SPARC Services and Programs 2020 **ANNUAL OUTCOMES REPORT**

SPARC
Services & Programs

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April 2021

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Our Mission is simple: We work to keep people out of expensive institutional care. We do this adhering to a strong set of Values set inside a strong culture. Our Team is dedicated to our consumers and each other, and we have spent our careers custom designing Programs to meet our mission.

- Value Based Purchasing Contracts
- Strong Agency Culture
- Values Driven, Organically Grown Behavioral Health Organization
- Strong and Experienced Leadership
- Efficient Electronic Referral Process
- Innovative, 100% Paperless Electronic Health Record
- Licensed to Provide Family Centered Treatment ®
- Custom Designed Programs Available

SPARC Services and Programs is dedicated to the mission of Keeping People Out of Institutionalized Care. We do this by truly meeting individuals and families where they are at; physically and emotionally.

SPARC
Services & Programs

OUR PROGRAMS ARE:

- Designed for individuals and families that have not had success with the traditional array of services available to them
- Able to work with individuals and families who are experiencing imminent crisis
- Mobile. We come to where the individual or family is at. That may be the hospital, crisis center, their home, a shelter, a residential placement, or other locations where the individual and family may feel most comfortable
- Able to start quickly. Our goal is to complete a face-to-face meeting with new referrals within 2 days
- Evidenced Based and Trauma Informed
- Collaborative. We partner with our stakeholders to meet the needs of the individual and family. We include stakeholders and support systems in the treatment process to facilitate the attainment of goals, safety, and stability
- Customizable. We have a long history of customizing our programs to meet a stakeholder and/or payers needs
- Value Based. We participate in several Value Based Purchasing Contracts for our services

SPARC VALUES

1. Work to keep people out of institutional care

• People who receive our Programs and Services shall develop hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning.

2. Be positive and solution-based

• People who work at SPARC shall maintain a solution-based demeanor and view crisis as opportunities. Negativity ruins company cultures.

3. Give and accept feedback appropriately, and grow

• We believe we must make it ok to give and accept feedback appropriately, and then grow from that experience. Gossip is unfair and hurtful.

Support the principles of System of Care

• We accept the principles of System of Care. We are family-driven, community-based, and culturally and linguistically competent. Collaboration is critical.

5. Maintain great customer service

• Great customer service will be achieved through genuine, transparent relationships.

6. Record what we do accurately and timely

• We have a responsibility to record accurately, timely, with confidentiality, and in a manner that adheres to local, state and federal standards.

Family Centered Treatment

FAMILY CENTERED TREATMENT®

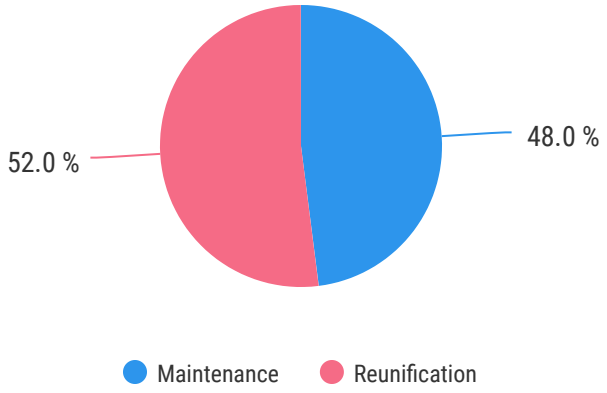
Evidenced Based Practice that is designed to work with children and families who have long/complex treatment needs, including multiple episodes of out of home placement and psychiatric hospitalizations. In the Cardinal Catchment, FCT is an alternative to Residential Level III Out of Home Placement.

- FCT is designed to find simple, practical, and common-sense solutions for families faced with disruption or dissolution of their family. FCT can be utilized to prevent an out of home placement or assist with reunifying the child back home from an out of home placement
- FCT works with the entire family system
- FCT is a trauma treatment and focuses on addressing the systemic dynamics of trauma on the family system as a whole and not just the individual. In 2018, FCT was recognized as a SAMHSA & National-Child Trauma-Stress Network Trauma Treatment model
- The program is provided with families of specialty populations of all ages involved with agencies that specialize in child welfare, mental health, substance abuse, developmental disabilities, juvenile-justice and crossover-youth
- Families receive multiple sessions per week and have 24/7 crisis response from their assigned clinician
- FCT is cost effective as an alternative to an out of home placement

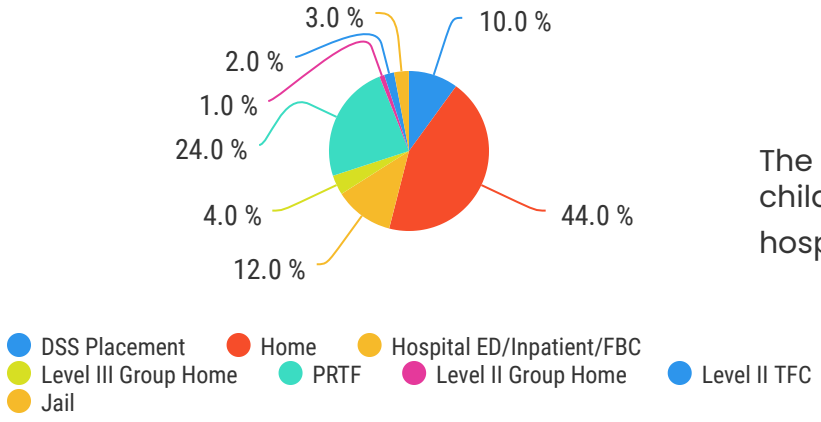
FCT and Trauma Treatment: FCT focuses on systemic trauma and generational patterns of trauma. The individualized incidence or aspects of trauma have broader impact than just the individual. It's how the individual and the subsequent response from those around them that is creating the maladaptive patterns. FCT looks to rewrite those patterns in the families narrative while addressing the trauma issues individually and when possible in a broader perspective including how individuals have learned to cope or not cope by watching others (generational).

SPARC provided FCT to a total of **221 families in 2020**. **48%** of the children were at home with family at the time of the referral and **52%** were reunifying from an out of home placement (i.e. Residential Treatment Center, Foster Care, Hospital Setting, etc)

Types of FCT Referrals



LOC at Time of Referral



The majority of Reunification Referrals are for children who are currently in PRTF settings and in hospital (ED, Inpatient, and FBC settings)

Family Centered Treatment, Continued

4.2

Average ACE Score

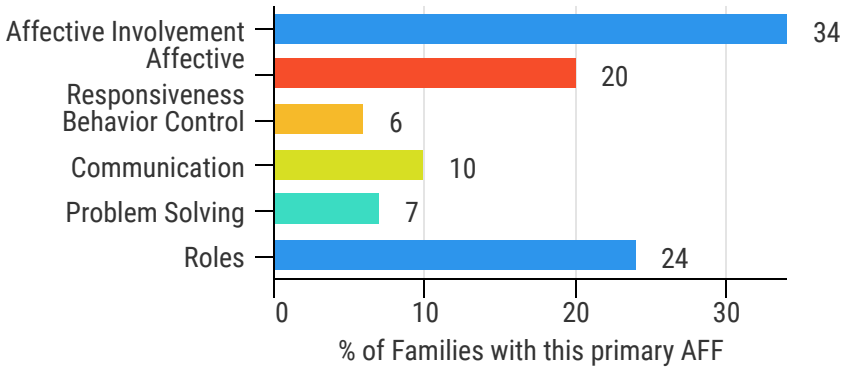
On average, the identified client has 4 or more ACES, which puts them at a higher risk for physical health issues, risk of suicide, and substance use disorder.

27.03

Average # of Weeks

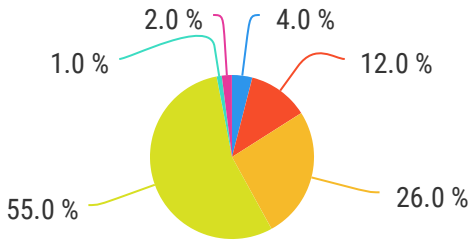
On average, families are involved in FCT services for 27.03 weeks.

Area of Family Functioning



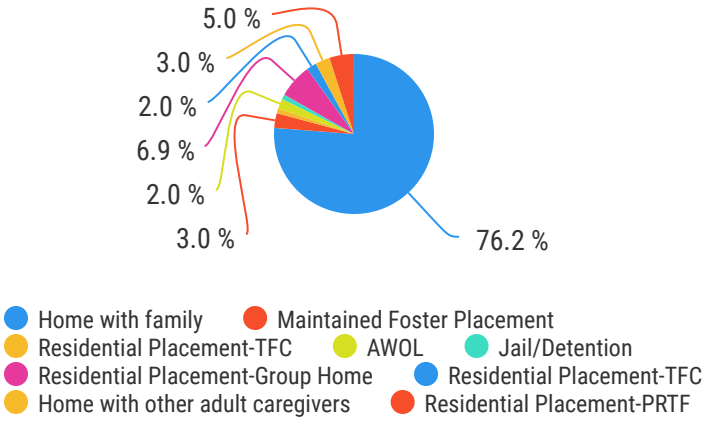
By assessing the AFF correctly, clinicians are able to laser in on goals and strategies to help the family achieve their treatment goals. The top three AFF relate to the relationships between the family members and needing to have clear roles within the family system. This aligns with the data of almost half of families participating in FCT have been separated due to an out of home placement, which has significant impacts on the family system.

Type of Discharge



The majority of discharges are planned successful discharges

LOC at Time of Discharge



As compared to the 52% of youth who were at home at the time of referral, at the time of discharge from services, **80% were home with family or other adult caregivers**

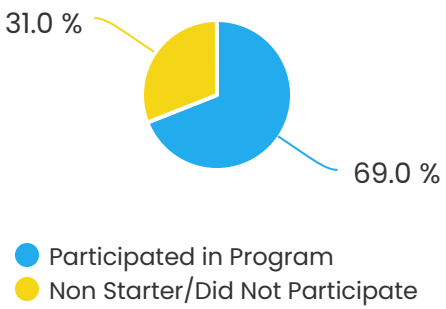
Enhanced Crisis Response

The ECR Program works with community stakeholders to meet the needs of youth with behavioral health needs who are at risk for abandonment in a hospital setting, at risk for DSS custody due to potential abandonment, and are experiencing crisis episodes and are at risk for restrictive levels of care.

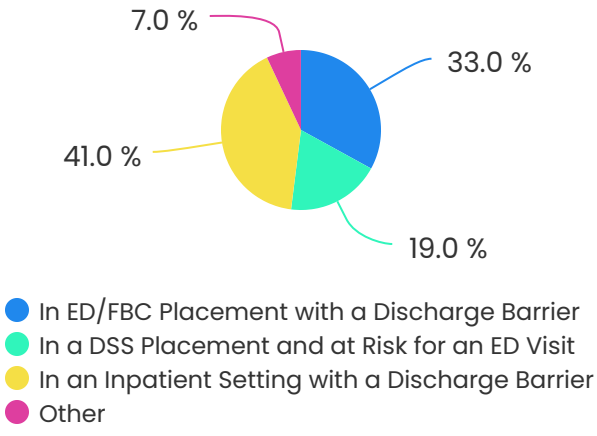
- Service elements include comprehensive assessment, crisis management, case management linkage to appropriate levels of care/therapeutic services, and discharge planning
- The program utilizes fully licensed clinicians who provide an immediate comprehensive clinical assessment along with 24-7 service delivery
- For youth in the Emergency Department (ED) or in a non-therapeutic DSS home/placement at risk of admission to the ED, the ECR staff will respond within 2 hours of referral and for other referrals, response will be same day or by end of the following day
- The program is short term, with services lasting on average 60-90 days. During this time, the staff will work with the child and family to diffuse the imminent crisis and link the family to the appropriate community-based services that will allow the child to thrive and meet their goals
- Family settings vs congregate care settings will be utilized whenever possible, as these are consistent with best practices for treatment of youth

Analysis for 2020: There were a total of 59 referrals into the program. Of those, 40 youth and their families participated in the program.

Participation in ECR Program

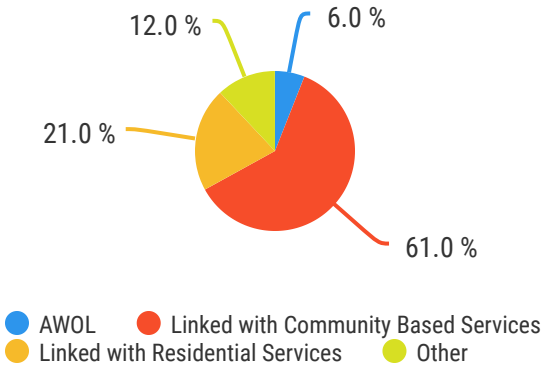


Types of ECR Referrals



ECR is designed to meet three target populations: 1) those with a discharge barrier in the ED or FBC setting, 2) those with a discharge barrier in an inpatient setting, and 3) those in a DSS Placement at risk for presenting to the ED. **73% of the program referrals were from the Hospital or FBC Systems.**

LOC/Placement at Discharge



61% of youth who were discharged from the program in 2020 were able to be discharged into the community with community-based services.

In Home Therapy Services

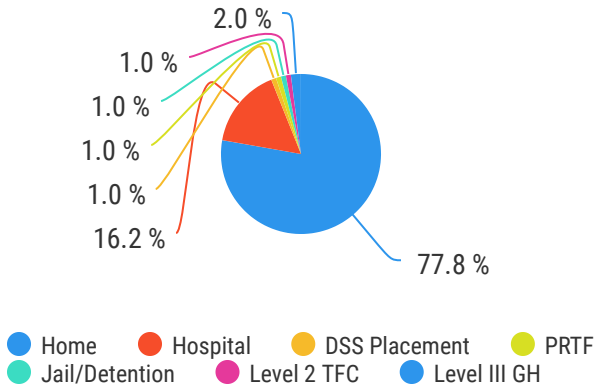
IHTS is a home and community-based therapy and case management service for children and their families who have needs too complex for traditional outpatient therapy.

- Service includes individual and family therapy, as well as case management supports. Families typically receive 1 multi hour therapy session per week and have access to 24/7 crisis response from their clinician
- The program is provided with families of specialty populations of all ages involved with agencies that specialize in child welfare, mental health, substance abuse, developmental disabilities, juvenile-justice and crossover-youth
- Goals are reducing presenting mental health needs, ensuring linkage with community supports and services, and reducing the need for out of home placement

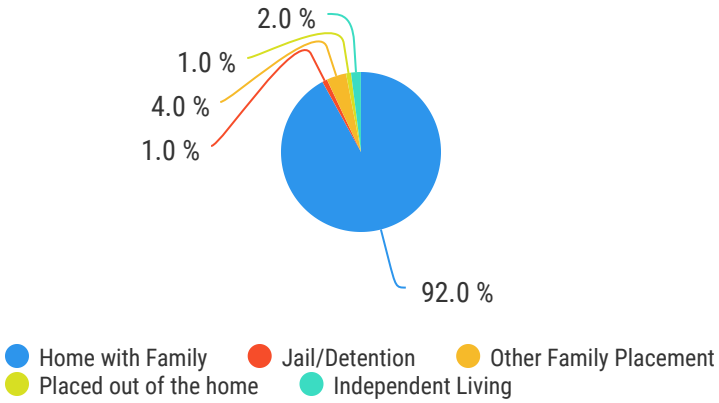
Analysis for 2020: A total of 265 families were served during 2020. Of those, 128 were discharge by 12/31/20 and make up the outcome discharge information.

In 2020, **78%** of the referrals for IHTS were for children and their families where the child was in the **home with family.**

LOC at Time of Referral

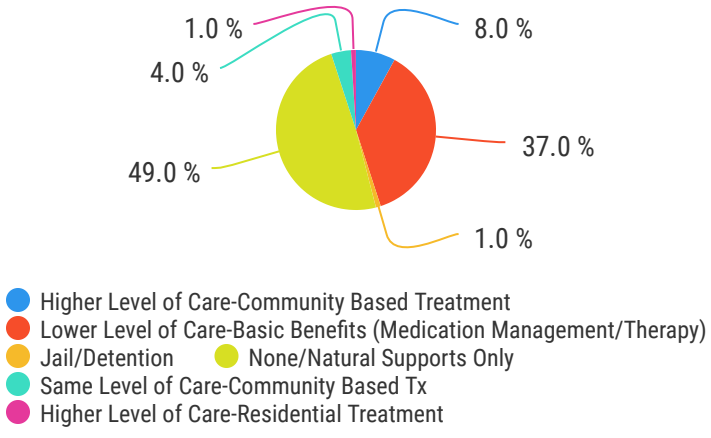


Placement at Time of Discharge



Placement at the time of discharge: **96%** of the youth were either at **home with family**, or in other family placements at the time of discharge.

Services at Time of Discharge



Treatment/Services at the time of Discharge: **86%** of the consumers discharged, were discharged with either **no professional services, or Basic Benefits only** (Outpatient Therapy and/or Medication Management) Services. An additional 12% were able to be maintained in the community with a higher or same level of care (i.e. IIH, FCT, MST, ABA Services).

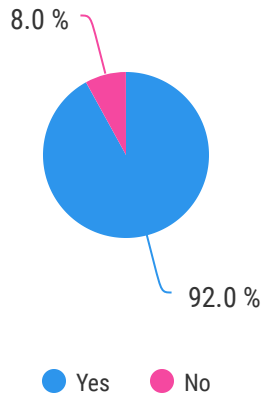
Transition Management Services

Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI). TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy.

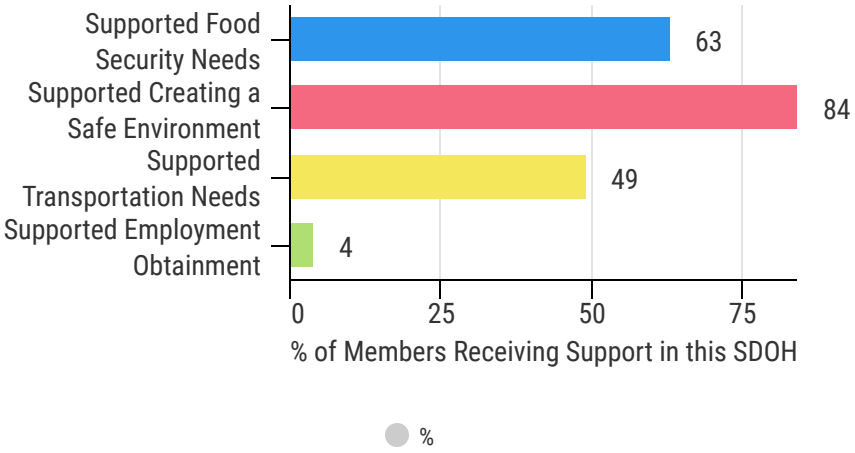
- TMS focuses on increasing the individual's ability to live as independently as possible, managing the illness, and reestablishing his or her community roles related to the following life domains:
  - Emotional
  - Social
  - Safety
  - Housing
  - Medical and Health
  - Educational and Vocational
  - Legal.

TMS is designed to assist members with obtaining and maintaining housing. Our TMS Team excels in this area with an average of **92% of members participating in services were able to maintain their housing in 2020.**

Maintained Housing in 2020



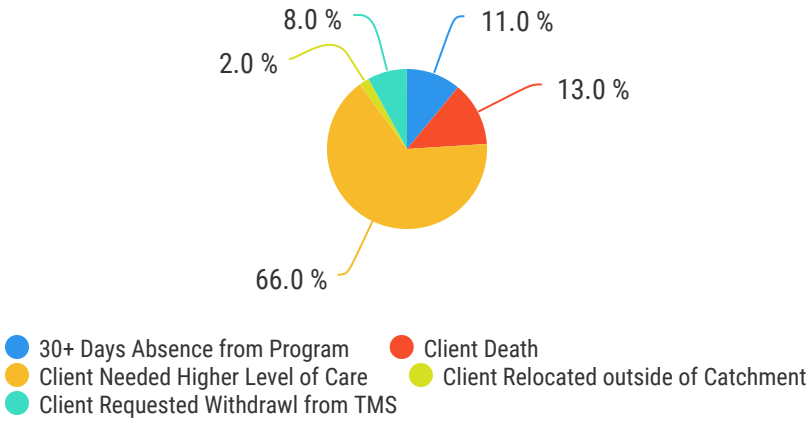
SDOH Addressed



Our TMS Team also assists members in addressing multiple **Social Determinants of Health** in addition to housing. Our TMS members self-reported working on additional SDOH in addition to their housing needs. The majority of members reported being supported in **2 or more SDOH in addition to Housing.**

Reasons for Discharge from TMS

A total of 181 adults were served in our TMS Program for 2020. Of those, **71% remain in the program in 2021.** Here are the reasons for discharge from this program.



Community Support Team

Community Support Team

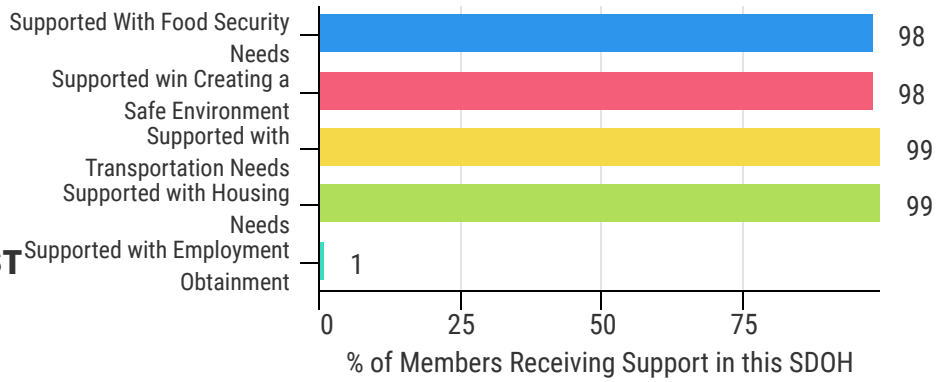
Community Support Team (CST) provides direct support to adults with a diagnosis of mental illness, substance use, or co-morbid disorder and who have complex and extensive treatment needs. This service consists of community-based mental health and substance use services, and structured rehabilitative interventions intended to increase and restore a beneficiary's ability to live successfully in the community.

- The team approach involves structured, face-to-face therapeutic interventions that assist in reestablishing the beneficiary's community roles related to the following life domains: emotional, behavioral, social, safety, housing, medical, health, educational, vocational, and legal.
- This is an intensive community-based rehabilitation team service that provides direct treatment and restorative interventions as well as case management.
- CST is designed to provide:

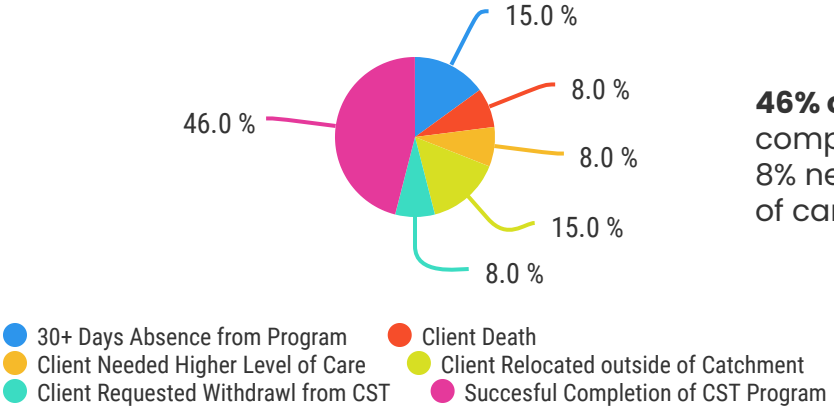
a. Symptom stability by reducing presenting psychiatric or substance use disorder symptoms
b. Restorative interventions for development of interpersonal, community, coping and independent living skills
c. Psychoeducation
d. First responder intervention to deescalate a crisis, and
e. Service coordination and ensure linkage to community services and resources.

SPARC provided CST Services to a total of **130 individuals in 2020** who had Mental Health and/or Substance Use Disorder treatment needs in addition to 99% of those individuals being housing insecure. They also had needs across multiple SDOH that were addressed as part of their treatment.

SDOH Addressed

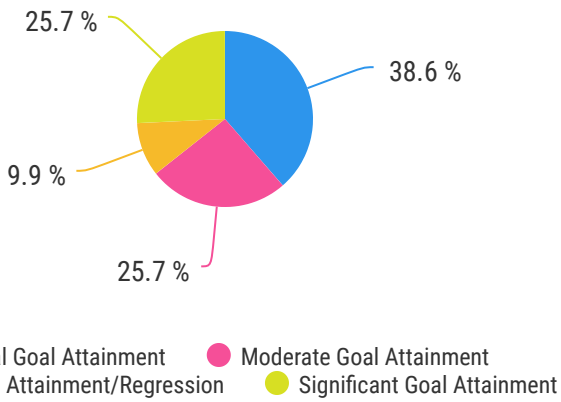


Reason for Discharge from CST



46% of individuals were able to successfully complete the CST program, while an additional 8% needed to be transitioned into a higher level of care to meet their needs.

Goal Attainment



90% of individuals were able to make some **progress towards their treatment goals**, with 52% making signifiant or moderate progress.

Individual Support Services

Individual Supports

Individual Support Services are “hands-on” individualized assistance with everyday activities that are required by a member with severe and persistent mental illness in order to live independently in the community. The services are intended to support adults ages eighteen (18) and older living in a private home, licensed group home, adult care home or a hospital that have a documented plan to transition to independent or shared housing.

- Specifically, this service provides assistance with Instrumental Activities of Daily Living (IADL) including:

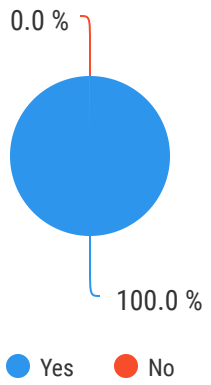
  - Preparing meals
  - Managing money
  - Shopping for household necessities
  - Using the telephone
  - Housecleaning
  - Laundry
  - Transporting the member to access the community,
  - Medication management
  - Supervision and cuing

The goal is to provide coaching to the member in areas of need and fade this support over time.

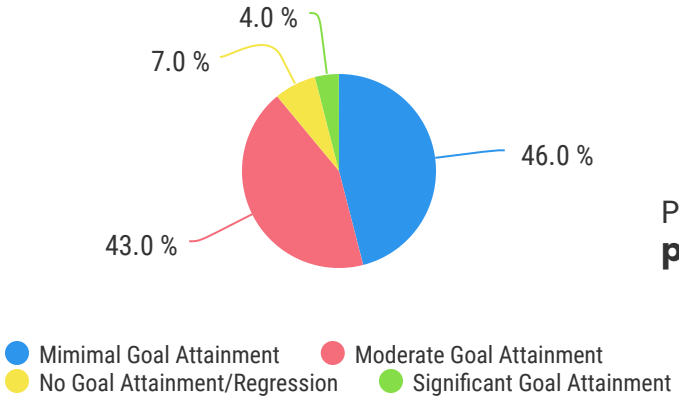
Analysis for 2020: SPARC served a total of 35 clients in this program. This program is designed to support individuals with the skills needed to maintain independent housing.

100% of the clients served in 2020, successfully **maintained their housing.**

Maintained Housing

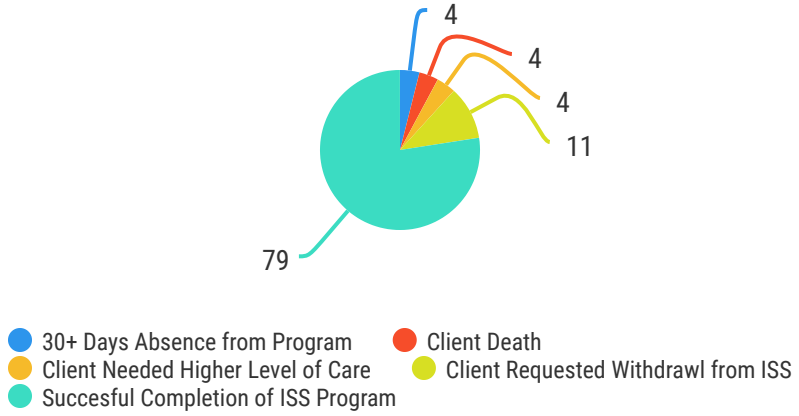


Goal Attainment at Discharge



Progress on Goals: **93% of the clients made progress on their treatment goals**

Reason for Discharge



Reason for Discharge: **78% of clients had a successful discharge** from ISS

Client Satisfaction Survey Outcomes

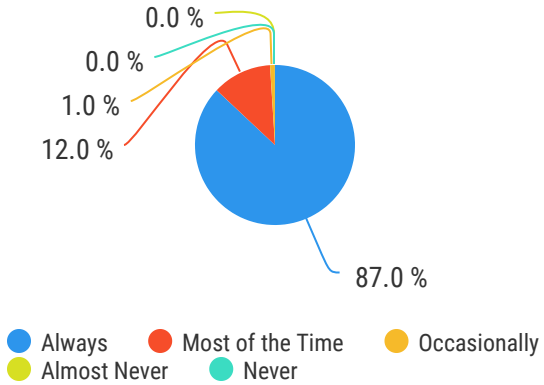
4.6★
average rating

We received a 4.6 rating for " Has SPARC Improved Yours/Your Family's Life"

"I like meeting with my staff at my home. We meet outside and can easily social distance".

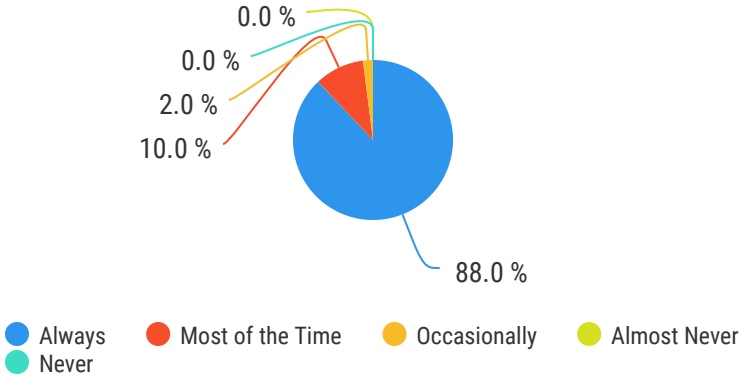
We asked our clients to rate our staffs skills as it relates to their services, here's what they had to say:

Spends Time Getting to Know Me/My Family and Whats Important to us

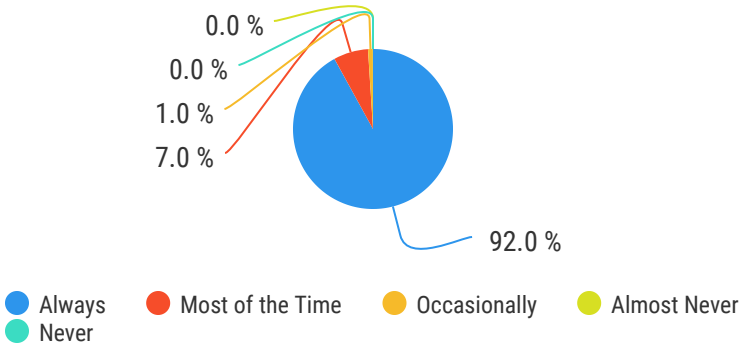


"I am beyond satisfied"

Is Available to Me/My Family in Between Scheduled Appointments



Is Working on the Goals that are Important to Me/My Family



"Services are fantastic. Seeing a lot of changes in our kids"

Collateral & Stakeholder Survey Data

4.0★
average rating

Recommend SPARC to a colleague: One of the best measures of how our agency is adhering to our values is if our customers would recommend SPARC to a colleague. We received a **4.0 star rating** from our stakeholders.

When asked about the skills of our staff, here is what was said:

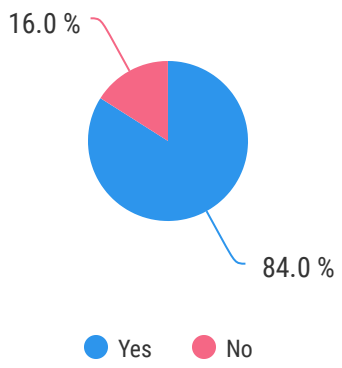
- ☑ Works Collaboratively
- ☑ Is Creative with Treatment Interventions
- ☑ Supports Clients/Families During a Crisis
- ☑ Provides Culturally Informed Services

"Your staff consistently provides the highest level of services for our members. I always consider SPARC first when I make referrals."

"Very timely responses. Two referrals submitted, quick engagement with families, good crisis planning and treatment planning."

Timely Response to Referral from SPARC: This measures how we did with providing follow up within 48 hours to all referrals. **84% of our stakeholders reported that we kept them informed of the status of their referral**

Received Timely Communication After Referral



2020 Outcomes Summary

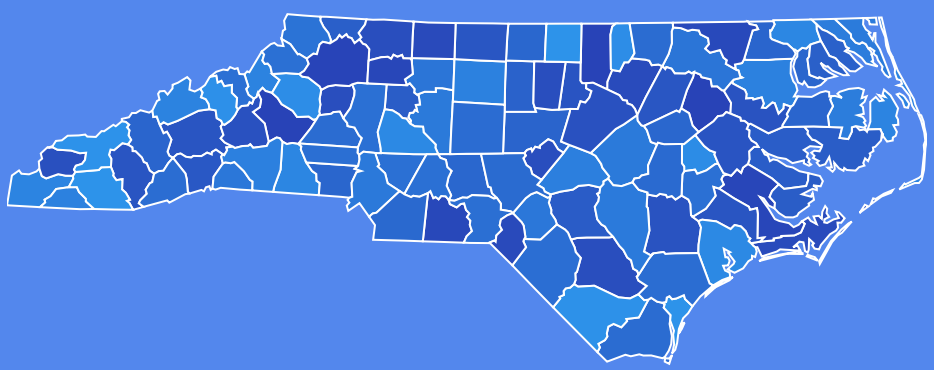
SPARC was able to see many successes during a very challenging and unprecedented year. For the majority of 2020, we were dealing with the implications of the Global COVID-19 Pandemic. We transitioned the majority of our home and community based services to virtual tele-health services very quickly. We supported our clients and families as they navigated "the new normal" all while ensuring that we focused on a plan that had a balance of staff and client safety as well as business sustainability that allowed us to meet our mission.

We are proud of the work that was done in 2020, and look forward to continued expansion of our mission of Keeping People out of Institutionalized Care in 2021 and beyond.

Outcome Highlights

- ☑ SPARC provided services to 863 unique individuals in 2020
- ☑ The majority of clients served across all service lines were able to maintain living in the community or be reunified to community living.
- ☑ Clients/families were very satisfied with the services they received
- ☑ Collaterals and Stakeholders reported high levels of satisfaction

For more information about SPARC, please go to our website at www.sparcprograms.net or call us at 1-888-700-1606



SPARC has offices located in:

- Charlotte
- Winston Salem
- Hickory
- Shelby