SPARC Services and Programs

2019 NC Outcome Data

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Table of Contents:

I. Introduction to SPARC Services and Programs

II. Outcome Highlights

III. 2019 Family Centered Treatment (FCT) Outcomes

IV. 2019 In Home Therapy Services (IHTS) Outcomes

V. 2019 Transition Management Services (TMS) Outcomes

VI. 2019 Enhanced Crisis Response Outcomes

VII. Client Satisfaction Survey Outcomes

VIII. 2019 Collateral & Stakeholder Survey Outcomes

IX. Summary

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

- FCT: 81% of those receiving FCT were able to remain with or be reunified in the community with their family or another caregiver.
- IHTS: 97% of the youth were either at home with family, or in other family placements at the time of discharge.
- TMS: 90% of members participating in services were able to both obtain and maintain their housing in 2019.
- ECR: 71% of youth who were discharged from the program in 2019 were able to be discharged into the community with community-based services:

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.

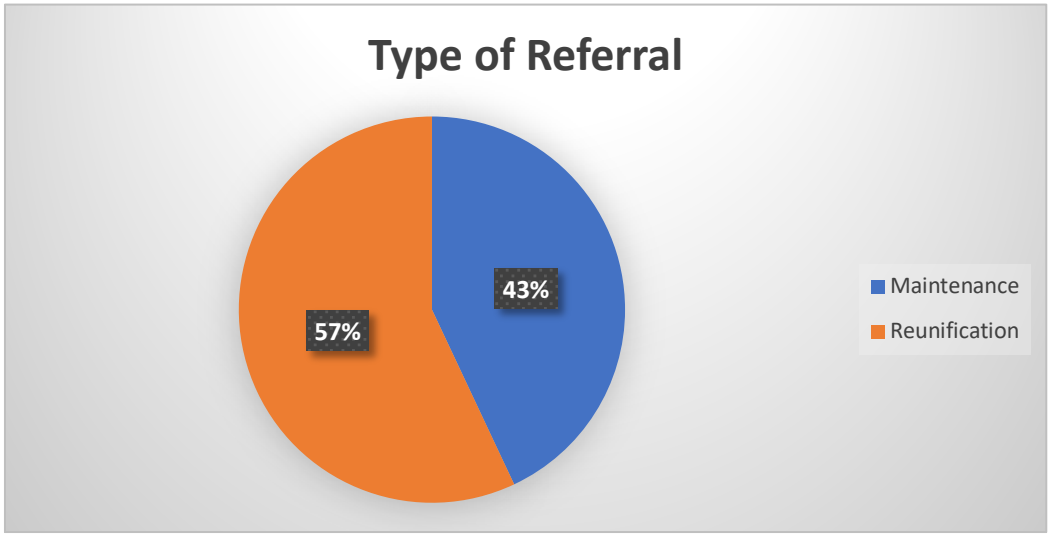
This service is targeted towards:

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

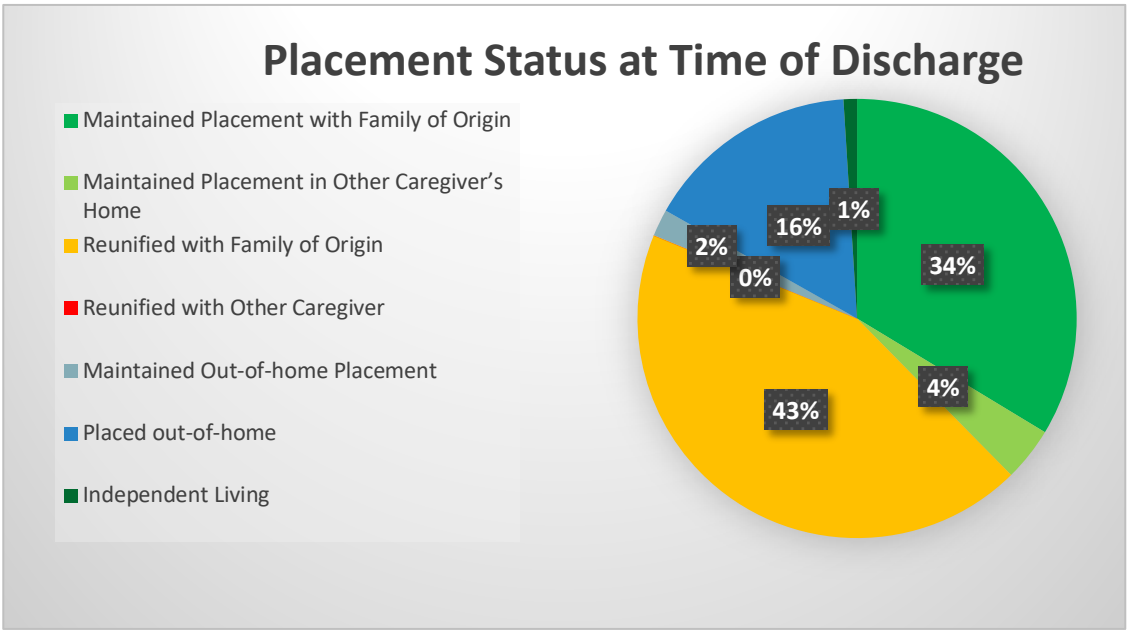
creating the maladaptive patterns. FCT looks to rewrite those patterns in the families narrative while addressing the trauma issues individually and when possible in a broader perspective including how individuals have learned to cope or not cope by watching others (generational).

Population Analysis for 2019: 57% of FCT referrals were in some form of an **out of home placement** at the time of referral to FCT. Only **43%** of FCT referrals were **at home** with their family at the time of the referral.

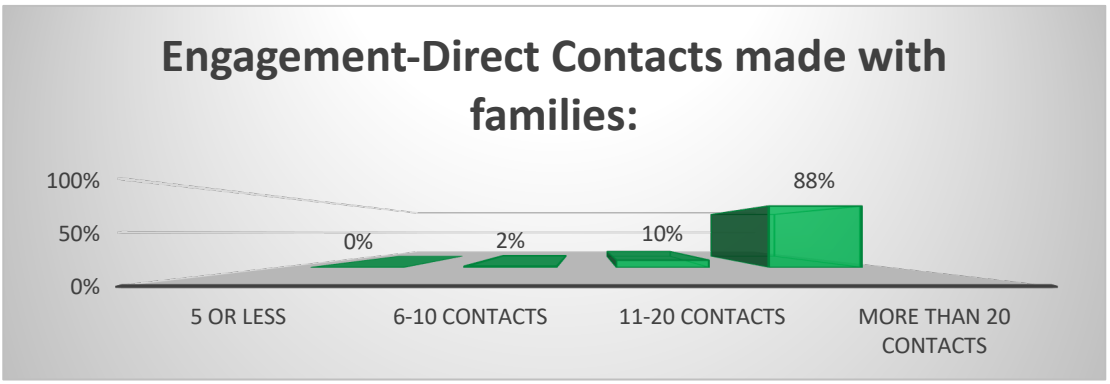


Discharge Analysis for 2019: Excerpts Taken From 2019 Licensing and Implementation Report Completed by the FCT Foundation. Full Report Available Upon Request.

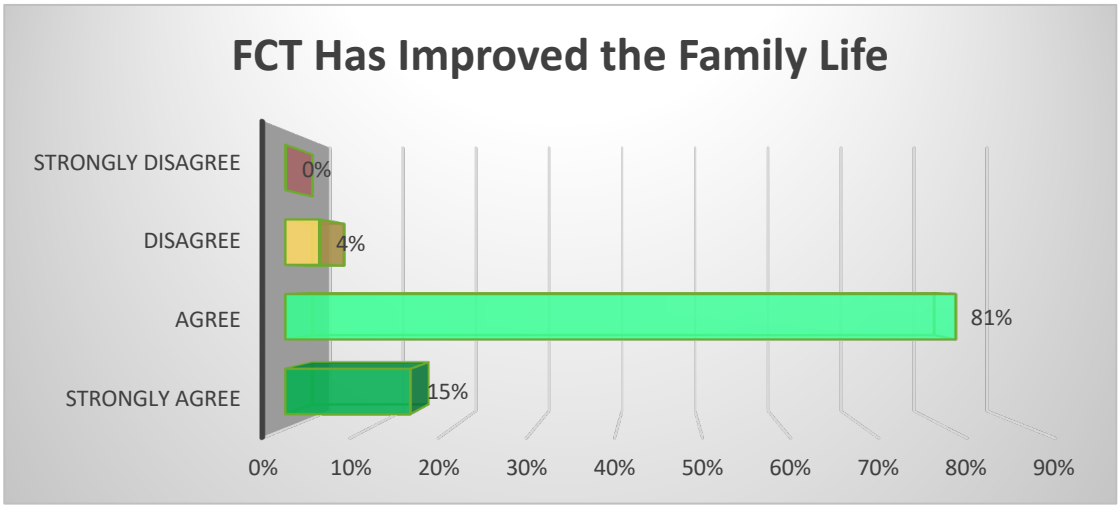
Status at Discharge: 81% of those receiving FCT were able to remain with or be reunified in the community with their family or another caregiver. 16% were placed out of the home.



Engagement in Treatment: 100% 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: 96% 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):

- "It helped me and my family try to work out problems"
- "There was a very clear and detailed plan that we were working on. I felt like I could share my concerns without judgement and she really tried to help"
- "They came on time and listened and gave us extra time for each session"
- "Helped with family problems and ways to making things run smother"
- "He was a wonderful clinician. He was non-judgmental, supportive, and extremely helpful. He made time for us in crisis situations and was flexible with any needs we had"

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 Case Manager 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.

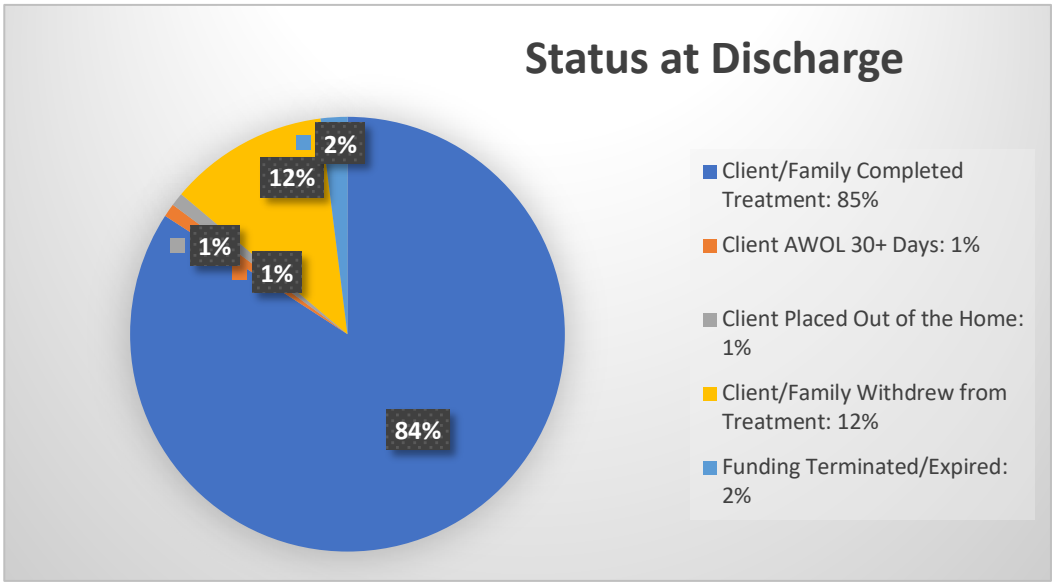
The goals of IHTS are to:

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

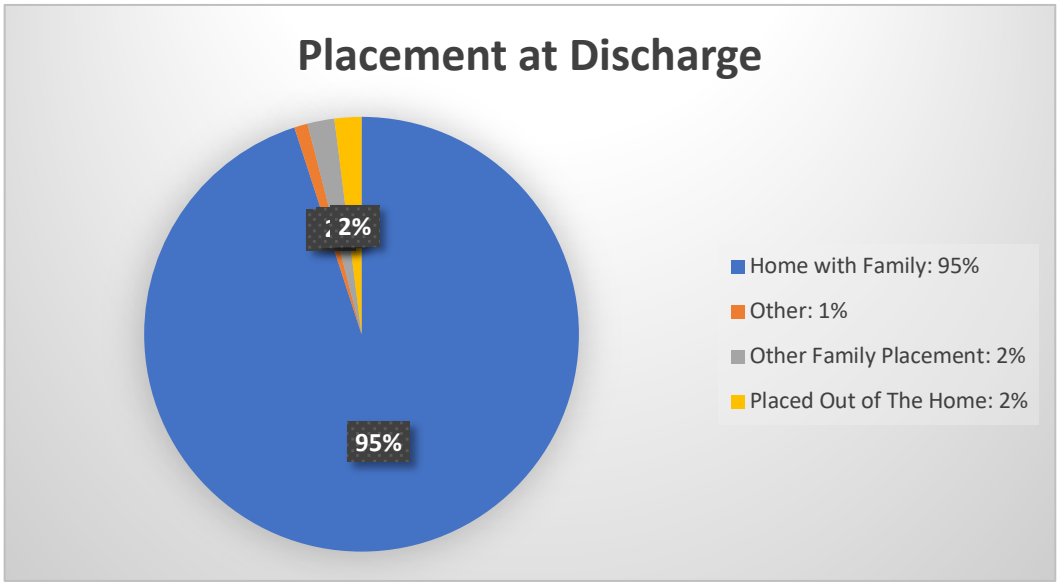
Analysis for 2019:

A total of 319 families were served during 2019. Of those, 198 were discharge by 12/31/19, 45 were considered Non-Starters, defined as less than 5 sessions after the authorization was obtained, and the remaining 76 continued to receive IHTS services into 2020.

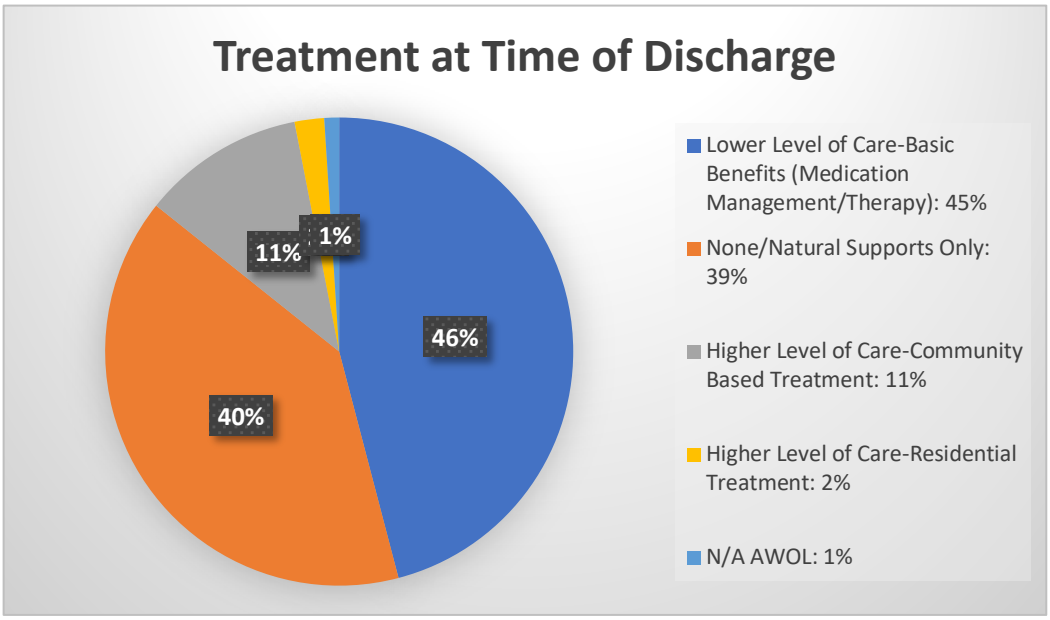
Reason for Discharge: 85% of the families that discharged were discharge to them successfully completing treatment.



Placement of the consumer at the time of discharge: **97%** of the youth were either at home with family, 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 11% 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):

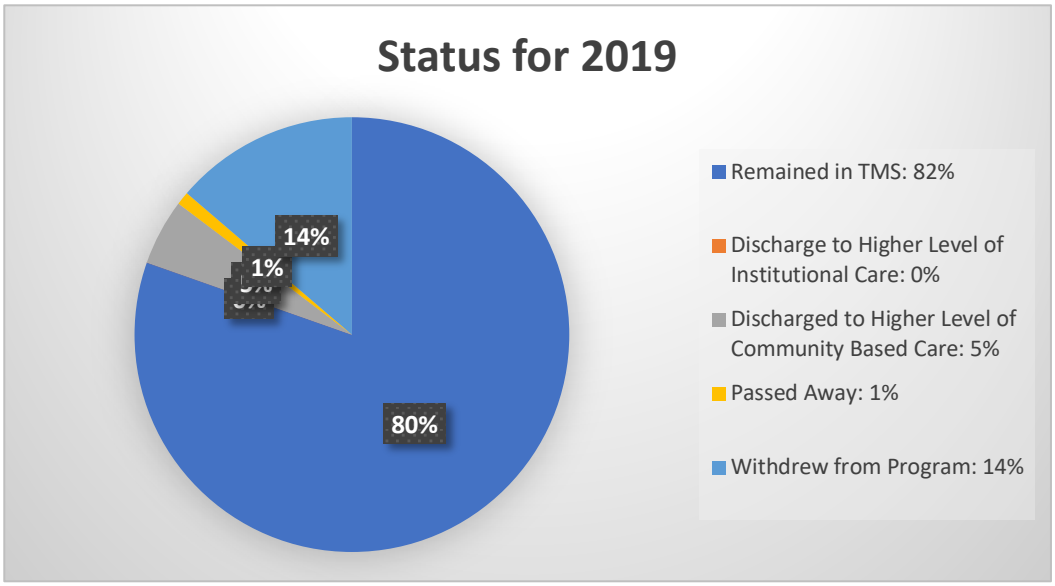
- "Person assigned to my daughter was wonderful to her and they bonded very well. She was also wonderful to the rest of our family"
- "how nice they treated me and my family and how much they help me with my anger"
- "How I as the parent was heard"
- "They went above and beyond to help us"

V. Transition Management Services (TMS)-

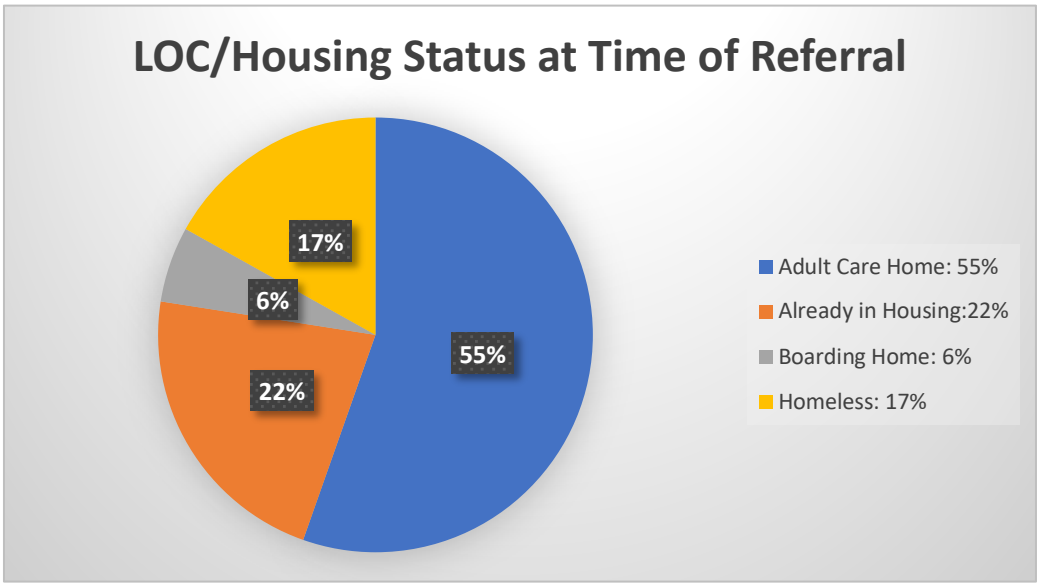
Transition Management Services (TMS) provides services to individuals participating in the Transitions to Community Living Initiative (TCLI). TMS is a rehabilitative service intended to increase and restore and individual's ability to live successfully in the community by maintaining tenancy (housing 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 2019:

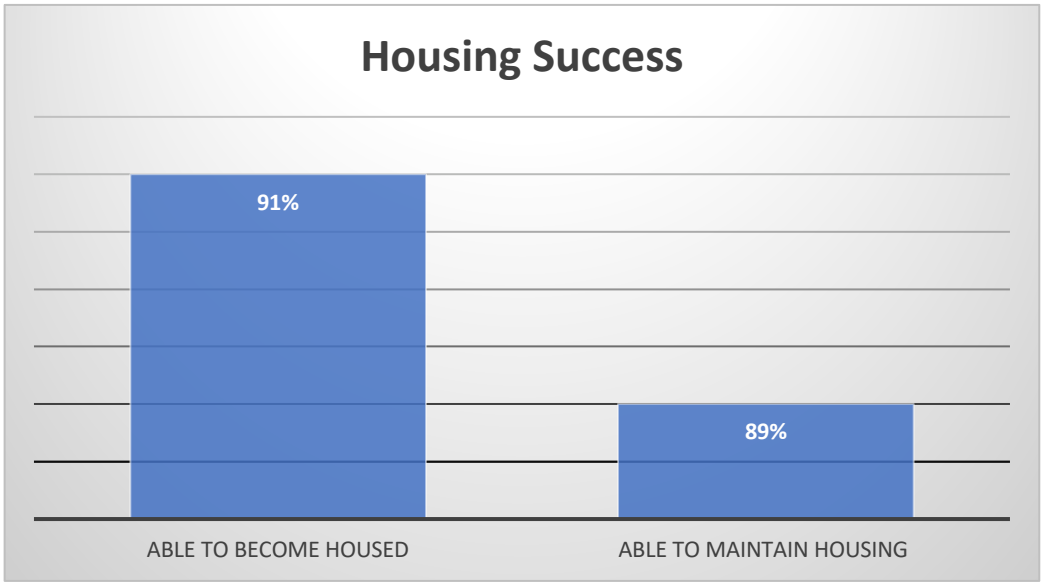
A total of 215 adults were served in our TMS Program for 2019. Of those, **82% remain in the program in 2020. Only 5% were discharged due to needing a higher level of care**



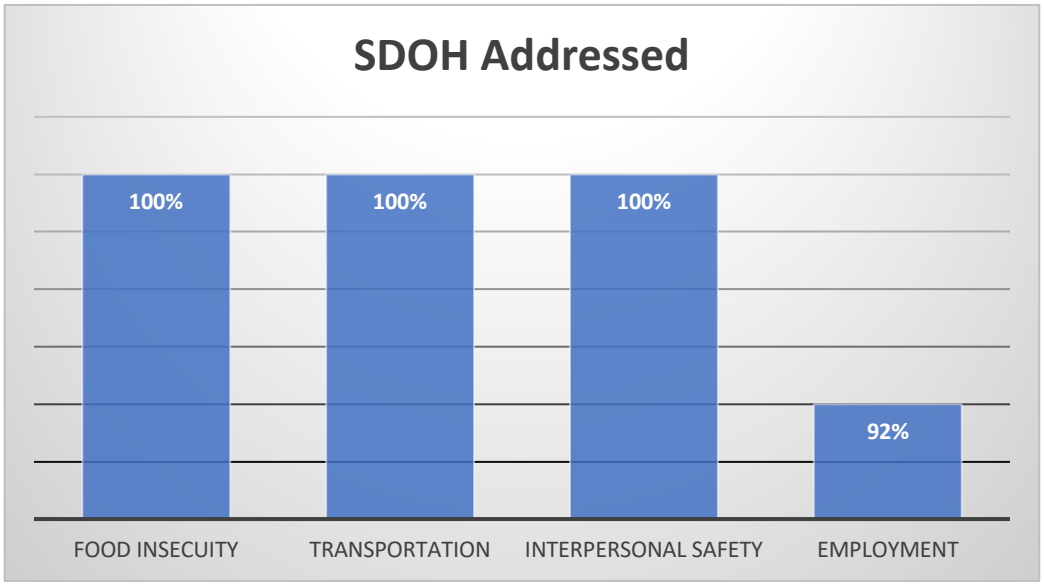
Below is a breakdown of where our members are living at the time of referral to TMS:



TMS is designed to assist members with obtaining and maintaining housing. Our TMS Team excels in this area with an average of **90% of members participating in services were able to both obtain and maintain their housing in 2019**.



Our TMS Team also assists members in addressing multiple Social Determinants of Health in addition to housing. **We have an average of 98% of our TMS members working on 4 or more SDOH in addition to their housing needs.**



Comments from TMS Clients (provided via the Client Satisfaction Surveys):

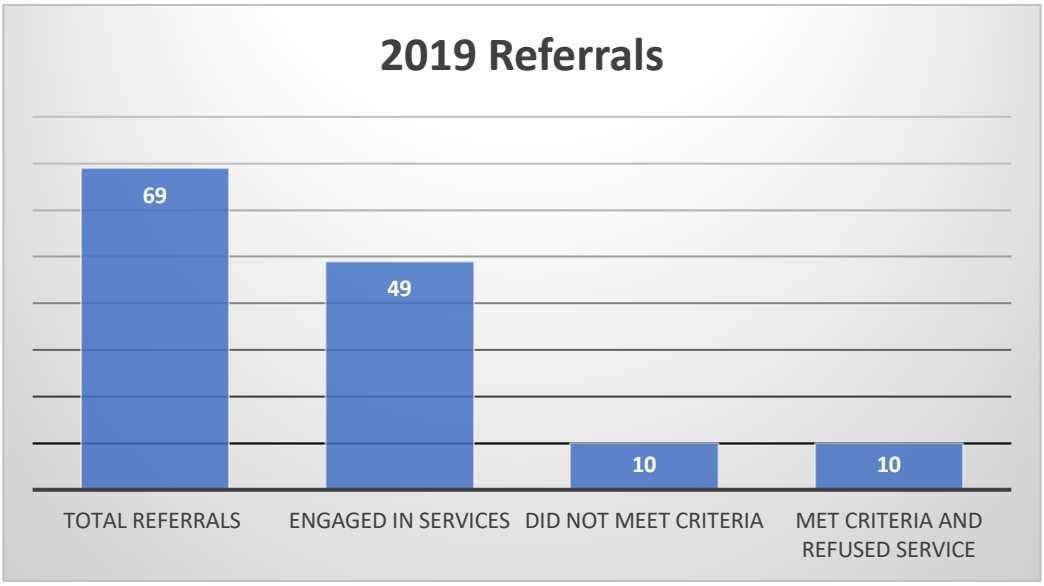
- "Have had more help from TMS staff than anybody else"
- "My worker is kind courteous, professional, and a pleasure to work with"
- "My worker is a blessing to me!"

VI. Enhanced Crisis Response-

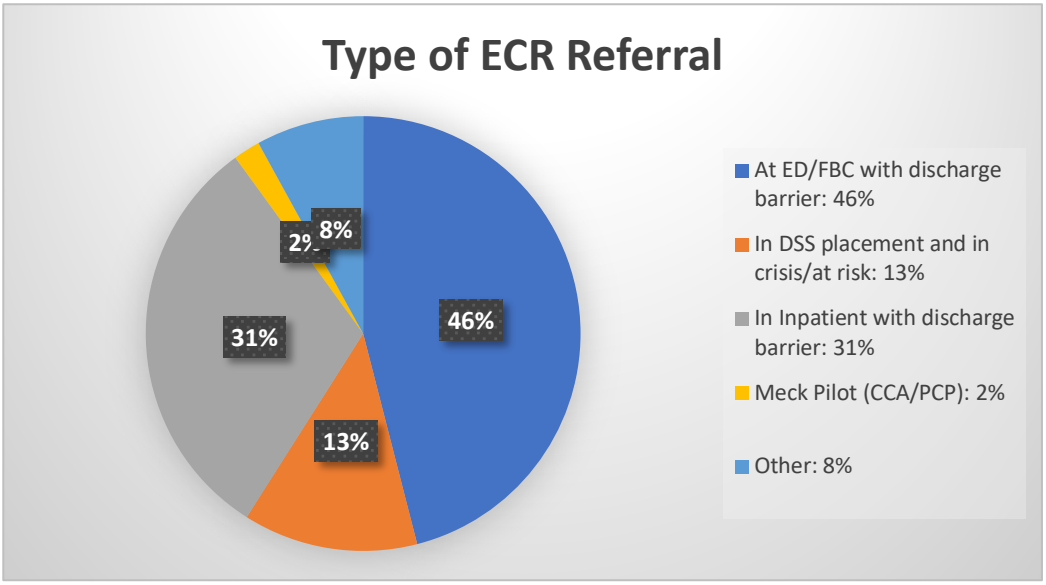
The intent of this program is to put enhanced supports in place as quickly as possible for youth with behavioral health needs that are at risk for abandonment, crisis episodes, or restrictive levels of care. With timely assessments and supports the intended outcome for youth is to be able to maintain 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.

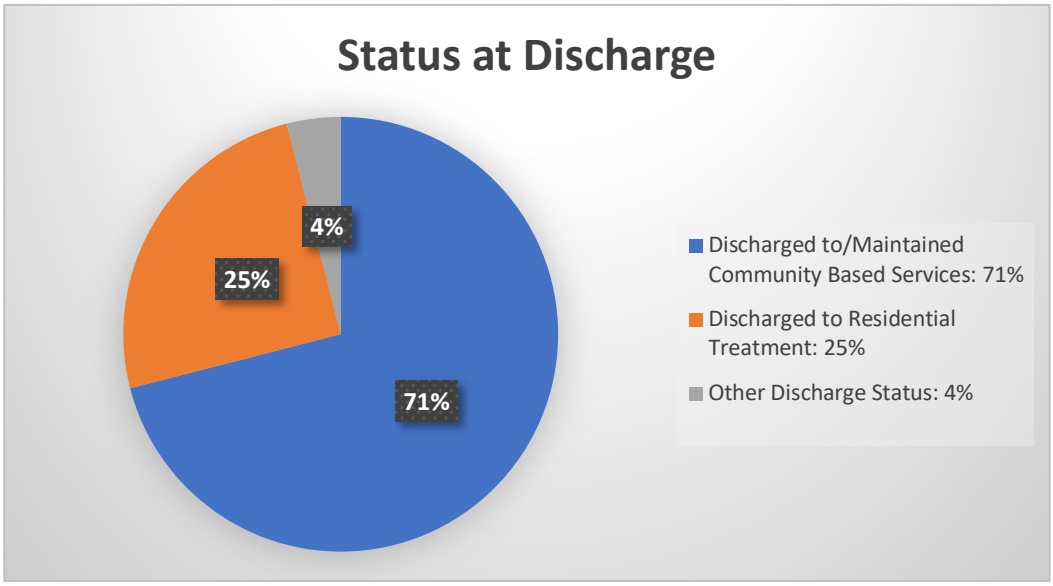
Analysis for 2019: There were a total of **69 referrals** into the program. Of those, **49 youth and their families participated in the program**.



ECR is designed to meet three target populations: those with a discharge barrier in the ED or FBC setting, those with a discharge barrier in an inpatient setting, and those in a DSS Placement at risk for presenting to the ED. **77% of the program referrals were from the Hospital or FBC Systems.**



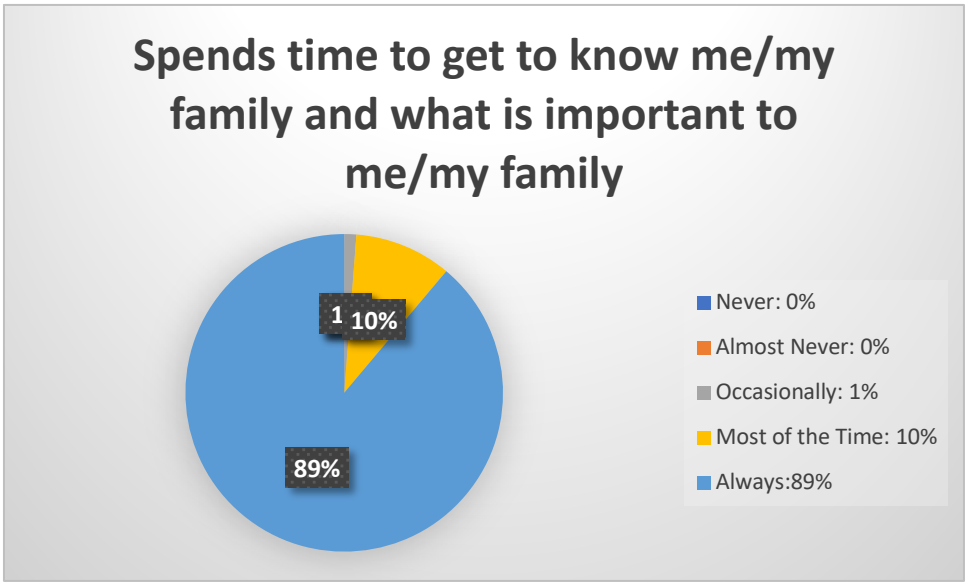
71% of youth who were discharged from the program in 2019 were able to be **discharged into the community with community-based services:**

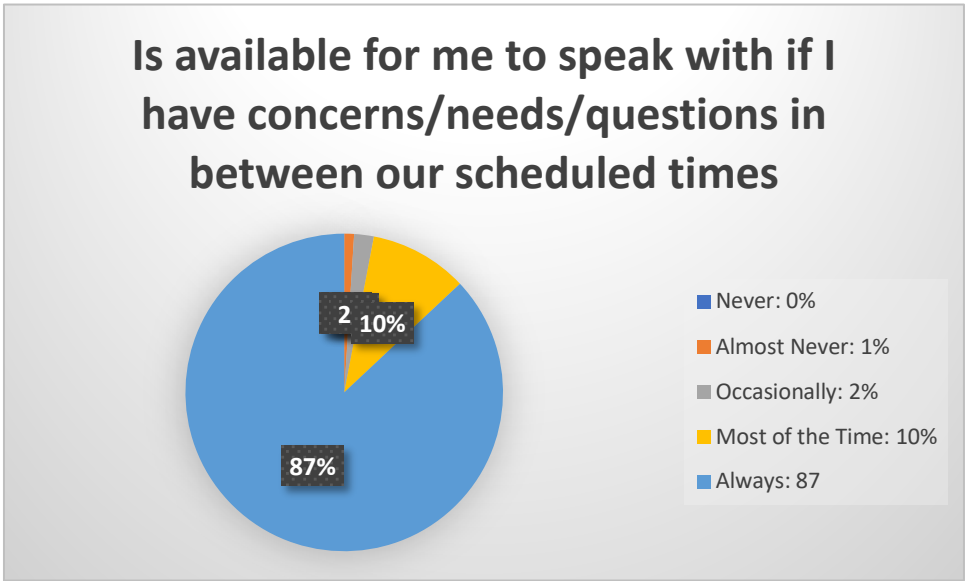


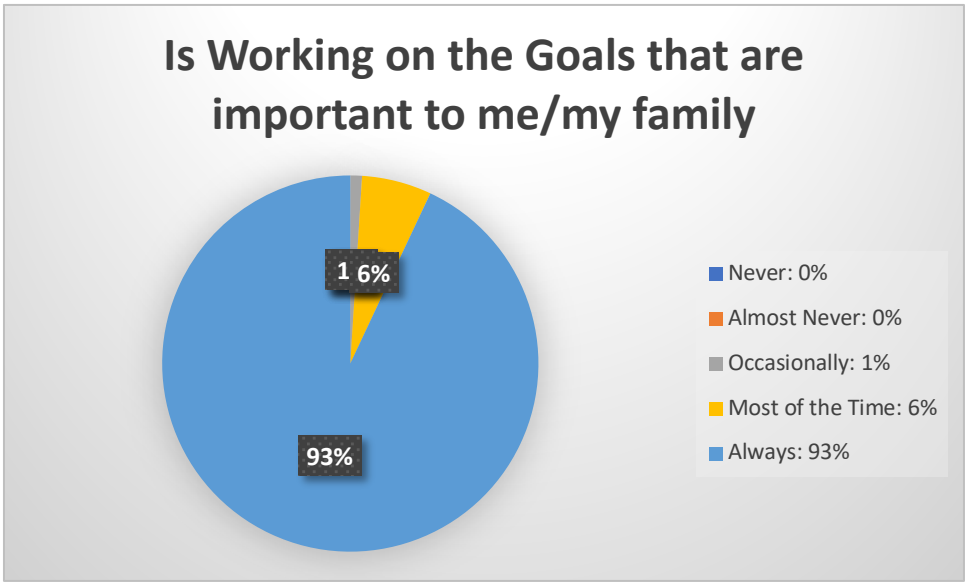
VII. Client Satisfaction Survey Outcomes

- **Has SPARC Improved Yours/Your Family's Life:**

- **Feedback from the Clients/Families on their Staffs Skills:**

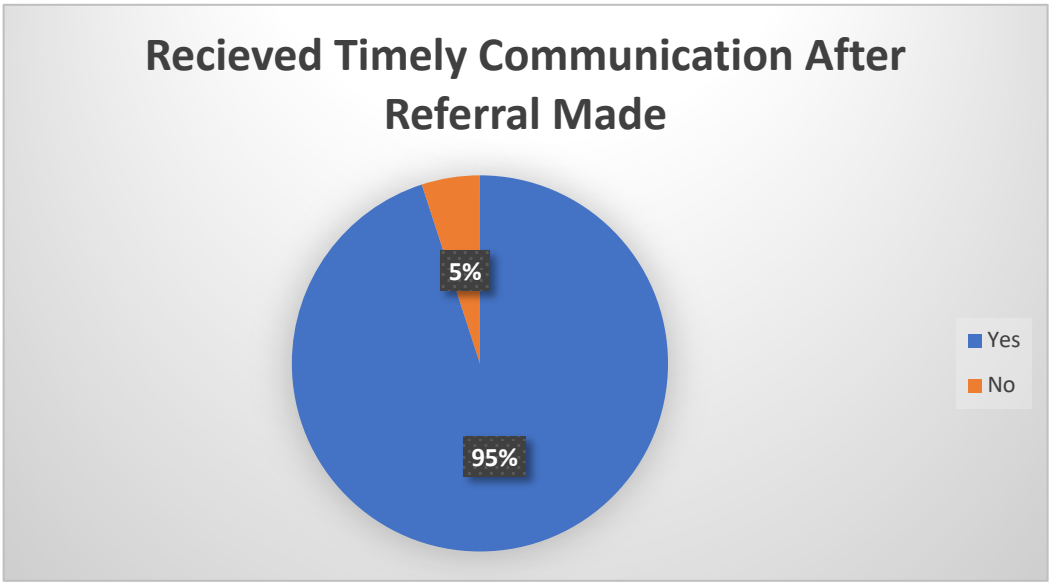

Spends time to get to know me/my family and what is important to me/my family
1
10%
89%
Never: 0%
Almost Never: 0%
Occasionally: 1%
Most of the Time: 10%
Always:89%


Is available for me to speak with if I have concerns/needs/questions in between our scheduled times
2
10%
87%
Never: 0%
Almost Never: 1%
Occasionally: 2%
Most of the Time: 10%
Always: 87

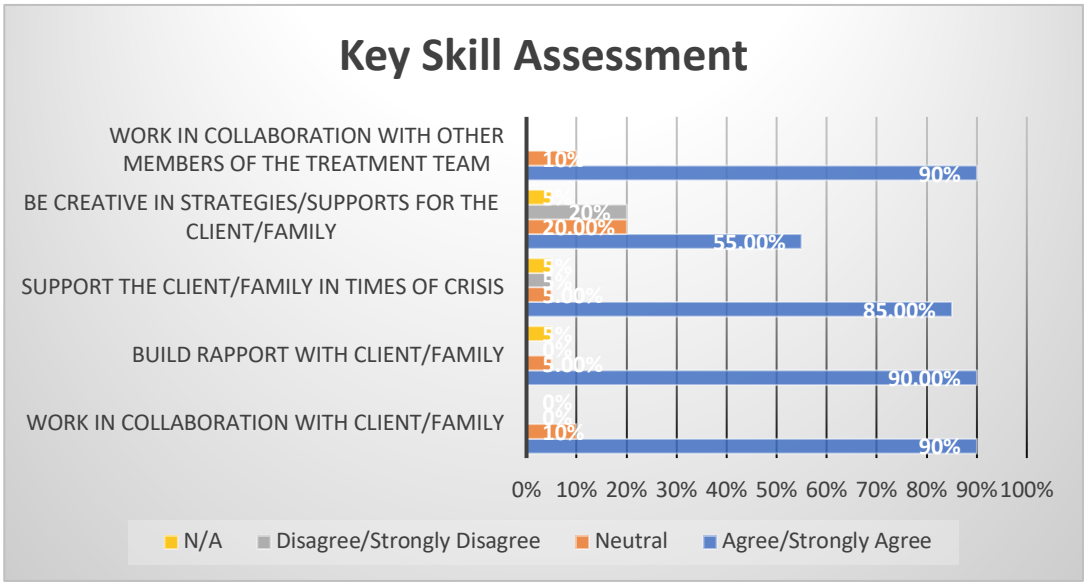


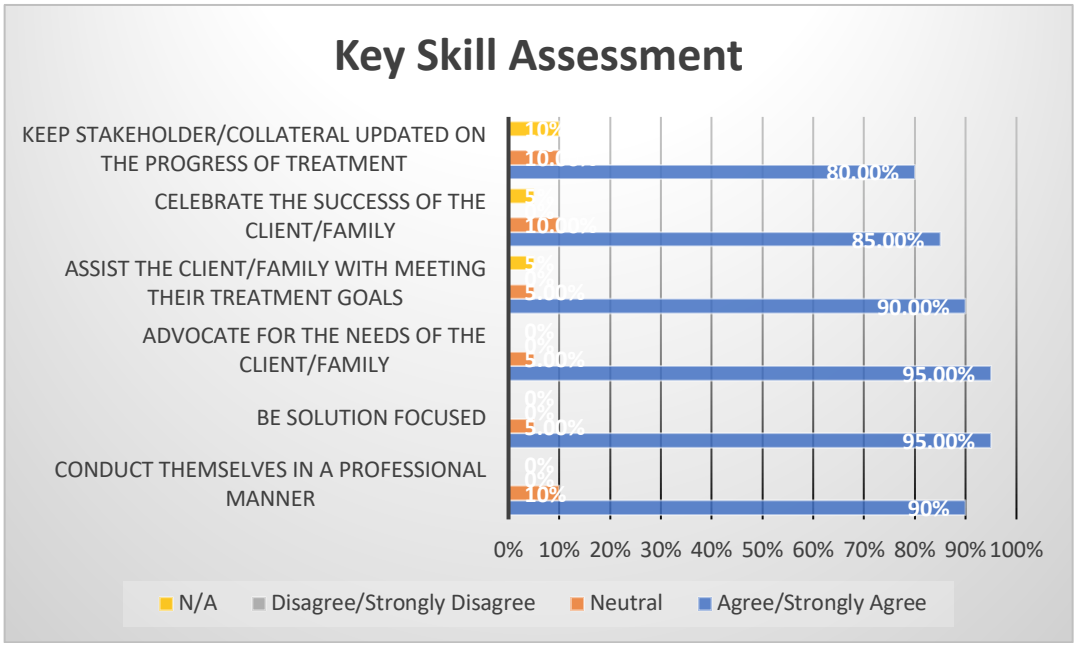
VIII. Collateral and Stakeholder Survey Data-

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. We received a 4.3 star rating from our stakeholders.

Comments Provided From Our Stakeholders:

- "My Preferred Agency"
- "I never worry that I am referring a member to an unknown experience when I refer to SPARC. Your employees, from those in the field to supervisors, are top-notch and I am able to say that up front to the parents that I work with. I appreciate your professionalism, thoroughness, dedication, caring attitude and collegial collaboration"
- "I have enjoyed working with the SPARC team in Charlotte and Triad areas"

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:

- FCT Program: 81% of those receiving FCT were able to remain with or be reunified in the community with their family or another caregiver.
- IHTS Program: 97% of the youth were either at home with family, or in other family placements at the time of discharge.
- TMS Program: 90% of members participating in services were able to both obtain and maintain their housing in 2019.
- ECR Program: 71% of youth who were discharged from the program in 2019 were able to be discharged into the community with community-based services:

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