SPARC Services and Programs

2017 NC Outcome Data

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*Other programs provided by SPARC did not have enough data to be evaluated in 2017, but will be included in the 2018 report

I. Introduction to SPARC Services and Programs:

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.

SPARC Services & Programs 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.

4. 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.

What Makes SPARC Different?

- Value Based Purchasing with Shared Risk Contracting
- Strong Agency Culture
- Value 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 committed to providing the highest quality behavioral health services to children, families, and adults. As part of this commitment, we review our outcomes to evaluate how our programs are performing to our Mission of **Keeping People out of Institutionalized Care.**

II. Family Centered Treatment® (FCT)-

Family Centered Treatment® (FCT) is an evidence-based practice (EBP) that is currently being provided in various states. FCT has been gradually formalized into a model of home-based treatment that lowers rates of out of home placements. It has been refined based on research, experience and evidence of effectiveness derived from practice. The foundations of the model are from eco-structural family therapy (Minuchin) and emotionally focused therapy (Johnson). FCT is a systemic family systems change model. FCT® has 4 phases of treatment: Joining and Assessment; Restructuring; Valuing Changes; and Generalization. The third phase of treatment, valuing changes (through use of paradoxical and experiential exercises), seeks to confirm and capitalize on internal changes within the family so that the family is not dependent on the therapist once services terminate. Families also have the opportunity to give back to their communities through the Family Giving Project that allows families to share what they have learned with other families. Services are intensive with a minimum of 10 hours per month provided to the family. FCT incorporates coordination with other systems, such as DSS, School System, Primary Care, and DJJ as well as 24/7/365 Crisis Intervention.

This service is targeted towards:

1) Consumers with prior treatment episodes of residential treatment with unsuccessful family reunification,
2) Consumers at risk for higher levels of residential, such as Level III,
3) Consumers who have been hospitalized with little prior treatment where hospital is recommending residential services,
4) Consumers currently in residential treatment where discharge is being prolonged due to lack of family systems work to make this successful
5) Consumers with extensive histories of utilizing enhanced services without successful outcomes.

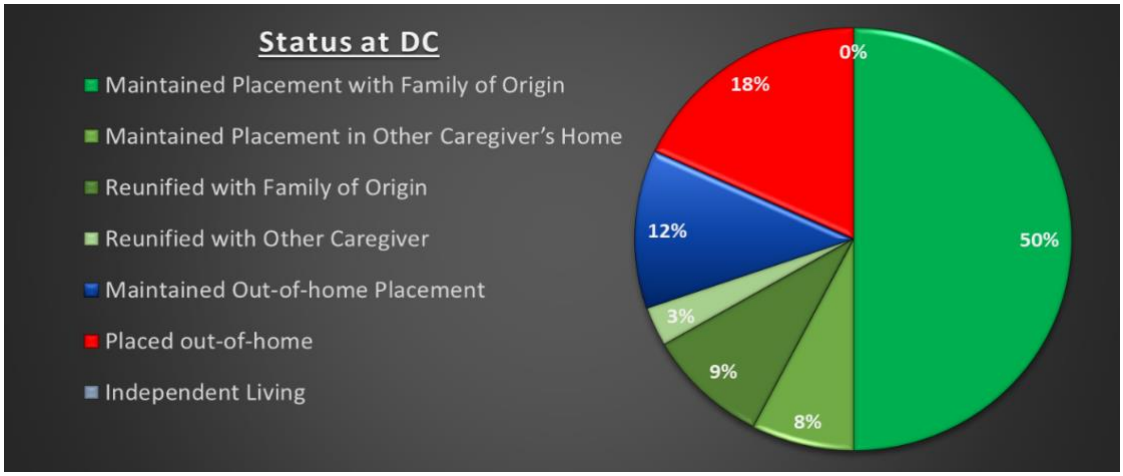
FCT and Trauma Treatment: FCT focuses on systemic trauma and generational patterns of trauma. The individualized incidence or aspects of trauma have broader impact than just the individual. It's how the individual and the subsequent response from those around them that is creating the maladaptive patterns. 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).

Discharge Analysis for 2017: Excerpts Taken From 2017 Licensing and Implementation Report Completed by the FCT Foundation. Full Report Available Upon Request.

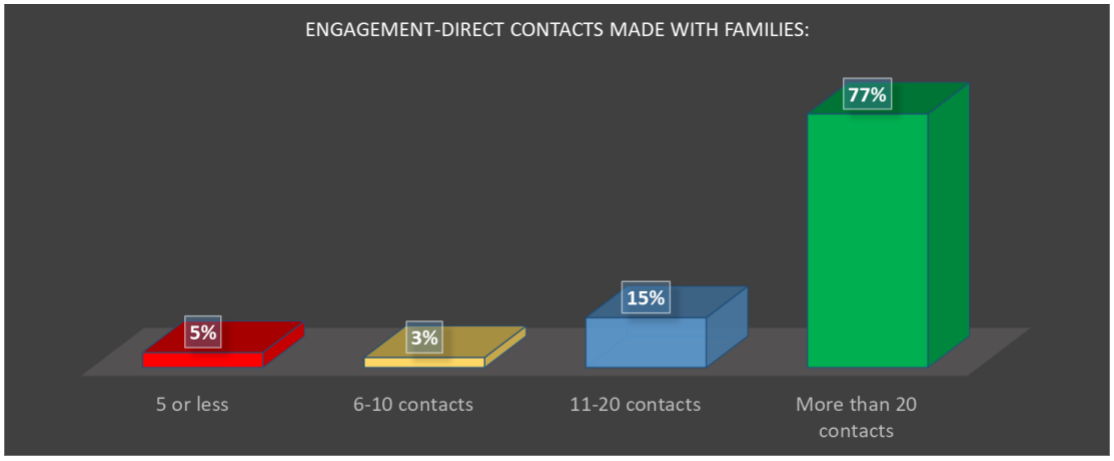
Of the 131 families provided FCT during 2017, 66 were discharged.

Discharged Clients	Sum of Maintainenced Referral	Sum of Reunification	Sum of Avg Length of Treatment (in days)
66	34	32	152
Grand Total	**34**	**32**	**152**

Status at Discharge: 70% of those receiving FCT were able to remain with or be reunified in the community with their family or another caregiver. 18% were placed out of the home and 12% had a treatment plan change and remained in an out of home placement.

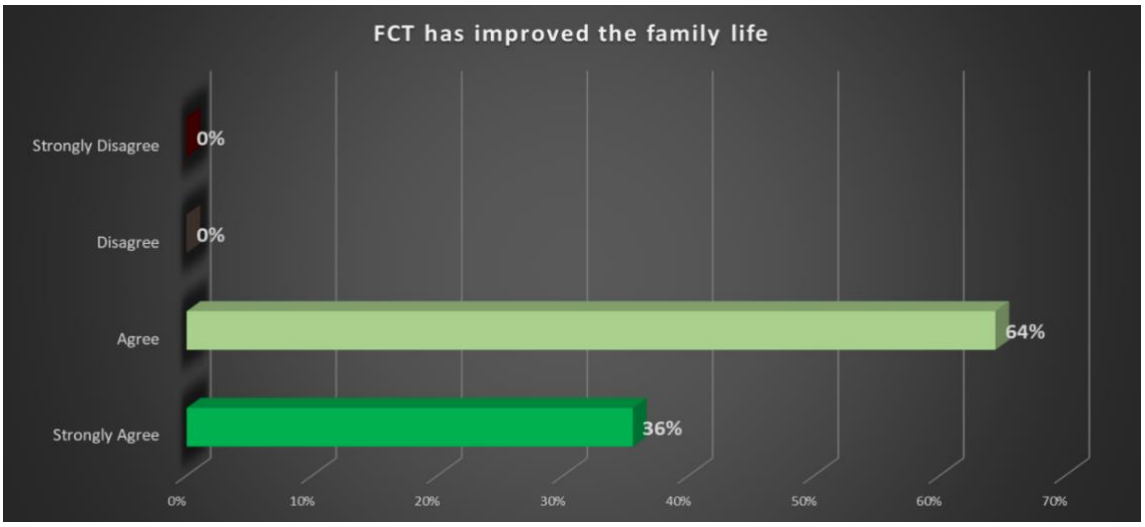


Engagement in Treatment: 95% of families served were engaged in services (FCT Foundation defines engagement at 5 or more sessions within 30 days).



Family Report of FCT Improving Their Family Life: 100% of families reported that

FCT has improved their family life. Of note, only 45 of 66 families reported on this domain



III. In Home Therapy Services (IHTS)-

In Home Therapy Services (IHTS) is a combination of the Evidenced-Based Therapy Practice Motivational Interviewing and coordination of care interventions provided in the home and community to children and their families where there are complex clinical needs that traditional outpatient therapy cannot adequately address.

IHTS is a time limited service, approximately 6 months, in which the Therapist and the Case Manager work with the child and their family to meet the therapeutic needs as well as provide linkage to professional and natural supports. The Therapist will provide individual and family therapy to address the child's mental health needs as well as family systems issues and needs that may complicate traditional outpatient therapy from being successful. The CM will approach the care coordination through the philosophies of System of Care and will work with the various systems involved with the child and family, such as DSS, DJJ, Primary Care, and School System. Upon discharge from IHTS services, children and their families will be able to continue to receive Outpatient Therapy from the Therapist to ensure continuity of care. The child/family will receive a minimum of 2 hours/week of therapy and care coordination activities.

The goals of IHTS are to:

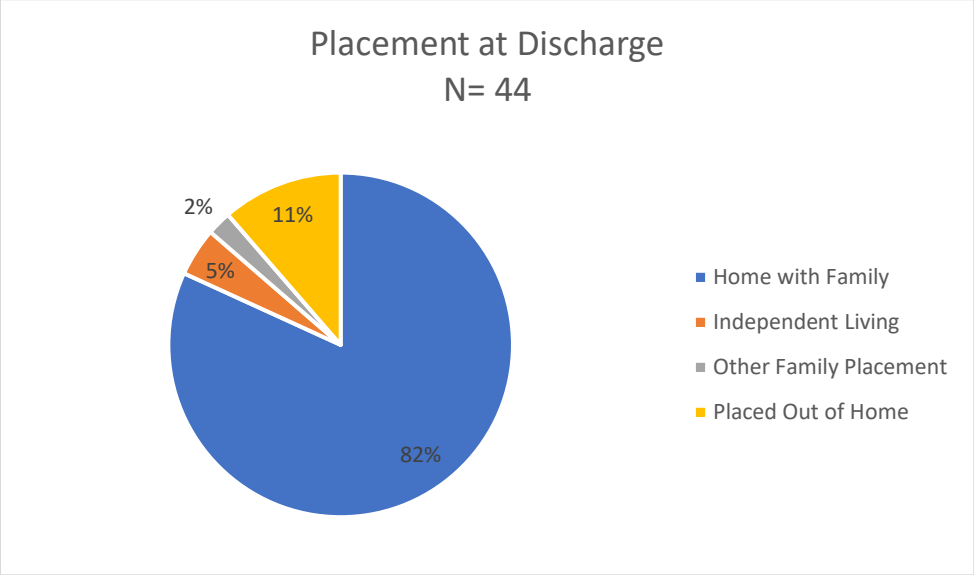
1) Reduce presenting mental health/psychiatric symptoms
2) Ensure linkage to and coordination with community services and resources
3) Prevent out of home placement

Discharge Analysis for 2017:

A total of 78 families were served during 2017. Of those, 44 were discharge by 12/31/17 and the remaining 34 continued to receive IHTS services into 2018.

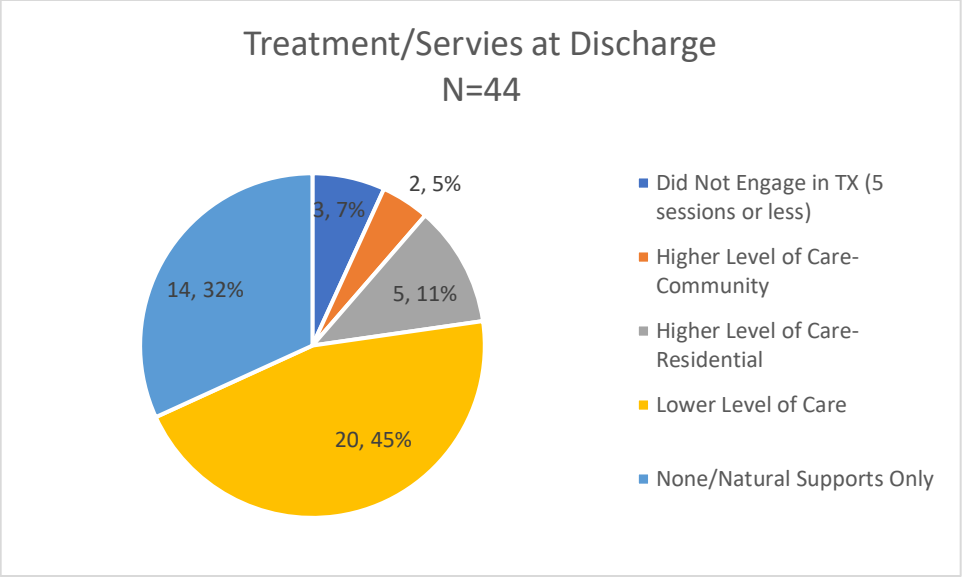
Placement of the consumer at the time of discharge: **88.64%** of the children were either at home with family, in independent living, or in other family placements at the time of discharge.

Placement at Discharge	Count of Placement at Discharge	Count of Placement at Discharge2
Home with Family	36	81.82%
Independent Living	2	4.55%
Other Family Placement	1	2.27%
Placed Out of Home	5	11.36%
Grand Total	**44**	**100.00%**



Treatment/Services at the time of Discharge: 77.27% of the consumers discharged, were discharged with either no professional services, or Basic Benefit (Outpatient Therapy and/or Medication Management) Services. An **additional 4.55% were able to be maintained in the community** with a higher level of care.

Treatment/Services	Count of Treatment/Servies at Discharge	Count of Treatment/Servies at Discharge2
Did Not Engage in TX (5 sessions or less)	3	6.82%
Higher Level of Care-Community	2	4.55%
Higher Level of Care-Residential	5	11.36%
Lower Level of Care	20	45.45%
None/Natural Supports Only	14	31.82%
Grand Total	**44**	**100.00%**



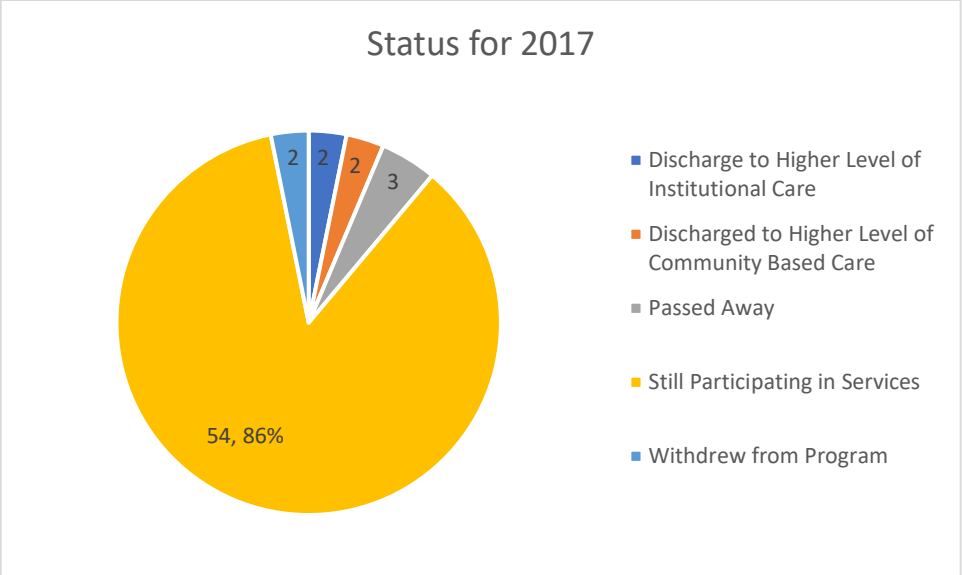
IV. Transition Management Services (TMS)-

Transition Management Services (TMS) provides services to individuals participating in the Transitions to Community Living Initiative (TCLI). TMS is a rehabilitative service intended to increase and restore and individual's ability to live successfully in the community by maintaining tenancy (housing in the community). TMS is focused 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, vocational, and legal. TMS provides structured rehabilitative interventions and works in partnership with the individual's behavioral health service provider.

Analysis for 2017:

A total of 63 adults were served in our TMS Program for 2017. Of those, **85.71% remain in the program.** Of the 14.29% that were discharged, **only 3.17% were placed into an institutional setting.**

Status of Members Served	Count of Outcome	Count of Outcome2
Discharge to Higher Level of Institutional Care	2	3.17%
Discharged to Higher Level of Community Based Care	2	3.17%
Passed Away	3	4.76%
Still Participating in Services	54	85.71%
Withdrew from Program	2	3.17%
Grand Total	**63**	**100.00%**

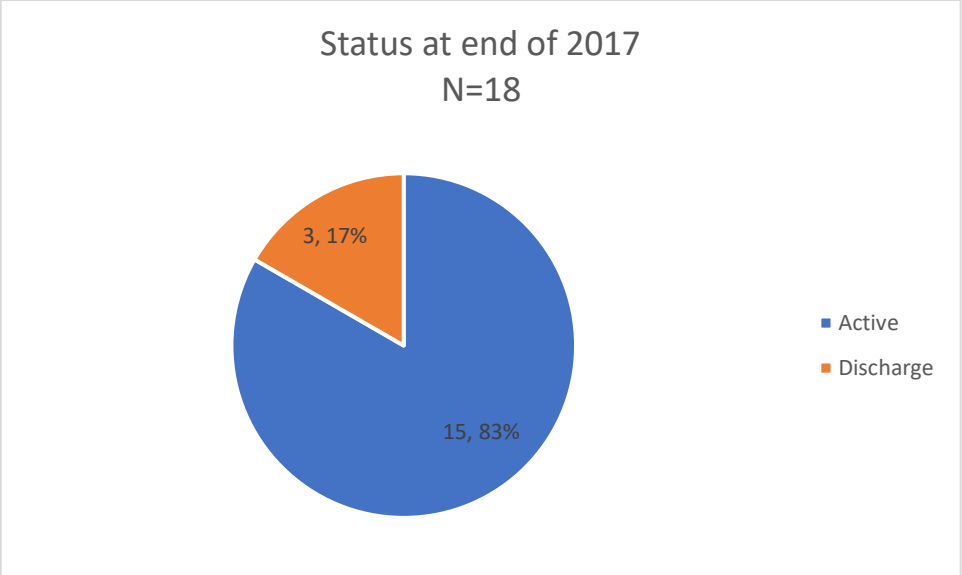


V. Bridge Team-

Managed by selected LME-MCOs, the Transition Bridging Teams will support identified individuals who experience a dual diagnosis of intellectual and developmental disabilities (I/DD) and serious behavioral challenges and are transitioning out of a PRTF or the state's Development Center Specialty Programs and into community settings consistent with the Home and Community-Based Services Final Rule. While the level of Bridging Team involvement may vary, the Team will provide intensive, "hands on," time-limited oversight and technical assistance to community-based support networks.

Analysis for 2017:
A total of 18 adults and children were served in 2017. Of those, **83.33% remain in services** with the Bridge Team into 2018.

Status	Count of Status at end of 2017	Count of Status at end of 2017_2
Active	15	83.33%
Discharge	3	16.67%
Grand Total	**18**	**100.00%**



Reason for Discharge:
Of the 3.17 % that were discharged, **66.67% were due to their insurance coverage changing** to an LME/MCO in a different catchment area due to their community-based AFL Placement.

Discharge Reason	Count of Discharge Reason	Count of Discharge Reason2
Insurance Coverage Changed to Out of Catchment	2	66.67%
Returned Back to Institutional Care	1	33.33%
(blank)		0.00%
Grand Total	**3**	**100.00%**