PROGRAM INFORMATION:

Program Title:	Adult Crisis Residential Treatment	**Provider:**	Central Star Behavioral Health Crisis Residential Treatment
Program Description:	Comprehensive treatment resources and interventions in a 24/7/365 residential setting, with a focus on supporting psychiatric stabilization and transition to community placements/housing.	**MHP Work Plan:**	1–Behavioral Health Integrated Access Choose an item. Choose an item.
Age Group Served 1:	ADULT	**Dates Of Operation:**	February 2019 – August 2023
Age Group Served 2:	Choose an item.	**Reporting Period:**	July 1, 2022 - June 30, 2023
Funding Source 1:	Choose an item.	**Funding Source 3:**	Choose an item.
Funding Source 2:	Choose an item.	**Other Funding:**	Click here to enter text.

FISCAL INFORMATION:

Program Budget Amount:	$2,519,356	**Program Actual Amount:**	$ 2,061,004
Number of Unique Clients Served During Time Period:	189		
Number of Services Rendered During Time Period:	49,518		
Actual Cost Per Client:	$ 15,358.88		

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	Crisis Stabilization
Contract Term:	December 1st, 2017 – June 30th, 2022. With an option for 2 twelve (12) month renewal terms.	**For Other:**	Click here to enter text.
		Renewal Date:	Click here to enter text.
Level of Care Information Age 18 & Over:	Choose an item.		
Level of Care Information Age 0- 17:	Choose an item.		

The levels of care shown in the menu do not apply. The program provides crisis residential treatment.

TARGET POPULATION INFORMATION:

Target Population: The CRT serves male and female individuals, who are 18 to 59 years of age, who are experiencing acute psychiatric episodes or crisis.

CORE CONCEPTS:

- **Community collaboration:** individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural competence:** adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
- **Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services**: adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Access to underserved communities:** Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services.
- **Integrated service experiences:** services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

Please select core concepts embedded in services/ program:
(May select more than one)

Community collaboration

Cultural Competency

Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services

Access to underserved communities

Please describe how the selected concept (s) embedded :

All core concepts are reflected in the operation of the CRT. Community collaboration and service integration are both increasingly critical foci to assure adult clients and their family members are connected into community services and supports post discharge. All Stars Behavioral Health Group (SBHG) programs build and implement a bi-annual Cultural Attunement Plan which addresses multi-cultural staff hiring, training and retention; programming, policies and procedures; and, elective initiatives carried out by teams to enhance cultural attunement to their service population(s). Each client's and family's issues and needs prompting crisis treatment are assessed and addressed through an individualized plan of care, and the client's own WRAP, with assertive attention to stabilizing the person while in the setting and connecting them into post discharge treatment services and resources. CS's CRT in Fresno County helps the

county to meet the community need for crisis services and offers an important gateway for those not prior linked to community-based mental health services.

PROGRAM OUTCOME & GOALS
- Must include each of these areas/domains: (1) Effectiveness, **(2)** Efficiency, **(3)** Access, **(4)** Satisfaction & Feedback Of Persons Served & Stakeholder
- Include the following components for documenting each goal: (1) Indicator, **(2)** Who Applied, **(3)** Time of Measure, **(4)** Data Source, **(5)** Target Goal Expectancy

Below details the data collection used to report program outcomes. Please refer to the Appendix for a description of each measurement tool.

Data Collection Tools[1]	Summary	Completion Rates
EMR Data		
Incoming Referrals	This year's report applies SBHG's Business Analytics (BA) Dashboard data. BA Dashboards automate staff's data entries into the SBHG EMR. CRT staffs are fully trained and monitored in their use of measurement tools, data entry and dashboard navigation.	Screenings/ assessments, youth enrollments, service entries, and Incident Reports are logged into SBHG's EMR. Data capture for each enrollment was mostly complete. Additional data notes are provided in the narrative and/or in endnotes.
Referral Disposition		
Screenings/Assessments		
Enrollments		
Service Entries		
Incident Reporting		
Measurement Based Care		

[1] Please refer to the Data Collection Tools Appendix for a description of all tools

Behavioral and Symptom Identification Scale (BASIS)-24	Outcome instruments to facilitate Measurement Based Care. Staff review the outcomes of persons served over time in treatment to inform care planning and monitor progress.	Staff completed N=97/204 (48%) matched BASIS-24 record sets.[2]
Discharge Forms		
DC Status Form	SBHG tool to track the treatment progress and discharge circumstances of persons served.	Out of 204 discharges in FY22-23, staff completed 195 discharge status forms, a robust 96% completion rate.
Stakeholder Surveys		
Agency Partnership Survey	Gather and review perceptions about and satisfaction with CRT programming and services from persons served, family members, and agency partners.	The CRT requested feedback from N=42 agency partners and N=7 responded (17% response rate).
Crisis Program Satisfaction Survey		The available sample from those served is 48 out of 204 discharges, a 24% response rate.

Describe the Program's analysis (i.e. have the program/contract goals been met? Number served, waiting list, wait times, budget to volume, etc.):

[2] Some of those served leave ACA and do not complete a BASIS prior to discharge. If a planned discharge, they complete the BASIS before leaving. Due to the incomplete sample, these results may not be generalizable to the entire discharged population, especially those who leave ACA.

Outcome Analysis

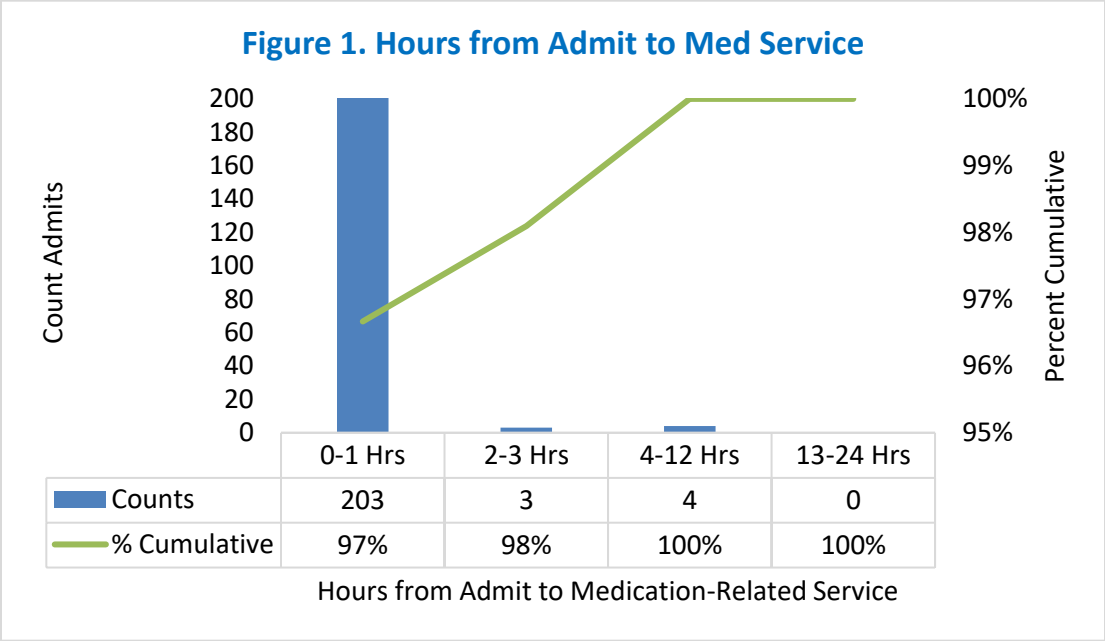
In Fiscal Year 2022-23, the CRT served 189 adults across 215 enrollments. There were 215 admits and 204 discharges. The sections below convey the program's performance to the Key Performance Indicators (KPIs) in the program's contract.

Access to care: The ability of persons served to receive the right service at the right time

Timeliness KPIs based on SBHG's Access to Care dashboards are based on 215 admissions, unless otherwise noted (e.g., some indicators relate to referrals not admissions). Some graphics show a distribution of results using slightly downward adjusted denominators due to a few missing records. This assumes data about (the few) unknowns would be distributed similar to the (large volume) of known records.

KPI: Timeliness of Bridging Prescriptions

N= 203/210 (97%) enrollments with complete relevant data received a medication-related service within one hour of admit, and all 210 (100%) received a medication-related service within 24 hours of admission (Figure 1). Note that this analysis focuses on the first medication-related service. Medication adjustments may also occur anytime during a person's stay in the CRT (not reported here).



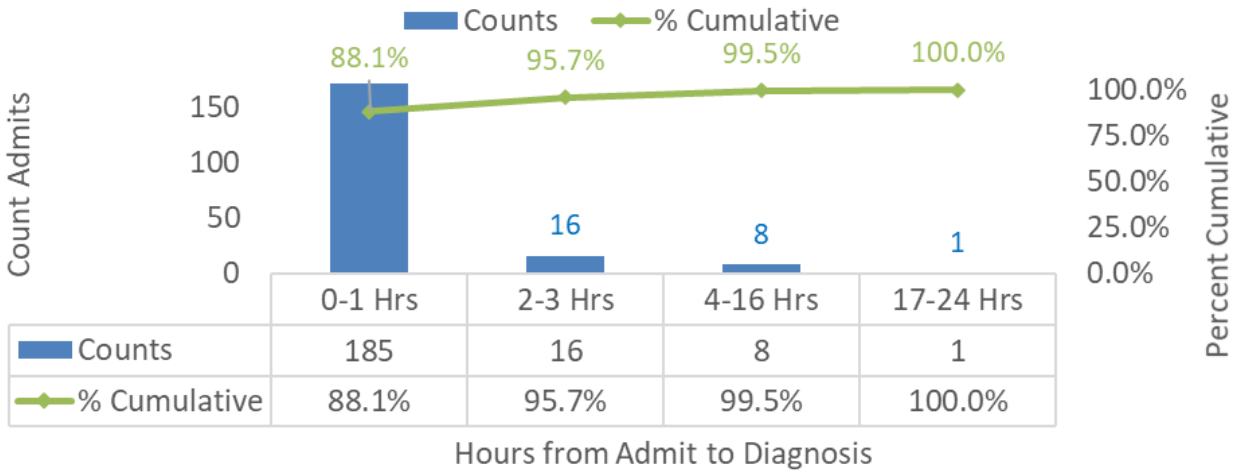
The above data shows that clients are seeing our Physicians/Nurse Practitioners very promptly as they start the program during which time the practitioner reviews their prior/current medications, pharmacy access, side effects and the benefits of the medications, and they make any initial adjustments that may be needed given the person's currently diagnosed condition(s).

At the time of discharge, nurses call in the adult's Prescriptions (Rx) with a 2-week refill and check to make sure the person being served is set up for an appointment with an outside psychiatrist.

KPI: Timeliness of identifying persons served with serious mental illness

Similar to bridging prescriptions, timely access to care provided by the CRT ensures that persons served with a serious mental illness are identified quickly (Figure 2). N=185 (88.1%) of enrollments received a clinical or psychiatric diagnosis within an hour of admit, and all 100% received a diagnosis within 24 hours of admission.

Figure 2. Hours Admit to Diagnosis



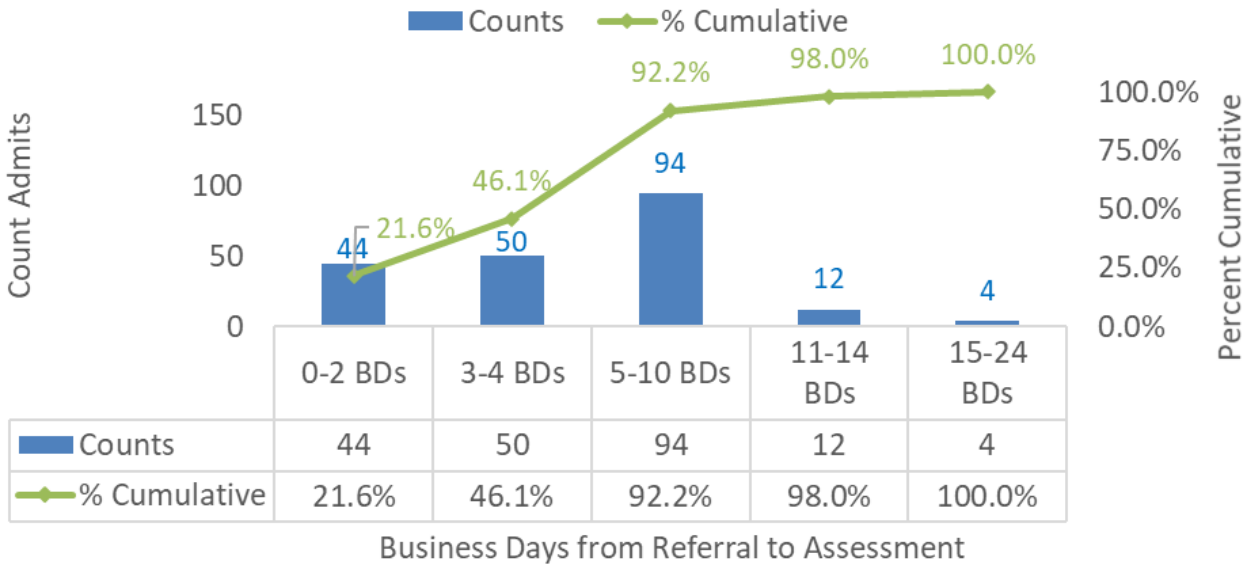
In addition to diagnoses, staff also administer additional assessments to identify at-risk persons served based on their history. These additional assessments include, among others, the BASIS (functioning, symptoms, substance use, social supports), Life Events Checklist (e.g., traumatic events), and Safe-T Suicide Screenings/Assessments (multiple components).

KPI: Timeliness between referral for assessment and completion of assessment; assessment to first treatment service; and, first treatment service to next follow-up

Referral to Assessment

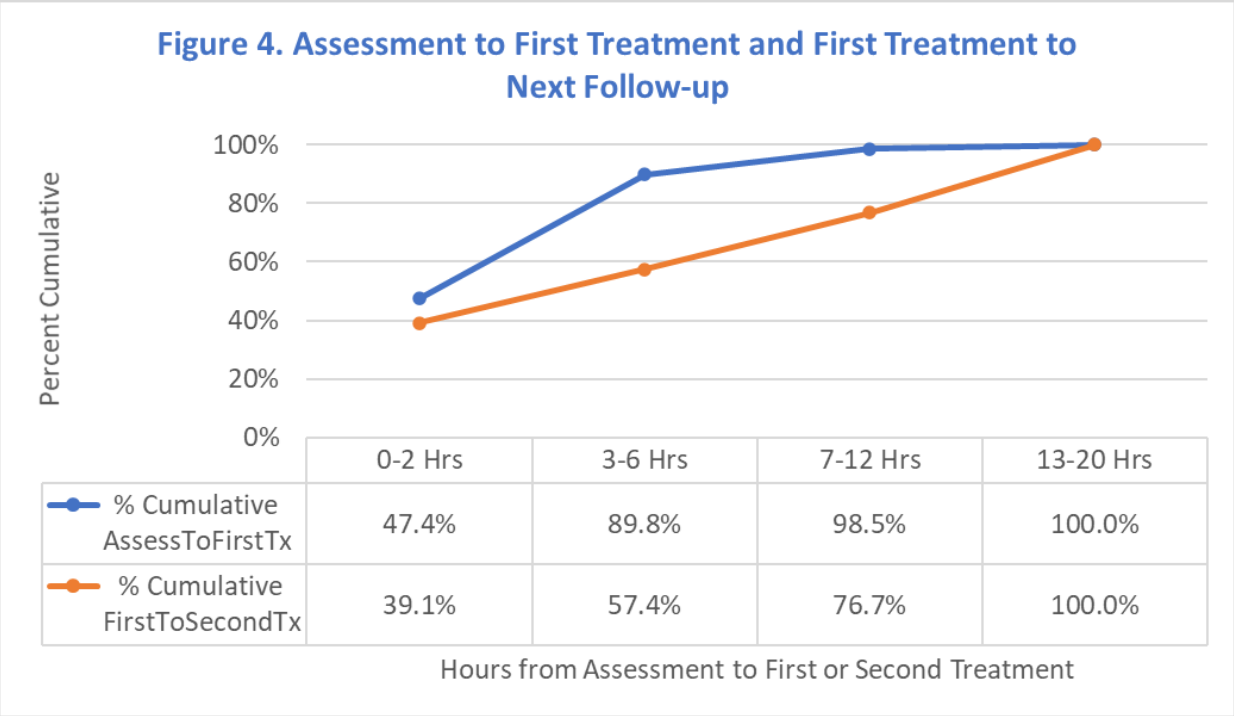
Among enrollments in FY 2022-23, based on n=204/213 with referral data, 46% met the DMHC guidelines of a 4-business day timeframe from referral to a mental health assessment (N = 94), and 98% received an assessment within 14 business days of referral (Figure 3).

Figure 3. Business Days from Referral to Assessment



Assessment to First Treatment and First Treatment to Next Follow-up

Following intake assessments, those enrolled began individual and group treatment services within hours (Figure 4); 91% received their first treatment service within 6 hours of assessment (N=176), and all (100%) did so within 11 hours. Moreover, most (76%) received their second treatment service within 12 hours of first treatment service (N=155), and all did so within 20 hours of first treatment service. On average, persons served received their first assessment, first treatment, and second treatment within a timeframe of 6.5 hours following admission (max = 45 hours, min = 1 hour).



KPI: Timeliness of subsequent follow-up visits

The CRT will explore extracting or accessing data from the county regarding the subsequent follow-up visits of those served, once we are beyond our current implementation of CalAIMS changes.

KPI: Timeliness of response to sick call/health service requests

There were N=23 incidents involving health issues, including allergic reactions and medication. All incidents were taken seriously and immediately responded to; fortunately, this last year none were life threatening and none resulted in physical bodily damage that necessitated significant physical recovery. Of these, N=6 required a 911 call and N=9 resulted in visits to emergency rooms for medical intervention and clearance to return to the facility. While event details

are recorded in QA logs, SBHG is exploring ways to further standardized data visualizations for response timelines on existing Incident Reporting Business Analytics (BA) dashboards

Effectiveness: Objective results achieved through health care services

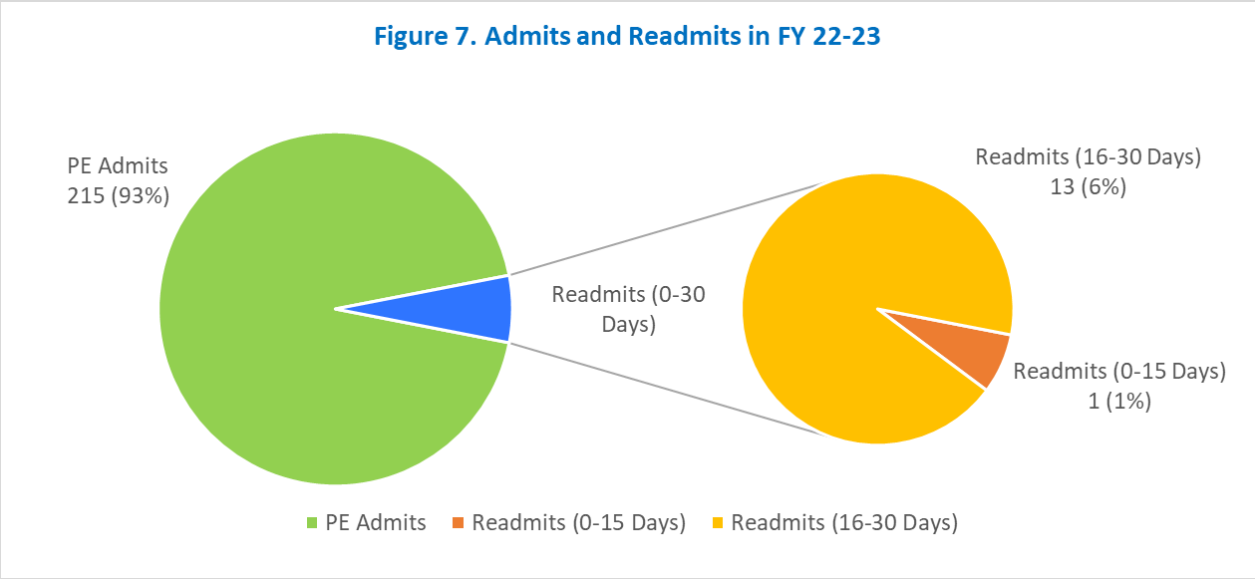
Safety & Security. Multiple aspects of program design and operations -- e.g., staffing levels, admission procedures, engaging programming, staff's ProACT training, facility and milieu management, IT security protocols, incident response, reporting and debriefing protocols, etc. -- facilitate the continued safety and security of the setting. CRT managers and staff continue to identify and to partner with others as needed to meet and maintain safety standards.

Incident Reporting. During FY 22-23, there were N=191 total incidents, a rate of 49.4 incidents of any type per 1,000 patient days. At Fresno CRT, the most common (43%) "incident" types are Against Medical Advice (AMA) and Health/Medical/Medication (12.0%). There are occasional (low counts) of Absent Without Leave (AWOL) (N=12), injury (N=10), Abuse (N=2), Equipment/Property (N=1), and Suicidality (N=1). Neither physical restraints nor seclusions were used during incident management. Early in the FY, Fresno County requested the CRT evacuate so the Exodus Crisis Stabilization Unit could use the facilities after a power outage. Adult clients were discharged or situated in area hotels. All incidents this past year were promptly and fully reported, investigated, reviewed by QA, and debriefed with staff on the unit. Risk behavior incidents (e.g. aggression, disruption of the milieu, etc.) may also culminate (when relevant) in a staff guided restorative justice process among CRT residents.

Also please see KPI #5 regarding stakeholder surveying – persons served, caregivers, and agency partners who responded to our surveys endorsed the safety and security of the setting.

KPI: Percent of persons served who return for crisis services in 15 days and in 30 days

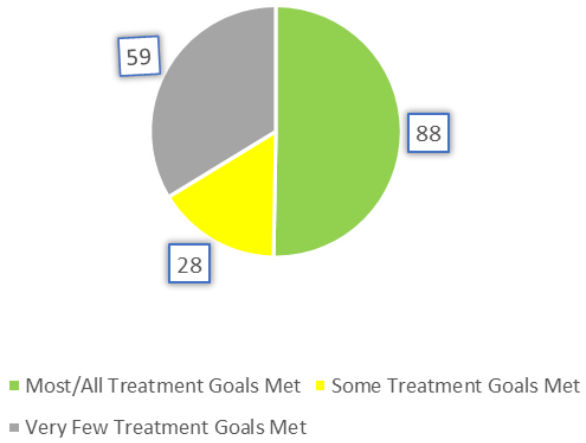
As shown in Figure 7 below, of the 215 distinct admits in FY 22-23, 14 were readmits within 30 days of the previous discharge (7%) and 1 of these clients readmitted within 15 days of the previous discharge (<1%). Though the number of readmissions seems low, CRT leadership notes that people -- often those who leave ACA -- call asking to re-enroll with the program soon after leaving. Unfortunately, the CRT is unable to accept people in this circumstance because of stipulated referral sources and processes with the County. The CRT has explored expanding the referral process with the County to increase utilization and to pave the way for those who change their mind soon after leaving ACA to be able to return. We recognize that human motivation and help-seeking can be a fickle process and we would like to see individuals in such circumstances supported forward through their newly emerging motivations.



KPI: 85%+ achieve most/all treatment goals

Out of 175 discharges*, 88 (50%) achieved all or most of their individualized treatment goals and 28 (16%) achieved some of their goals. Thus, 66% made at least some progress. (Figure 8).

Figure 8. Treatment Progress at Time of Discharge

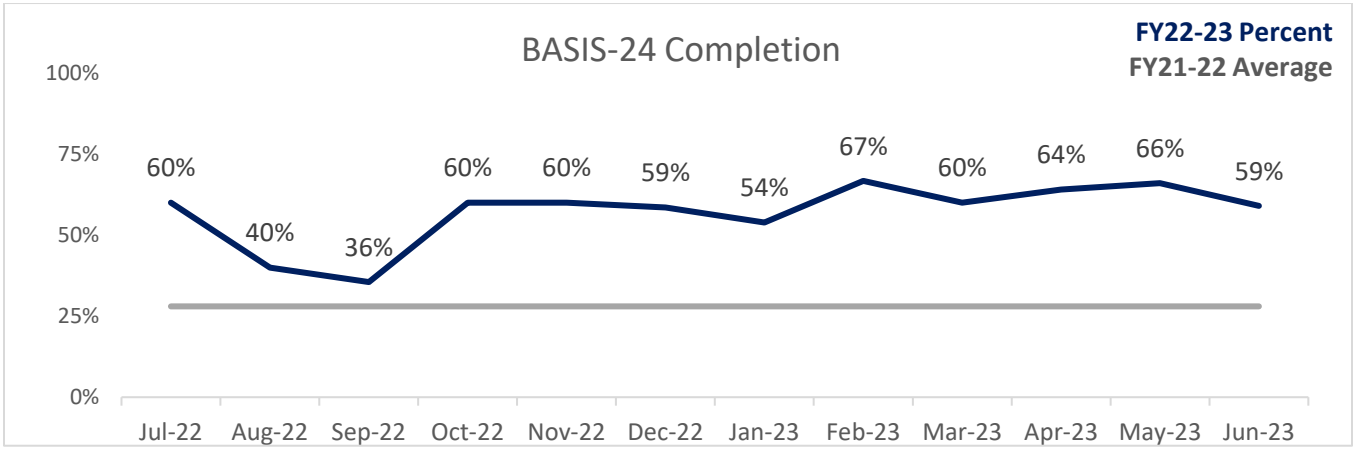


* There were 195 program discharges, but a subset of clients did not complete assessments, nor receive significant services, and thus were removed from the denominator for reporting on this indicator.

KPI: BASIS-24 statistically desirable improvement

Last Fiscal Year (FY 21-22), the CRT had an overall BASIS-24 completion rate of 28% and 19 matched pairs. Although marginally significant improvements were found in some subscales, the small sample size undermined generalizing to the larger population. This Fiscal Year (FY 22-23), the CRT undertook a quality improvement project to improve the BASIS-24 completion rate. The QI included retraining staff on outcome administration, creating an internal tracker, and routinely monitoring completion rates at monthly systems meetings. This Fiscal Year, the CRT had an overall completion rate of 57% (Figure 9 below) and 95 matched pairs; a 400% increase in matched pairs from the previous Fiscal Year! This improvement in completion rates lends more confidence when interpreting the aggregate results of the BASIS-24.

Figure 9. BASIS-24 Completion Rate



The BASIS Total and Subscales initial and latest mean results for the whole population are shown in Figure 10 below (N = 95). The total score and each sub-scale score exhibited improvements (where a lower score is better). Matched-pair t-tests indicated statistically significant reductions in all scales ($p < .00$) except emotional lability. Please defer to Table 1 for the t-statistic and sample size for each subscale.

Figure 10. Basis-24 Aggregate Mean Scores Over Time in Treatment

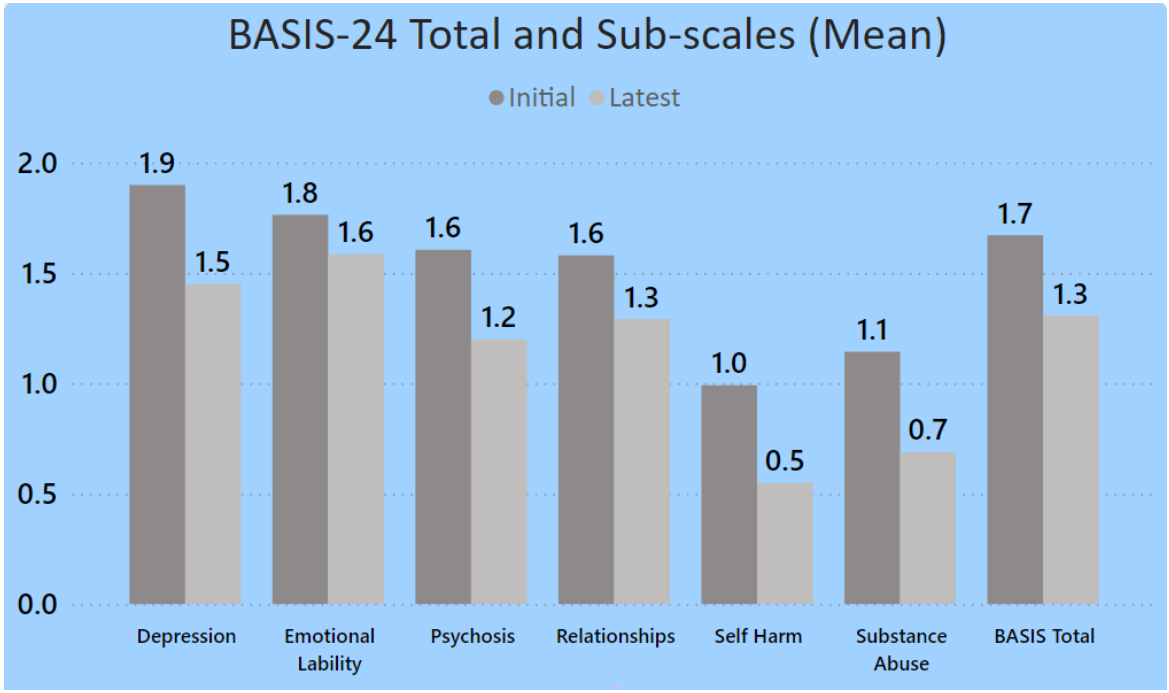


Table 1. Basis-24 Scale Significance Statistics and Sample Size

Note: "*" or p<0.05 indicates statistically significant difference; "**ms**" or p<0.1 indicates marginally significant statistical difference; "**ns**" indicates non significant statistical difference

Matched Pairs T-Tests (for N>=30)

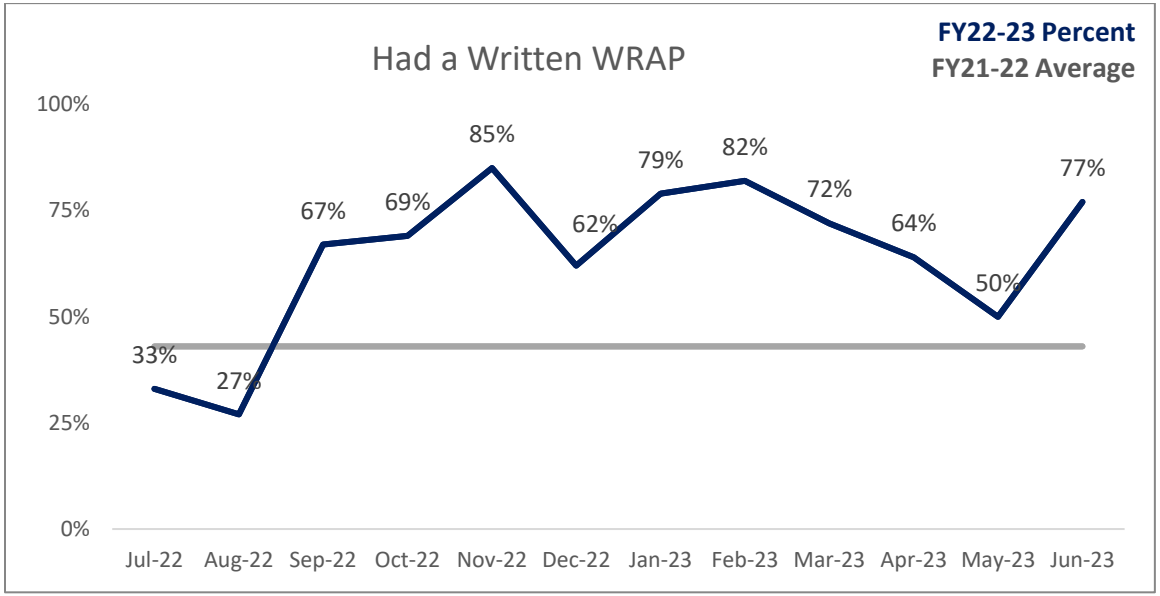
Domain	Statistic	P.Value	N
BASIS Total	5.96	0.00 (*)	78
Depression/Functioning	4.62	0.00 (*)	89
Relationships	3.26	0.00 (*)	93
Self Harm	4.16	0.00 (*)	95
Emotional Lability	1.66	0.10 (ns)	93
Psychosis	3.41	0.00 (*)	91
Substance Abuse	4.37	0.00 (*)	91

KPI: 85%+ complete WRAP by DC

Last Fiscal Year, 43% of discharged clients had a written Wellness Recovery Action Plan (WRAP) according to the DC Status Form. To address this low result, program leadership: retrained staff how to complete the DC Status Form, incorporated more weekly group sessions on WRAP, and introduced WRAP into individual therapy sessions. Leadership monitored results of their QI in their monthly WRAP meetings using data from both the DC Status Form and the DC Crisis

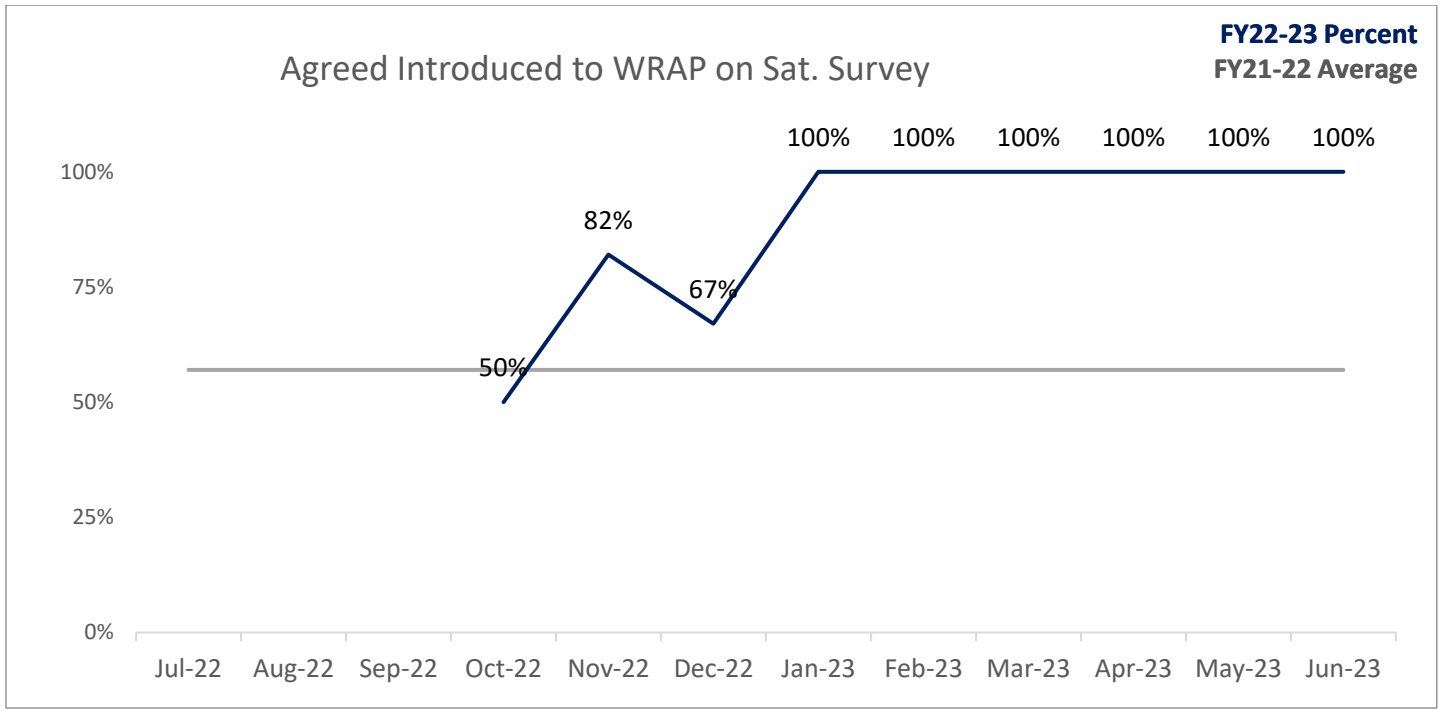
Satisfaction Survey. This Fiscal Year, 66% of clients discharged with a WRAP; a 53% increase from last Fiscal Year! Figure 10 below shows the percentage of clients who discharged that had a written WRAP over time.

Figure 10. Written WRAP at Discharge



Additionally, leadership monitored the recognition of those served about whether they were introduced to WRAP (data tracked on the DC Crisis Satisfaction Survey). Figure 11 below shows the % of people who agreed they were introduced to a WRAP. This Fiscal Year, 89% of people agreed they were introduced to WRAP compared to 57% from FY21-22.

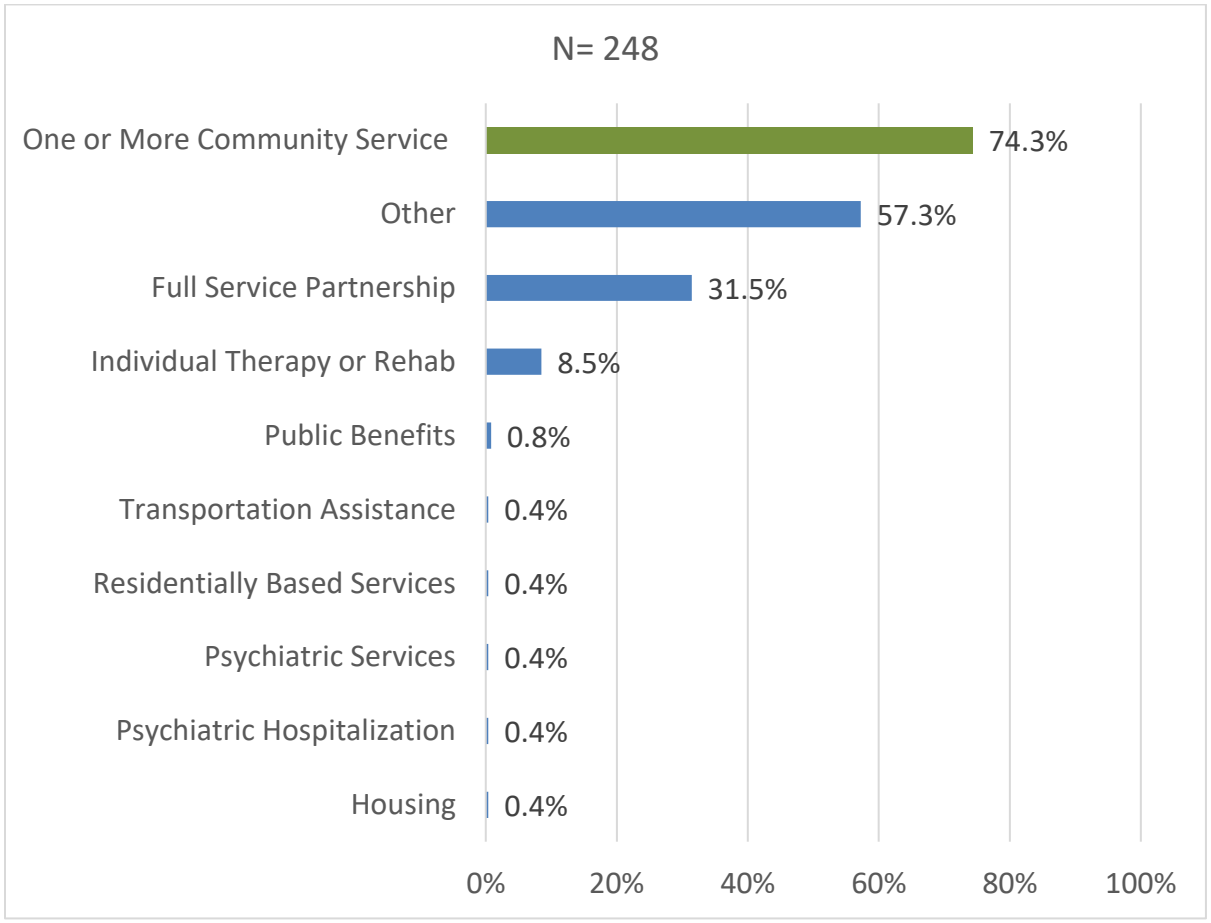
Figure 11. Percent Agreed Introduce to Wrap



KPI: 90%+ connected to Community Services

Of the 195/204 (96% completion rate) discharges with a DC Status Form, 145 (74%) received a referral or linkage to one or more community services (Figure 11). The most common types included Other (57%), Full-Service Partnership (32%), and Individual Therapy or Rehab (9%). Leadership will revisit the training of the DC Status Form and ensure staff use the "Other" option only when the linkage does not fit an existing category.

Figure 11. Community Services Linkages at Discharge



KPI: 85%+ have prescription continuity

Last Fiscal Year, the CRT relied on the Post-DC Follow-Up Survey to ask about prescription. The protocol was discontinued this Fiscal Year as staff struggled to complete surveys given (i) many clients left to ATOD rehab that excluded outside contact and (ii) many clients had temporary phones from the county that became inactive after the client left the program. Central Star now monitors this KPI using the DC Status Form. According to the DC Status Form, 92% of people adhered to or somewhat adhered to medications at time of Discharge. Additionally, discharged persons are linked to other Behavioral Health Treatment Services who help support medication continuity. For instance, 70% of persons served are linked to outpatient Full-Service Partnership services.

KPI: 85%+ have transportation to participate in aftercare services

SBHG provides Community Resource Linkages at time of discharge. According to the DC Status Form, one person required and was subsequently linked to transportation assistance to their after-care services. The CRT also provides teams with vouchers for public transportation as needed.

Efficiency: The demonstration of the relationship between results and the resources used to achieve them

KPI: Create data partnerships

Cost efficiency is best managed through data partnerships. Central Star participates in workgroups and contributes to county datasets to shape meaningful cost reduction studies that demonstrate the positive impact of CRTs to the community's bottom line and those served. Central Star also hosts annual CQI Councils and invites county and community partners to review Fiscal Year data. These are opportunities to share and reflect on internal data analysis and procedures. If the county provides a data set for analysis, we would be delighted to analyze and report further on the CRT's impact.

Satisfaction & Compliance: The degree to which persons served, COUNTY, and other stakeholders are satisfied with the services.

KPI: 90%+ Resident Satisfaction

There were 48/204 (24% sample) persons served who completed the Discharge Satisfaction Survey. Most or 97.9%% somewhat or very much agreed they were satisfied with the services they received from the program and 97.9 % would recommend it to others. Figure 15 depicts the average score of satisfaction during FY 2022-23. Table 2 depicts the average satisfaction scores by question.

Figure 15. General Satisfaction by FY and Quarter

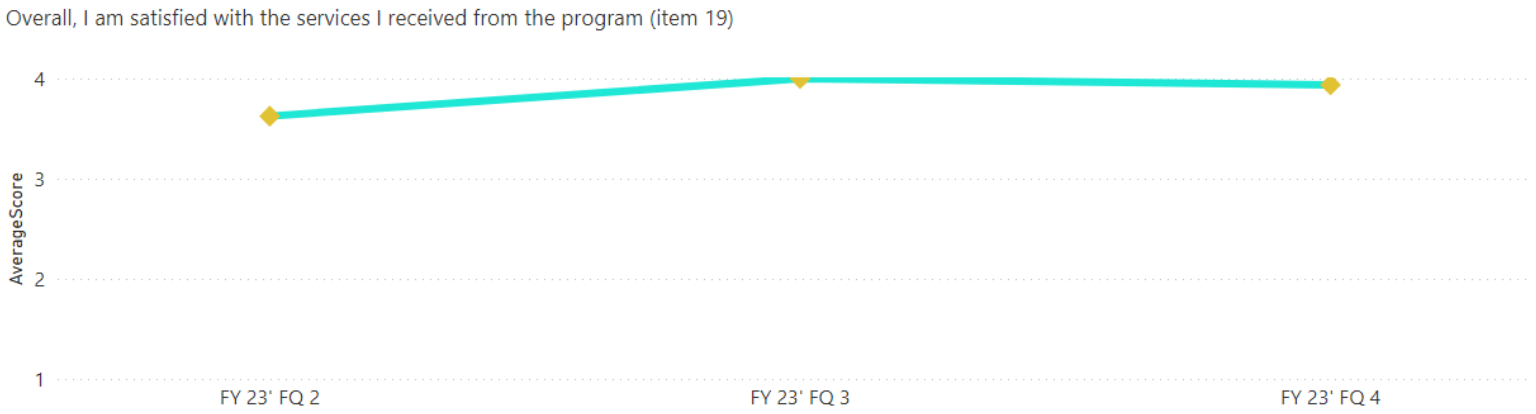


Table 2. Discharge Satisfaction Survey by Question

Number	Item	Not at All/ A Little (1-2)	Somewhat/ Very Much (3-4)	Don't Know (0)	Average Score	Sample Size
1	I received services in a timely manner	7.8%	91.2%	1.0%	3.70	102
2	I was introduced to the Wellness Recovery Action Plan	14.4%	81.7%	3.8%	3.52	104
3	I was provided useful information about my medication and health	14.4%	84.6%	1.0%	3.52	104
4	I was introduced to resources in my community	13.6%	83.5%	2.9%	3.48	103
5	My needs and goals for using this service were met	10.7%	87.4%	1.9%	3.61	103
6	Staff understood, respected, and sympathized with my unique identities	7.3%	90.6%	2.1%	3.71	96
7	I was treated with dignity and respect by staff	7.7%	90.4%	1.9%	3.76	104
8	Staff took time to listen to what I needed and were available to talk when I was troubled	8.7%	88.5%	2.9%	3.71	104
9	Staff helped me feel safe and develop a safety plan if needed	11.5%	86.5%	1.9%	3.65	104
10	Staff helped me develop a plan for after I leave this program	9.6%	88.5%	1.9%	3.61	104
11	I felt safe and supported during my crisis	8.7%	90.4%	1.0%	3.67	104
12	The setting was safe, clean, and comfortable	5.8%	94.2%		3.80	104
13	I get along better with family members	9.9%	81.7%	8.5%	3.55	71
14	I have the support I need from family or friends	14.1%	80.3%	5.6%	3.51	71
15	I will do better in school and/or work	5.6%	87.3%	7.0%	3.67	71
16	I deal more effectively with daily problems and my symptoms don't both me as much	16.9%	77.5%	5.6%	3.42	71
17	I am more resilient and am more likely to overcome challenges after participating in the program	7.0%	87.3%	5.6%	3.67	71
18	I feel more hopeful after participating in the program	7.1%	90.0%	2.9%	3.72	70
19	Overall, I am satisfied with the services I received from the program	8.7%	89.3%	1.9%	3.70	103
20	I would recommend this program to others	5.9%	92.1%	2.0%	3.74	101

The majority of the persons served commented that what they liked best from the program was the staff. Others liked group meetings, the services offered by the facility and the food. Some people served (n=30) wrote positively about the staff. Below are examples from among those offering observations and comments:

- "Everybody is caring and don't treat us like some crazy people. Help find a place."
- "That there was always someone to talk to if I was in need."
- "The staff were caring, groups, actually had good stuff to learn."
- Groups and meetings were "On time, spot on with needs and very helpful."
- "Community of medical, social and therapeutic sources."
- "One-on-one treatment and services."

- Facility was “Clean and neat.”
- “Everything, being able to take a shower (to cope).”

KPI: 90%+ Family Satisfaction

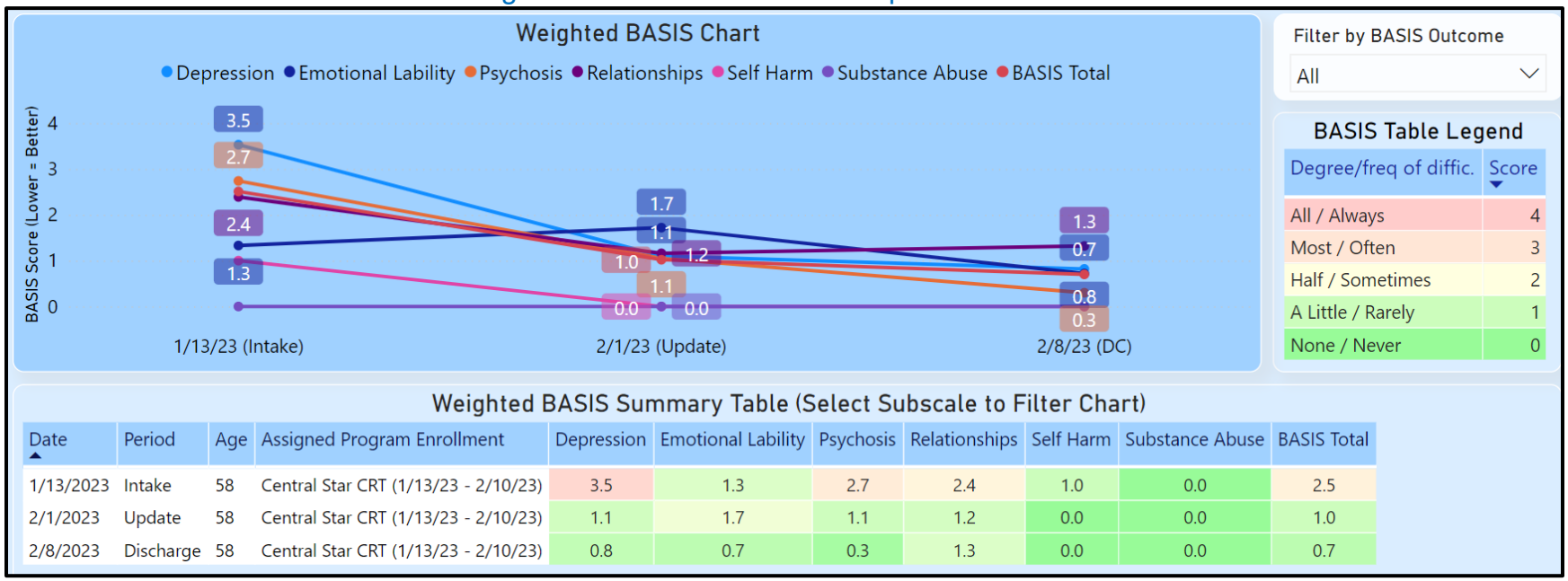
The CRT serves adults. Often times, persons served do not have natural supports which might include caregivers, and other supports such as conservators involved in their treatment. When available, the CRT engages adult’s natural supports. This engagement often focuses on discharge and after care planning. In previous Fiscal Years, the CRT has relied on using data from the Consumer Perception Survey (CPS), which the team completed at request of DBH. The CPS is no longer completed. Next Fiscal Year, the CRT will discuss implementing a Natural Support Survey to measure engagement, satisfaction with services and perception of adult treatment while at the CRT.

KPI: Solicit person served & family input for interpreting outcome data

This KPI is addressed through the a) CRT Satisfaction Surveys, b) the BASIS Treat to Target (T2T) process, c) Agency Partner Survey and d) the program’s annual Continuous Quality Improvement (CQI) process. The CRT generally hosts two satisfaction surveys. The Crisis Program Satisfaction Survey is an opportunity for persons served to provide their perspectives regarding services and the results of services, for a latter example there are items such as whether the needs & goals for using the services were met. The free response option also provides an opportunity for persons served to provide feedback of any type which can be found in the 90%+ resident satisfaction KPI section. Please refer to Figures 15 and table 2 to review data on the Crisis Program Satisfaction Survey. The Agency Partnership Survey was administered twice this Fiscal Year to identify agency partner satisfaction and solicit feedback.

SBHG built and maintains a suite of Business Analytics (BA) Dashboards to support Treat to Target (T2T) individualized tracking of client progress and results over time. Clinicians utilize the dashboard to inform treatment planning and to host discussions with those served about their progress, and the services and interventions they may need. Persons served are expected to have at least three BASIS-24 assessments while at the CRT: at intake, an update every 2 weeks, and a discharge. Those who stay past the expected 30-day length of stay may receive an additional BASIS-24 every 30 days. The T2T dashboards show progress over time for individual BASIS-24 items, subscales and a Total Score. Please refer to the Appendix for more details about the BASIS-24 tool. Figure 18 below shows an example of the BASIS-24 T2T dashboard for an anonymous person served.

Figure 18. BASIS-24 T2T Example Dashboard.



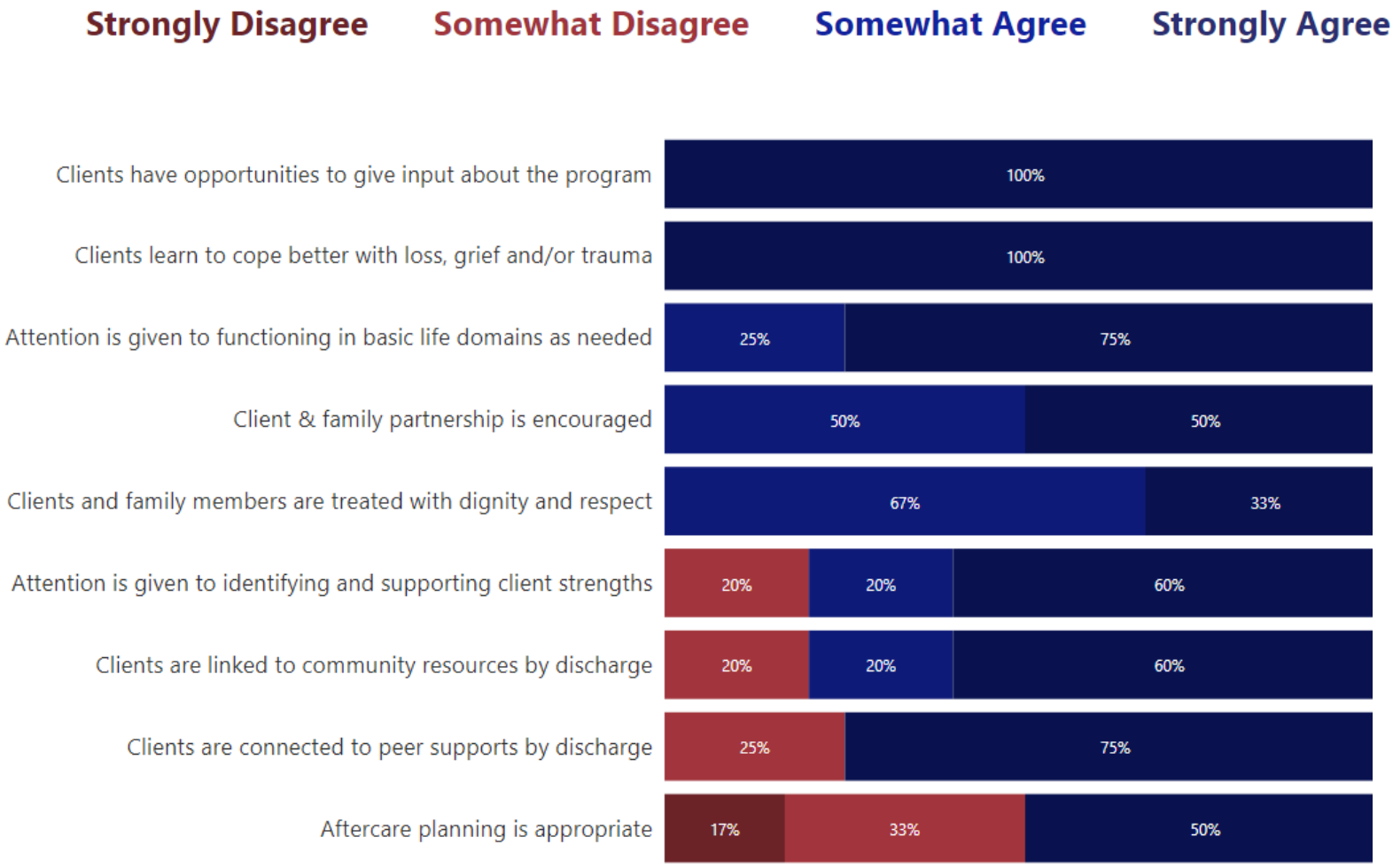
Weighted BASIS Summary Table (Select Subscale to Filter Chart)

Date	Period	Age	Assigned Program Enrollment	Depression	Emotional Lability	Psychosis	Relationships	Self Harm	Substance Abuse	BASIS Total
1/13/2023	Intake	58	Central Star CRT (1/13/23 - 2/10/23)	3.5	1.3	2.7	2.4	1.0	0.0	2.5
2/1/2023	Update	58	Central Star CRT (1/13/23 - 2/10/23)	1.1	1.7	1.1	1.2	0.0	0.0	1.0
2/8/2023	Discharge	58	Central Star CRT (1/13/23 - 2/10/23)	0.8	0.7	0.3	1.3	0.0	0.0	0.7

Agency Partner Feedback

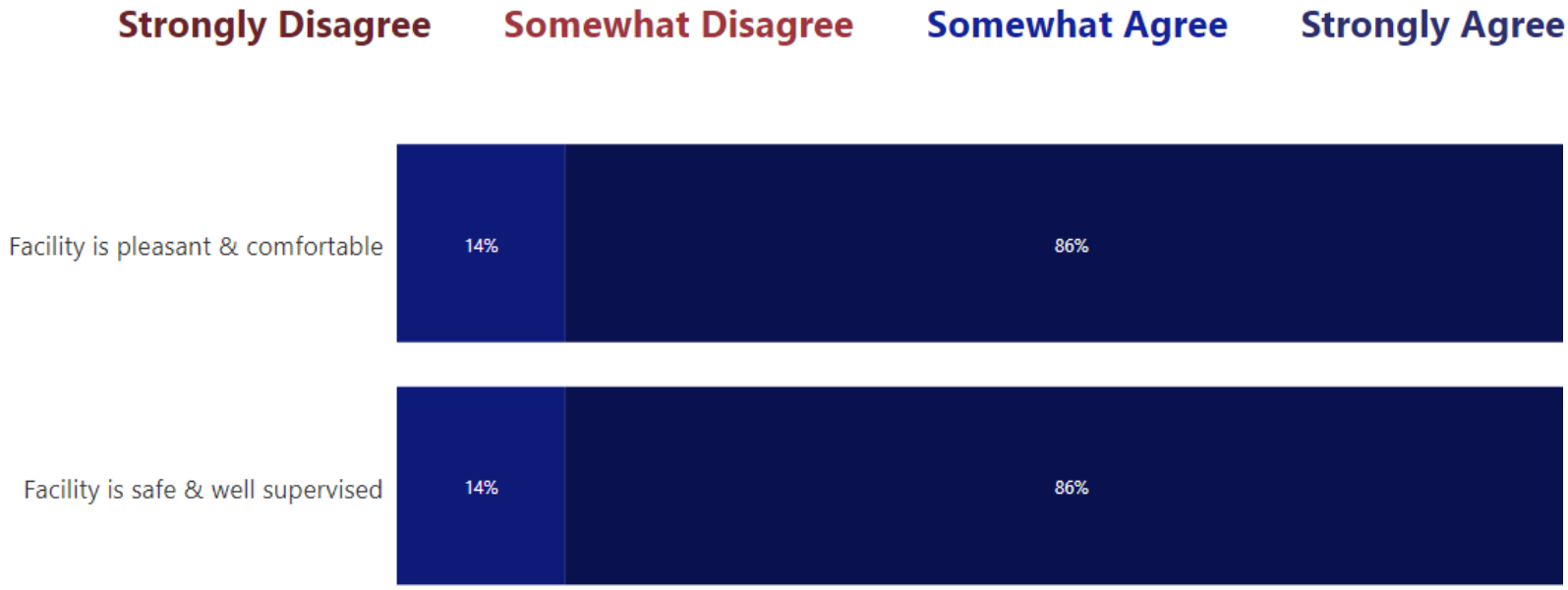
The team requested feedback from N=42 agency partners and N=7 responded (17% response rate). Half or more of the respondents agreed with all the statements in the perceptions about services category. Half of the respondents disagreed that aftercare planning is appropriate. Two respondents recommended better communication and coordination around pending discharges. One respondent recommended the CRT improve their coordination with community based treatment providers regarding unplanned discharges and to accept individuals back into the program after having been discharged to a higher level of care. We note that we have no objections to the latter, but that it is a county decision. Meanwhile, the team is exploring steps and processes they can implement to improve care coordination with other providers around discharges, whether planned or unplanned. Note that the team requested feedback at two points in the fiscal year, in August 2022 (N=6) and in March-April 2023 (N=1). The one respondent that completed the survey later in the fiscal year, somewhat agreed or agreed with all questions.

Figure 19. Fresno CRT Perceptions about Services



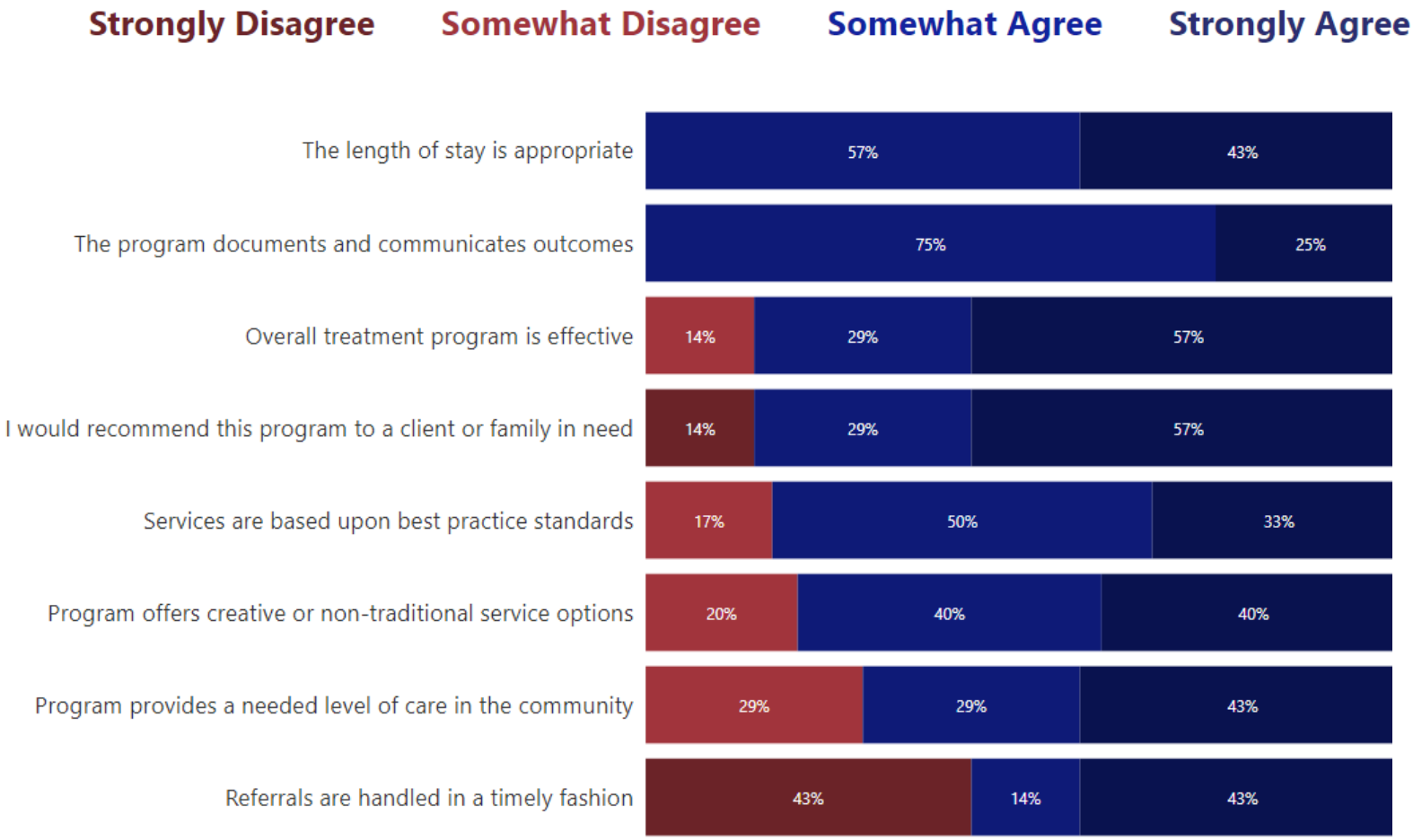
The respondents agreed with all the statements in the Facility category.

Figure 20. Fresno CRT Perceptions about Facility



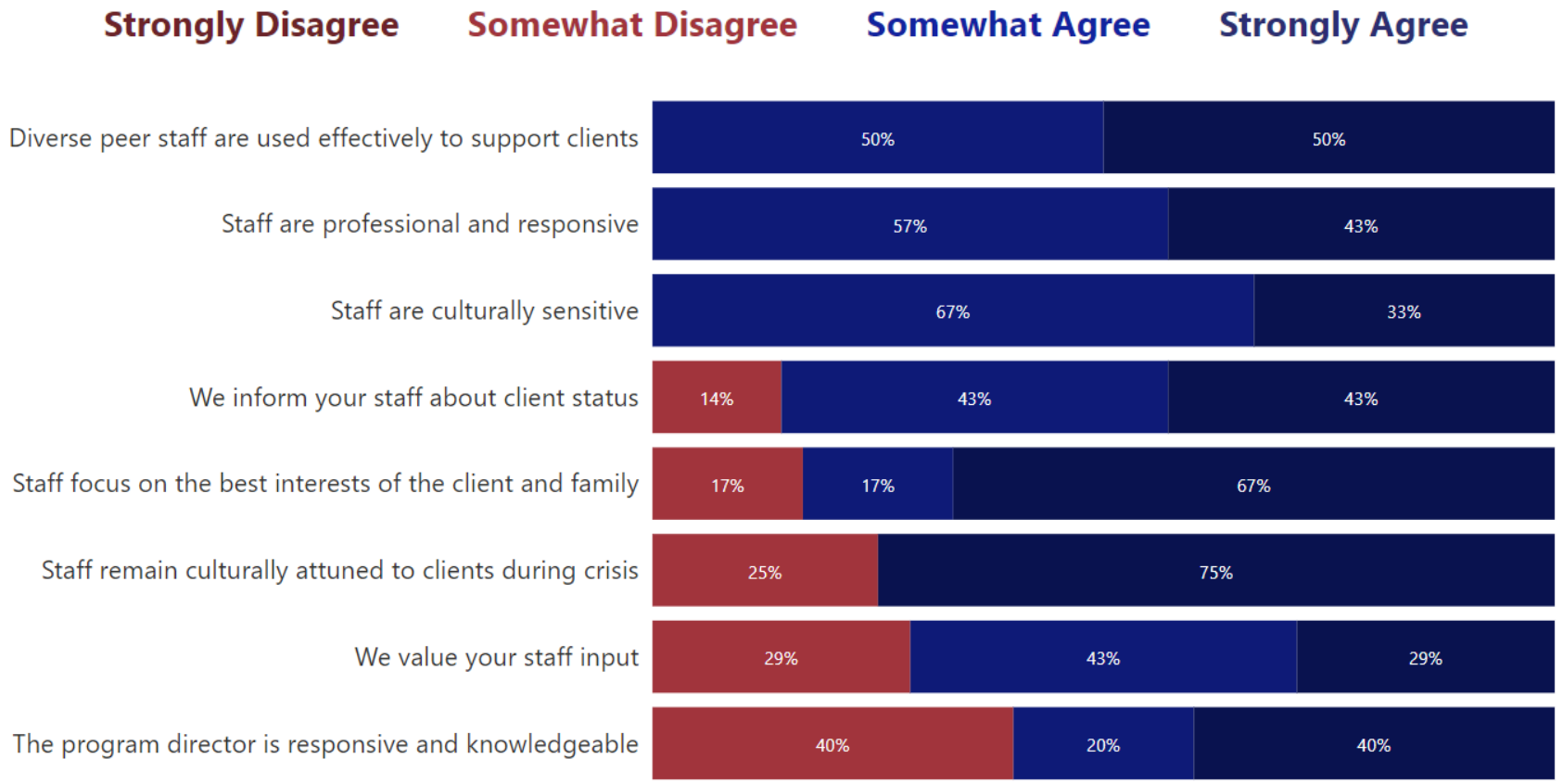
More than half of the respondents agreed with the statements in the program category. Over half agreed that referrals are handled in a timely fashion. Regarding referrals, one respondent recommended responding more quickly when collaborating with agencies and to have the criteria outlined and given to the other programs/community partners who refer to them. Another respondent recommended to be more responsive to emails from community-based providers who are seeking additional information about their client's stay at CRT (HIPAA covered entities). They also recommended the CRT become more involved with community-based organizations to understand how the CRT process intersects with outpatient programming and other community-based services. The team greatly values this feedback and will engage in further outreach with others in the community.

Figure 21. Fresno CRT Perceptions about Program



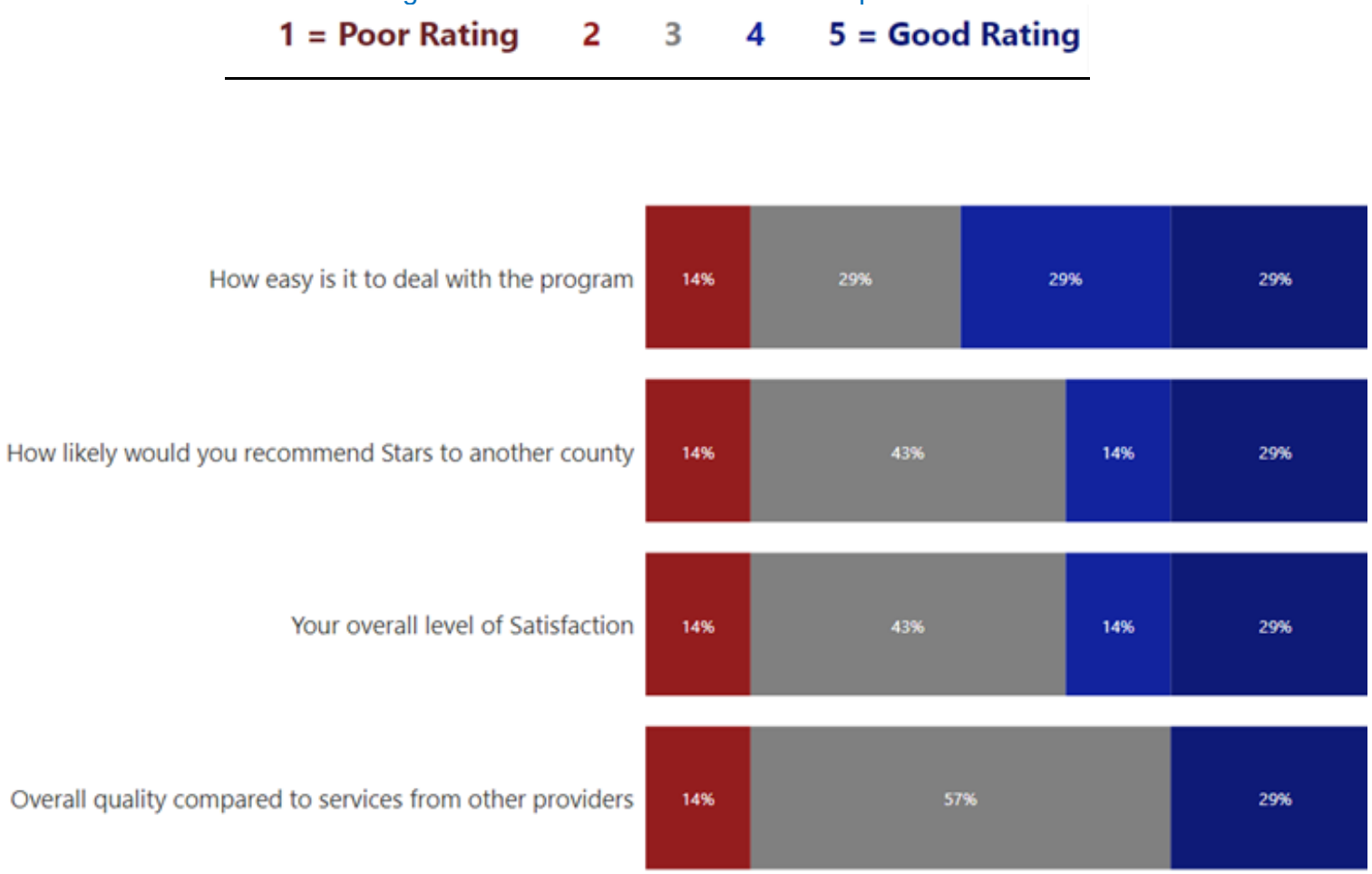
Most respondents agreed with most of the statements in the staff category. One respondent stated the CRT staff are doing a great job.

Figure 22. Fresno CRT Perceptions about Staff



Below are the respondents' rating on their overall perception regarding the Fresno CRT. One respondent stated that overall services are very great. Most respondents rated a 3 or higher.

Figure 23. Fresno CRT Overall Perceptions



Fiscal Year 22-23 Quality Improvement Projects

Continuing QI Project – Understanding and Addressing ACA Discharges. The CRT engaged in a number of quality improvement projects this Fiscal Year, including those reported above on improving the completion rate of the BASIS-24 and the number of people with a written WRAP. The CRT also aimed to decrease their overall percentage of Against Clinical Advice (ACA) discharges through a variety of means. Last Fiscal Year, the CRT reported 35% of people discharged ACA; and 34% of persons discharged ACA this Fiscal Year. Thus, the project will be a continued focus during FY23-24 with new strategies being explored (1) implementing the milieu coaching project (described below); and, (2) introducing an incomplete admission program modifier to better track clients who come to the facility but do not sign the admissions agreement as this may be inflating the reported number of ACAs.

New QI Project: Milieu Coaching Program. Upon emerging from the COVID pandemic, and the related health and human workforce phase of job leaving and high turn-over, the SBHG Clinical Services team reviewed how we train and support new staffs to deliver services, especially across higher-end programs. As part of this effort, an initiative was launched and piloted this last year with Central Star's CRT and PHF leadership teams that aims to strengthen staff skill sets for working with clients, how they run groups, and how they manage their program's milieu. The basic hypothesis is that we can improve our staff's confidence and connectivity to their work by providing more individualized attention to their skill set development (including, yet beyond trainings to include coaching), and this will also positively impact client care.

Over the year the following were in focus -- and are now continuing as an organized quality improvement project that is also cascading across all SBHG milieu programs: a) tracking, communicating and making sure staff get through SBHG's orientation courses including the Basics of Group Facilitation, WRAP, Seeking Safety and Aggression Replacement Training; b) identifying and assigning at least two internal coaches in each setting to observe at least one group service, individual rehab and/or nursing session weekly and provide coaching feedback to the staff involved; and, c) coaches submit a log about their coaching encounters and participate in open "office hours" at least once monthly with the Senior Director of Research & Program Practices (RPP) toward the development of their coaching skills. The project at Central Star's CRT moved forward last year with on-site orientation of n=3 program leaders; brief meetings with all relevant staff so they were aware of the coming observations/coaching sessions; the development of a centralized resource site for group services and coaching; and, an improved group services dashboard along with monthly "pushed report" tracking/reporting on varied relevant indicators. This project has a formal written evaluation plan, an identified evaluator, SBHG departmental staff attention and assignments, and it will transpire over the next two years as a company-led QI project meeting JC Re-Accreditation standards for such projects.

Quality Councils – You are Invited! The CRT hosts an annual Continuous Quality Improvement (CQI) council. People served and other community members are invited to the CQI. The CRT reviews aggregated outcome data during the CQI and provides an opportunity for attendees to ask questions, give feedback, and offer suggestions for program improvement.

Appendix – Data Collection Tools

Standardized Outcome Tools Measurements

BASIS. The Behavioral and Symptom Identification Scale (BASIS) is a standardized outcome tool to track progress over time and inform treatment for persons served. SBHG released a BASIS BA Dashboard suite in 2021 to support the program's T2T data driven care efforts. Clinicians were trained to use the BPRS T2T Dashboard to inform treatment and aftercare service planning. The BASIS also meets JC accreditation standards. The BASIS-24 consists of 24 questions (with additional demographic questions) that score six (6) subscales and an overall average. Subscales include: (i) Depression, (ii) Relationships, (iii) Self-Harm, (iv) Emotional Lability, (v) Psychosis, & (vi) Substance abuse. Questions use a 5-point Likert scale, where 0 indicates lower frequency and a 5 is higher frequency. Please note that not all items are negative and need understanding of the tool to properly interpret. The BASIS is administered at intake, update (if person served stays beyond 30 days), and at discharge.

Discharge Surveys

DC Status Form. One program goal is to discharge the person served into favorable circumstances with sufficient supports. Contextually, this encompasses their reason for discharge, circumstances related to discharge, discharge destinations and placement types, including if they were discharged to a situation of homelessness or shelter, and what referrals and linkages were provided. The SBHG DC Status Form, with entries made by clinicians in the EMR at the time the person served is discharged, tracks categorical information for each of these elements. Please note that some questions on the DC Status Form allow multiple selections and thus not all percentages will add to 100%. The DC Status Form is administered at discharge.

Satisfaction Surveys

Agency Partnership Survey. Agency Partnership Surveys are administered every year to agency partners to assess their satisfaction with the agency's (i) treatment, (ii) staff, and (iii) general operations. The questions use a 4-point Likert scale, where 4 = Strongly Agree, 3 = Somewhat Agree, 2 = Somewhat Disagree, 1 = Strongly Disagree. A 5th option, "Don't Know" is also available to respondents; this option is excluded from analysis and thus response rates will vary by question.

Crisis Program Satisfaction Survey. The SBHG DC Crisis Satisfaction Survey measures person served satisfaction and identifies areas for improvement. The survey uses a 4-point Likert scale to measure satisfaction: 4 = Very Much, 3 = Somewhat, 2 = A little, and 1 = Not at All. The survey also has an option for "Don't Know." This response was excluded from analysis, so sample size will vary across questions. The DC Crisis Satisfaction Survey is a voluntary survey administered at discharge.

DEPARTMENT RECOMMENDATION(S):

Click here to enter text.