FRESNO COUNTY MENTAL HEALTH PLAN   OUTCOMES REPORT- Attachment A

PROGRAM INFORMATION:c

Program Title:	Adolescent Psychiatric Health Facilty (PHF)	**Provider:**	Central Star Behavioral Health, Inc.
Program Description:	Acute inpatient care for adolescents age 11 through 18 years.	**MHP Work Plan:**	4-Behavioral health clinical care
			Choose an item.
			Choose an item.
Age Group Served 1:	CHILDREN	**Dates Of Operation:**	April 1, 2015 - present
Age Group Served 2:	Choose an item.	**Reporting Period:**	July 1, 2018 - June 30, 2019
Funding Source 1:	Medical FFP	**Funding Source 3:**	Other, please specify below
Funding Source 2:	Realignment	**Other Funding:**	Private Insurance

FISCAL INFORMATION:

Program Budget Amount:	$4,402,134	**Program Actual Amount:**	$2,683,038 (Fresno County)
			$4,741,400 (Total)

Number of Unique Clients Served During Time Period: 444 Fresno County (632 total)

Number of Services Rendered During Time Period: 2,620 Fresno County Bed Days, 4,630 Total Bed Days

Actual Cost Per Client: $6,042.88 per Fresno County client

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	PHF/Inpatient
Contract Term:	01/1/2015 – 6/30/2018 plus two optional one-year extensions	**For Other:**	Click here to enter text.
		Renewal Date:	June 30, 2020

Level of Care Information Age 18 & Over: Choose an item.

Level of Care Information Age 0- 17:   Choose an item.

The levels of care shown in the menu do not apply. The program provides acute inpatient services to adolescents.

TARGET POPULATION INFORMATION:

Target Population: Adolescents, ages 12 to 18 years, in acute mental health distress who present a threat of harm to self, and/or others, and/or grave disability (severe personal disorganization and inability for self-care and/or functioning safely in the community). Inclusive of Medi-Cal beneficiaries, Medicare and Medicare/Medi-Cal beneficiaries, and the indigent/uninsured who are referred by DBH, other County departments, a contract provider with the DBH,

hospital emergency room, Juvenile Justice Campus, other counties, and other agencies. Additionally, the program serves those with private insurance through contracts and referrals from Kaiser, Anthem Blue Cross, Avante Behavioral Health Plan, Cigna Behavioral Health, Magellan, MHN, Three Rivers Provider Network and Value Options.

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)

Integrated Service Experience

Community collaboration

Cultural Competency

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

Access to underserved communities

Please describe how the selected concept (s) embedded :

All core concepts are reflected in the operation of the PHF. Community collaboration and service integration are both increasingly critical foci to assure youth and their families are connected into community services and supports post discharge. All Stars Behavioral Health Group (SBHG) programs build and implement a bi-annual Cultural Attunement Plan which addresses multi-cultural staff hiring, training and retention; programming, policies and procedures; and, elective initiatives carried out by teams to enhance cultural attunement to their service population(s). Each youth and family's issues and needs prompting crisis and hospitalization are assessed and addressed through an individualized plan of care, and the youth's own WRAP, with assertive attention to stabilizing the youth while in the setting and connecting them into post discharge treatment services and resources. CS's PHF in Fresno County helps the county to meet the community need for acute psychiatric care, and provides an important gateway for those not prior linked to community-based mental health services.

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

Additional details regarding key performance indicators, tools/measurements, available data and analyses are on Form C. Please note that we aim to overhaul our reports next year to clarify assignment of Key Performance Indicators to the county's report categories.

Measurement Protocols

Indicator (Type and Target)	Who Applied	Time of Measure	Data Source	Target Goal Expectancy
ACCESS Time between receipt of a referral to the PHF and contact with the referring agency. Time between referral and admission to the PHF.	Intake Staff (Nursing Dept)	Admission	• Packet Tracker • SBHG EMR	*New Target for FY 19-20:* % Referrals responded to within 1 hr. Average length of response time. % Referrals admitted to PHF within 24 hrs. Average length of referral to admission time.
ACCESS & EFFICIENCY Denial rate of admissions when a bed is available Denial rate of PHF days not meeting Medi-Cal necessity criteria per utilization review.	Internal & External QA/UR	Admissions & Days in Setting	• Packet Tracker • Internal & County UR	*New Target for FY 19-20:* % Denials of admissions when bed is available will not exceed 20% % Denials for PHF days due to not meeting medical necessity will not exceed 5%
EFFECTIVENESS Reduced high risk behaviors and associated incidents.	PHF Psychiatrist, Nurses & Social Workers	BPRS at admission, every three days, discharge (DC) IRs completed at time of incidents	• Brief Psychiatric Rating Scale (BPRS) • SBHG EMR Incident Report (IR)Tracking	Majority of clients will show reductions in one or more individualized target behaviors by discharge (new tool -- we will set baseline by Jan. 1, 2020). IRs (esp. those related to aggression, suicidality) will continue at low rates per 1000 patient days as in prior years.
EFFECTIVENESS Acquisition of coping, communication and community life skills.	PHF Psychiatrist, Nurses & Social Workers	Discharge (DC)	• EMR DC Status Form	Majority of clients will have met all/some of their treatment goals and the majority of both clients and caregivers will report improved

Indicator (Type and Target)	Who Applied	Time of Measure	Data Source	Target Goal Expectancy
			• Client/Family DC Interviews/ Surveys	capacities by discharge (improved data collection underway – we will set new baselines by Jan. 1, 2020).
EFFICIENCY Average length of stay.	Internal QA	Admission to Discharge	• Avatar • SBHG EMR	Average length of stay will remain stable, similar to prior years (average of 6 days). % of those who discharge within 10 days does not exceed 90%.
EFFECTIVENESS & EFFICIENCY Collaborative approaches and treatment strategies to reduce hospital readmission of clients, esp. among those with frequent PHF readmissions.	PHF Nursing/Clinical & QA Leaders & Tx Staffs (in collaboration w/ external entities)	Varied QI Projects Undertaken Annually	• Varied QI Projects (Recidivism data from County and/or EMR; project specific tracking logs are also used)	Varied per QI Project *Examples:* % clients introduced to WRAP % clients w/ family sessions % clients/families endorsement of service approach on DC surveys % readmitted within 30 days of DC
EFFECTIVENESS & EFFICIENCY Effective discharge planning as demonstrated by referral and linkage to other DBH programs, community providers and other community resources.	PHF Nursing/Clinical & QA Leaders & Tx Staffs (in collaboration w/ external entities)	DC planning starts at admission and continues daily through DC to Aftercare linkages	• SBHG EMR Aftercare Plan • SBHG EMR DC Status Form • Post DC follow-up phone interviews*	Majority (85%) of PHF clients return to a home/family settings Majority (85%) of PHF clients DC with at least 2 referral/linkages to community resources & supports. NOTE: County QA also tracks KPIs related to timely uptakes to next-on services (e.g., 48 hrs., 7 days).
CUSTOMER SATISFACTION Multiple Protocols & Survey Items *Examples:* (Client) "More confident now, after being in the program, in my ability	Family Advocate and/or PHF Psychiatrist QA/Others TBD	Client/Family: Discharge & (possibly) Post DC Interviews/Surveys	• Youth Survey Caregiver Survey • Post DC follow-up phone interviews*	Performance benchmark is 85% items endorsed positively. Items or areas that fall below benchmark are reviewed and prioritized for QI.

Indicator (Type and Target)	Who Applied	Time of Measure	Data Source	Target Goal Expectancy
to recover and cope with mental health problems." (Caregiver) "Family received the help we needed for our child." (Agency Partner) "The program provides a needed level of care in the community."			• Agency Partner Surveys	

* NOTE: Currently pilot testing Post DC protocols to see if feasible to sustain.

Access to Care:

1. Short amount of time between client referral and admission to the PHF.
2. Low denial rate related to those who do not meet Medi-Cal medical necessity criteria.

- The PHF tracking log encompassed 2,054 referrals of 1,650 distinct individuals from July 1, 2018 through June 30, 2019.
- Almost invariably (99%), the referral source (referral contact person) was contacted by the PHF's admissions staff within 24 hrs. (114 mins. on average). The PHF admissions team has a new target to make contact with each referring person within 1 hr. of their call and they are assessing changes needed to make this possible.
- Out of the referrals, there were 747 admissions (36% of all referrals) of 632 unduplicated youth (38% of referred individuals). Of these, N=540 (73%) of the admissions and N=444 (70%) of the youth were from Fresno County.
- The majority (77%) of those referred and accepted for admission are admitted within 24 hrs. (269 mins. on average); nearly all others (22%) within 48 hrs.
- The reasons for not entering the PHF at time of referral are tabled below. For improved clarity, in the future the team will code constraints related to client behavior (such as extreme aggression, including sexual aggression) separately from constraints related to medical status. The former are assessed on a case by case basis and the latter are diverted to medical facilities. We also have a new target for FY 19-20, that the % denials of admissions when bed is available will not exceed 20%. We will work collaboratively with the county to assure denial reasons such as below are tracked and grouped to assess and meet performance on this goal.

Admission Denial Reasons

Client Placed Elsewhere		873	63.6%
No Contract with County, Insurer		224	16.3%
No Bed Available		95	6.9%
Client Too Young or Too Old		92	6.7%
Constraint Related to Client Behavior or Medical Status		77	5.6%
Incomplete Referral Information		12	0.9%
	TOTAL	1373	100.0%

- The Medi-Cal (County Utilization Review) denial rate for the year was <1%. There were 2 denials by Fresno county – one client's Medi-Cal was through another county; another client did not meet medical necessity. A low denial rate means those being admitted qualify for a psychiatric hospitalization (they require this level of safety, structure and support) during a mental health crisis abiding Medicare guidelines; and, that this type of expensive, restrictive resource is being appropriately focused and used for those meeting eligibility criteria.
- The team worked collaboratively with Fresno County this past year to gain a clear understanding of Fresno's presumptive transfer process and how to admit clients who are medically covered through another county yet residing in Fresno county at the time of need for hospitalization.
- In summary, the counts and percentages of referrals and admissions of Fresno youth and those from other counties, Medi-Cal proportions, and unduplicated youth are shown below, based on the PHF 'Packet Tracker' dataset:

	Count–Percent *Referrals*	Count–Percent *Admissions*	Count–Percent *Medi-Cal Funded Admissions*	Count–Percent *Unduplicated Youth*
Fresno County	1045/2054 – 51%	540/747 – 73%	402/747 – 54%	444/632 – 70%
All Other Counties	1009/2054 – 49%	207/747 – 27%	197/747 – 27%	188/632 – 30%

- Overall, the youth were ages 11.9 to 17.9 yrs. at the time of their first admission (average and median age is 15 yrs.; 85% are <17 yrs.). 65% are females. Admitted youth's demographics are shown below, first all admitted youth, then Fresno county youth only*:

Demographics of All PHF Youth FY 18-19

	Ages 11 thru 14		Ages 15 thru 17		
	Female	Male	Female	Male	Ethnic Subtotals:
African American	20	9	21	12	62 (10%)
Caucasian	51	18	65	43	177 (28%)
Asian American	3	3	6	4	16 (3%)
Latinx	87	44	138	76	345 (55%)
Native American	0	0	1	0	1 (<1%)
OTH, Mixed	8	3	4	4	19 (3%)
UNK	0	0	1	2	4 (<1%)
Age Grp x Gender:	169	77	236	141	624

Demographics of Fresno County PHF Youth FY 18-19

	Ages 11 thru 14		Ages 15 thru 17		
	Female	Male	Female	Male	Ethnic Subtotals:
African American	15	6	15	8	44 (11%)
Caucasian	29	15	43	23	110 (26%)
Asian American	2	3	2	3	10 (2%)
Latinx	59	32	99	45	235 (56%)
Native American	0	0	1	0	1 (<1%)
OTH, Mixed	6	3	4	3	16 (4%)
UNK	0	0	0	0	1 (<1%)
Age Grp x Gender:	111	59	164	82	417

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* Please note we have a small total unduplicated count discrepancy (624 vs 632) in our EHR compared to counts and percentages table a few bullets above, the latter aligns to the referral processing 'Packet Tracker' and data in Avatar. These discrepancies are being examined to assure accurate EHR data entry.

Effectiveness of Care:

3. Reduced high risk behaviors (safety)
4. Increased acquisition of community living, coping and communication skills
5. Collaborative approaches and treatment strategies to reduce readmission of clients with frequent readmissions to the facility
6. Effective discharge planning as demonstrated by referral and linkage to other DBH programs, community providers and other community resources
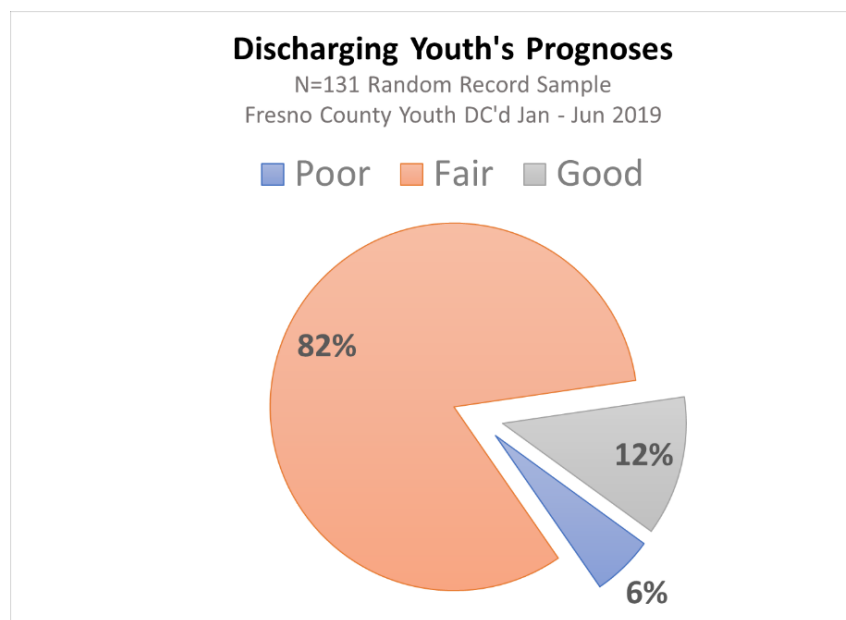
Institutionally, safety is our number one priority for youth, staffs and visitors at the PHF. The team tracks incidents related to youth's risk behaviors and the use of restrictive interventions, as well as other kinds of occurrences that may present safety risks. Incident details, including antecedents, descriptions and follow-up activities, including external reporting when required, are recorded in the SBHG EHR and monitored for quality of care and potential improvements by CS's QA staffs and managers. Below are tabled data on some of the indicators the team tracks. The team is to be commended for zero AWOLs, zero client allegations of staff abuse, and exceptionally low rates of medication errors. Overall, staff manage the setting proactively and generally achieve low rates per 1,000 patient days of incidents. The most common incident type by far is the discovery and necessity of filing child protective service (CPS) reports regarding youth being maltreated by persons in their lives; such maltreatment greatly contributes to their psychiatric trauma and the need for intervention, services and supports.

Incident Reports

	Total for Year	Average Per Month	Rate per 1,000 Patient Days
AWOLs or MISSING CLIENTS	0	0.0	0.000
Allegation of staff abuse of clients	0	0.0	0.000
Medication errors	7	0.6	1.510
Assaults (client to client, client to staff)	13	1	2.804
Sexual misconduct (client:client)	15	1.3	3.236
All other patient injuries (incl.falls)	35	2.9	7.550
Beneficiary complaint/grievance reports filed	37	3.1	7.982
Self injury incidents	43	3.6	9.276
Clients with an APS or CPS report filed	124	10.3	26.750

When addressing risky behaviors, particularly bizarre or out of control behaviors, assaultiveness or sexual aggression that poses imminent harm to self or others, staff use ProACT™ (professional assault training) to de-escalate the situation with the goal of minimizing the use of restrictive or chemical interventions. They succeed: this year, the rates of such interventions were 3.1 physical restraints per month; <1 involuntary seclusions, <1 escort; 0 mechanical restraints; and 3.3 IM PRN/STAT medication injections. Physical restraints lasted, on average, 11.3 minutes; involuntary seclusions 19 minutes; and escorts 2.5 minutes. Additionally, there were no clients with more than 5 restrictive interventions during their entire stay at the PHF. Staff activate debriefing protocols with clients after incidents, and after calm is restored, to maximize youth's opportunities to learn from the encounters, reflect on how they'd like to handle things better for themselves in the future, and to provide feedback to staff about how they might be more effectively de-escalated.

Youth's prognoses at discharge (likelihood they will remain stable and not require additional hospitalization(s))*, per PHF psychiatrist and social worker is graphed below. Those with poor prognoses (6%) are among those discharging to other hospital settings, law enforcement or child protective services and group homes. This coming year, we will analytically tie psychiatry/social worker discharge prognoses, new BPRS ratings, discharge destinations and recidivism analyses to bring greater focus on potentially improvable patterns in client treatment at the PHF and the overall system of care."

Discharging Youth's Prognoses
N=131 Random Record Sample
Fresno County Youth DC'd Jan - Jun 2019

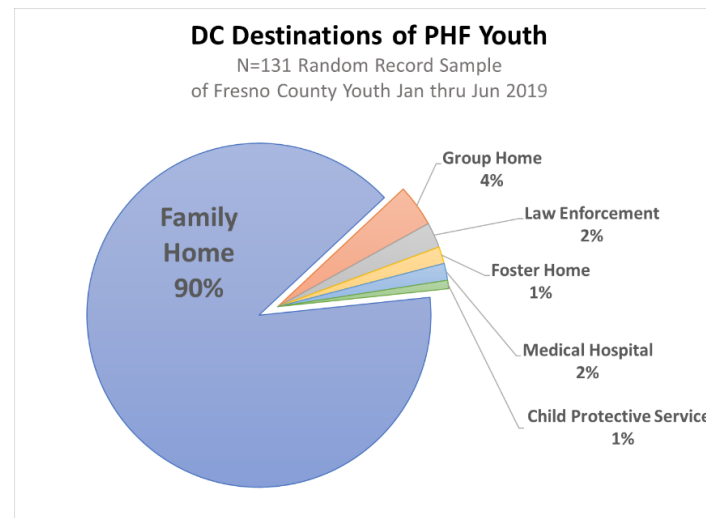■ Poor ■ Fair ■ Good

82%

12%

6%

Youth continue to have from 0 to 7 behavioral health issues each as they exit the facility, with an average of 5 discrete behaviors identified per client. The proportions with varied types of issues that are essential to address through aftercare planning, ongoing services and supports are tabled below**:

Moods & Emotional Regulation	120	91.6%
Self-Harm	108	82.4%
Other Types of Difficulties	96	73.3%
Anger & Aggression	57	43.5%
Bizarre/Psychotic Symptoms	25	19.1%
Substance Abuse	8	6.1%
History of High End Service Use	5	3.8%

Most youth (88%) leave the facility with one or more prescriptions for psychiatric medication(s) and with initial behavioral stability achieved. The proportion with 1 prescription (Rx) is 26%; 2 Rx = 28%; 3 Rx = 16% and 4 or 5 = 8%. On average, each youth has 1.6 prescriptions.

Most youth (90%) are discharged home***; proportionately, very few transfer to another hospital facility at the time of discharge.

DC Destinations of PHF Youth
N=131 Random Record Sample
of Fresno County Youth Jan thru Jun 2019

Family Home 90%
Group Home 4%
Law Enforcement 2%
Foster Home 1%
Medical Hospital 2%
Child Protective Services 1%

The PHF team continued this past year to build on prior collaborative efforts (originating in part from the county's EQRO QI project) to affect the range of activities such as communication, coordination, resource finding, and active problem solving for each youth to become positively situated with needed referrals/linkages at discharge. They continue to flag and work especially intently with those youth and their families experiencing repeated crisis and PHF admissions. Within the FY -- among youth referred from any county -- the majority (92%, N=576) had 1 CS PHF episode (discrete admissions); 7% (N=92 youth) had 2 episodes each; and 1% (N=7 youth) had 3 episodes. Within the FY – among youth referred from Fresno County only -- the majority (91%, N=379) had 1 CS PHF episode (discrete admissions); 7% (N=31 youth) had 2 episodes each; and 2% (N=7 youth) had 3 episodes.

The program team focused efforts on boosting outreach, engagement and family sessions with caregivers and other family members of Fresno County youth, often mission critical for youth's success once they leave acute care. They prioritized youth whom had prior PHF episodes (20% did, compared to 9% in overall population) and/or those they considered at risk for PHF recidivism. The focus is to offer more wellness education (including more orientation to WRAP) and therapy sessions with family members; to improve family members' understanding and capacity to support and helpfully problem-solve issues with their youth; and, to prime family members so they follow-up with aftercare services and supports on behalf of their youth and family. The ultimate goal is to avoid the kinds of escalation of youth's behaviors and symptoms that lead to crisis and hospitalizations. Enhanced Family Sessions involve increasing the number of family therapy sessions of those youth with repeat PHF hospitalizations. During the year, the team tracked N=82 youth who received Enhanced Family Sessions and we will be able to assess such youth's downstream recidivism rates and patterns compared to others in the setting in order to gauge the impact of these efforts.

On average, each youth has 2.2 post discharge referrals and linkages to aftercare services and supports (range of 1 to 3). The proportions of clients with a discrete type of referral/linkage are tabled below, along with the proportions of all referrals represented by the discrete type, based on the EHR record abstract study of Fresno clients:

Services PHF Youth are Referred to Upon Discharge

DC REFFERAL TYPES		% Clients	% Referrals
Psychiatrist	74	56%	26%
Mental Health Provider (public funded)	119	91%	41%
Mental Health Provider (insurance company)	22	17%	8%
County Mental Health (e.g., Case Management)	64	49%	22%
Group Home or Residential Treatment	5	4%	2%
Court, Legal, Probation, Detention	3	2%	1%

DATA NOTES:
*   Based on random sample of N= 131 SBHG EHR discharge records of Fresno County youth Jan thru Jun 2019.
**   Average discrete behaviors per youth = 5; average (tabled) categories these fall into per youth = 3.
*** This pattern from the discharge record review is corroborated by our initial set of N=63 EMR DC Status Form data (May, June discharges, any county), in which 89% returned home and no one left to another hospital. It is also verified in the QA Key Indicator Tracking (KIT) monthly log: for the full fiscal year, the proportion discharging to a lower level of care was 92%.

Efficiency:

The program has a 16-bed capacity and this year they maintained an average daily census of 12.7 clients. For the community's referral network, this means they can typically readily tap this resource for youth in need of hospitalization. Indeed, <7% of reasons for non-admission pertain to the program being full at any given request; and, as reported under Access to Care, PHF intake staff are quick to respond to incoming referrals. They sort out eligibility, gather needed paperwork, and facilitate timely admissions, all of which are important to their busy professional partners in the community.

Over just a few days, PHF staff provide the following discrete service processes to each youth/family on average, during an episode of care, organized by broad types:

- 13 Intake protocols (range from 3 to 20; e.g., informational sessions, consents, patient rights/handbook, admission authorizations, admission summaries, etc.)
- 10 Screening and Assessments (range from 8 to 12; e.g., AIMS, Pain Health Nutrition, History and Physical, Nursing Assessments, MH Assessments, varied Behavioral and Medical Risk Assessments, Diagnoses, etc.)
- 24 Psychiatry and Medication services (range from 2 to 215; e.g., consults/ evaluations, doctor's orders, eMARs, psychiatric/medical progress notes, etc.)
- 24 Milieu Program services (range from 4 to 127; e.g., nursing, rehab and social worker sessions documented in progress notes, shift summaries and interdisciplinary notes, etc.)
- 3 Discharge protocols (range from 1 to 4; e.g., discharge orders, summaries/notes, aftercare plan with referrals & linkages listed for client/caregiver, etc.)

Hospital care is expensive. The PHF team actively manages youth's lengths of stay (LOS), with clients discharging as soon as they are behaviorally safe and stable. As in prior years, the program's average LOS this year was stably low, at 6 days (median is 5 days). While LOS ranged from 1 to 30 days, 90% discharge within 10 days and there were only 16 episodes in the year that went beyond 2 weeks.

Client Satisfaction:

    PHF Staff are to gather at least 3 surveys weekly from clients and caregivers as they exit the program, and this past year they did not meet their sampling targets – thus, this is a current QI focus for the program. Surveys were collected for N=34 youth and N=20 caregivers, with results shown below.

    Based on these small samples, topics for potential QI (items below SBHG 85% benchmark) include, from youth perspective: helping youth feel more comfortable in the setting; supporting youth's spiritual needs; and, helping youth address family problems. Importantly, all discharging youth in the sample reported "Yes" to the question "Are you more confident now, after being in the program, in your ability to recover and cope with your mental health?". Many youth commented positively about the food at the facility, for example, one youth liked the "seasoning, cooked thoroughly, hits all the food groups, warm meals, and you don't get rushed." Some suggested more variety at breakfast. They were also positive about the PHF's staff, with comments such as: "All of them were very helpful and I thank and appreciate all of them." Others noted the staff are "trained good", "good at their job". There were some comments/feedback about specific staff -- positive as well as appropriate, constructive criticism -- which management is reviewing to guide future training/coaching. The youth also welcome staff to prompt them to attend groups more.

PHF Youth Surveys
N=34 Jul 2018 thru Jun 2019
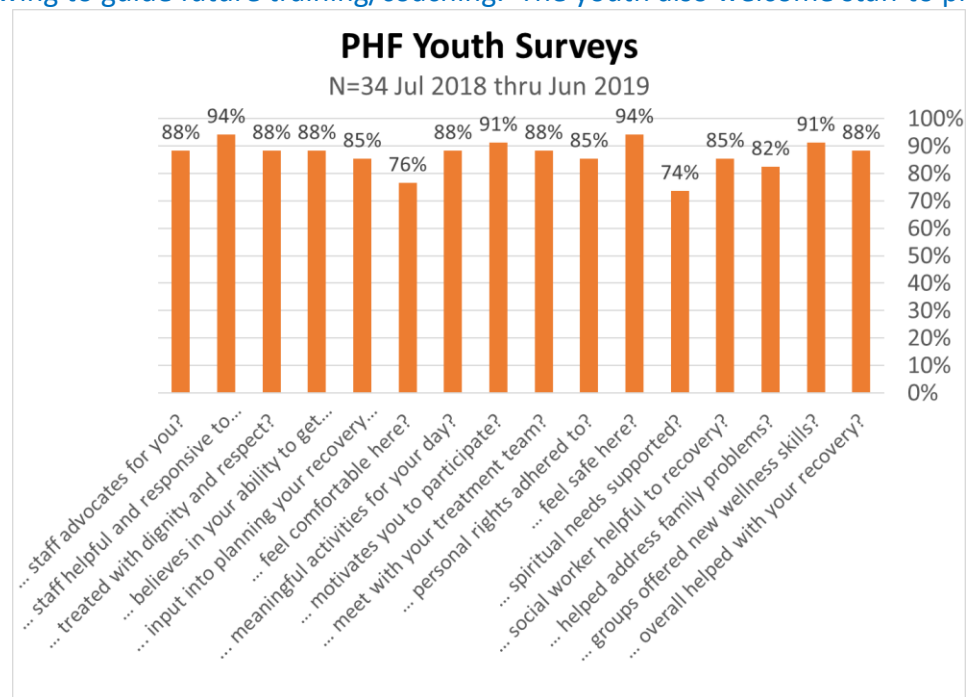
From the caregiver perspective, potential 'improvables' are providing meaningful activities in the day, motivating youth to participate, and supporting youth's spiritual needs. The majority (90%) of caregivers in the sample reported "Yes" to the question "Are you more confident now, after they were in the program, in your child's ability to recover and cope with their mental health?". Two persons reported they were "Not Sure". Among the few caregivers who commented, their feedback was positive and constructive. Caregiver's value the staff: "Angels sent down from heaven. Amen" was one comment; and, the facility/program: "Safe, clean, respectful … safe, safe" was another comment. There were a few comments about making sure to observe youth's privacy, calling family back promptly, and making sure to take the time needed to clearly explain forms. Even though the samples are small, we very much appreciate the feedback from youth and caregivers, which will be reviewed for QI.
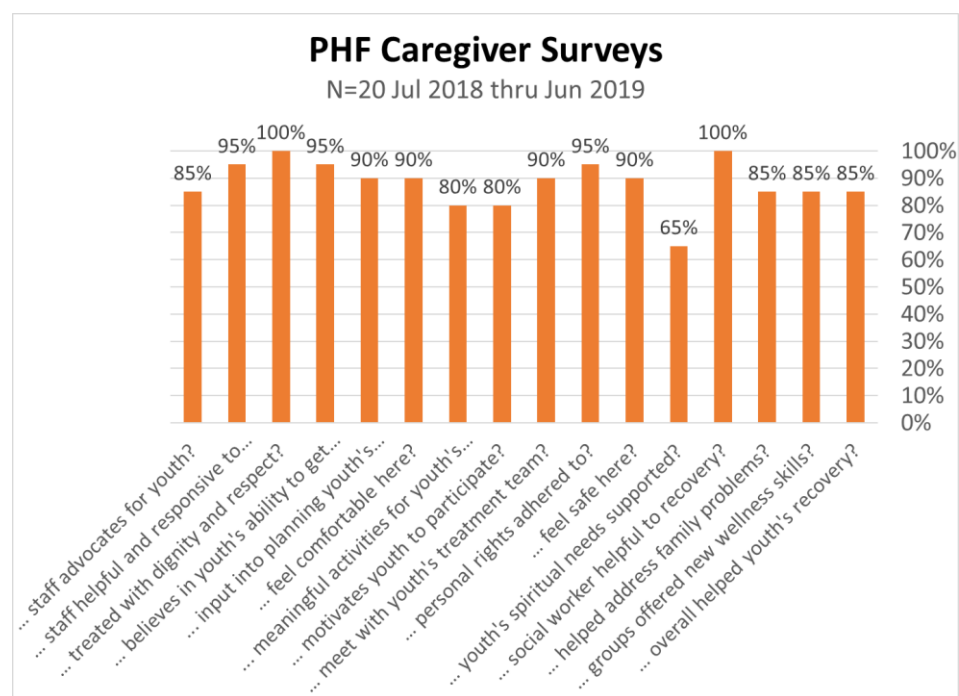
What Barriers Prevent the Program from Achieving Better Outcomes? We participated in the multi-year CAEQRO PIP project, and recently consolidated our understanding of these efforts in a separate report, available upon request. We value the collaborative processes being built to help assure that youth and families are connecting into services per their aftercare plans and we will continue to prioritize and partner with the county and community of providers around such important efforts.

What Changes to the Program Would You Recommend to Improve the outcomes ? 1) Improved leadership monitoring and reinforcement of data collection: new data codes and tracking as identified in this report, DC Status Form, Youth/Family Surveys, Post DC Follow-Up Interviews, Agency Partner Surveys, etc.; 2) Implementation as required by the Joint Commission of at least one standardized behavioral monitoring tool (tool identified and implemented; focus on sustainment); 3) Continued work on the rehab/milieu program and family sessions to assure there is focused clinical content, meaningfulness to participants, and maximum participation.