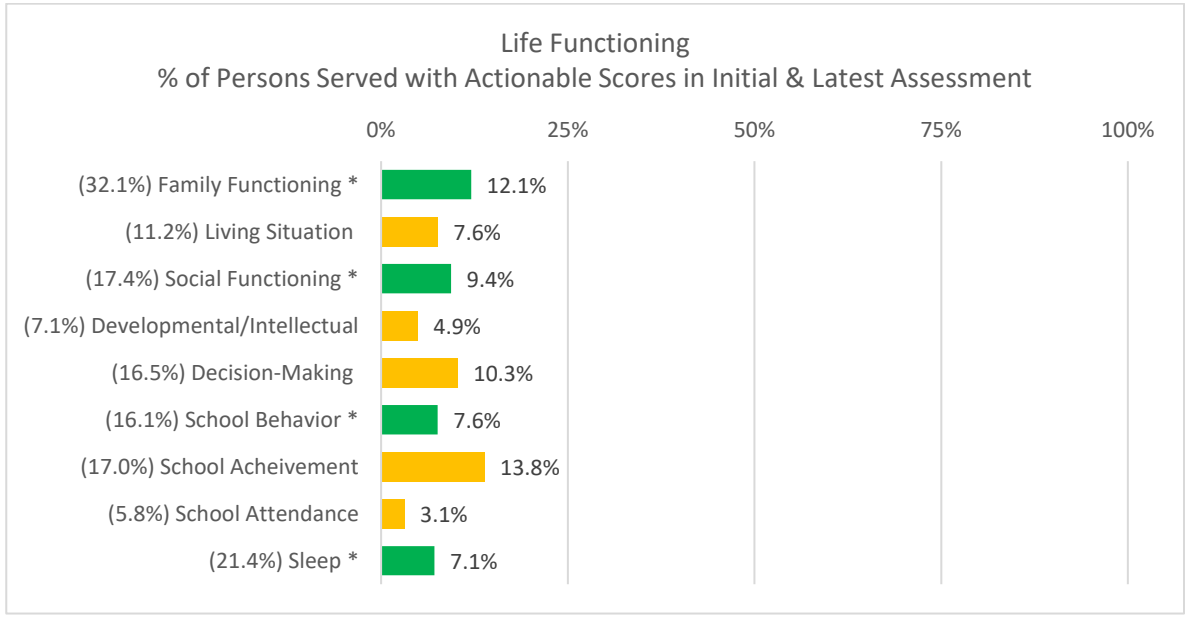


Figure 3 – Risk Behavior Domain - Proportions with Actionable CANS Scores Over Time in Treatment

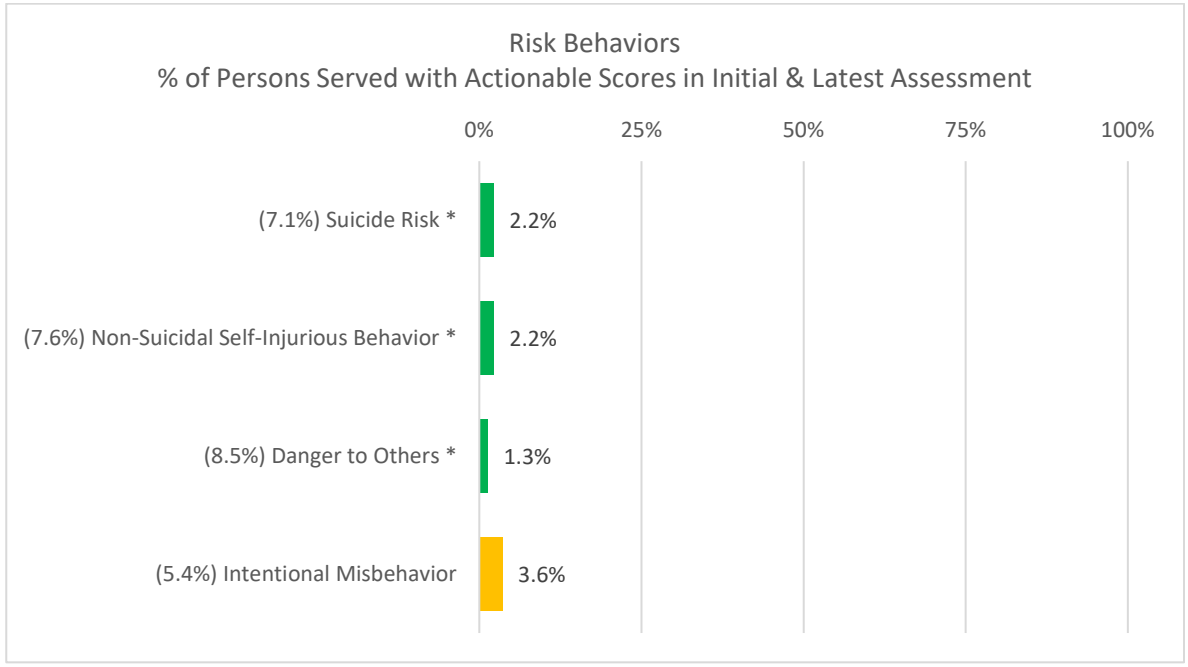


Figure 4 – Caregiver Needs & Strengths Domain - Proportions with Actionable CANS Scores Over Time in Treatment

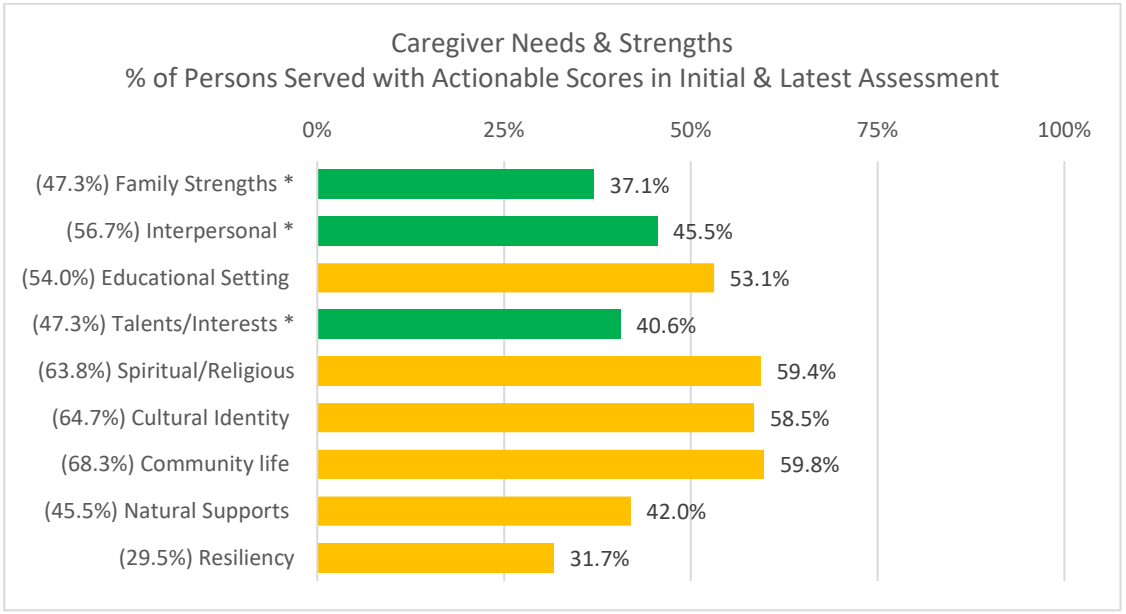
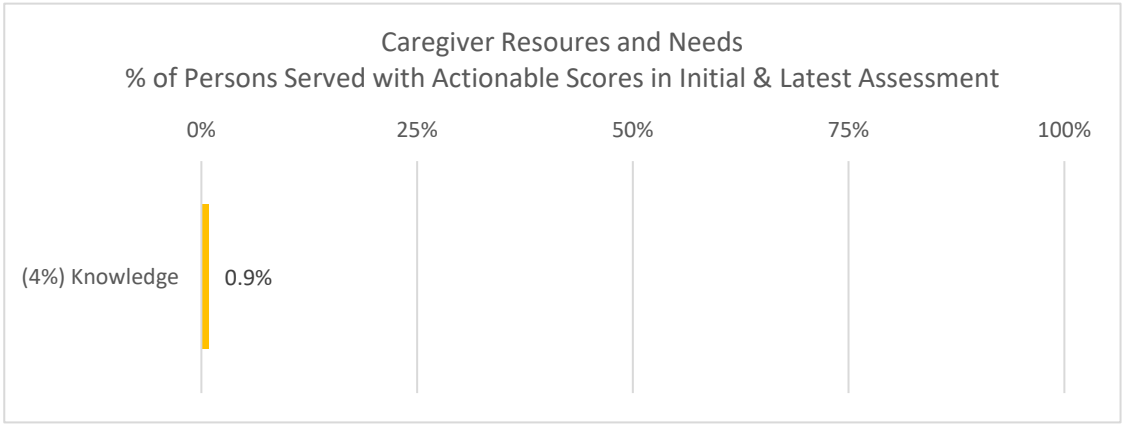


Figure 5 – Caregiver Resources Domain - Proportions with Actionable CANS Scores Over Time in Treatment

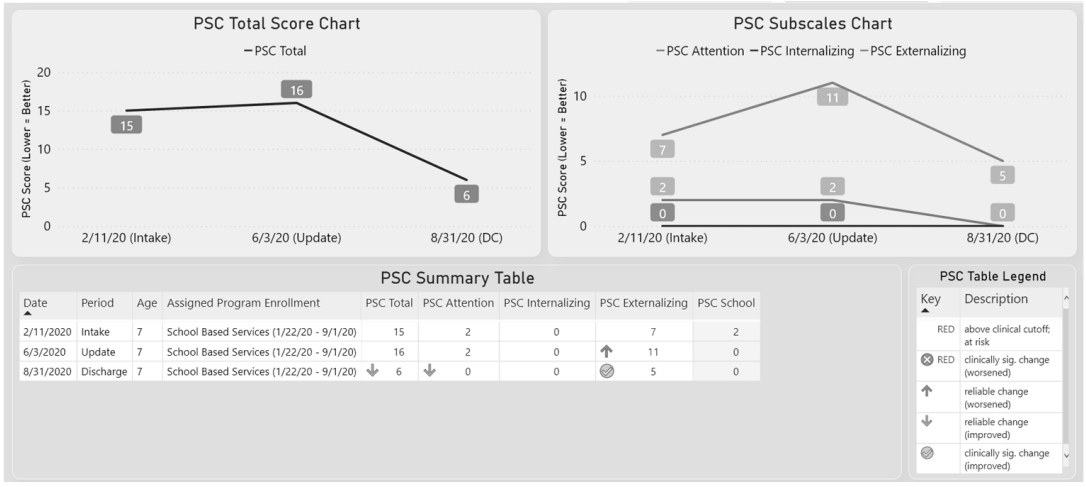


Pediatric Symptom Checklist (PSC-35)

The Pediatric Symptom Checklist (PSC-35) consists of 35 items the caregiver rates about their child's behaviors. PSC-35 questions use a 3-point Likert scale to assess frequency of behavior: 0 = Never, 1 = Sometimes, 2 = Often. Schooling related questions include an NA option. For each person served, a total score is computed by summing the score of the completed items; no more than 4 items may be missing for a valid sore. The PSC has different total-cutoff scores for psychological impairment between children aged 4 – 5 years old (cut-off = 24) and 6 – 18 years old (cut-off = 28). If the person served scores above the cut-off, they are considered to be "at-risk." The PSC is administered at intake, every 6 months, and at discharge. This analysis uses matched pairs; only children/youth with an intake score and a later subsequent score are analyzed. Using our new PSC T2T reporting system, there were matched pairs available on 347 of 762 children/youth.

Figure 6 provides a snapshot of the PSC Treat to Target (T2T) Dashboard, an individual example. The person served had 3 assessments: at intake, update, and discharge. The graphs show the individual's PSC total and subscale scores over time.

Figure 6 - PSC T2T Dashboard Example



In aggregate, upon intake, 29% of persons served were considered at-risk while at the last assessment only 14% of persons served were considered at-risk. Additionally, paired t-tests indicate there were statistically significant

(unlikely chance occurrences) improvements found between the initial and latest assessment regarding: the total scores of persons served, ages 3 – 5 (p-value = 0.01), the total scores of persons served aged 6+ (p-value = 0.01), the internalizing sub-scale (p-value = 0.00), and the externalizing sub-scale (p-value = 0.00).

Ages & Stages Questionnaire (ASQ)

The Ages & Stages Questionnaire (ASQ) assesses children's development in communication, motor skills, problem solving, and personal-social skills. The assessment identifies children that would benefit from additional support in the screened areas. Clinicians were trained to use the ASQ-3 to inform treatment and aftercare service planning. The ASQ-3 also meets our company's JC measurement of care accreditation standards.

The ASQ is a set of questionnaires with age-appropriate indicators to measure a child's development from 2 – 60 months. Questionnaires are administered every 2 months until 24 months, then every 3 months until 36 months, then every 6 months until 60 months. Questions use a 3-point Likert scale, where Yes = 10, Sometimes = 5, and Not Yet = 0. Question sub-scales are totaled and then compared to a cut-off to determine the level of actionable concern (above the cutoff = means no concern). Sub-scale scores are adjusted when items are missing. Table 1 below shows the cut-off scores for the ASQ-3 administered from 23 months to 25.5 months.

Table 10 - Sample of ASQ-3 Cut-Off Scores by Developmental Domain (23 months 0 days thru 25 months 15 days)

ASQ Area	Cut-off Score
Communication	22.77
Gross Motor	41.84
Fine Motor	30.16
Problem Solving	24.62
Personal Social	33.71

Table 11 below shows overall scores by age interval. Details regarding levels of actionable concerns by developmental domain are available in the Appendix. Please note that analysis below is for both Central Star's TEAMMATES Wraparound & Community Services programs. Unfortunately – and we apologize - data for the past fiscal year was not recorded with a program identifier. This glitch is currently being resolved and next year we will report program results separately.

Table 11 - ASQ-3 Overall Levels of Concern by Age Intervals

N=221	Concerning		Not Concerning	
Intervals, Sample	Count	Percent	Count	Percent
2 months, n=3	2	67%	1	33%
4 months, n=19	9	47%	10	53%
6 months, n=13	5	38%	8	62%
8 months, n=8	4	50%	4	50%
9 months, n=2	1	50%	1	50%
10 months, n=3	2	67%	1	33%
12 months, n=7	3	43%	4	57%
14 months, n=12	7	58%	5	42%
16 months, n=5	3	60%	2	40%
18 months, n=11	5	45%	6	55%
20 months, n=4	2	50%	2	50%
22 months, n=1	1	100%	0	0%
24 months, n=5	3	60%	2	40%
27 months, n=6	3	50%	3	50%
30 months, n=17	9	53%	8	47%
33 months, n=8	3	38%	5	63%
36 months, n=14	10	67%	5	33%
42 months, n=24	13	50%	13	50%
48 months, n=18	10	56%	8	44%
54 months, n=16	10	59%	7	41%
60 months, n=21	8	38%	13	62%
Overall		51%		49%

Behavioral and Symptom Identification Scale (BASIS-24)

The Behavioral and Symptom Identification Scale (BASIS-24) is a standardized outcome tool to track an individual's progress over time and inform treatment. The BASIS-24 consists of 24 questions (with additional demographic questions) that yield scores on six (6) subscales and an overall average. Questions use a 5-point Likert scale, where 0 indicates that the individual has less frequent symptoms/difficulty and a 4 indicates the individual has more frequent symptoms/difficulty. The BASIS is administered at intake, every 6 months, and at discharge. This analysis uses matched pairs; only individuals with an intake score and a later subsequent score are analyzed.

Figure 2 below shows a sample of our new BASIS Treat to Target (T2T) Dashboard. This dashboard view shows an individual with 3 assessments: an intake, another intake, and discharge. The graphs show the individual's BASIS Total score across time and the individual's BASIS subscale scores over time.

Figure 7 - BASIS T2T Dashboard Example

For aggregate results, BASIS matched pairs data were available for 183 of the 353 caregivers (a 52% completion rate. Please note the changeover to new database reporting tools; and, not all persons served were expected to have matched pairs within the reporting period). On average, there were 151 days between outcome measurements. There was a statistically significant difference between the average initial BASIS total scale = 0.4 and the average latest BASIS total scale = 0.1 for the population (p = 0.02). The Initial-Latest means were also statistically significantly different, showing treatment gains (reduced scores) for the Depression/Functioning, and Psychosis subscales. Table 12 below shows the BASIS Total & Sub-scale Statistical Significance Information.

Table 12 - BASIS Total and Sub-scales Statistical Significance Information

Domain	Initial Mean	Latest Mean	T-Statistic	P Value	N
BASIS Total	0.4	0.1	2.52	0.02*	57
Depression/Functioning	0.7	0.2	3.04	0.00**	58
Relationships	0.5	0.3	1.66	0.11	58
Self-Harm	0.0	0.0	NA	1	58
Emotional Liability	0.6	0.3	1.72	0.09	58
Psychosis	0.3	0.1	2.47	0.02*	57
Substance Abuse	0.2	0.1	1.14	0.26	58

Note: Paired T-test was run between scores for the individual's initial & latest assessments.
* Indicates statistically significant at p <= 0.05 and ** indicates statistically significant at p <= 0.01
T-Statistic for self-harm is NA due to equal initial-latest means.

Child Outcome Report (COR)

Below is a selection of results based on the SBHG Child Outcomes Report (Child COR). The tool was recently decommissioned from use. A full report called *Central Star Mental Health for Child Welfare: SBHG Child Client Outcome Report Data* on these data was submitted to the county along with this Annual Report to the county.

- The program helped stabilize many children/youth to remain with their families or to return to a family home from foster care or other placements. For example, during the 2020-21 Fiscal Year, more youth were in a family home at discharge or last record than were upon admission (from 27% to 46%, a 70% increase) and fewer were in foster homes over time in treatment (from 70% to 48%, a 31% decrease).

- Concomitantly, Parent/Legal Guardianships increased from 14% to 22% while children were in treatment. There was a 23% net gain in Family Reunifications, a 7% net gain in Permanent Foster Care arrangements, 8% net gain in the Identification of Permanency Placements, and N=48 New Adoptions! Such upticks pertain to all years of the program as measured by the Child COR, and the pattern of upticks held during this last fiscal year.

- Regarding Caregiver Challenges that impact the child's mental health, there were statistically significant desirable average decreases in the number of such challenges per family (10 measured including CPS reports, mental illness, domestic violence, etc.) in the years prior to the last fiscal year ($\bar{x}$ 1.22 to $\bar{x}$ .51, p<.000), and during FY 20-21 ($\bar{x}$ 1.25 to $\bar{x}$ .51, p<.000). Results indicate program staff are successful in their efforts to intervene with caregivers on behalf of the child's mental health, and this was especially evident this past FY where all observed declines (9/10 challenges reduced over time) were statistically significant, meaning they were unlikely chance occurrences (McNemar p <.000).

- Among the children and youth, regular public school classroom placements remained steady over their time in treatment (at about 87%). For many years, the children/youth in aggregate maintained the same overall level of school attendance (90% regularly attending 4-5 days per week) although there was some degradation, to 82% at last record this past FY. In both time samples, there were upticks in academic achievement: prior to this last FY, from 72% to 79%, a 10% increase in those achieving passing "C" grades or better in their coursework; during the last FY, from 71% to 78%, a 9% increase in those achieving passing "C" grades or better.

SBHG EMR DC Status Form

The DC Status Form is used to track categorical information at the time of discharge, including discharge reasons, circumstances related to discharge, living situation, treatment progress and referrals/linkages that are part of the individual's aftercare plan. Please note that some questions on the DC Status Form allow multiple selections (more than one pertinent to a given individual) and thus not all percentages add to 100%.

During the 2020-21 Fiscal Year, a DC Status Form was completed for 474 of the 497 child discharges (95%) and for 254 of the 278 caregiver discharges (91%).

- Regarding Discharge Reasons, 36% of children and 21% of caregivers completed the program, 7% of children and 13% of caregivers refused services, and 37% of children and 49% of caregivers had an "other" reason related to discharge.
- Regarding Circumstances at Discharge, 5% of children and 13% of caregivers were unavailable. Only 1% of children required discharge to a higher level of care.
- For Treatment Progress, 42% of children and 25% of caregivers met most or all treatment goals, 24% of children and 23% of caregivers met some treatment goals, and 21% of children and 42% of caregivers met no or very few treatment goals.

- As to Living Situation at Discharge, 45% and 46% of children were living in a family home or a foster family home respectively. Among caregivers, 39% were living in a family home and 37% were living independently. A few, 4% of children and 5% of caregivers, were either in a shelter, temporary housing, or homeless at discharge.
- Finally, for Community Resource Linkages (CRL), 58% of children and 50% of caregivers were provided linkages at discharge, and 34% of children and 27% of caregivers were not in need of linkage after discharge.

Efficiencies

Aspects of Program Design

While primarily relevant to access, services are provided where the person served is located or wants to be served, which also makes services efficient from the youth/caregiver perspective. Staff try to balance field work with encouraging children, youth and families to come to one of two service sites available to the community for these services. Service contacts in the field and at these sites can help counter the social isolation that often impacts child welfare families. This last year the teams took great measures to provide services continuously during COVID-19 by offering on-line telehealth sessions and taking active steps to see youth/families at offices or in the field when safe to do so, abiding all public health directives.

Efficiencies also derive from how the county's collaborating agencies (behavioral health, child welfare) leverage the program to support the needs of child welfare families in a coherent and comprehensive way: for examples, the program offers psychiatric evaluations to referred individuals in need of just this service; mental health treatment services to the adult caregivers of the child welfare referred families, and medication supports to enrolled children/youth and separately enrolled adult caregivers. The Community Services team also pays attention, communicates and coordinates with the relevant providers about caregiver's substance abuse treatment needs.

Utilization: Service Volumes & Mixes, incl. Screenings, Evaluations

Table 3 and Table 4 below provide an overview of service utilization, disaggregated for child and adult caregivers. Table 3 shows the total number of services (discrete service encounters) for each population. Table 4

shows the total number of hours of those services for each population. The counts portrayed are of services delivered during the last FY, not completed episode data.

Table 3 - Service Encounters by Modality

Services	Child Services	Caregiver Services	Grand Total Services
Assessments	3,147	1,059	4,206
Case Management	6,569	1,211	7,780
Collateral	1,346	11	1,357
Crisis Intervention	17	1	18
Family Therapy	61	25	86
Group Therapy	-	5	5
Individual Rehabilitation	3,242	169	3,411
Individual Therapy	4,815	2,159	6,974
Outreach	2	-	2
Plan of Care	1,212	336	1,548
Grand Total	**23,676**	**6,135**	**29,811**

* Child N = 762, Caregiver N = 356

Table 4 - Hours of Service by Modality

Services	Total Hours - Child	Total Hours - Caregiver	Grand Total Hours
Assessments	1,296	581	1,877
Case Management	3,092	421	3,513
Collateral	1,290	13	1,303
Crisis Intervention	22	1	23
Family Therapy	62	36	98
Group Therapy	-	3	3

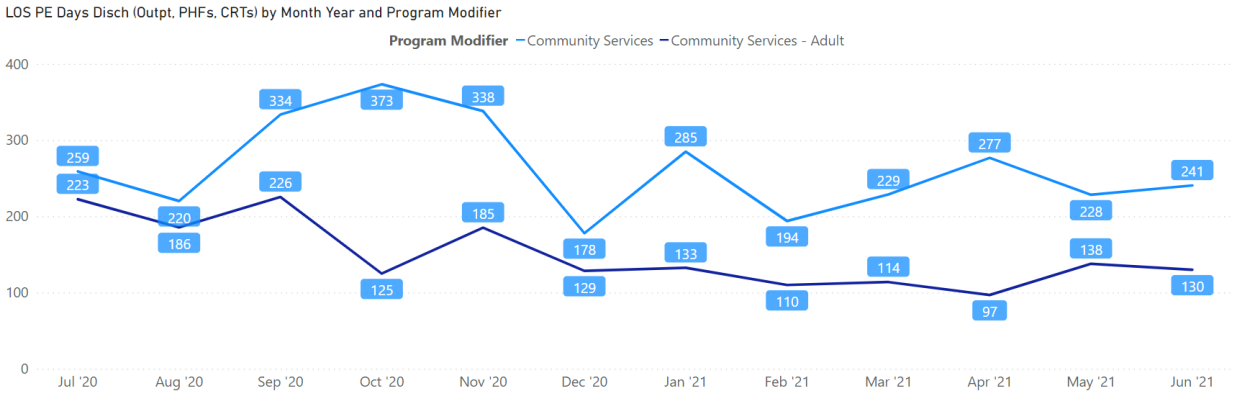
Individual Rehabilitation	4,461	170	4,630
Individual Therapy	5,556	2,110	7,666
No Contact Note	2	-	2
Plan of Care	320	91	411
Grand Total	**16,101**	**3,425**	**19,526**

* Child N = 762, Caregiver N = 356

Length of Stay (LOS)

Among the 756 children served and discharged during the 2020-21 Fiscal Year, the average LOS was 258 days. For the 356 served and discharged adults, the average Length of Stay (LOS) measured by Discharge was 147 days. Figure 8 below shows the LOS of children & caregivers over the 2020-21 Fiscal Year.

Figure 8 – Child & Adult Caregiver LOS in Days by Discharges



Stakeholder Satisfaction

Agency Partnership Survey

Agency Partnership Surveys are administered every few years to agency partners to assess their satisfaction with the agency's (i) treatment, (ii) staff, and (iii) general operations. The questions use a 4-point Likert scale, where 4 = Strongly Agree, 3 = Somewhat Agree, 2 = Somewhat Disagree, 1 = Strongly Disagree. A 5th option, "Don't Know" is also available to respondents; this option is excluded from analysis and thus response rates will vary by question.

The Community Services program had 7 respondents to the Agency Partnership Survey this last year. All respondents rated the general and staff related questions positively (strongly or somewhat agree) and, all but one respondent rated the treatment topics positively.

Figure 9, Figure 10, & Figure 11 below shows respondent agreement ratings on the Agency Partnership Survey for (i) general items, (ii) staff items, and (iii) treatment items respectively.

Figure 9 - Agency Partnership Survey Results - General Topics

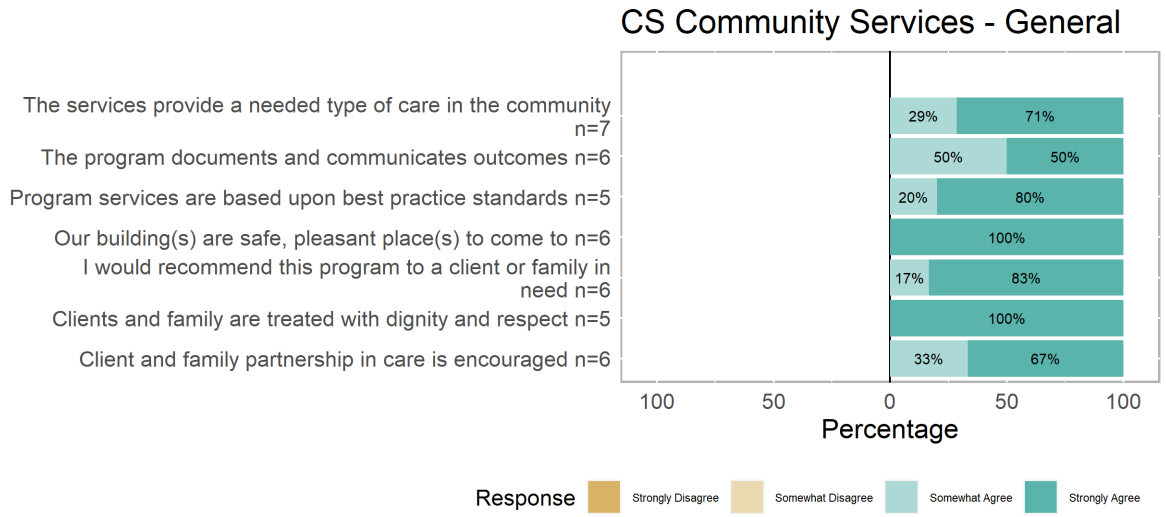


Figure 10 - Agency Partnership Survey Results - Staff Topics

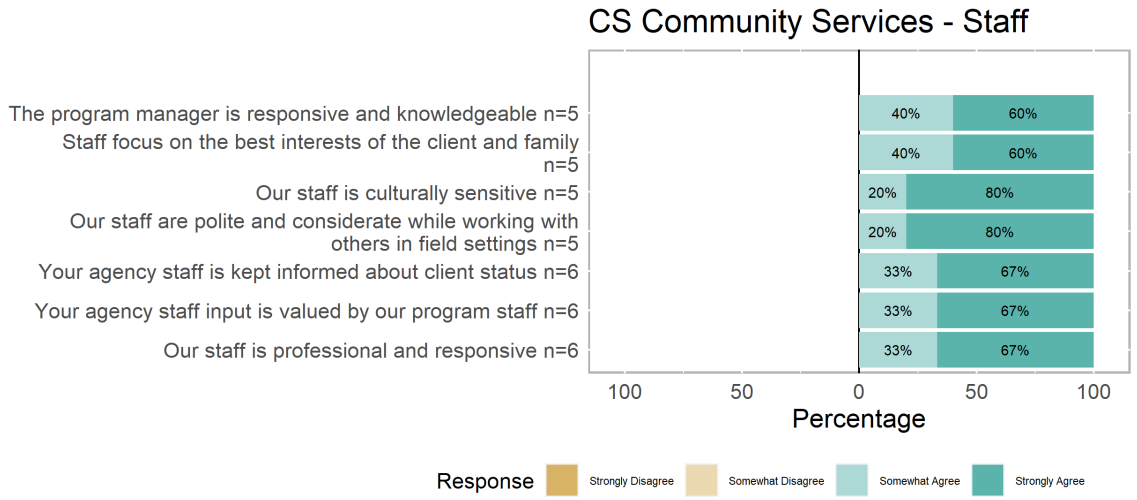
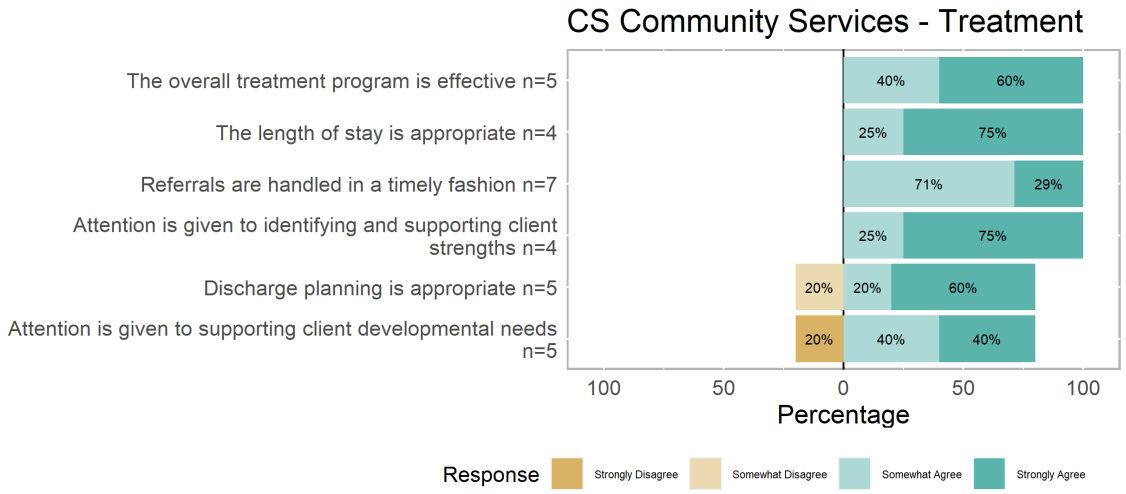


Figure 11 - Agency Partnership Survey Results- Treatment Topics



Consumer Perception Survey (CPS)

Community Services participated in the state mandated Consumer Perception Survey (CPS) in Spring 2021. We no longer have access to all the forms as they are completed - survey forms are either completed on-line or on paper and immediately submitted to the county. SBHG eagerly anticipates a report from the University of California, Los Angeles (UCLA) the responsible entity for providing reports at this time. Please also note the fall 2020 survey cycle was cancelled by the state due to the COVID pandemic, and because of new data system development that was not yet ready at the time.

Quality Management

The program utilizes SBHG's Total Quality Management (TQM) system, a comprehensive and integrative approach that incorporates Joint Commission standards for the delivery of behavioral healthcare. SBHG's TQM system includes: (1) staff trainings; (2) Cultural Attunement to the population; (3) Rapid Cycle Improvement Process (RCIP); (4) Quality Assurance & Compliance (e.g., incident report tracking, complaints & grievances); and, (5) EBP/Practice Fidelity tracking, .

Training

The Central Star Training Department keeps detailing training logs of training delivered and provided to staff. During the Fiscal Year 2020-21, N = 44 staff participated in a total of 1,079 courses. On average, each staff participated in 25 courses (std = 13.02, median = 20). Staff participated in a combined total of 2,727 hours in training; each staff participated in 62 hours in training on average (std =34.81, median = 51). For the courses that required passing tests, staff passed with an average of 94%. There were 144 training courses delivered, listed in the Appendix. Almost half (48%) of the courses occurred on-line.

Cultural Attunement

SBHG refers to our program as 'Cultural Attunement' (vs 'Cultural Competency') to reflect principles of humility and continuous learning so that we can beneficially attune our programming, services, and interventions to the needs of our diverse youth and families. This past spring, Central Star updated their bi-annual Cultural Attunement Plan to focus on staff trainings; updates to policies and procedures (vis a vis national Culturally and Linguistically Appropriate Services (CLAS) standards); and, elective projects. For the latter, the agency team is launching initiatives to focus on child/family engagement toward better use of interventions and resources that address substance abuse; and, for measuring their progress and outcomes. The is in addition to sustaining their Cultural Attunement Committee's roster of community integration activities along with a newsletter that the committee created this past year.

RCIPs

As part of SBHG's quality management system, programs engaged in Continuous Quality Improvement (CQI) projects including Rapid Cycle Improvement Process (RCIP). During the Fiscal Year 2020-21, RCIP topics included: Care Timelines & Discharge Documentation. TQM data are reviewed each fall at the program's Quality Council to which stakeholders are invited to attend.

Tracers

A tracer conducted in February 2021 found that "[STAFF NAME REDACTED] was very knowledgeable of her role within the individual's treatment team, the intake process, and explained the collaboration between programs and agencies well." The program documented the intent to conduct more tracers in the future to familiarize new staff with the process.

Incident Reports (IR)

Clinical supervisors and QA staff actively monitors an individual's high-risk issues, incident reporting (IRs), and grievances. In the 2020-21 Fiscal Year, there were 48 IRs filed for children served. Twenty-seven of these incidents were for abuse and 11 were for sexual misconduct. As a result of these IRs, 73 incident interventions were taken by staff, including 32 filings of Suspected Child Abuse Reports.

Complaints & Grievances

The program received no complaints nor grievances this past year.

COVID Response

Our company's Infection Control Plan (ICP) provides guidance to minimize the spread of COVID-19, including protocols and actions to implement/relax as public health directives change. When COVID-19 hit, SBHG subsidiaries relied on the ICP to minimize its spread. The plan includes protocols for screening staff, persons served and visitors; responding to positive symptoms; increased cleaning/disinfecting; reconfiguring activities and spaces to facilitate physical distancing; ensuring masks are available to/used by staff and persons served; and ensuring adequate PPE. SBHG hosts information sessions with all staff for Q & A regarding any and all info about COVID, vaccines, etc. These calls are held as frequently as needed to keep staff informed. For those working in our facility-based programs, we contracted with a lab statewide to provide rapid COVID testing to staff and persons

served. The company also launched: « an internal website for treatment staff with information, resources and materials (e.g., fillable forms, telehealth navigation, engagement & session scripts); « a public website for family and persons served to discover reliable information, sheltering-in-place activities, resources and materials (e.g., creative things to do with children in the home, teaching aides, how to find rental assistance); and « evaluative protocols to track and understand the impact the agency's pandemic responses (e.g., provision of telehealth services) has on program operations, staff and youth/families. SBHG has stayed abreast of changes in CDC CA DPH, DSS CCLD, and DHCS, and County requirements related to COVID-19 and will continue to do so to ensure compliance.

Telehealth Services

Telehealth services occur when staff and persons served have real-time, synchronous communication through both video and audio. This can be accomplished through computer, tablet, laptop, cellphone or other internet-connected devices with audio and video capabilities using our approved MS Teams Platform, a HIPAA compliant Telehealth application, for which we maintain a HIPAA Business Associates Agreement with Microsoft. Our Telehealth Policy and Procedure (PGM 1.91 Telehealth Services) addresses the purpose and appropriate uses (per DHCS Information Notice 20-009) of telehealth, its definition, how to get real-time user support/technical assistance, and procedures. Procedures encompass technical set-ups/steps, informed consent, HIPAA/privacy and rights protections, session logistics (e.g., schedule and conduct a session so that a child at home has privacy with their therapist), behavioral de-escalation during a session, documentation and claiming. Additional clinical topics are addressed through clinical rounds led by our Vice President of Clinical Services. These included issues such as how to translate our use of EBPs well into a telehealth context, and how to monitor for high-risk behaviors and heightened vulnerabilities of youth and family members. Some of these risks/vulnerabilities (e.g., abuse/maltreatment, domestic violence, substance abuse, suicidality) may be less observable and/or disclosed in a telehealth context; thus, extra guidance to staff and their sustained attention and vigilance to such risks were very important and helpful to address.

Our outpatient staff continued to provide intake, crisis interventions, and aftercare planning/discharge sessions in person whenever possible during the pandemic, and more routinely during periods in which the pandemic wanes. Thus, youth/families typically experience a mix of delivery contexts (office, field, telehealth) over the course of care. Staff are instructed to pay attention to what service contexts seems to work well -- or not -- with individual youth/families, and to abide youth/family preferences as safety allows. They are also expected to continue to deliver their practices to fidelity so that we remain grounded in optimal clinical care, regardless of service context. We think of Telehealth as a method or mechanism for connecting and communicating that should not alter basic sound clinical practice and judgment.

DEPARTMENT RECOMMENDATION(S):

Click here to enter text.