



Programs
2021
ANNUAL

OUTCOMES

REPORT







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*Programs that served smaller populations of individuals served do not have outcomes reported



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.



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.

Who We Serve

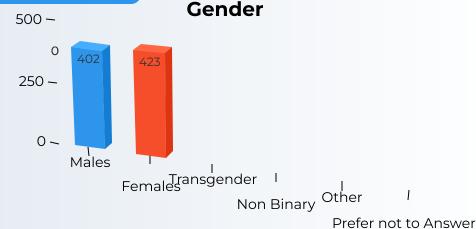
It's important to be able to look at the cultural and demographic information for our clients. This data can tell us many things, but most importantly, we have an opportunity from a cultural competency perspective to better know our clients and ensure we have staff that can best meet the needs of our clients.

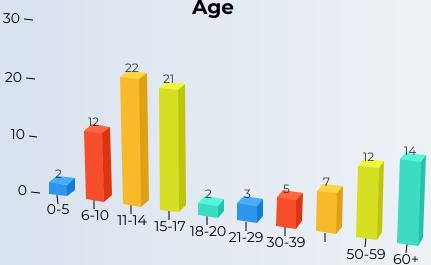
We want staff who not only have the passion, knowledge, skills, and abilities to provide excellent services, but who also meet the culture and language preferences of our clients. 10 Service Lines

Provided to Children, families, and Adults

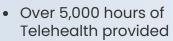
825 Unique Individuals

Served in 2021

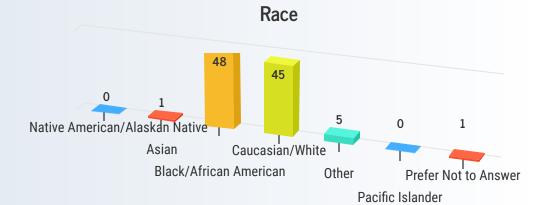




- Services provided to clients in 25+ counties
- Services provided to client with 14 different payers
- Referrals received from over 50 collaterals and stakeholders
- Services provided in English and Spanish



- Over 35,000 hours of services delivered
- Over 900 Screening Tools administered
- Over 400 SDOH Assessments Completed

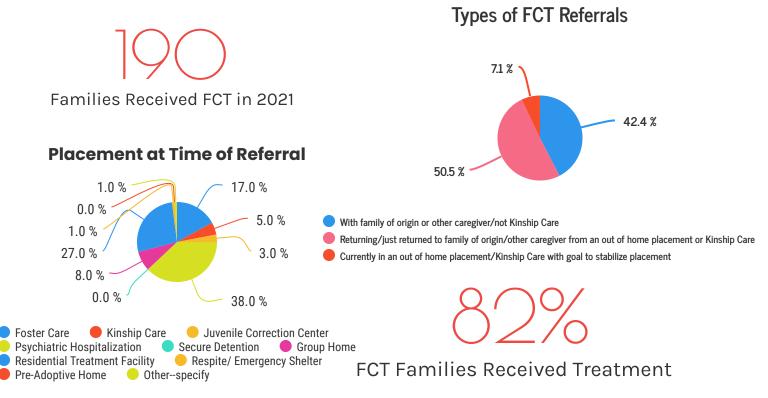




Family Centered Treatment (FCT) is a well supported in-home therapy model designed to work with children and families who have long/complex treatment needs, including multiple episodes of out of home placement and psychiatric hospitalizations. FCT is one of few home-based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

- 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 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).



25.34

Average # of Weeks

On Average, families received 25 weeks of FCT

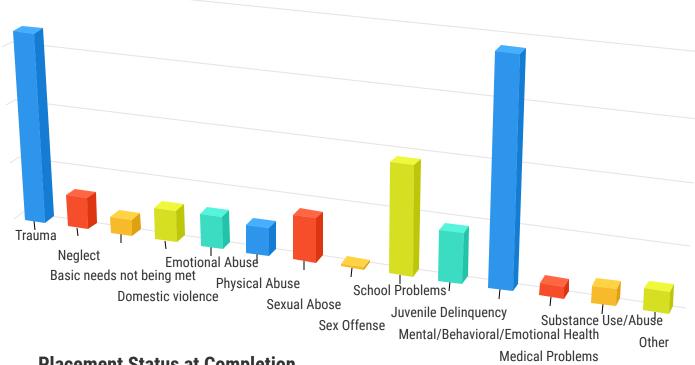
for Trauma

Average ACE Score

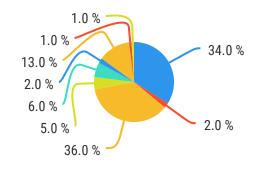
On average, the identified client has 4 or more ACES, which puts them at a higher risk for physical health issues, risk of suicide, and substance use disorder.

Family Centered Treatment, Continued





Placement Status at Completion



83% of youth either stabilized at their placement or were reunified with family!



Placement Risk vs Placement Outcome





Placed Out of Home at FCT Completion



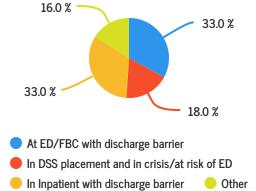
Enhanced Crisis Response (ECR) is a program designed to put intensive clinical supports in place for youth with complex needs who have discharge barriers from hospital/FBC settings or who are in DSS Custody, in a DSS Placement and at at risk for presenting to the Emergency Department due to a Mental Health Crisis. Crisis Response

The goal is to be able to keep children at home with their parent/quardian and prevent/minimize out of home placements for these children.

Service Elements Include:

- Crisis Management: Crisis intervention and support on a 24/7/365 basis.
- Intensive Case Management: Assists members to gain access to necessary care: medical, behavioral, social, and other services appropriate to their needs.
- Linkage to individualized Therapeutic and Behavioral Support Services: Services may include In Home Therapy Services, Family Centered Treatment, Multi-systemic Therapy, Respite, and Day Treatment (these services would overlap for two weeks to ensure linkage).
- Linkage to Residential Treatment: Therapeutic Foster Care and other programs as appropriate/clinically warranted. (these services would overlap for 30-60 days)
- Intensive supports for children in DSS Homes or Kinship placements: DSS Foster Home/DSS group home (recommended service provision: 60-90 days)
- Discharge and aftercare planning: Processes to decide what the member needs for a smooth move from one level of care to another and for ongoing monitoring.





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. 66% of the program referrals were from the Hospital or FBC Systems.

Youth and their families

Participated in ECR Services in 2021

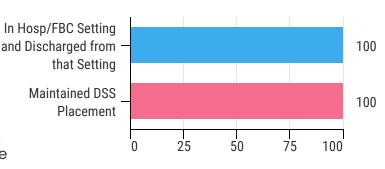


On average, the identified client has 4 or more ACES, which puts them at a higher risk for physical health issues, risk of suicide, and substance

49% of youth who were discharged from the program in 2021 were able to be discharged into the community with community-based services. 43% were able to be admitted into the medically necessary residential treatment programs.

100% of the youth who were in a hospital or FBC setting where able to be discharged from that setting and linked with the appropriate services. 100% of youth who were in a DSS placement and needed stabilization, were able to maintain that DSS placement.

Referral Type and Disposition







In Home Therapy Services (IHTS) and Opt Plus are services designed to meet the individual and family therapy needs of the child and their family, as well as provide any case management/care coordination needs in a manner that is more intensive than traditional outpatient services allow, but not as intensive as other enhanced levels of care.

These two programs are similar levels of care/services, with parallel goals, but have different names based on the Medicaid LME/MCO. As such, we track these programs together.

- The 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

Youth and Their Families

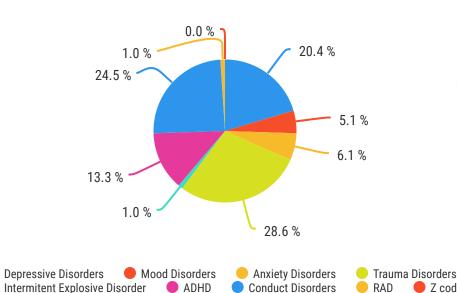
of Referrals Were as a Step-down From a Hospital Setting

Participated in This Program in 2021

On average, 90% of the youth served in SPARC's IHTS/Opt Plus Program are able to remain at home in the community with family.

Z code

Diagnostic Breakdown



Through this level of care, SPARC Staff were able to support youth and their families with a wide range of mental health needs, as well as Social Determinant of Health (SDOH) Needs. On average, each client had 2, or more, SDOH needs that were identified and addressed in treatment



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:
- o Emotional
- o Social
- o Safety
- o Housing
- o Medical and Health
- o Educational and Vocational
- o Legal.

INDIVIDUALS RECEIVED TMS SERVICES IN 2021

12.5%

Decrease in Hospitalizations for TMS Members



100%

Of Individuals Had Housing Needs Addressed

14.6%

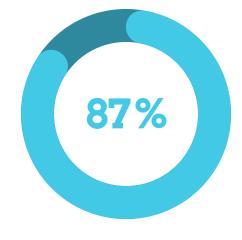
Decrease in Problems Interfering

Daily Life Functioning

100%

Were enrolled in the TCLI Program

87% of individuals Had 3 or more Social Determinants of Health (SDOH) that were identified and addressed during care





Community Support Team (CST) provides direct support to adults with a diagnosis of mental illness, substance use, or comorbid 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.

108
Individuals

Received CST Services in 2021

These individuals had Severe and Persistent Mental Health and/or Substance Use Disorder treatment needs, in addition to often being housing insecure.

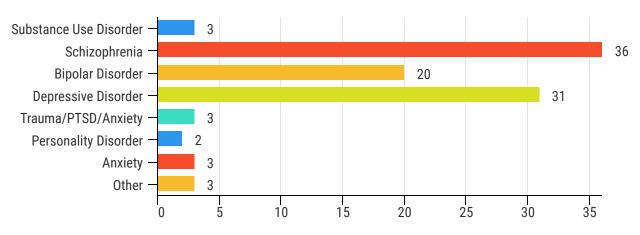
On average, CST clients had 3 or more Social Determinant of Health (SDOH) needs that were identified and addressed in treatment.

67%

of CST Clients Were Enrolled in TCLI

The Transitions to Community Living (TCL) provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment and community integration.

Primary Diagnostic Breakdown





Individual Support Services (ISS) 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:
- o Preparing meals
- o Managing money
- o Shopping for household necessities
- o Using the telephone
- o Housecleaning

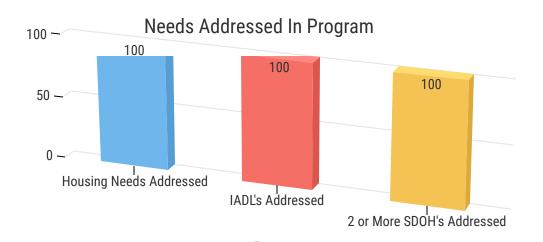
- o Laundry
- o Transporting the member to access the community,
- o Medication management
- o Supervision and cuing

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

19 Individuals Participated

in this program in 2021







Client Satisfaction Survey Outcomes

4.5★ average rating

We received a 4.5 out of 5 rating for "Has SPARC Improved Yours/Your Family's Life"

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

 $\frac{100\%}{\text{of respondents}}$

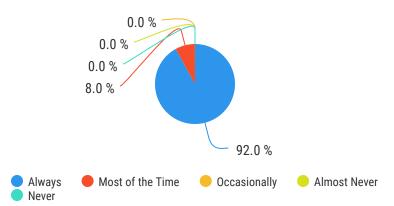
Said that their staff honors their/families beliefs and values

"My worker goes above and beyond.He has helped me for than anyone In the past"

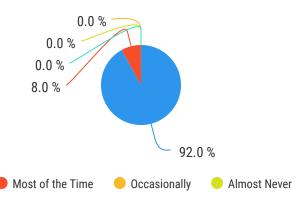
Always



Is Available to Me/My Family in Between Scheduled Appointments



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



Never

"I am truly grateful for the experience we have had."



Collateral & Stakeholder Survey Data



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 **4.5 out of 5 star rating** from our stakeholders.

"Big fan of SPARC over here!" 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
- Solution Focused
- Celebrate the successes of the client/family



9.2★ average rating



We received a **9.2 out of 10** from our stakeholders when asked if they would recommend SPARC to other colleagues

"Overall have positive experiences with SPARC staff"

"Every service the team made referrals to, the staff have been hard working and dedicated to helping members and their families."



2021 Outcomes Summary

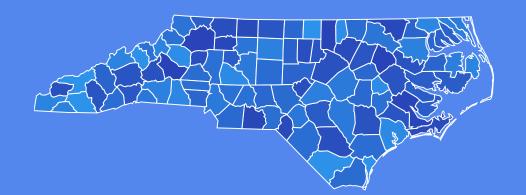
SPARC was able to see many successes during another challenging and unprecedented year with COVID continuing to have a major impact on the health of our clients, staff, community, and economy. For the majority of 2021, we were dealing with the implications of the Global COVID-19 Pandemic. We provided a hybrid model of care to our clients which allowed for flexibility of in-person and virtual service delivery. We continued to support 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 were also able to successfully navigate the first phase of NC Medicaid Transformation and add an additional 5 Medicaid Standard Plan Payers as well as 3 new LME/MCO Medicaid Payers. We look forward to 2022 and being able to expand our mission across North Carolina and be able to support North Carolinians in meeting their behavioral health and overall health and happiness goals.



- SPARC provided services to 825 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, ext 115



SPARC has offices located in:

- Charlotte
- Winston Salem
- Morganton