



SPARC Services and Programs

2018 NC Outcome Data

Prepared by
Teri Herrmann, MA
CEO of SPARC Services and Programs
March 2019

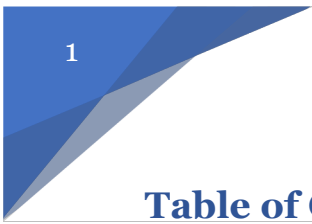


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I. Introduction to SPARC Services and Programs:

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
- 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 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. Outcome Highlights

- 61% of families referred for Family Centered Treatment (FCT) the Identified Client was returning home from an out of home placement. The majority (35%) of out of home placements were a Psychiatric Residential Treatment Facility (PRFT) placement.
- 71% of families receiving FCT were able to have their children successfully remain in their home community
- 98% of families receiving FCT reported that FCT had improved their family life
- 93% of families referred for In Home Therapy Services (IHTS), the Identified Client was able to remain in their home community
- 84% of families referred for IHTS services were able to successfully step down from this level of care to receive either Basic Benefits (Outpatient Therapy and/or Medication Management) or just be supported with natural supports
- 100% of adults engaged in our Transition Management Services (TMS) were able to be housed in the community and maintain their housing in the community
- 100% of adults engaged in TMS services had 3 or more Social Determinants of Health (SDOH) addressed in addition to their housing
- 78% of the members engaged in Bridging Team were able to be transitioned from a state facility into the community
- 100% of members engaged in Bridging Team had supports from the team around behavioral interventions, social/community engagement, and coordination of care
- 69% of members referred for the Enhanced Crisis Response (ECR) Program came from the hospital or Facility Based Crisis
- 70% of members engaging in ECR were able to receive treatment in the community vs having to go into an institutional setting
- 90% of our collaterals and stakeholders indicated that they would refer a colleague to SPARC
- Of the 11 skills assessed for a community-based staff, our collaterals indicated an average of over 90% that our staff are strong in these core skills

III. 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

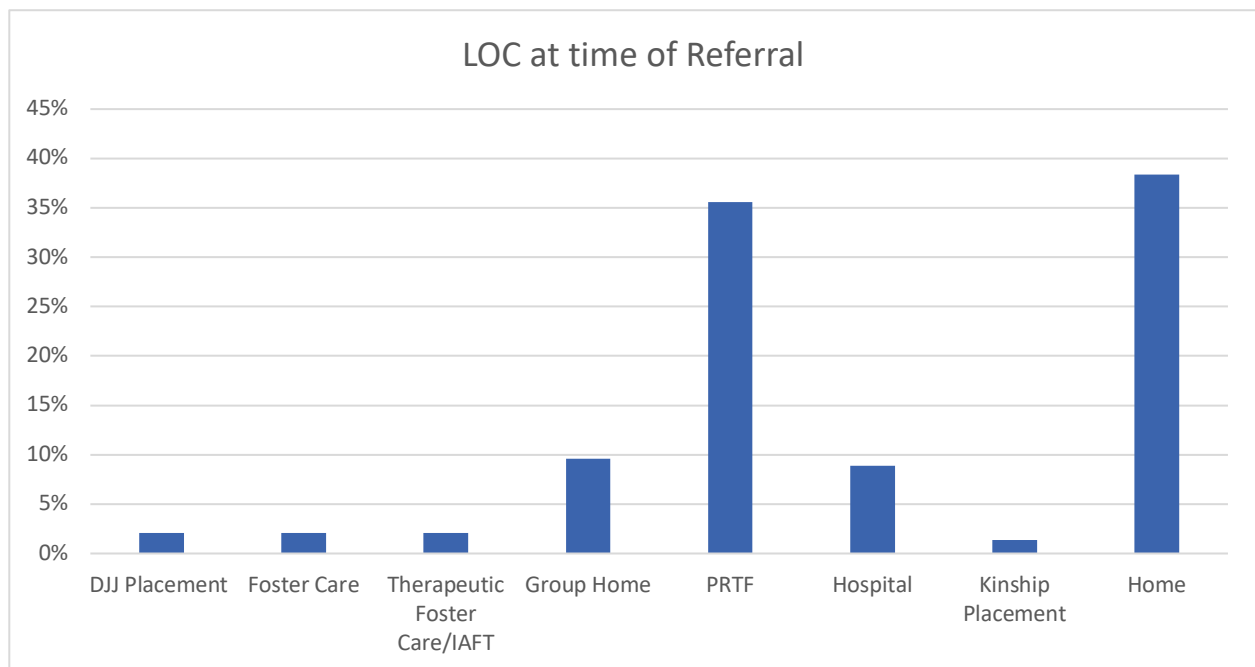
provided to the family. FCT incorporates coordination with other systems, such as DSS, School System, Primary Care, and DJJ as well as 24/7/365 Crisis Intervention.

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.

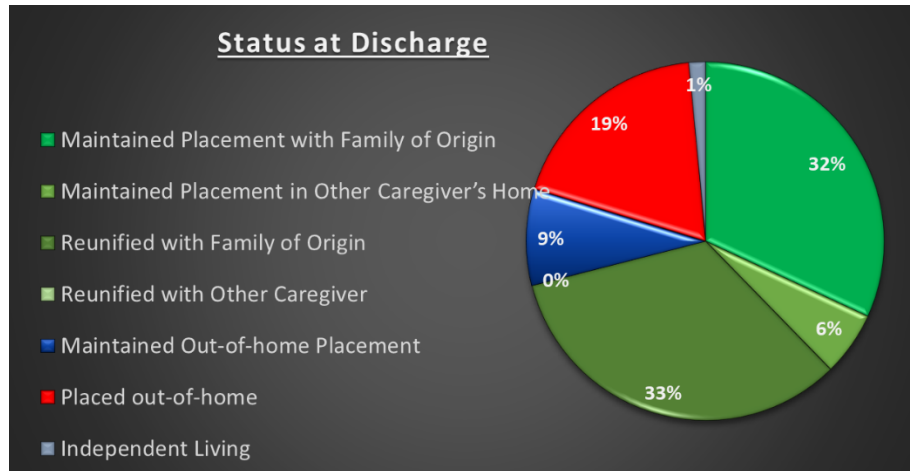
FCT and Trauma Treatment: FCT focuses on systemic trauma and generational patterns of trauma. The individualized incidence or aspects of trauma have broader impact than just the individual. It's how the individual and the subsequent response from those around them that is creating the maladaptive patterns.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

Population Analysis for 2018: 62% of FCT referrals were in some form of an **out of home placement** at the time of referral to FCT. Only **38%** of FCT referrals were **at home** with their family at the time of the referral.

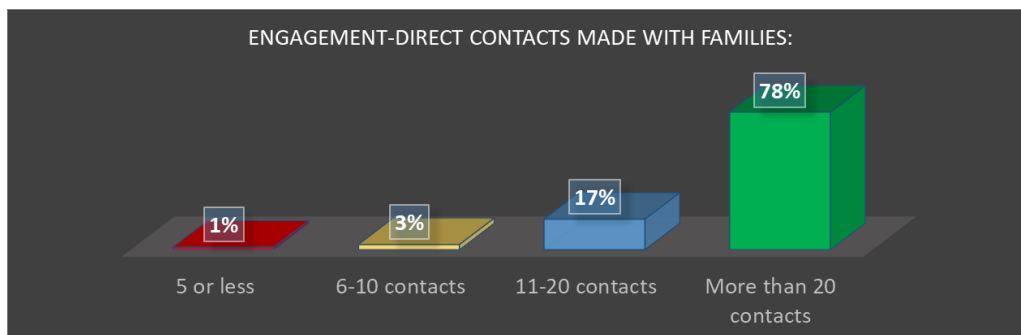


Discharge Analysis for 2018: Excerpts Taken From 2018 Licensing and Implementation Report Completed by the FCT Foundation. Full Report Available Upon Request.

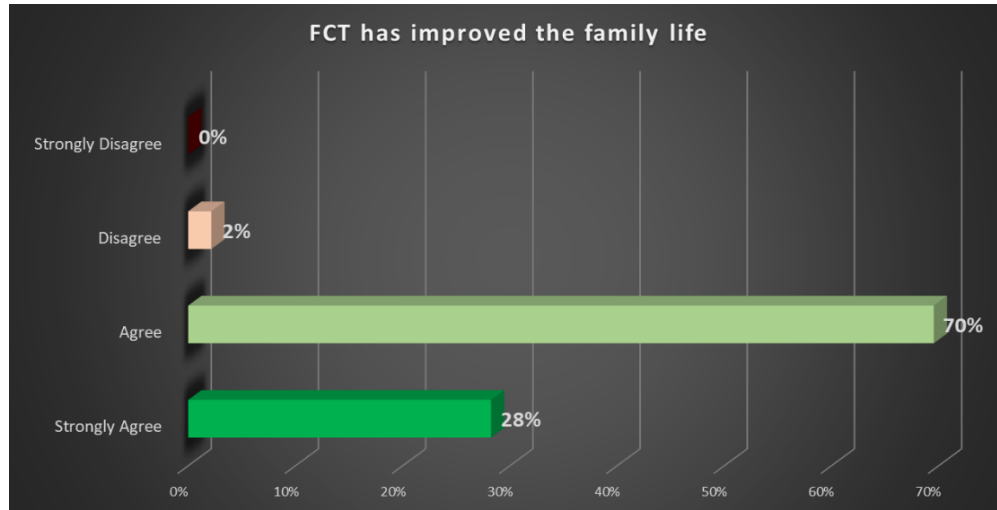
Status at Discharge: 71% of those receiving FCT were able to remain with or be reunified in the community with their family or another caregiver. 19% were placed out of the home and 9% had a treatment plan change and remained in an out of home placement.



Engagement in Treatment: 99% 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: 98% of families reported that FCT has improved their family life.



Comments from FCT Families (provided to the FCT Foundation via the Family Satisfaction Survey Process):

- Coming to our home and starting us on the road to healing our issues.
- She really connected with us and showed us some new things that we had not really considered before like family tree
- She would listen to issues that would come up and work to find solutions and ways to handle the problem.
- We like how flexible they were.
- The therapist. She was wonderful and put her all into what she did. Was there for us when we needed her most
- He was always there if needed, if not right at the moment it was asap
- The patience that our therapist had with our family. Also, the way she was able to refigure her approach to our family's therapeutic needs.
- Being able to have open conversation with each other.
- Our clinician was the best clinician we have had in our home for 2 years
- How he took the time to explain things and broke them down in ways we could understand
- We like that our clinician was easy to reach and flexible. She had a great personality and was easy to talk and relate to. We felt as though she listened to us and provided great insight.

IV. 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.

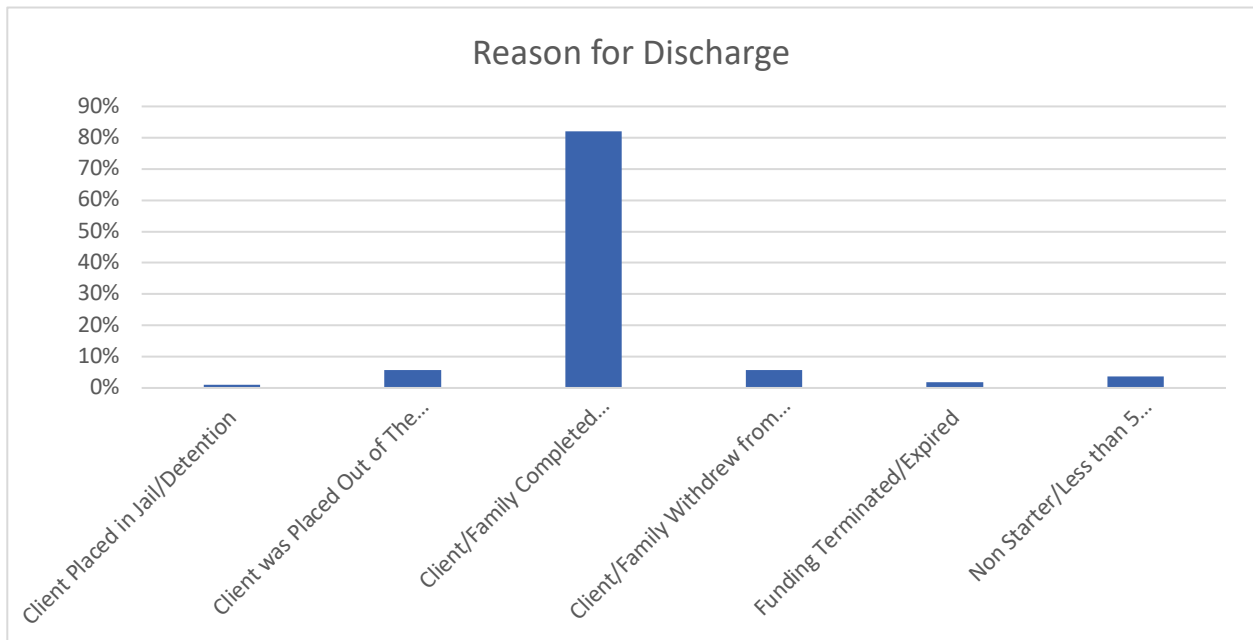
The goals of IHTS are to:

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

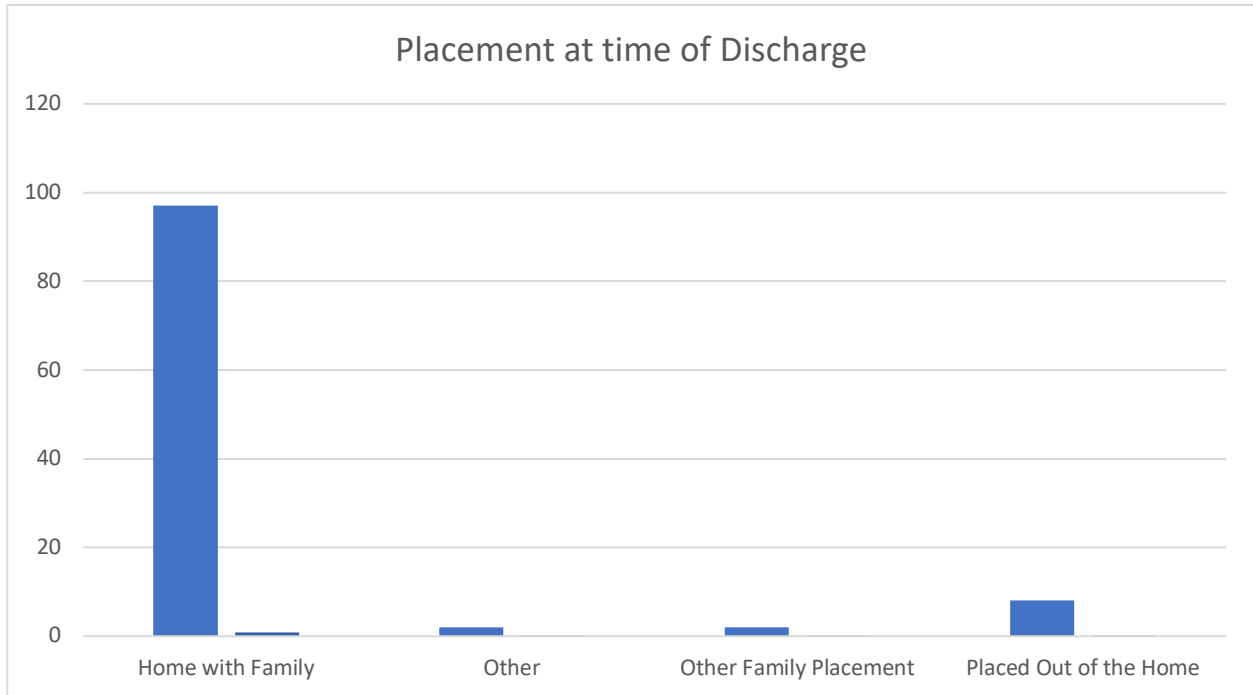
Analysis for 2018:

A total of 147 families were served during 2018. Of those, 106 were discharge by 12/31/18 and the remaining 41 continued to receive IHTS services into 2019.

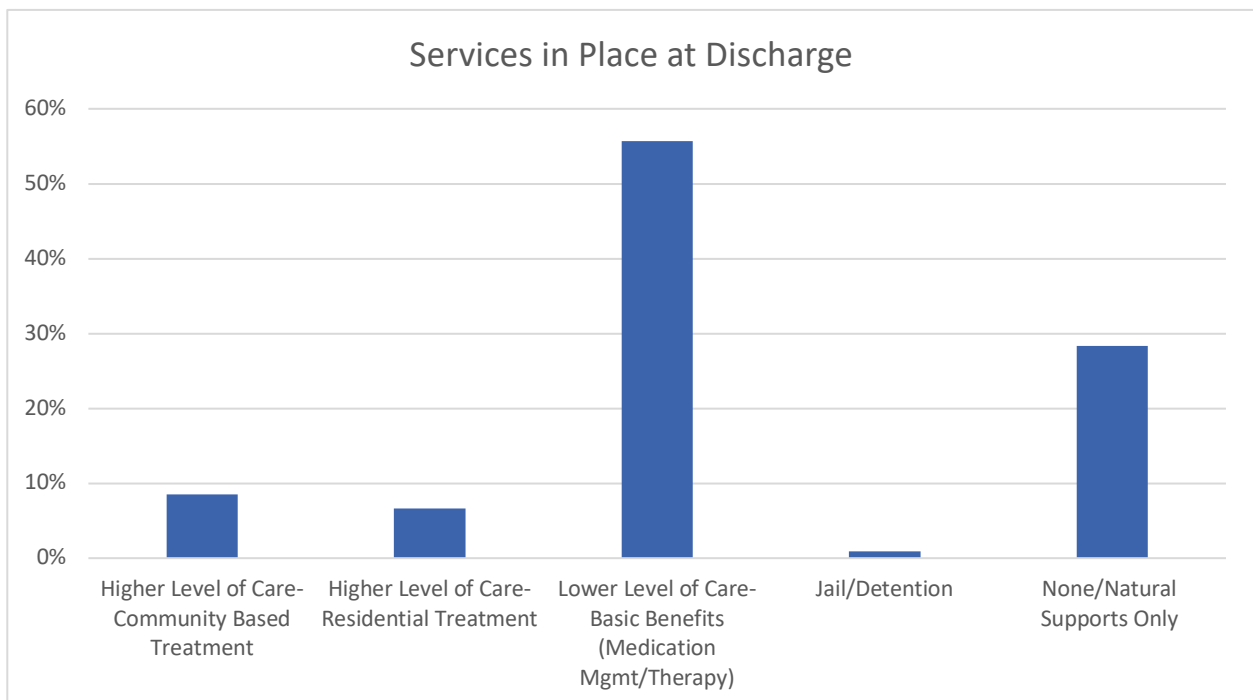
Reason for Discharge: 82% of the families that discharged were discharge to them successfully completing treatment. The IHTS teams were able to have 90% of authorized families receive IHTS treatment (measured by families not withdrawing from treatment).



Placement of the consumer at the time of discharge: 93% of the children were either at home with family, in independent living, or in other family placements at the time of discharge.



Treatment/Services at the time of Discharge: 84% of the consumers discharged, were discharged with either no professional services, or Basic Benefit (Outpatient Therapy and/or Medication Management) Services. An **additional 8% were able to be maintained in the community** with a higher level of care (i.e. IIH, FCT, MST).



Comments from IHTS Families (provided via the IHTS Family Satisfaction Survey):

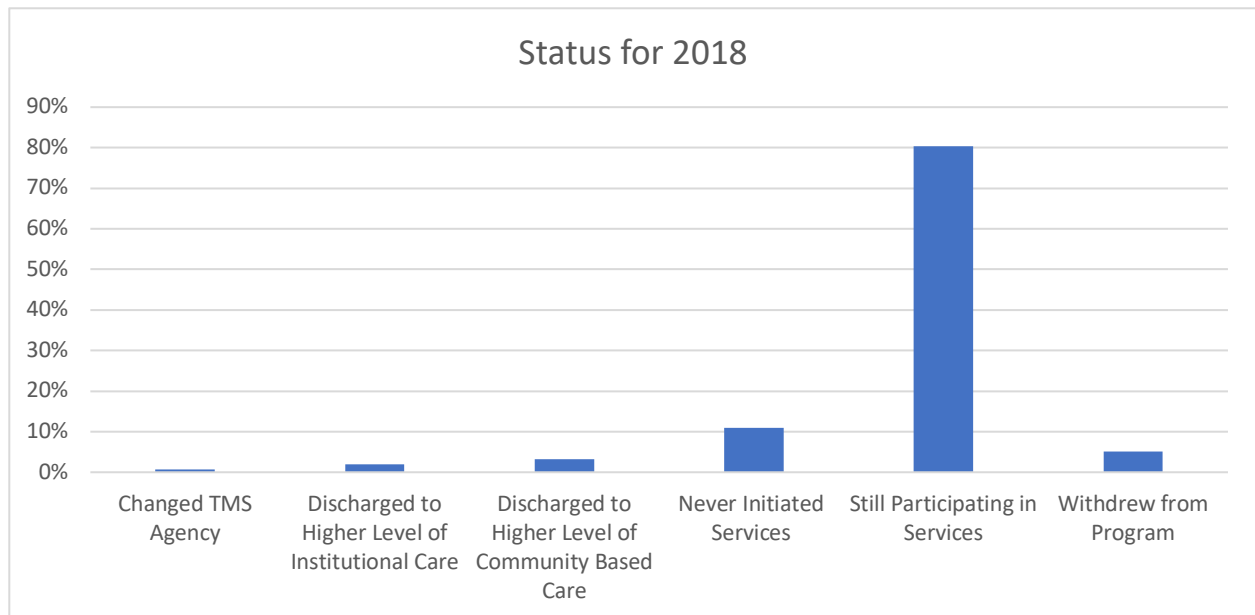
- I liked the structure of the sessions and improved communication with my mom.
- Everything it was very helpful
- Keep up the good work!
- Conducted sessions in the home, engaged whole family
- Learning new ways to communicate

V. Transition Management Services (TMS)-

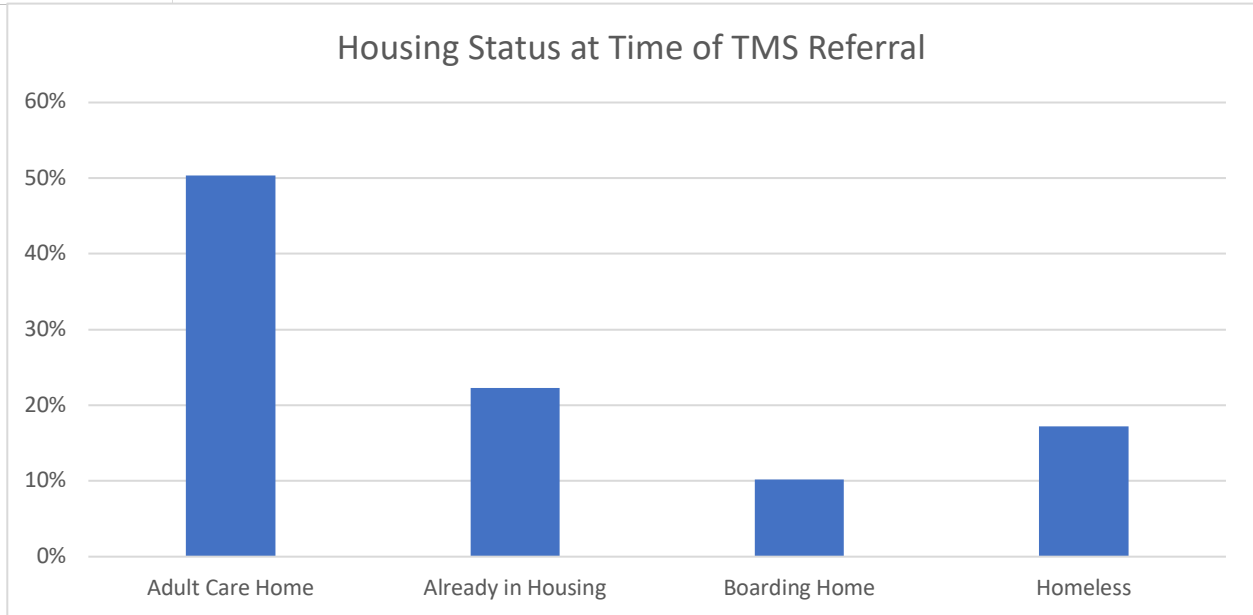
Transition Management Services (TMS) provides services to individuals participating in the Transitions to Community Living Initiative (TCLI). TMS is a rehabilitative service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy (housing 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 2018:

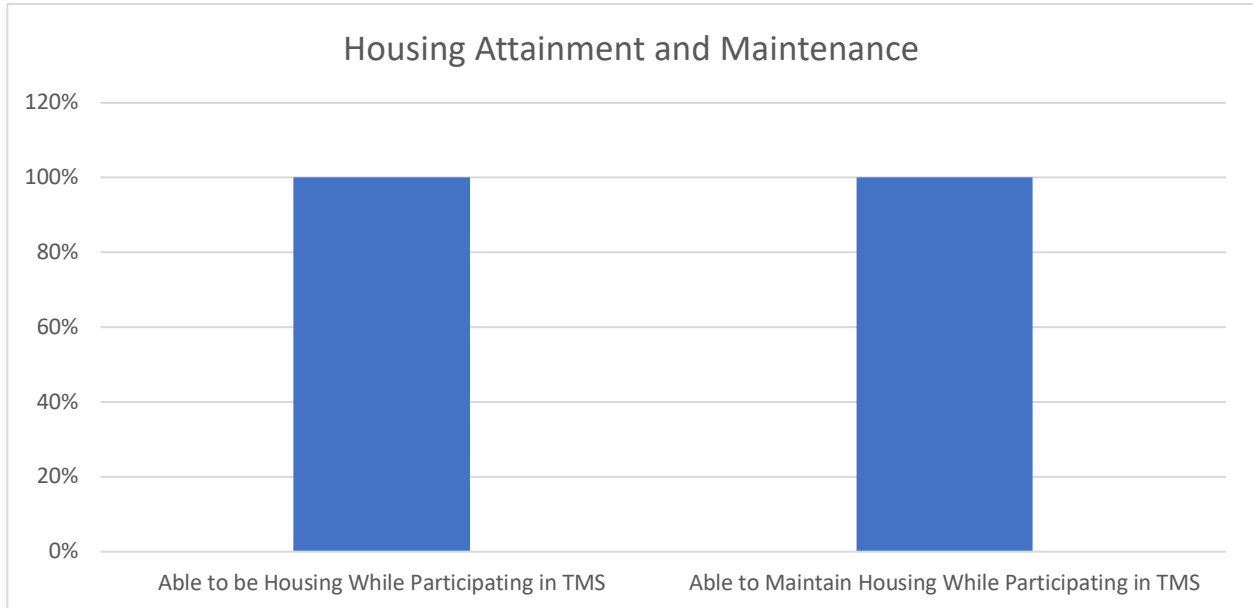
A total of 144 adults were served in our TMS Program for 2018, an additional 14 adults were referred for TMS services, but did not initiate services for various reasons. Of those, **80% remain in the program in 2019.**



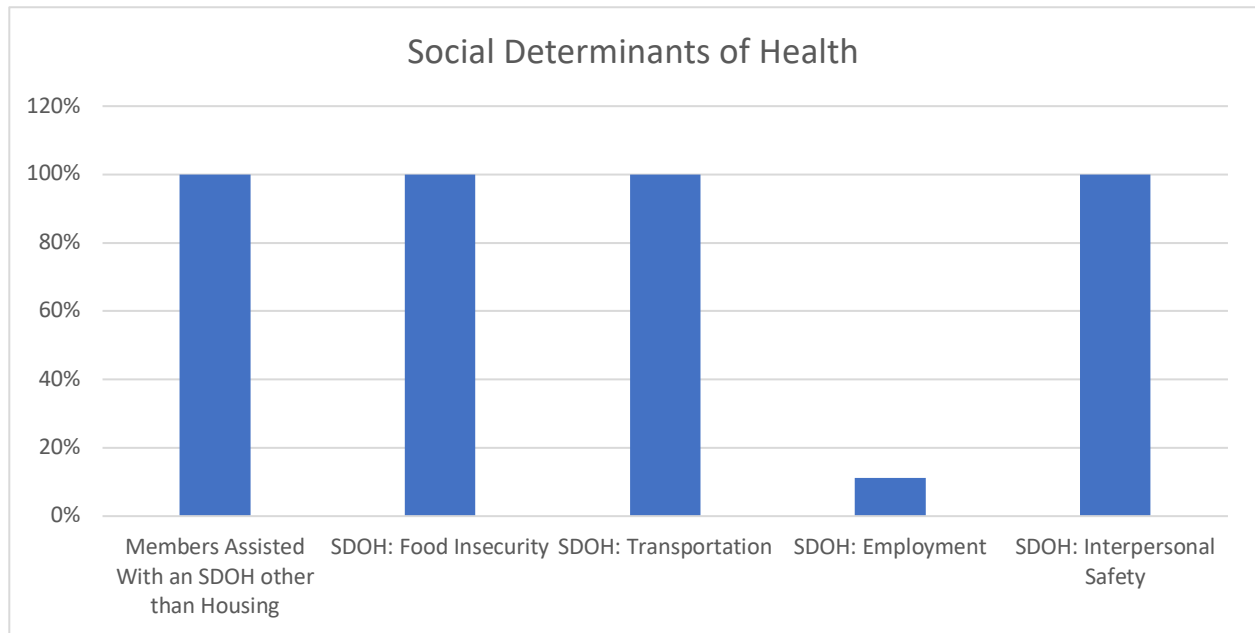
Below is a breakdown of where our members are living at the time of referral to TMS:



TMS is designed to assist members with obtaining and maintaining housing. Our TMS Team excels in this area with **100% of members participating in services were able to both obtain and maintain their housing in 2018.**



Our TMS Team also assists members in addressing multiple Social Determinants of Health in addition to housing. **We have 100% of our TMS members working on 3 or more SDOH in addition to their housing needs.**

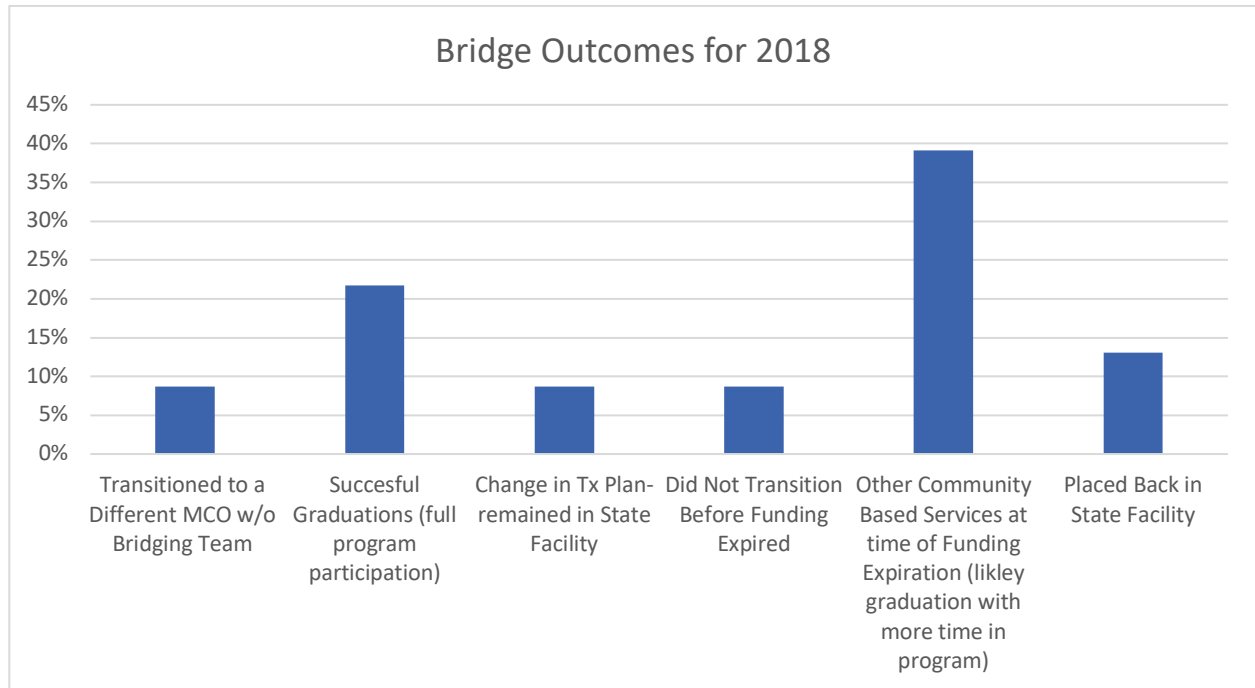


VI. Bridge Team-

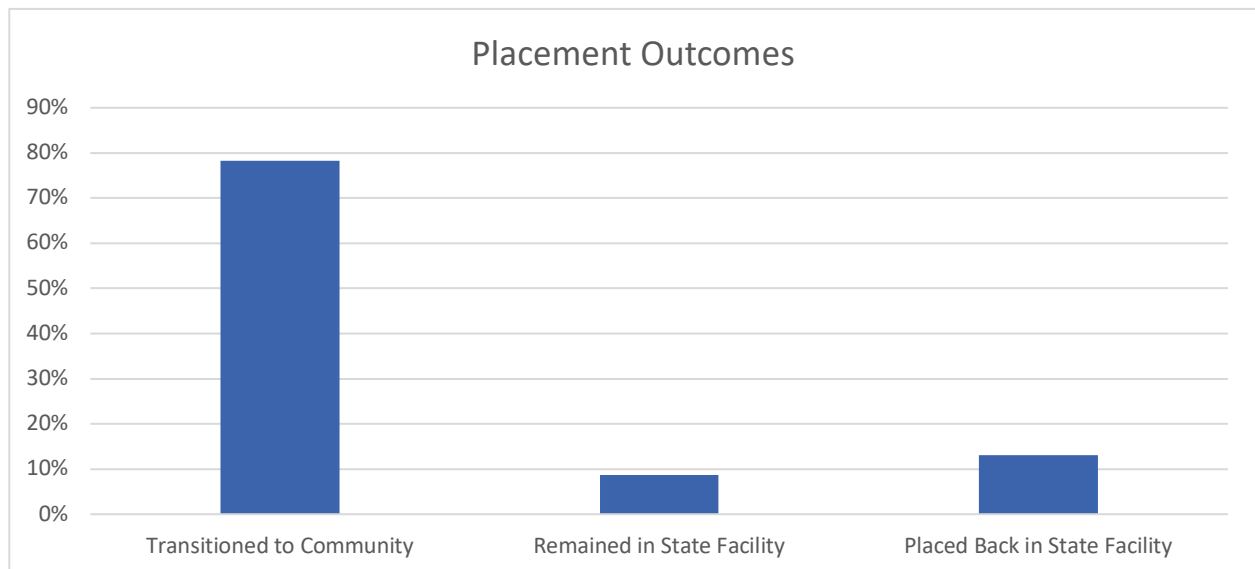
The Transition Bridging Teams will support individuals who experience a dual diagnosis of intellectual and developmental disabilities (I/DD) and serious behavioral challenges and are transitioning out of a PRTF or the state's Development Center Specialty Programs and into community settings consistent 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 2018: The Bridging Team served 23 members (children and adults) in 2018. The program ended in November 2018, when the MFP allocation ended. Not all members were able to experience the full course of Bridging Team interventions due to the program funding ending in November 2018.

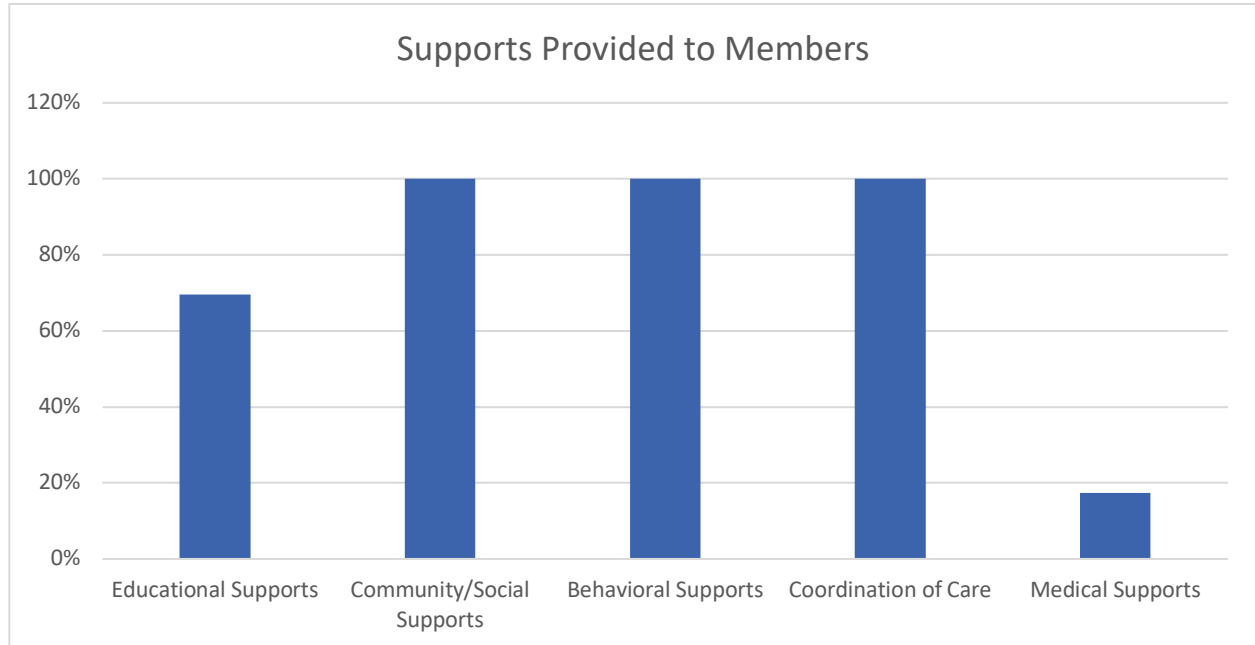
Below reflects where each of the members were at the time of the program ending:



With the primary focus of supporting individuals around transitioning from state institutions into a community placement, the Bridging Team was successful in supporting **78% of the individuals served back into a community setting.**



Bridging Team supported members and their treatment team members in multiple domains of their lives including:

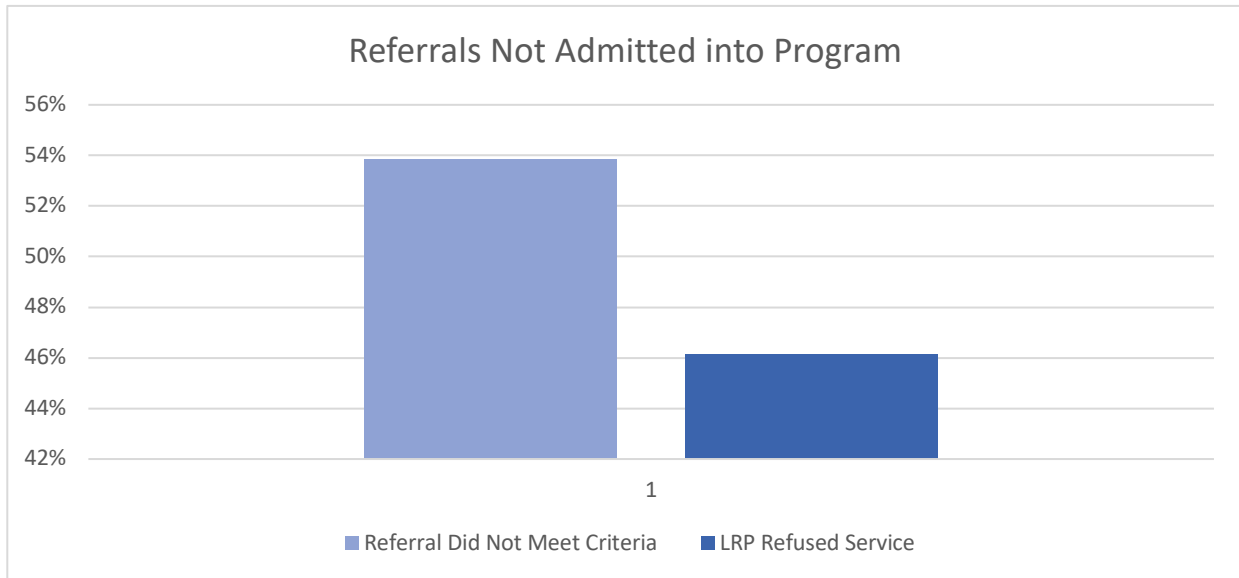


VII. Enhanced Crisis Response-

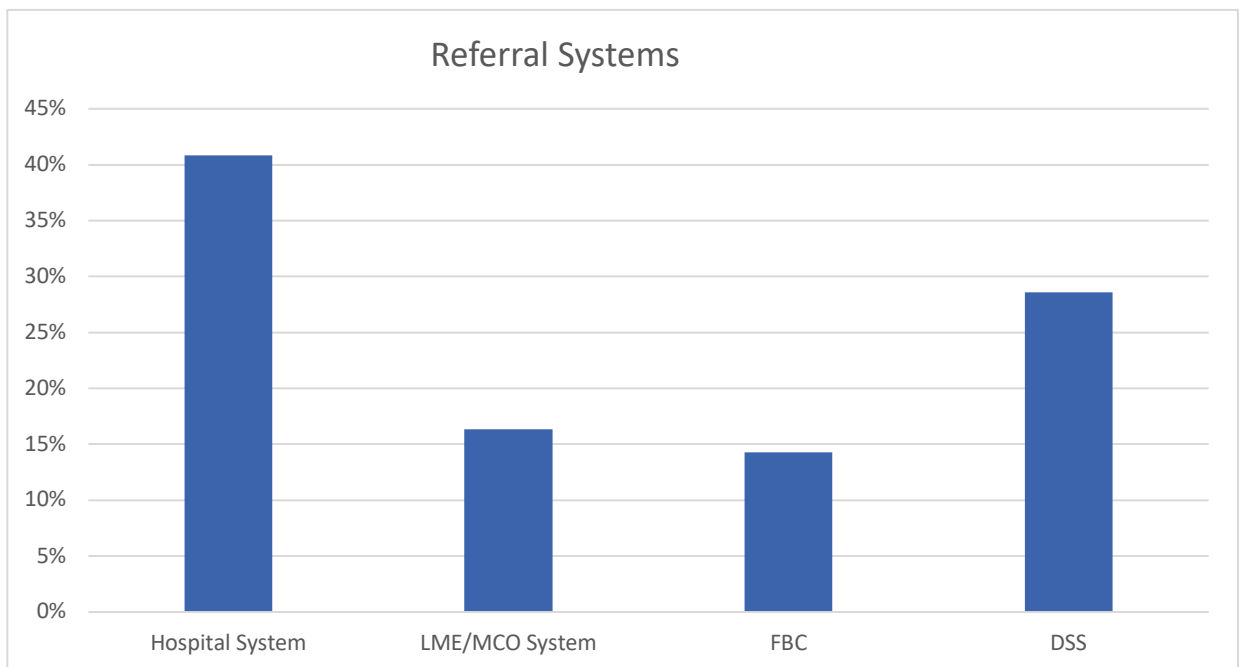
The intent of this program is to put enhanced supports in place as quickly as possible for youth with behavioral health needs that are at risk for abandonment, crisis episodes, or restrictive levels of care. With timely assessments and supports the intended outcome for youth is to be able to maintain them in their home environment, non-therapeutic foster homes, kinship placements, or minimize needs for long residential treatment stays.

This program operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family, and/or a safe permanent alternative. It is intended to be short term, with services lasting on average 60- 90 days. During this time, the program staff will work with the child, their family, to diffuse the imminent crisis and get the family linked to appropriate community-based services that allow the child to thrive and meet their goals.

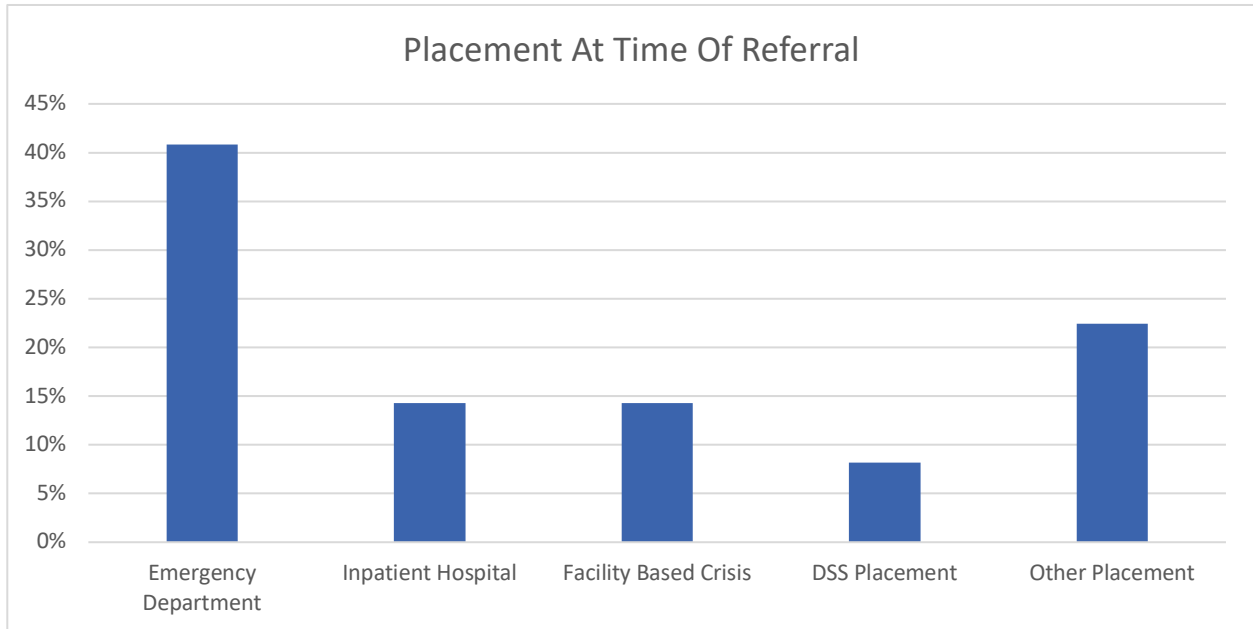
Analysis for 2018: There were a total of **51 referrals** into this new program. Of those, **38 youth and their families participated in the program**. For the 13 referrals who did not participate in the program, 54% of those were for referrals that did not meet service definition criteria and the remaining is due to the Guardian/Legally Responsible Person not providing consent for participation.



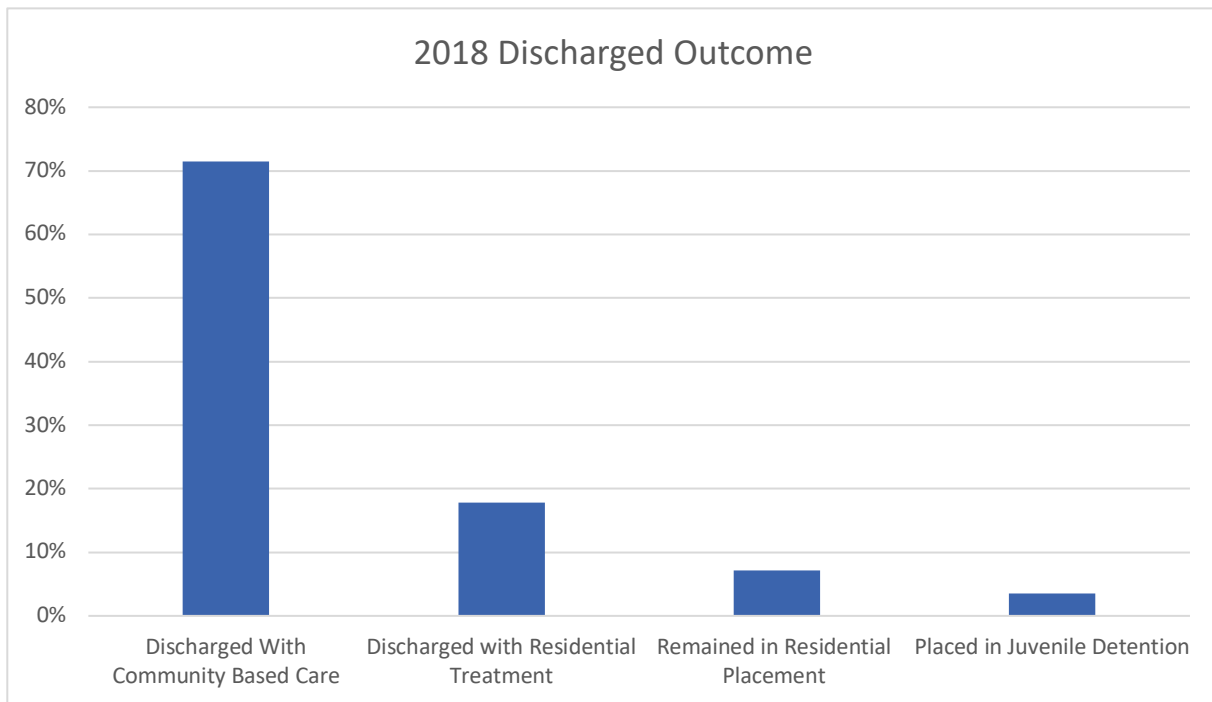
Referral Sources and Level of Care at Time of Referral Analysis: The **hospital systems** (Atrium and Novant) comprised over **40% of the total referrals to the program**



69% of the youth referred to the program were in a **Hospital (ED or Inpatient) or Facility Based Crisis Bed** at the time of referral:

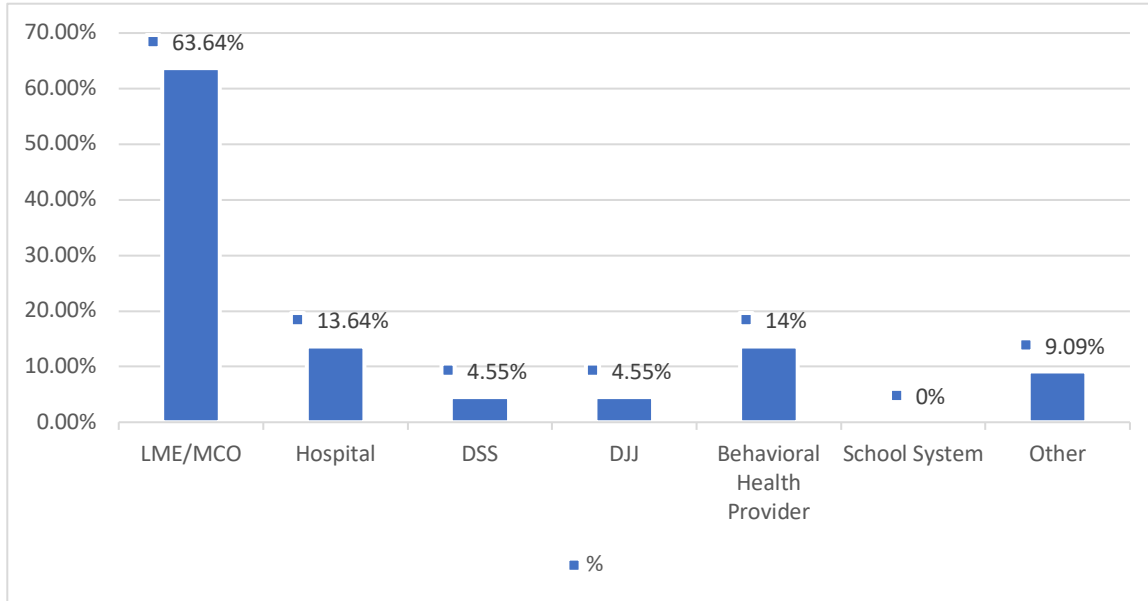


70% of youth who were discharged from the program in 2018 were able to be **discharged into the community with community-based services:**

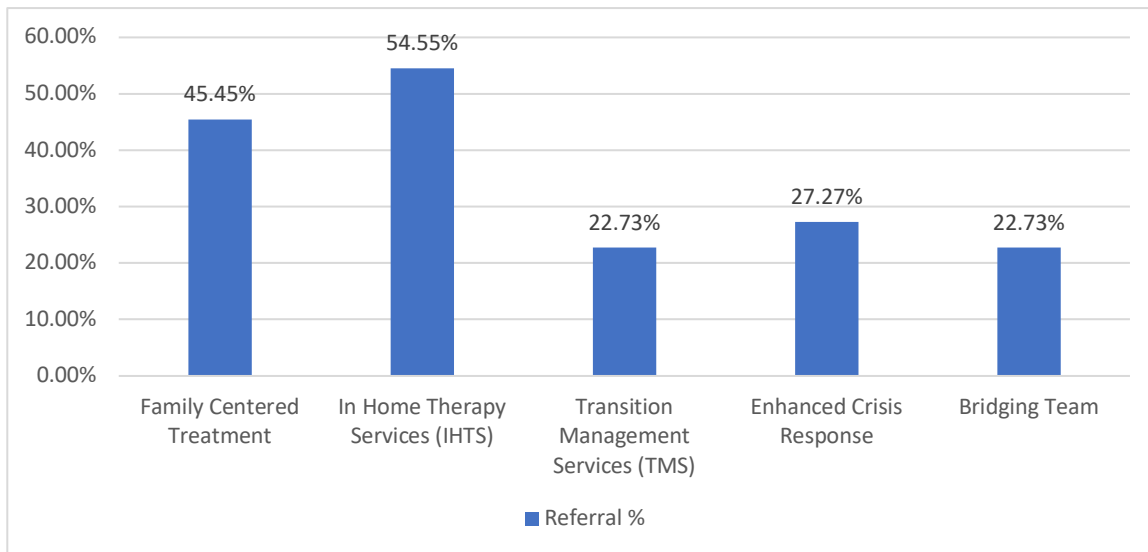


VIII. Collateral and Stakeholder Survey Data-

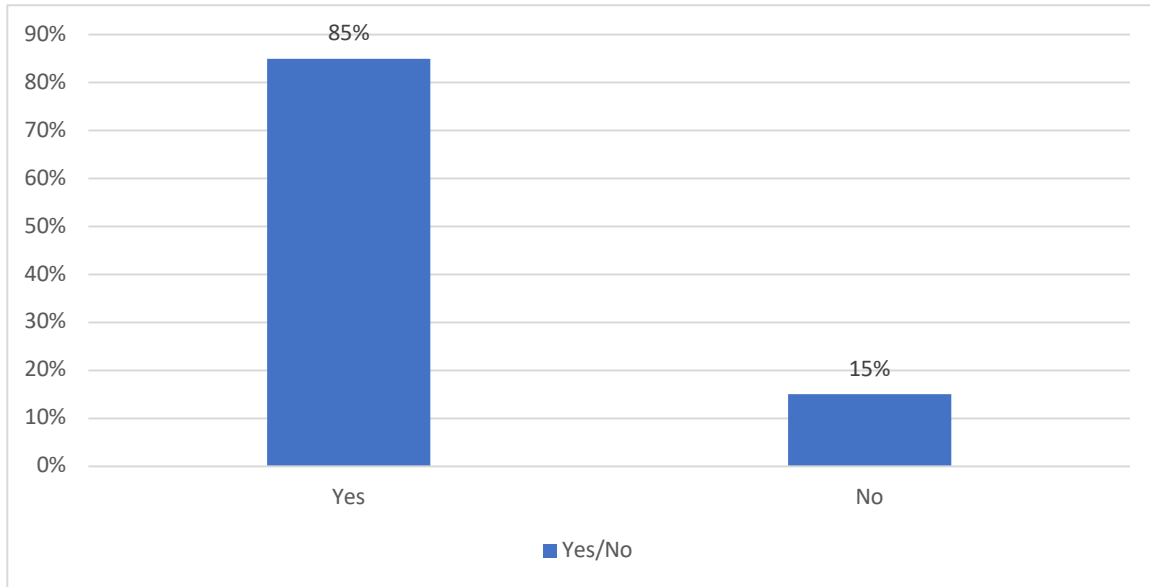
Survey Respondents: This is a summary of the agencies/entities of who responded to the survey. The majority of the responses came from staff at the LME/MCO



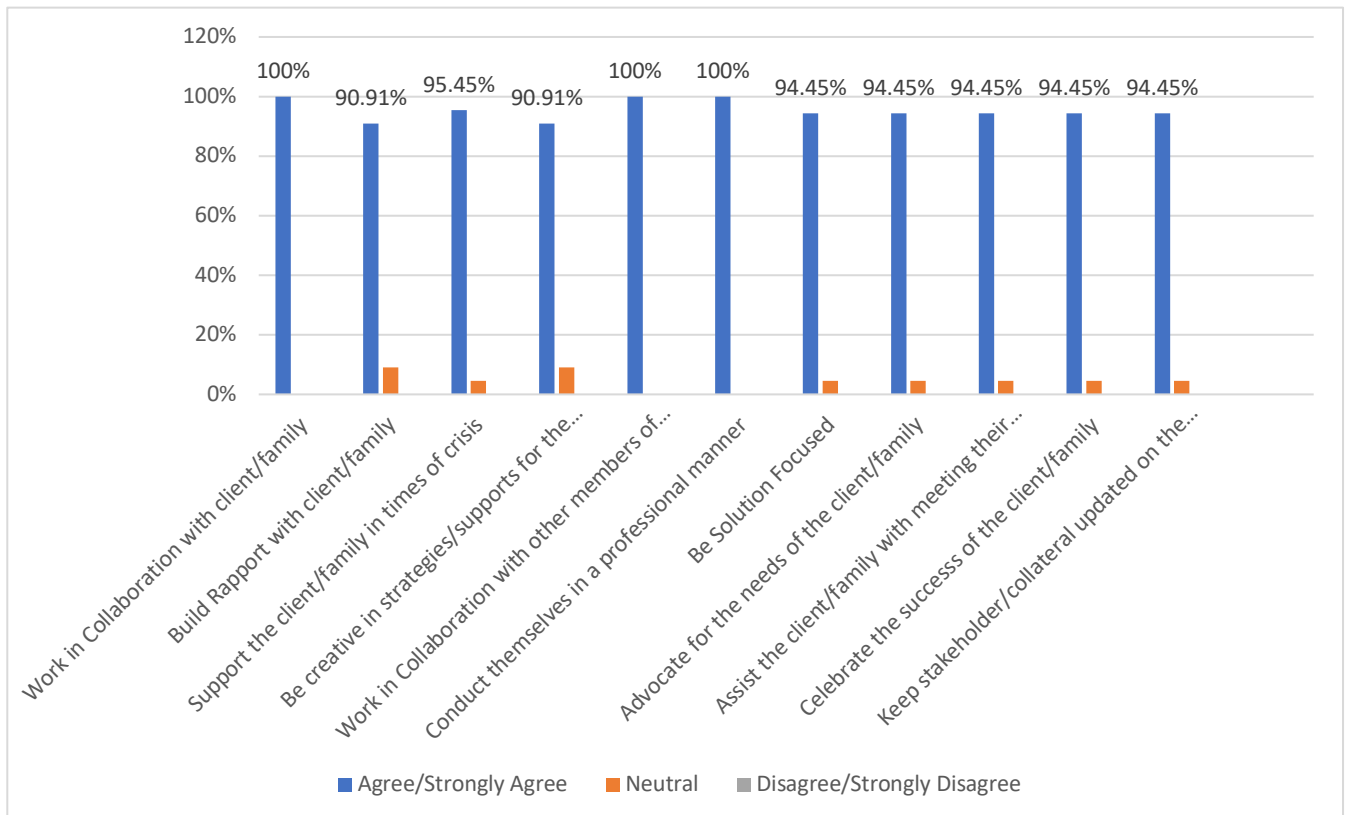
Services Referred to SPARC: These are the services that the collaterals/stakeholders reported as having referred to us/worked with us on



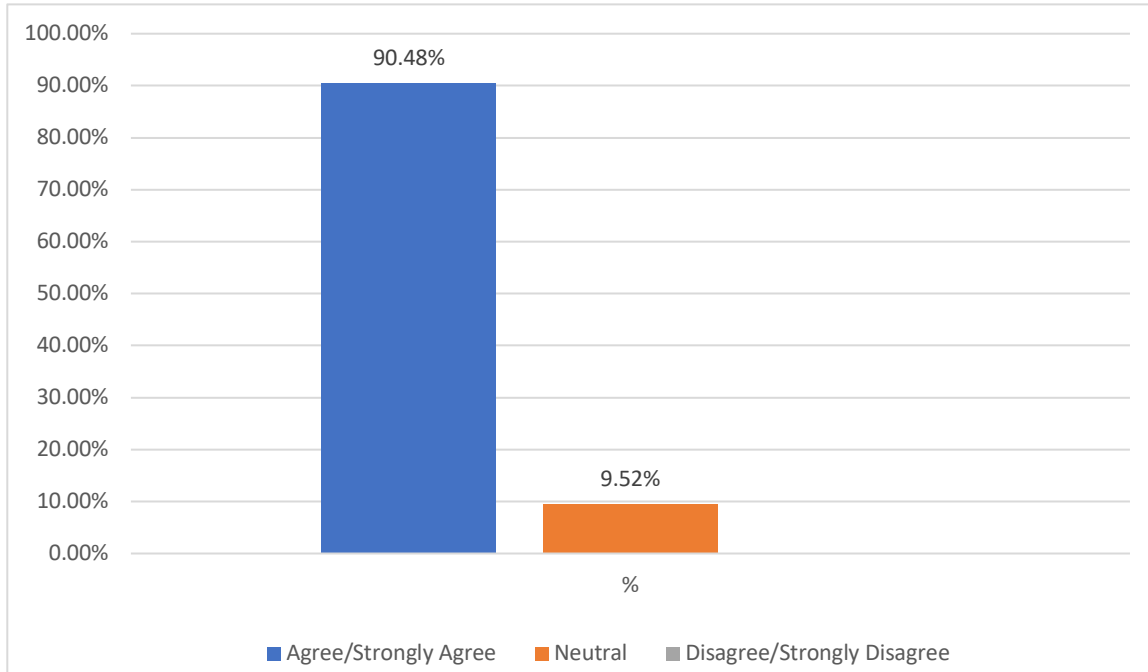
Timely Response to Referral from SPARC: This measures how we did with providing follow up within 48 hours to all referrals. 85% of our stakeholders reported that we kept them informed of the status of their referral.



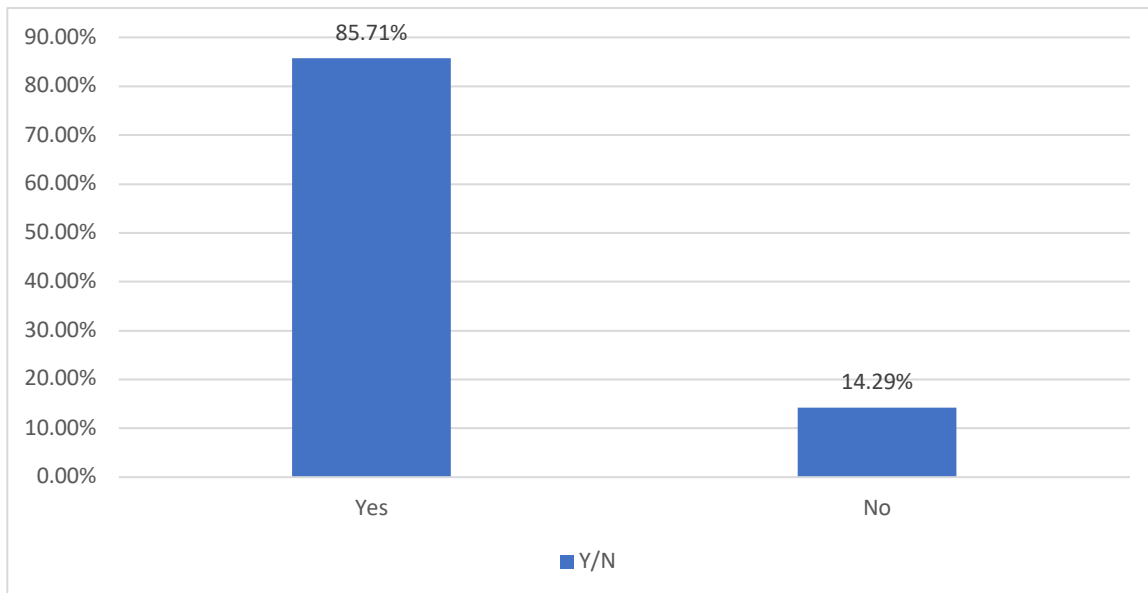
Skills in working with client/families: This is a measure of various skills we want all staff employed at SPARC to possess. Overall, our stakeholders agree that are our staff have strong skills at providing community-based services to clients and families



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, and almost 91% indicated that they would



Kept Informed: This measures how well we kept the stakeholder informed about the referral/case we were working on together. 85.71% of our stakeholder responded that we kept them informed of what was occurring the client/family referred for services



Comments Provided From Our Stakeholders:

- I was provided timely updates on the status of my referral 100% of the time
- Staff are very open to feedback
- The supervisor worked with a staff who was having difficulties
- Asha Smith-Murray (Triad TMS Program) is absolutely wonderful. She is member focused and gets the job done
- Andrew Barber is a great person to work with. He truly cares about his families and helping them reach their goals
- Sherrae is doing a wonderful job
- We make referrals to SPARC with no hesitation
- Thank you for the wonderful work you do for our community and for the continually being collaborative, solution-focused partners
- Thank you for your quick responses and your consistent open communication with us
- Fred and Dr. Murphy were excellent to work w/ on the Bridging Team
- Especially appreciative of TMS assistance with consumers with help getting annual special assistance in home documentation and FL2 from doctors
- Please consider paneling with some commercial insurances, there are so many families in need of SPARC and can't access due to insurance barriers
- I have had very positive interactions with SPARC staff, and they have done a wonderful job with all consumers we have collaborated on
- SPARC Programs are a trusted treatment and clinicians are well trained and prepared to work with complex children and families

IX. Summary-

SPARC Services and Programs is committed to providing the highest quality behavioral health services to children, families, and adults. And our Mission is Simple; **Keep People out of Institutionalized Care.**

In all of our Programs, we accept referrals for some of the highest risk, most acute individuals for community-based care. And we are able to be successful in our mission of keeping them out of institutionalized care:

- In our **FCT Program**, **71%** of youth and families served were able to remain in the community
- In our **IHTS Program**, **93%** of youth and families were able to remain in the community
- In our **TMS Program**, **100%** of the individuals served were able to be housed in the community
- In our **Bridging Team**, **78%** of individuals served were able to transition to community-based living
- In our **Enhanced Crisis Response Program**, **70%** of youth were able to successfully remain in the community

To learn more about SPARC Services and Programs, please visit our website www.sparcprograms.net