PROGRAM INFORMATION:

Program Title:	Adolescent Psychiatric Health Facility (PHF)	**Provider:**	Central Star Behavioral Health, Inc.
Program Description:	Acute inpatient care for adolescents ages 12 through 17 years.	**MHP Work Plan:**	4-Behavioral health clinical care Choose an item. Choose an item.
Age Group Served 1:	CHILDREN	**Dates Of Operation:**	August 1st, 2015 - present
Age Group Served 2:	Choose an item.	**Reporting Period:**	July 1, 2022 - June 30, 2023
Funding Source 1:	Medical FFP	**Funding Source 3:**	Other, please specify below
Funding Source 2:	Realignment	**Other Funding:**	Private Insurance

FISCAL INFORMATION:

Program Budget Amount:	$5,438,914	**Program Actual Amount:**	$6,204,442
Number of Unique Clients Served During Time Period:	376		
Number of Services Rendered During Time Period:	48,880		
Actual Cost Per Client:	$ 12,753.44		

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	PHF/Inpatient
Contract Term:	01/1/2015 – 6/30/2018 plus two optional one-year extensions	**For Other:**	Click here to enter text.
		Renewal Date:	June 31, 2022
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 acute inpatient services to adolescents.

TARGET POPULATION INFORMATION:

Target Population:	Adolescents, ages 12 to 17 years, in acute mental health distress who present a threat of harm to self, and/or others, and/or grave disability (severe personal disorganization and inability for self-care and/or functioning safely in the community). Inclusive of Medi-Cal beneficiaries, Medicare and Medicare/Medi-Cal beneficiaries, and the indigent/uninsured who are referred by DBH, other County departments, a

contract provider with the DBH, hospital emergency room, Juvenile Justice Campus, other counties, and other agencies. Additionally, the program serves those with private insurance through contracts and referrals from Kaiser, Anthem Blue Cross, Avante Behavioral Health Plan, Cigna Behavioral Health, Magellan, MHN, Three Rivers Provider Network and Value Options.

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 PHF. Community collaboration and service integration are both increasingly critical foci to assure youth and their families 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 youth and family's issues and needs prompting crisis and hospitalization are assessed and addressed through an individualized plan of care, and the youth's own WRAP, with assertive attention to stabilizing the youth while in the setting and connecting them into post discharge treatment services and resources. CS's PHF in Fresno County helps the county to meet the community need for acute psychiatric care,

and provides an important gateway for those not prior linked to community-based mental health services.

Integrated service experiences

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

Measurement Tools & implementation notes are shown below. A written program Evaluation Plan is available upon request. Below details the data collection used to report program outcomes. Please refer to the Appendix for a description of each measurement tool.

Measurements[1]	About	Completion Rates
Electronic Medical Record (EMR)		
Incoming Referrals	This year's reports utilize SBHG's Business Analytics (BA) Dashboard suite, which includes Youth Service Information (CSI). Staff are fully trained and making use of the SBHG EMR, including customized modules built to ease automated reporting.	All screenings/assessments, youth enrollments, service entries, and Incident Reports are logged into the SBHG EMR. Central Star aims to start logging incoming referrals & referral dispositions in the EMR as well. Additional data notes are provided in the narrative and/or in End Notes.
Referral Disposition		
Screenings/Assessments		
Youth Enrollments		
Service Entries		
Incident Reporting		
Outcome Measures		
Brief Psychiatric Rating Scale (BPRS-Child)	The BPRS is used to meet Joint Commission (JC) standards for Measurement Based Care.	Staff completed BPRS-Child ratings on 427/437 (98%) youth enrollments.

[1] Please refer to the data tools appendix for descriptions of the tools.

Discharge Status Form	SBHG tool to track youth treatment progress and discharge circumstances.	Staff completed DC Status Forms on 386/430 (90%) discharges.
Access to Care		
Authorized Days Workbook	An Excel log used to track whether the county approved admissions and days for treatment.	We are awaiting authorization for one person from Fresno County who was served in June.
Packet Tracker	An Excel log used to track referrals and the completion of documentation related to intake.	The team collected data for 11 months and then transitioned to the SBHG EMR for tracking referrals which will be used for reporting next Fiscal Year.
Stakeholder Surveys		
Agency Partnership Survey	Monitor youth and agency partner satisfaction with services.	We asked 14 Agency Partners to complete the survey and received 2 responses.
SBHG Caregiver Survey	A generic SBHG Caregiver Satisfaction Survey was implemented late 2022.	There were 13 respondents. The sample is small; we report but do not interpret nor generalize the results.
Crisis Program Satisfaction Survey	Gathers youth feedback about PHF services.	Youth surveys were obtained from N=97/430 (23%) completed surveys.

Persons Served

During FY 2022-23 the PHF served 376 distinct youth across 437 enrollments (at first admission, average and median age 14.7; range:12-18 yrs.). Tables 1 present the demographics of those served.

Table 1. All Youth Demographics

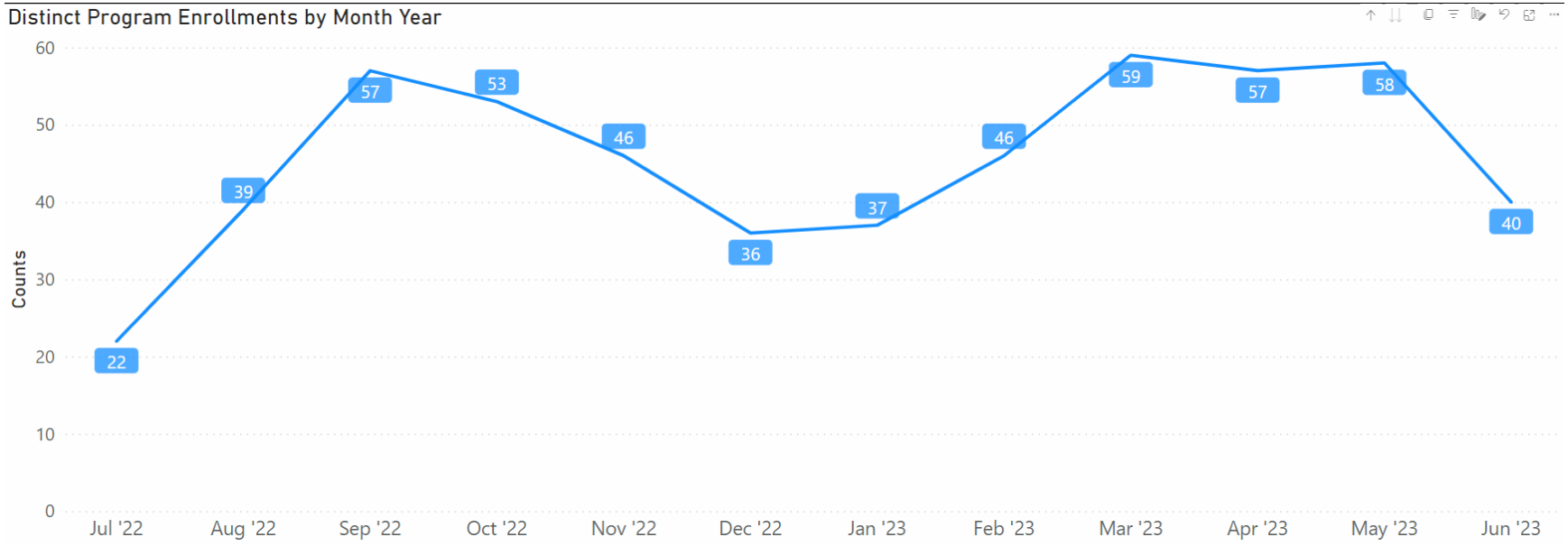
	Child/Youth (0-15)			TAY (16-25)			
	Female	Male	Transgender	Female	Male	Transgender	**Ethnic Subtotals**
American Indian					1		**1 (0%)**
Asian	6	1		1	1		**9 (2%)**
Black	16	5		3	7		**33 (9%)**
Hispanic	60	31	2	40	29	2	**166 (44%)**
White	61	23	7	24	9	3	**125 (33%)**
Mixed	2	5	6	11	4	2	**33 (9%)**
Other	10		1			1	**3 (1%)**
Unknown	3			1	2		**6 (2%)**
Gender Subtotals	**158 (66%)**	**65 (27%)**	**16 (7%)**	**80 (56%)**	**53 (37%)**	**8 (6%)**	**376**

Service Utilization

Key Performance Indicator (KPI) = Serve 57 youth/month or 684/year

Utilization was shy of the contract target. Figure 1 presents the number of enrolled youth each month during the fiscal year. There were 437 enrolled youth during FY 2022-23 and on average, 37 youth were enrolled per month, compared to an average of 53 youth each month last Fiscal Year. While improving utilization had been a hopeful focus of the program team for the Fiscal Year, they were challenged in July '22, when a power outage impacted operations and stopped new admissions. As such, there were fewer admissions in July and August. The clinical leadership team also experimented with longer lengths of stay to lower recidivism which affected the number of youth served.

Figure 1. Distinct Program Enrollments by Month and Year FY 2022-23



Access & Efficiency

According to the Packet Tracker, the PHF received 1,326 referrals. Of these, 632 (47.7%) of total referrals were from Fresno County. Among Packet Tracker referrals, 267 were accepted (20.1%), 186 of which were from Fresno County (70.0%; Table 3).

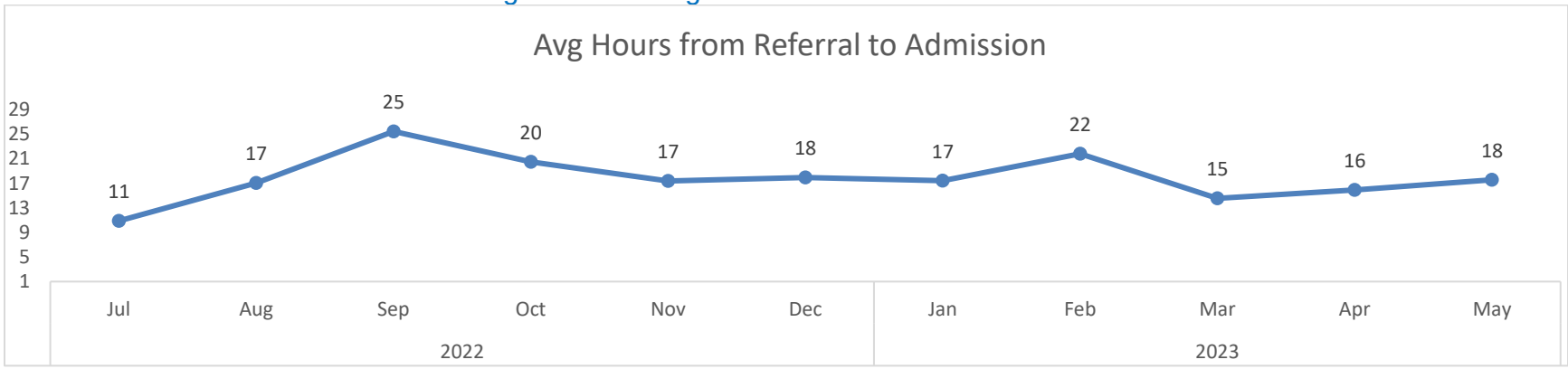
Key Performance Indicator (KPI) = Time between receipt of a referral and contact with the referring agency is prompt.

Last Fiscal Year, PHF staff responded to referrals on average within 6-hours. To improve the responsiveness, the PHF distributed the responsibility to respond to calls to all staff and monitored timeliness every month in their systems meeting. This Fiscal Year it took an average of 4.6 hours – 21% faster response times than last Fiscal Year. Timeliness of response is a metric that the leadership team closely monitors. Almost half (42%) of referrals were addressed within 1 hour.

Key Performance Indicator (KPI) = Time between referral and admission to the PHF meets state timely access to care standards.

During FY 22-23, 72% of youth were admitted within 24 hours of the incoming referral. On average, accepted referrals were admitted within 19.3 hours. Figure 2 below shows the average hours from referral to admit. Please note that the data is only available until May 2023. In June, the team transitioned to the EMR Referral Module. SBHG will build a reporting system for this data from the SBHG EMR and present this data in next year's report.

Figure 2. Average Hours from Referral to Admit



Key Performance Indicator (KPI) = Denial rate of admissions when a bed is available

The PHF denied 11% of incoming referrals when there was a bed available. No denials were made because of bed availability per se, however, rather because of the person's status, insurance, or the absence of a signed contract with the county or insurer. Table 2 presents the reasons for not entering the PHF at the time of referral.

Table 2. Reasons for Non-Admittance to the PHF

Row Labels	Count	Percentage
No Contract with County	53	22%
Client does not meet program requirements	30	13%
No Contract with Private Insurance	29	12%
Client is overage	18	8%
Client is underage	18	8%
Client does not benefit from program	5	2%
Does not meet program requirements	3	1%

No contract with private insurance	1	0%
No Contract with insurance	1	0%
Client is under age	1	0%
Other	80	33%
Total	**239**	**100%**

Key Performance Indicator (KPI) = Denial rate of PHF days not meeting Medi-Cal necessity criteria per utilization review

The overall Medi-Cal denial rate for the FY was 3/3281 days or .91 per 1,000 days, indicating that admitted youth qualified for psychiatric hospitalization abiding Medicare guidelines and that this type of expensive restrictive resource is being appropriately used for those who genuinely need it. The 3 days denied by Medi-Cal were from Stanislaus County in August 2022, due to not meeting medical necessity. Table 3 presents the number of days approved and denied by Medi-Cal by month across FY 2022-23.

Table 3. Days Approved by Medi-Cal

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Days Approved	154	306	441	286	306	232	304	280	382	396	320	203
Days Denied	0	3	0	0	0	0	0	0	0	0	0	0
% Denied	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Effectiveness

Key Performance Indicator (KPI) = Reduced high-risk behaviors and associated incidents

There are two primary data sources that inform this KPI – the Brief Psychiatric Rating Scale (BPRS) and Incident Report (IR) data.

Brief Psychiatric Rating Scale (BPRS):

At the PHF, each youth is assessed by clinicians at admission, every 2 days, and at discharge. During FY 2022-23, 427/437 (98%) of youth received at least 2 assessments, with an average of 7 days 20 hours between initial and final assessments.

To examine changes in youth' behaviors from first to last available records, a paired t-test was conducted on the total BPRS scores, comparing each youth's score on their first and last available records of the same enrollment. As seen in Figure 3, youth show a statistically significant reduction (p<.01) in their overall BPRS scores, indicating they manifest fewer overall symptoms over the course of their PHF episode of care. The average total score declined by 59%. Additionally, a McNemar's Chi-Square test shows that the proportion of youth who fell below the cutoff score (a total score of 27 or above is considered "at risk") slightly shifted (1% fewer youth "at risk") from their initial to latest assessment (Figure 4). We are pleased to see zero at-risk clients being discharged in FY 22-23. Specific reductions in average scores at the item level can be found in Figure 5, demonstrating there were improvements across all items. In particular, note the good effect sizes with respect to items 4. Depressed Mood, 5. Inferiority, 8. Tension and 9. Anxiety.

Figure 3. BPRS Average Total Scores

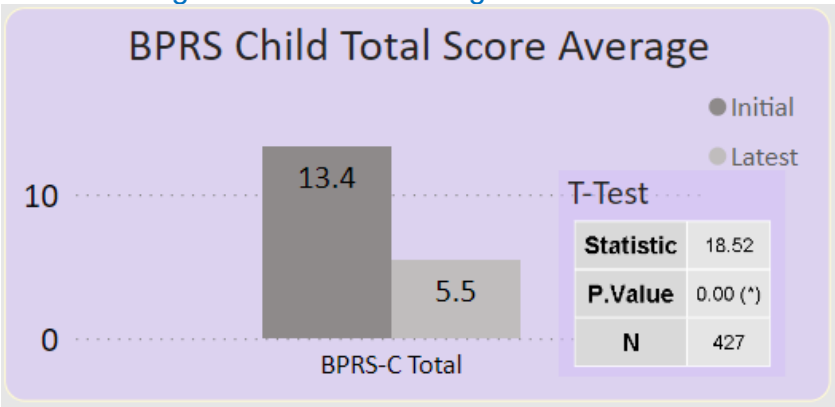


Figure 4. BPRS Youth at Risk

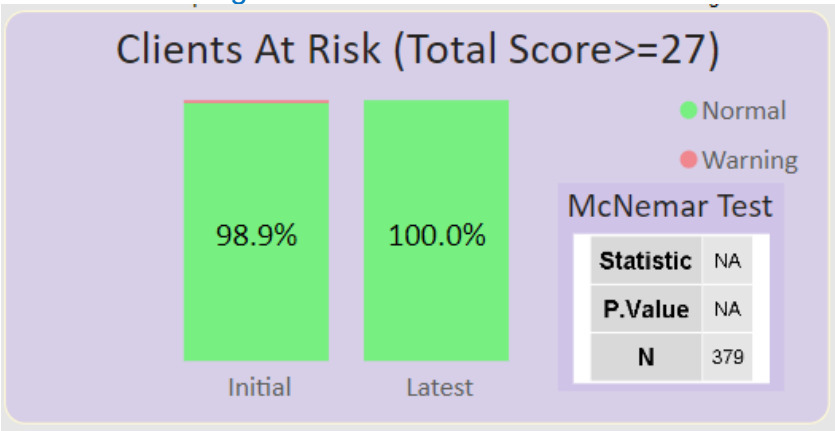


Figure 5. BPRS Child Items
[Reduced average scores are desirable]

Average Initial and Latest Item Scores

Item	Initial	Latest
01. Uncooperativeness: negative, uncooperative, resistant, difficult to manage	0.70	0.32
02. Hostility: angry or suspicious affect, belligerence, accusations and verbal condemnation of others.	0.39	0.18
03. Manipulativeness: lying, cheating, exploitive of others.	0.36	0.29
04. Depressed mood: sad, tearful, depressive demeanor.	3.08	1.06
05. Feeling of Inferiority: lacking self: confidence, self-depreciatory, feeling of personal inadequacy.	2.07	0.65
06. Hyperactivity: excessive energy expenditure, frequent changes in posture, perpetual motion.	0.87	0.32
07. Distractibility: poor concentration, shortened attention span, reactivity to peripheral stimuli.	1.48	0.82
08. Tension: nervousness, fidgetiness, nervous movements of hands or feet.	1.27	0.47
09. Anxiety: clinging behavior, separation anxiety, preoccupation with anxiety topics, fears or phobias.	3.15	1.40

Incident Reports (IRs)

Staff intervene and/or respond to, monitor and report risk behaviors and other types of incidents that occur at the PHF. During FY 2022-23, the PHF had 277 total incidents, involving 130 distinct youth. Figure 6 shows incident counts by month. Table 4 shows incidents by type. Table 5 shows staff interventions by type.

Many (26%) incidents were about staff discovering child maltreatment which had occurred prior to admission and may have precipitated or contributed to the youth being in crisis. These usually (95%) required CPS reporting by our staff (sometimes the report was already or recently made by other providers prior to a youth's arrival on the unit).

Of all incidents, the most common incident types involved youth risk behaviors such as Assaults (33%), Threatening Others (16%), Injury to Self/Others (13%), and Equipment/Property Damage (12%). Incident rates may be affected by the balance of youth in the milieu at that time – for example, more admissions of those with anger management and aggression issues, or with self-harm tendencies, may raise a month's rates.

The program team applies Professional Assault Crisis Training (Pro-ACT) that focuses on early intervention, prevention and mitigation – thus staff know how to avoid use of restrictive interventions whenever possible and they apply such at low rates, which can be seen in Figure 6 across the months of the FY. Overall, staff managed the setting competently and generally achieved low rates of incidents, 69 per 1,000 patient days.

For individual youth, PHF treatment usually results in a reduction in risk behaviors -- 97% are discharged because they no longer meet medical necessity -- and youth may not discharge back to the community if they remain a threat to themselves or others or are profoundly disturbed in ways that manifest in disorganized and/or impulsive risky behaviors.

Figure 6. PHF Incidents by Month (FY 2022-23)

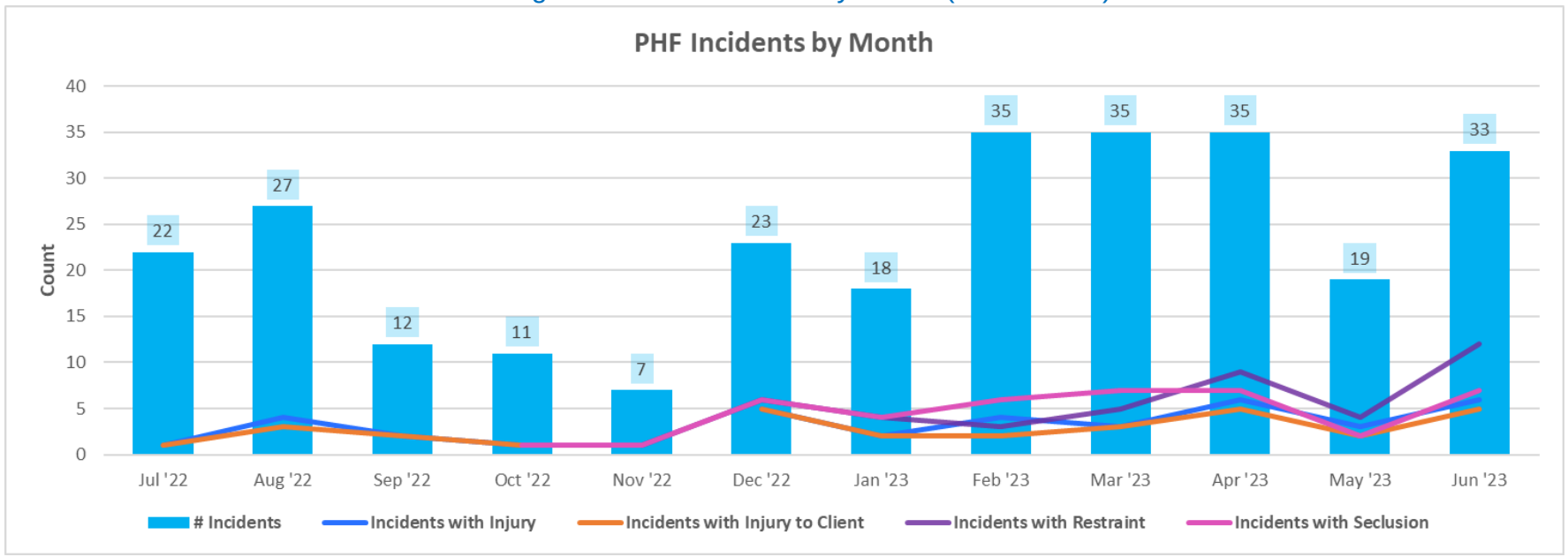


Table 4. Incident at the PHF by Type (FY 2022-23)

Incident Type	# Incidents	Rate	Monthly Avg
Assault	92	33%	7.7
Abuse	71	26%	5.9
Threats	44	16%	3.7
Injury	37	13%	3.1
Equipment/Property	33	12%	2.8
Other	22	8%	1.8
Health/Medical/Medication	19	7%	1.6
Sexual Behavior	5	2%	0.4
AWOL	3	1%	0.3
Blood/Body Fluid Contact	2	1%	0.2
Suicidality	2	1%	0.2
Domestic Violence	1	0%	0.1
Interfering in a Crisis	1	0%	0.1
Total	**277**	**100%**	**23.1**

Table 5. Most Common Incident Interventions (FY 2022-23)

Incident Actions Taken	Asso. Incidents	Proportion of Incidents
Report Filed, Child Abuse (Suspected)	76	27%
Medical Doctor Notified	74	27%
Intramuscular Medication Administered	66	24%
Change of Environment	53	19%
Counseling	53	19%
Parent/Guardian Notified	49	18%
Brief Physical Prompt	42	15%
Seclusion	41	15%
Physical Restraint*	35	13%
Debriefing, Staff	31	11%
Facts recorded on Chart	27	10%
ER Visit	24	9%
Denial of Rights (Other)	21	8%
Contract for Safety	18	6%
Debriefing, Client	16	6%
Assessment, Dangerous Behavior	13	5%
Other	13	5%

* This does not include Mechanical Restraints which are not used at SBHG facilities.

Key Performance Indicator (KPI) = Acquisition of coping, communication, and community life skills

Based on clinician's entries on the SBHG Discharge Status Form, 99.97% of youth met some, most or all of their treatment goals. Understanding youth's treatment progress helps understand the program's effectiveness from a clinical perspective as treatment goals typically focus simultaneously on reducing risk behaviors while advancing the youth's coping, communication and community life skills.

In the caregiver survey, most respondents (83%) agreed that the program helped the child recover and cope. Half of respondents (50%) agreed that the program helped them communicate and develop community life skills. One respondent wrote that their child was improving well and working on family relationships and another shared that their child learned a lot of coping skills.

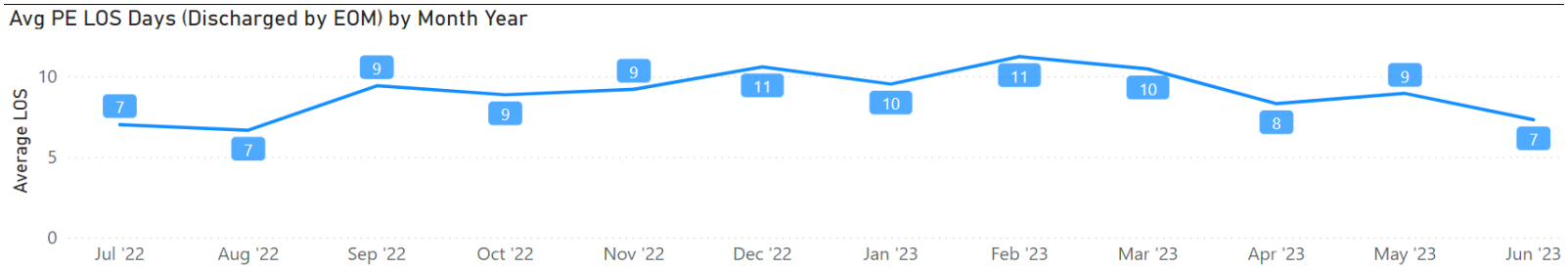
Efficiency

In our reporting this year, efficiency is reflected in: a) maintaining a disciplined, focused program despite some external challenges (COVID outbreaks, facility power generation failures) in which the team accomplished comprehensive screenings, assessments and treatment so the youth quickly stabilized; b) having effective strategies that help youth learn how to better manage their wellness, which they may value and carry forward into their lives; c) effecting after-care plans with linkages to next-on services, especially those that are community-based; and, d) minimizing the need for youth to be readmitted to the PHF, especially within 30 days of being discharged from the PHF.

Key Performance Indicator (KPI) = The average length of stay is within county expectations

Among the 430 discharged enrollments during FY 2022-23, the average length of stay was 9 days, and the range was 1 to 127 days -- there were 2 unusual circumstances exceeding a month.[i] One client had returned to the PHF for the third time and a judge granted conservatorship; the other client has also recidivated to the PHF multiple times and is currently enrolled. Much service is provided in the little over one week of an average stay – we have thoroughly documented our service types and varied practitioners' contributions in prior annual reports and service utilization data (types/mixes) for FY 22-23 is readily available upon request.

Figure 7. PHF Average LOS in Days by Month FY 2022-23



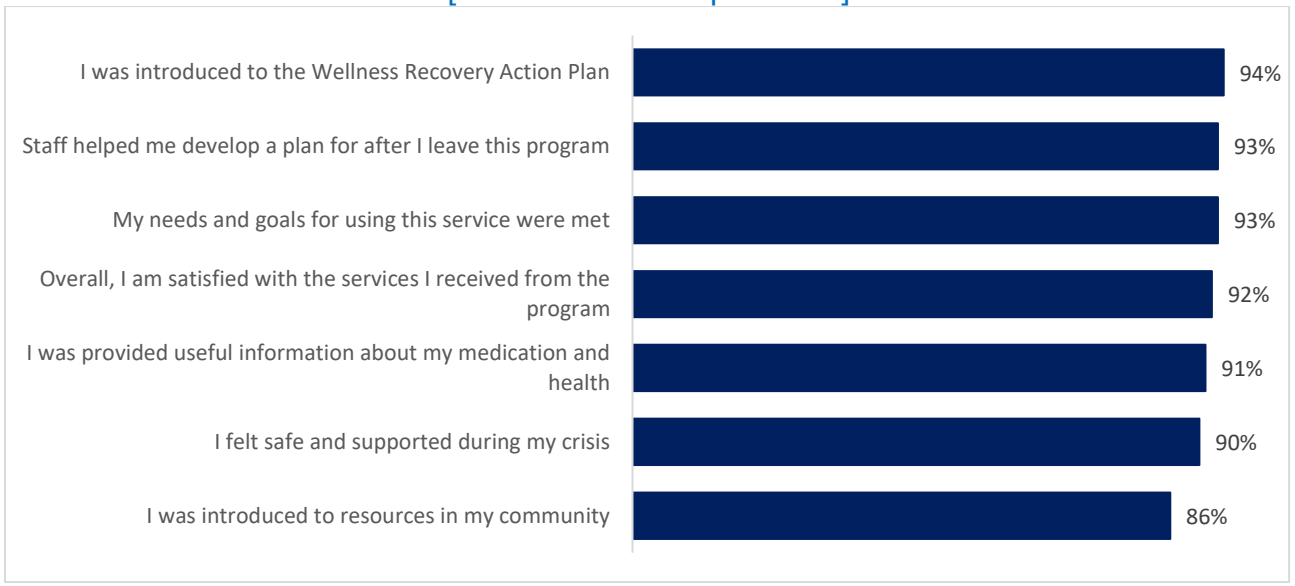
Key Performance Indicator (KPI) - Collaborative approaches and treatment strategies to reduce hospital readmission of youth, esp. among those with frequent PHF readmissions

Central Star uses various strategies to reduce hospital readmissions. For example, staff use Motivational Interviewing (MI) -- trained to in our Core Practices training program -- to engage and align with youth's own desires to feel better, learn from their crisis experience and to apply what they are learning to their life so they might avoid future crisis as much as possible. Almost all (99%) youth were introduced to and guided to develop a Wellness Recovery Action Plan (WRAP) during groups and individual rehabilitation sessions this last year. In this process, the youth and staff create a wellness toolbox, identify early warning signs for a crisis, and create a crisis plan. Youth on a repeat admission are asked about their WRAP and engaged in updating it; this includes discussing what worked before and what more they might include in their wellness toolkit, and benefit from with respect to aftercare and social supports. Additionally, youth and family are also provided many opportunities to collaboratively join in treatment, as well as in planning for discharge/aftercare. For instance, staff collaborate with the youth on a Behavioral Health Plan when they have challenging behaviors.

Another approach implemented at the request of Fresno County was to review all charts for individuals re-admitted within 30 days. The SBHG EMR shows a youth's previous enrollments. When a youth is readmitted to the PHF, their charts are reviewed by staff. This is standard policy regardless of how long ago they were prior admitted to the program and it is a good standard practice in place for all youth, from any referring/authorizing county.

On the Crisis Program Satisfaction Survey, the majority of youth somewhat or very much agreed that they developed WRAP, safety and after care plans, received useful information, and were satisfied with the services (Figure 8).

Figure 8. Crisis Program Satisfaction Survey
-- somewhat/very much agreed on items pertinent to avoiding crisis --
[N=104 Youth Respondents]

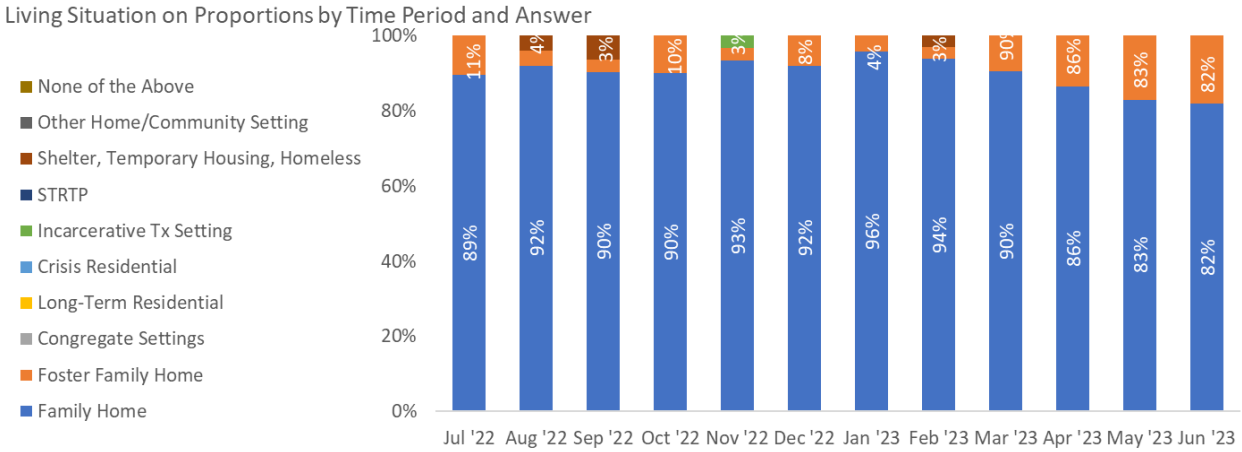


Key Performance Indicator (KPI) = Effective discharge planning as demonstrated by referral and linkage to other DBH programs, community providers and other Discharges

The PHF team brings focused efforts and produces results at connecting youth into after-care services. We first present the discharge destinations of PHF youth during FY 2022-23, estimate the proportions who leave to higher end care, followed by information about the community based after-care linkages and supports the team effected.

Based on available SBHG Discharge Status Form data (90% completion rate), most youth (92%) discharged to a family home. Others left to foster homes (2.3%), shelters/temporary housing (0.01%), independent living (<1%), or unknown destinations (<1%, related to moving out of the area or the county). This information is consistent with the patterns seen in prior years using other types of data collection and record sets.

Figure 9. Discharge Destinations of PHF Youth by Month FY 2022-23



Very few youth (3%) were discharged to higher-end care (including medical and psychiatric hospitals, residential care and incarcerative settings).

Regarding the referrals and/or linkages[ii] staff provide, of the 386 discharges with a Discharge Status Form, 100% were provided one or more referrals/linkages (n=386). The most common types of referrals and/or linkages included referrals to Psychiatric Services (42%) and Individual Therapy or Rehab (36%). Figure 10 shows the proportions of youth who receive different counts of referrals/linkages. Table 6 arrays referrals/linkages by types.

Figure 10. Proportions of Youth/Families with Referrals/Linkage Counts
[n=386/430 (90%) Discharge Status Forms Completed]

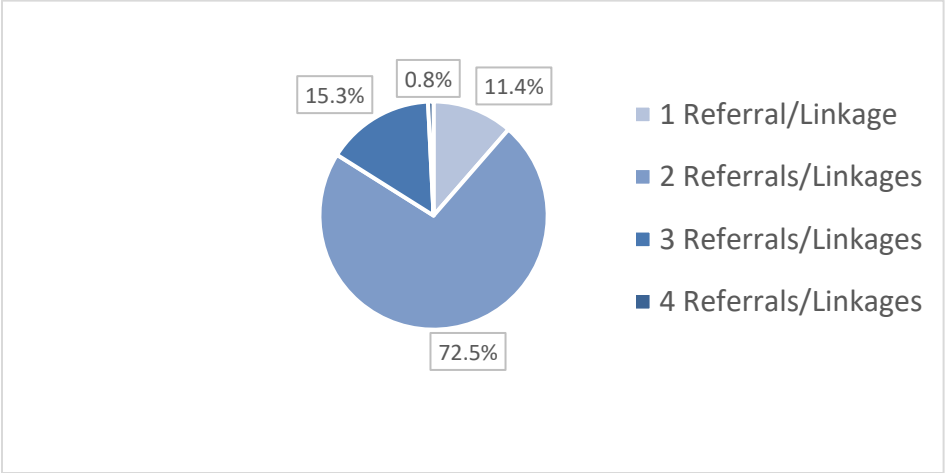


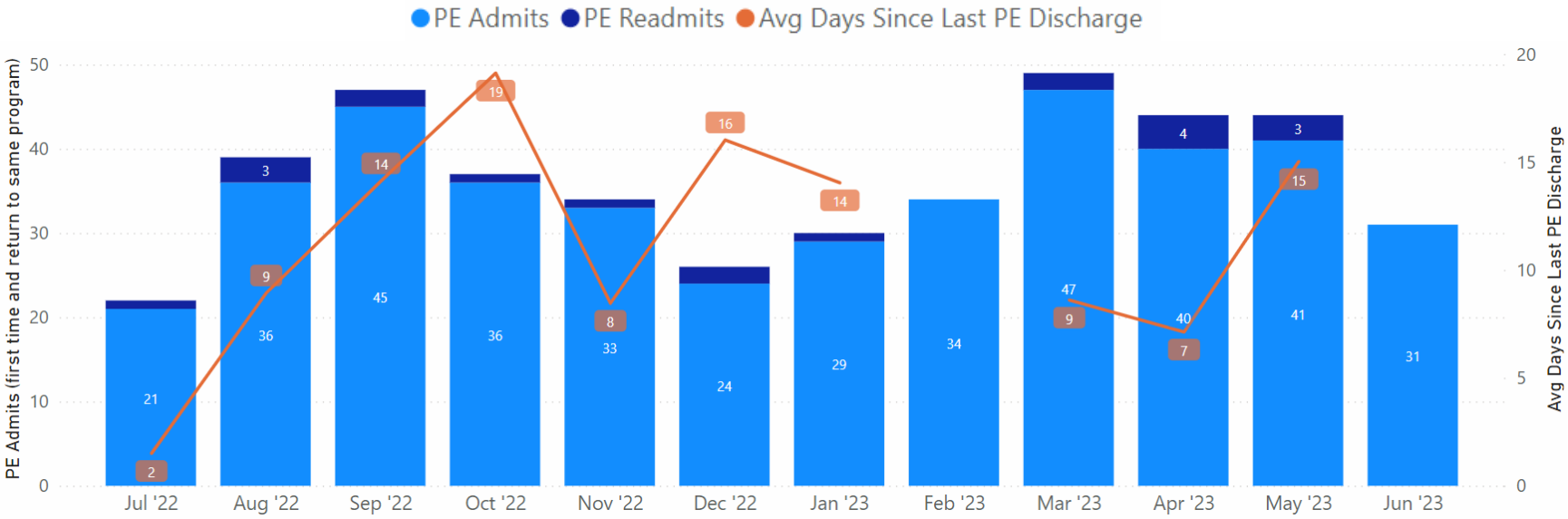
Table 6. Behavioral and Community Linkages for PHF Youth FY 2022-23

Psychiatric Services	42.2%
Individual Therapy or Rehab	36.2%
Intensive Outpatient & Case Management	7.1%
School-Based MH Counseling	4.3%
County Case Management	3.3%
Other	1.5%
Day Rehab or Tx	1.4%
Wraparound	1.1%
Outpatient SA Education or Tx	1.1%
Residentially Based Services	0.6%
Family Therapy or Rehab	0.5%
Group Therapy or Rehab	0.3%
Peer-to-Peer Services	0.1%
Parenting Skills	0.1%
Intensive Tx Foster Care	0.1%

Key Performance Indicator (KPI) = Most youth were admitted to the PHF once and few required repeat admissions.

In our organization's culture, we highly value being data driven and have built dashboards that enable our staff teams to actively monitor readmissions to the PHF. The proportions of youth readmitted to the PHF within 30 days is shown below from our Business Analytics (BA) dashboard (Figure 11). During FY 2022-23 there were 20 (5%) readmits out of 437 total admissions that occurred within 30 days of the previous admission.

Figure 11. PHF Readmissions Within 30 Days.



Stakeholder Satisfaction

Key Performance Indicator (KPI) = Youth and caregivers report being satisfied with the services they or their youth received.

Youth Satisfaction

Youth are surveyed as they prepare for discharge. They may decline and thus there may be sampling bias in the results. This last year the team was able to collect n=105 surveys for FY 2022-23. The majority of youth (92.4%) rated 'somewhat' or 'very much' that they were overall satisfied with the services of the program. Indeed, based on this sample, all survey items scored above 81% - even "recommending the program to others" was endorsed by 81% of the youth. We note that Fresno County expects at least 80% endorsements from youth on overall satisfaction, a performance indicator that was met. Additionally, safety items that are necessary inquiries for our company's Joint Commission Accreditation, were met at high levels of endorsement (86.5% or greater) (Figure 13, items 9, 11 & 12).

Figure 12. Crisis Program Satisfaction Survey Results

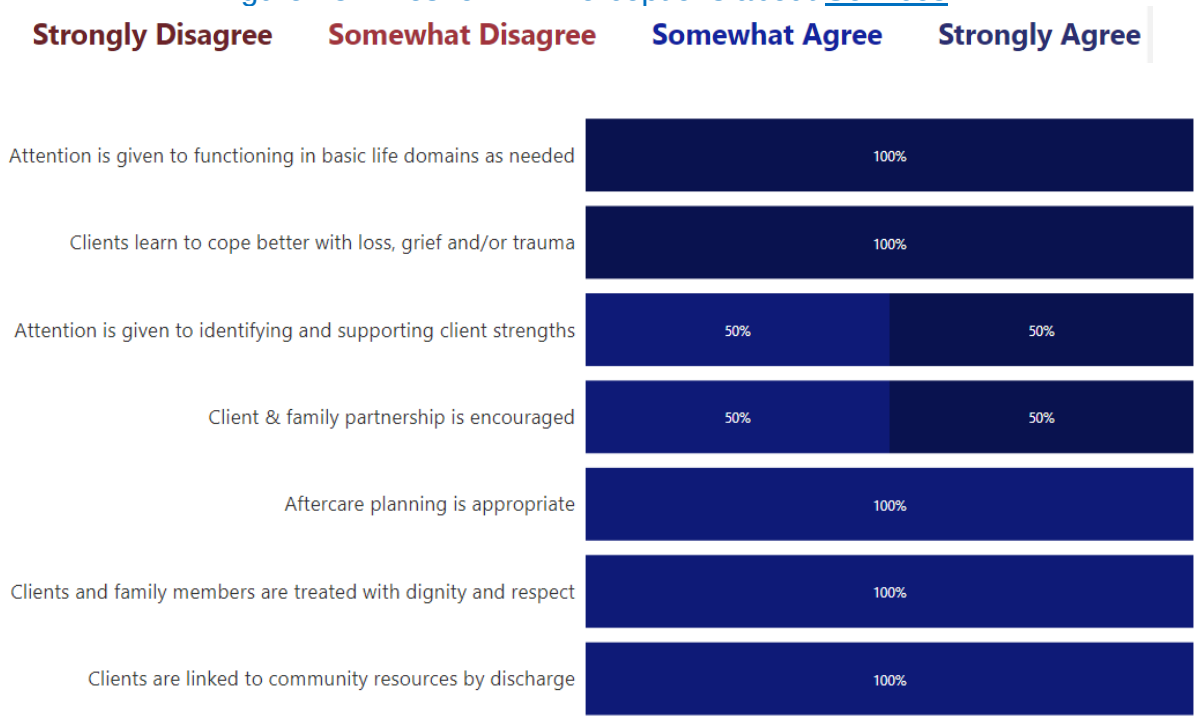
Number	Item	Not at All/ A Little (1-2)	Somewhat/ Very Much (3-4)	Don't Know (0)	Average Score	Sample Size
1	I received services in a timely manner	5.7%	93.3%	1.0%	3.62	105
2	I was introduced to the Wellness Recovery Action Plan	4.8%	94.2%	1.0%	3.83	104
3	I was provided useful information about my medication and health	6.7%	91.3%	1.9%	3.72	104
4	I was introduced to resources in my community	10.5%	85.7%	3.8%	3.48	105
5	My needs and goals for using this service were met	6.7%	93.3%		3.61	105
6	Staff understood, respected, and sympathized with my unique identities	8.6%	90.5%	1.0%	3.67	105
7	I was treated with dignity and respect by staff	6.7%	93.3%		3.57	105
8	Staff took time to listen to what I needed and were available to talk when I was troubled	9.6%	89.4%	1.0%	3.63	104
9	Staff helped me feel safe and develop a safety plan if needed	6.7%	91.4%	1.9%	3.71	105
10	Staff helped me develop a plan for after I leave this program	6.7%	93.3%		3.70	105
11	I felt safe and supported during my crisis	8.7%	90.4%	1.0%	3.66	104
12	The setting was safe, clean, and comfortable	13.5%	86.5%		3.45	104
13	I get along better with family members		88.9%	11.1%	3.75	9
14	I have the support I need from family or friends	11.1%	88.9%		3.44	9
15	I will do better in school and/or work		88.9%	11.1%	3.75	9
16	I deal more effectively with daily problems and my symptoms don't both me as much		100.0%		3.33	9
17	I am more resilient and am more likely to overcome challenges after participating in the program	11.1%	88.9%		3.56	9
18	I feel more hopeful after participating in the program		100.0%		3.67	9
19	Overall, I am satisfied with the services I received from the program	6.7%	92.4%	1.0%	3.70	105
20	I would recommend this program to others	17.1%	81.0%	1.9%	3.40	105
21	Staff communicated hope and confidence in me to overcome my	7.4%	90.5%	2.1%	3.65	95

Key Performance Indicator (KPI) = Agency partners report being satisfied with the PHF program

Agency Partner Satisfaction

The team requested feedback from N=14 agency partners and N=2 responded (14% response rate). The respondents agreed with all the statements in the Services, Facility & Program category.

Figure 13. Fresno PHF Perceptions about Services



Although both respondents agreed on the following facility statements, one respondent who stated they were a visiting social worker recommended having a private place to meet with their clients in the facility.

Figure 14. Fresno Perceptions about Facility

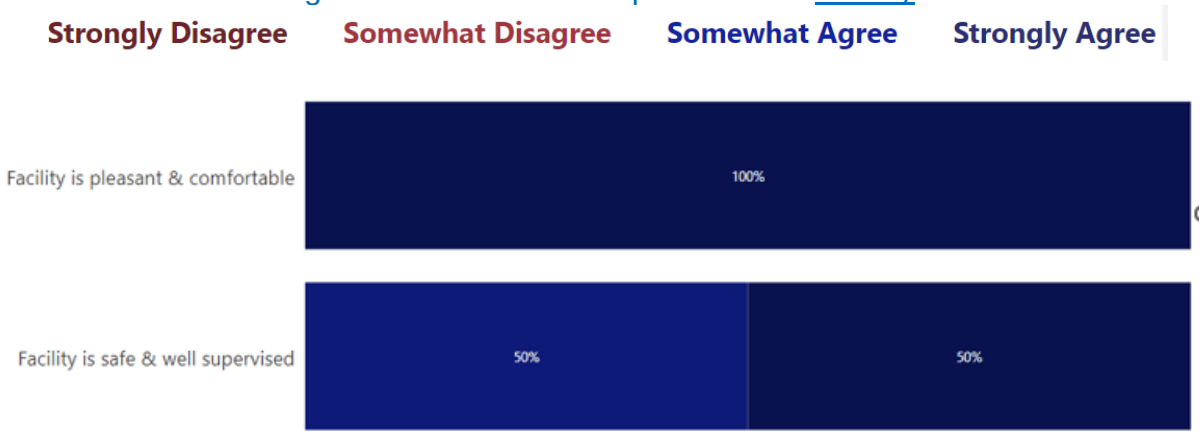
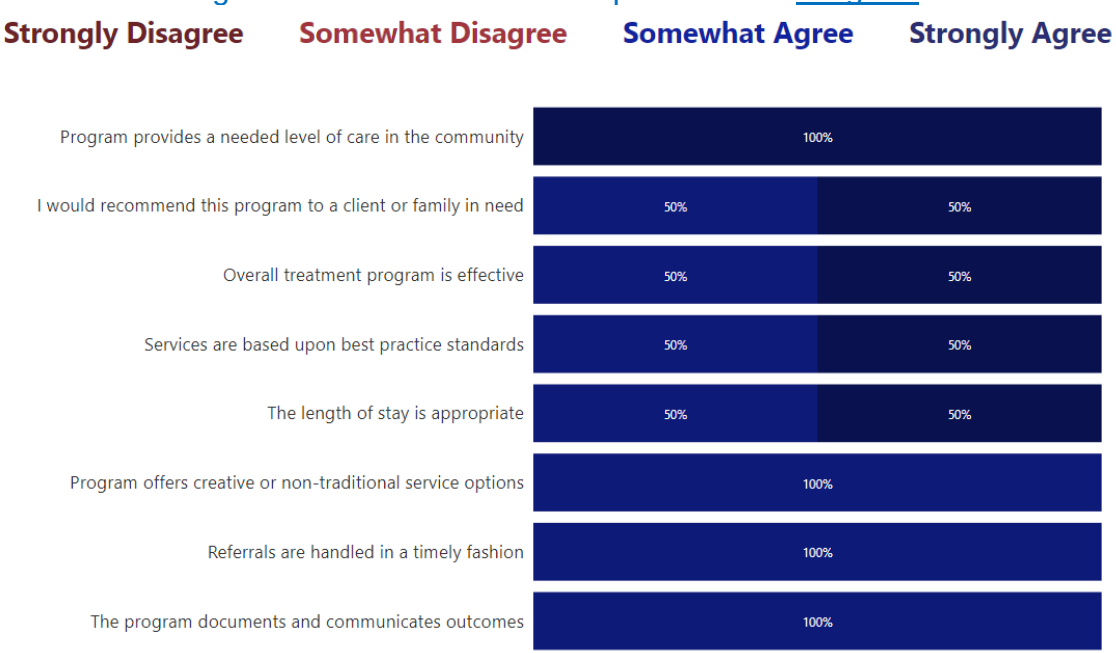
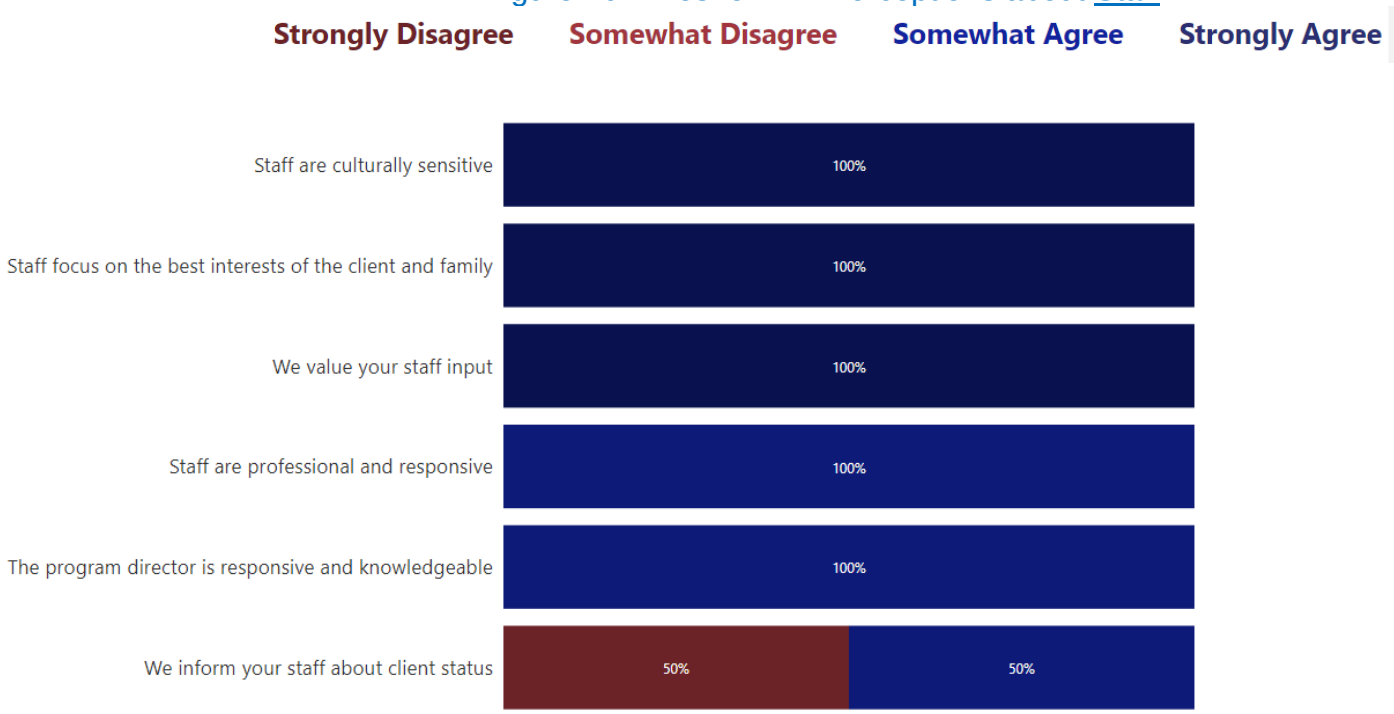


Figure 15. Fresno PHF Perceptions about Program



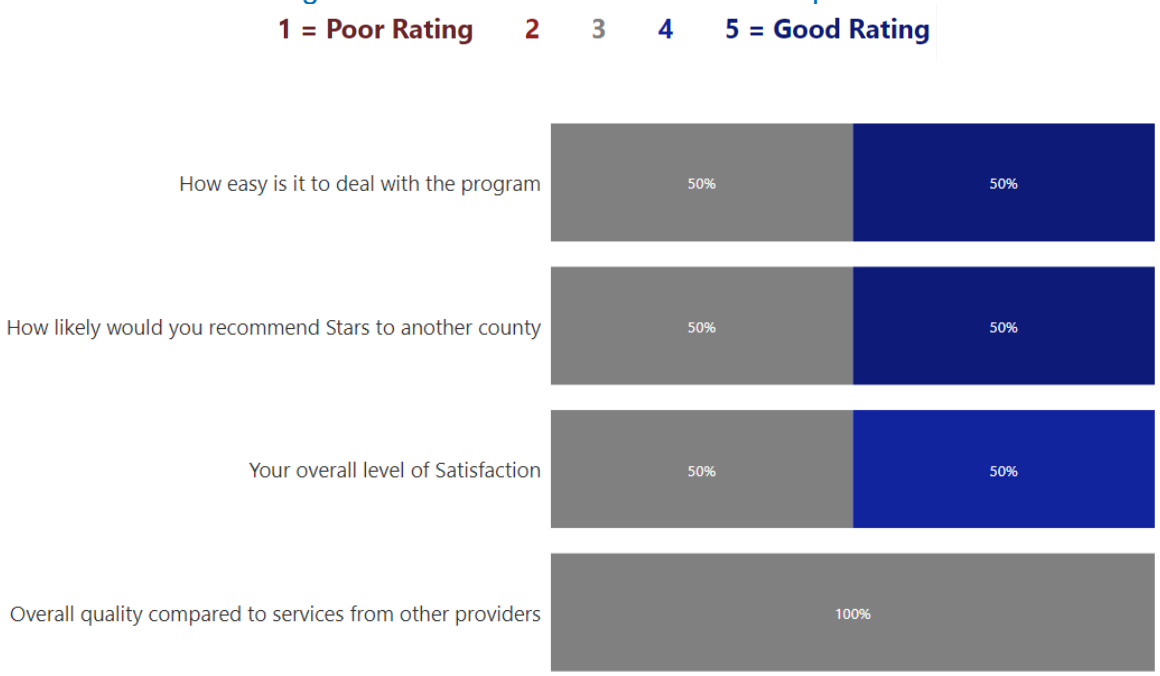
The respondents agreed with most of the statements in the staff category. One respondent strongly disagreed with the statement "We inform your staff about client status". Both respondents elaborated on this statement. They both recommended social workers provide timely updates on their clients. They elaborated that it is challenging to obtain updates on clients, and they no longer receive phone or email updates from staff as they previously did years ago. One respondent recommended to provide the contact information of the social workers along with the best times to contact them. Although both respondents agreed that staff are professional and responsive, one respondent recommended that staff in the nursing station ought to offer a greeting to visitors to better their customer service.

Figure 16. Fresno PHF Perceptions about Staff



Below are the respondents' rating on their overall perception regarding the Fresno PHF.

Figure 17. Fresno PHF Overall Perceptions

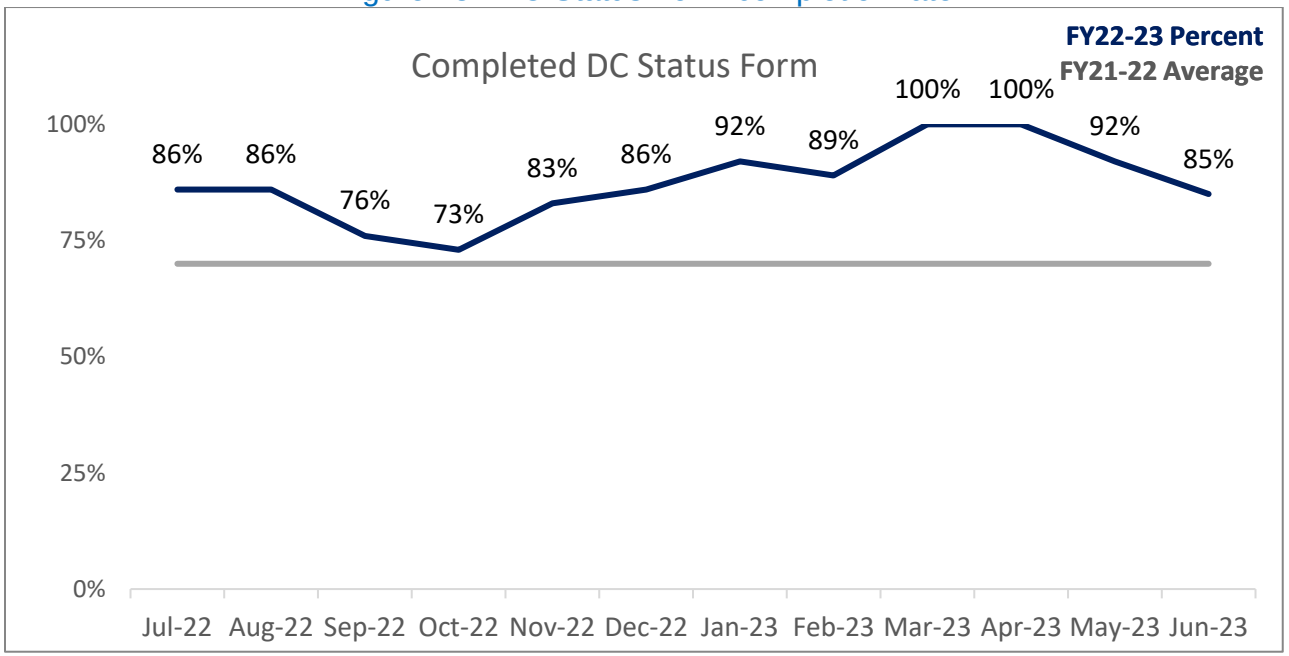


FY22-23 Quality Improvement Projects

QI Project: Suicide Safe Care: In addition to the quality improvement projects already described (referral response times and recidivism), the PHF participated in the company's Suicide Safe Care Initiative over the last few years which produced improvements in SAFE-T screening/assessment completion rates, better use of EMR Alerts and Safety Plans – and most importantly, reductions in risky self-harm behaviors and suicidality (ideation, plans, and/or attempts). For example, data shows a marked increase in the PHF's post-screening assessments completion rates for all clients presenting suicide risk (specifically, completion rates rose from 47% in July 2022 to 86% in July 2023). A Suicide Safe Care Dashboard suite will soon become available to program staff and ease their process of monitoring toward continuous quality improvement regarding the initiative's indicators along with the incident tracking and reporting that has been in place since the program opened.

QI Project: DC Status Form Completion Rate: The PHF team also worked to improve the DC Status Form completion rate: In the prior Fiscal Year (21-22), the DC Status Form completion rate was 70%. This Fiscal Year, staff were retrained to complete the DC Status Form and completion rates were monitored monthly at the team's systems meeting. This Fiscal Year, the PHF had a completion rate of 87%, a 24% increase from last Fiscal Year! Figure 19 below shows the DC Status Form completion rate over time.

Figure 18. DC Status Form completion rate



QI Project: Post-DC Follow-Up Survey. SBHG uses the Post-DC Follow-Up Survey to understand the impact of the program on outcomes and report on individual client status to the Department of Health Care Access & Information (HCAI). From November '22 to June 23, the PHF aimed to contact 97 people after their enrollment. Most (N=60) consented to be contacted and 33 Post-DC Follow-Up Surveys were completed. It is standard protocol to call each person's contact three times to connect on their aftercare plan and complete the Post DC Follow-Up Survey. Note that the Post-DC Follow-Up Survey has two purposes:

1. Intervention: The survey asks questions about the client's linkage and support. If the client is unsure or needs assistance, the interviewer helps the previous client troubleshoot. For instance, the interviewer may help a previous client problem solve where to fill their prescription.

2. Data Collection: collect critical information on client's medication, after care appointments, and acuity since discharge. Program KPIs are also included.
   Sometimes, clients may be uncertain about a question.

During the survey interview, 91% of children had not experienced high acuity symptoms since discharge. The three children who did have symptoms experienced hard days at schools, stopped taking their medications, or ran away. When asked about their prescription, all people knew that there was prescription on their After Care Plan, 70% had already filled their prescription; of the 30% who did not fill their prescription, 94% knew how. Staff helped respondents troubleshoot how to fill their prescription in these cases.

Staff also inquired on Services & Supports to help respondents troubleshoot any challenges. Most people were linked to therapy and psychiatry. Respondents who had already attended their first appointments (33%) reported no challenges. Most respondents (57%) had scheduled their first appointment with the referral and had no challenges doing so, though one respondent shared that they were changing their child's medication because it affected her stomach. Few (10%) respondents still needed to schedule their appointment. At this point, staff reminded them and provided the number of Fresno DBH to one person.

Very few respondents (6%) reported experiencing distress since leaving the PHF. One respondent had housing challenges and another had a police encounter with no arrests because of a conflict with other children at school. When ending the Post-DC Follow-Up Survey, staff check that the respondent is familiar with WRAP and check if they want more information. Only one respondent was not familiar with WRAP and they did not want more information. Overall, 94% of clients were doing well after Discharge. Staff were concerned with 6% (n=2) of the respondents because one client ran away and another was violent and destroyed the home. Staff informed the caregiver to call the crisis line of 911.

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.

Appendix: Data Tools [LISTED IN ALPHABETICAL ORDER]

Agency Partnership Survey

Agency Partnership Surveys are administered every few years 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 vary by question.

Brief Psychiatric Rating Scale (BPRS)

The BPRS-C-9 is used by clinicians nationally to measure short-term changes in youth psychiatric symptoms and it is especially fitted for crisis settings as it addresses high risk behaviors/symptoms that are sensitive to change when

effective short term mental health treatment is provided. Each one of its 9 items is scored on a 7-point scale: 0= "Not Present" to 6= "Extremely Severe", and reductions in scores are desirable. Youth are categorized at "risk" if they have a total score greater than or equal to 27. The BPRS is administered at intake, updated as needed, and upon discharge by a clinician trained on the tool. SBHG released a BPRS BA Dashboard suite in 2021 to support the program's measurement of care efforts – for tracking individual youth as well as aggregated data. The aggregated dashboards represent analysis that use matched pairs only (youth with both an initial and subsequent score). Clinicians were trained to use the BPRS T2T Dashboard to inform treatment and aftercare service planning. This process meets and fulfils Joint Commission (JC) accreditation standards for measurement based care.

Caregiver Satisfaction Survey

The SBHG Caregiver Satisfaction Survey measures caregiver satisfaction and identifies areas for improvement. The tool includes some standard, required questions from the Joint Commission about safety in the setting. The survey includes 5-point Likert scale agreement questions and also captures the caregiver's voice through free response questions.

Crisis Program Satisfaction Survey

The SBHG Crisis Program Satisfaction Survey is gathered from willing youth as they discharge, and measures youth satisfaction and their ideas about areas for improvement. The tool includes some standard, required questions from the Joint Commission about safety in the setting. 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." A 5th option, "Don't Know" is also available to respondents; this option is excluded from analysis and thus response rates vary by question.

Discharge Status Form

The SBHG DC Status Form, with entries made by clinicians in the EMR at the time the youth is discharged, tracks categorical information of varied types. A program goal is to discharge the youth into favorable circumstances with sufficient community-based 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. 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.

Post-DC Follow-Up Survey

The Post-DC Follow-Up Survey dual functions as an intervention and a data collection tool. Staff call the caregivers after 3 days because the persons' discharge and inquires on their: prescription continuity, aftercare plan, and

acuity since discharge. During their discussion, staff help troubleshoot the person's challenges. For instance, staff will help connect a person to a pharmacy if the person does not know where to get their prescription filled. If any of the responses are concerning to the interviewer, they then confer with staff regarding a follow up plan. At any point during the survey, if the person served is afraid, agitated, uninterested, or non-cooperative, staff will discontinue the survey. As needed, staff provide the person with additional resources for their Wellness Recovery Action Plan.

EndNotes

[ii] We aim for actual contacts made between our staff, next on provider(s) and the youth/family, not just referral names and numbers given to the youth/caregiver on a piece of paper. However, sometimes the latter is best possible in a circumstance.