EMERGENCY MOBILE PSYCHIATRIC SERVICES

EMPS is a program funded by the State of Connecticut in partnership with the United Way of Connecticut 2-1-1.

EMPS Crisis Intervention Services Performance Improvement Center (PIC)

Annual Report: Fiscal Year 2012

July 1, 2011 - June 30, 2012

Updated 8/14/2012

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The Emergency Mobile Psychiatric Services Performance Improvement Center

is housed at the Child Health and Development Institute's

Connecticut Center for Effective Practice

Connecticut Center for Effective Practice

Child Health and Development Institute of Connecticut, Inc.

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Executive Summary

EMPS Crisis Intervention Services (EMPS) is a mobile intervention service for children and adolescents experiencing a behavioral or mental health crisis. EMPS is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1. The statewide EMPS network is comprised of approximately 150 trained mental health professionals that can respond immediately by phone or within 45 minutes in person when a child is experiencing an emotional or behavioral crisis. The purpose of the program is to serve children in their homes and communities, reduce the number of visits to hospital emergency rooms, and divert children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative. EMPS is implemented by six primary contractors, each of whom has satellite offices or subcontracted agencies. A total of 15 EMPS sites collectively provide coverage for every town and city in Connecticut.

The EMPS PIC is housed at the Child Health and Development Institute (CHDI) and was established to support the implementation of a best practice model of mobile crisis intervention for children and families. Since August 2009, the PIC has provided data analysis, reporting, and quality improvement; standardized training; and standardized practice development. The PIC is responsible for submitting monthly, quarterly, and annual reports that summarize findings on key indicators of EMPS service access, quality, and outcomes as well as other quality improvement activities.

The FY2012 Annual Report summarizes results from EMPS data entry into the Programs and Services Data Collection and Reporting System (PSDCRS; DCF's web-based data entry system) as well as other activities and results relevant to EMPS implementation. **This year, EMPS continued to demonstrate strong results in service access, quality, and outcomes.** Achievement of these results is due to strong collaboration among various partners including DCF, EMPS providers, the EMPS Performance Improvement Center (EMPS PIC), 211-United Way, the Connecticut Behavioral Health Partnership (CT BHP), KJMB Solutions, family members and advocates, and other partners and stakeholders.

This Executive Summary reviews data and activities from Fiscal Year 2012 (FY2012; July 1, 2011 to June 30, 2012), and when appropriate, includes comparisons to previous years. The report is organized according to the following sections:

- Characteristics of Children and Families Served
- Performance Measures and Quality Improvement
- Standardized Training and Technical Assistance
- Collaboration among EMPS Partners
- Model Development and Promotion
- Goals for Fiscal Year 2013

Characteristics of Children and Families Served

In FY2012, there were 13,814 calls to 211 requesting crisis intervention, which is 12.6% higher call volume than FY2011 (12,266 calls), 30.1% higher than FY2010 (10,135 calls), and 176% higher than FY2009 (estimated 5,000 calls). Of the 13,814 calls this year, **10,560 resulted in EMPS episodes of care** (the rest of the calls were not transferred to an EMPS provider for intervention). For episodes with at least one face to face contact, data were entered into PSDCRS for demographic characteristics, case characteristics, and intake clinical/functional characteristics.

Demographic Characteristics

Gender: Among all EMPS episodes of care, 52% were for boys and 48% were for girls.

Age: Most children served by EMPS were 13 to 15 years old (36.5%) or 16 to 18 years old (28.0%). An additional 21.9% of children were 9 to 12 years old and the remaining 13.6% of children were 8 years old or younger. The age breakdown of children served in FY2011 was very similar to FY2010.

Ethnic Background: Most families (69.7%) reported non-Hispanic ethnicity. Of the total 30.3% of children from a Hispanic ethnic background, most reported their ethnicity as "Hispanic/Latino" (16.4%) or "Puerto Rican" (11.1%).

Racial Background: Many children served by EMPS reported "Caucasian" (59.0%) racial background, followed by "Black/African-American" (19.3%), and "Other Race" (16.2%).

Health Insurance Status: **Most children served by EMPS were covered by public insurance** including Husky A (57.0%) and Husky B (2.4%). Private insurance coverage was reported by 33.2% of youth served (private insurance generally does not reimburse for EMPS services). About 4.4% of children served by EMPS this year had no insurance coverage.

Temporary Assistance for Needy Families (TANF) eligibility: Statewide, **53% of children were eligible for TANF**. Across all 15 EMPS sites, the percentages ranged from 24% (Middlesex Hospital) to 77% (Community Health Resources, subcontractor in the Eastern service area).

Case Characteristics

Referral Source: **Most children were referred by parents or family members (43.3%), schools (33.3%), or emergency departments (11.2%)**. Compared to FY2011, a slightly higher percentage of youth were referred from schools, about the same percentage was referred by self/family, and a slightly lower percentage was referred by emergency departments.

Length of Stay (LOS): The average LOS in FY2012 among discharged episodes of care coded as "Stabilization Follow-Up" was 22.1 days, compared to 24.5 days in FY2011 and 26.4 days in FY2010. In FY2012, EMPS providers engaged in data cleaning efforts, in part, to ensure that a discharge date was entered into PSDCRS for all closed cases. These efforts resulted in **only 6% of episodes exceeding the 45 day LOS benchmark** for "Stabilization Follow-up" episodes. This is an improvement over FY2011 (7.0%) and FY2010 (11.6%). In FY2012, the average LOS for episodes coded as "Face-to-Face" was 6.0 days (6.7 days in FY2011), and for "Phone Only" episodes the average LOS was 0.8 days (0.6 days in FY2011).

DCF Involvement: At intake, **most children (76.4%) served by EMPS were not involved with DCF**. The most common types of DCF involvement at intake were CPS in-home services (9.2%), CPS out-of-home services (6.4%), and the Voluntary Services program (3.9%).

Juvenile Justice Involvement: Statewide, 6.8% of children served by EMPS had been arrested in the past six months (7.9% in FY2011) and 1.6% during the current episode of care (1.8% in FY2011).

Clinical and Functional Characteristics at Intake

Primary Presenting Problems: The six most common primary presenting problems at intake were **Harm/Risk of Harm to Self (27%); Disruptive Behavior (27%); Depression (13%); Harm/Risk of Harm to Others (9%); Family Conflict (6%); and Anxiety (5%)**. These percentages are very similar to FY2011.

Diagnosis: The five most common primary diagnoses on Axis I at intake were Adjustment Disorders (18.0%); Depressive Disorder, NOS (15.7%); Mood Disorder, NOS (11.7%); Other Diagnoses (10.8%); Attention Deficit/Hyperactivity Disorder (8.5%); and Oppositional Defiant Disorder (6.5%). These percentages are very similar to FY2011.

Trauma exposure: Statewide, **63% of children served by EMPS reported one or more trauma exposures**, compared to 61% in FY2011. Across service areas this year, the percentage of youth reporting trauma exposure ranged from 44%

(Central service area) to 72% (New Haven service area). Among those with trauma exposure, the most common types were witnessing violence (25%), being a victim of violence (18%), and sexual victimization (12%).

Emergency Department Utilization and Inpatient Hospitalization: Statewide, 24% of children served by EMPS had been evaluated in an ED one or more times in the past six months. More than one in five (21%) children referred to EMPS during the year had experienced an inpatient admission in their lifetime (down from 23% in FY2011). Inpatient admission rates in the six months prior to EMPS referral were 12% statewide and 7% were admitted to inpatient units *during* the EMPS episode of care (identical data were reported in FY2011).

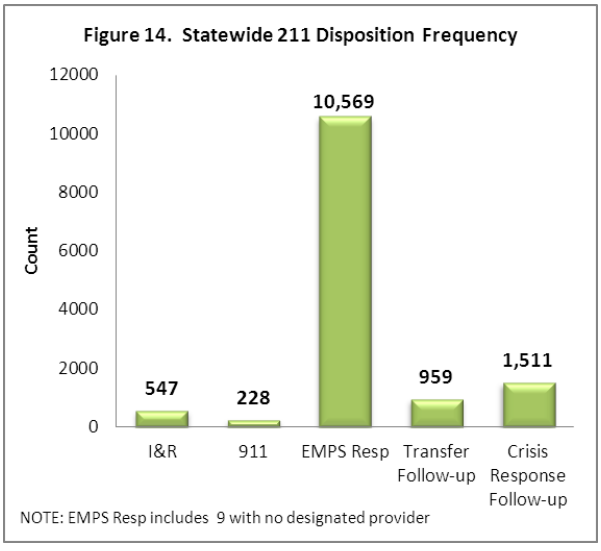
School Issues: Across the state, the top four issues at intake that had a negative impact on the youth's functioning at school were emotional (27%), behavioral (24%), social (21%), and academic problems (17%).

Performance Measures and Quality Improvement

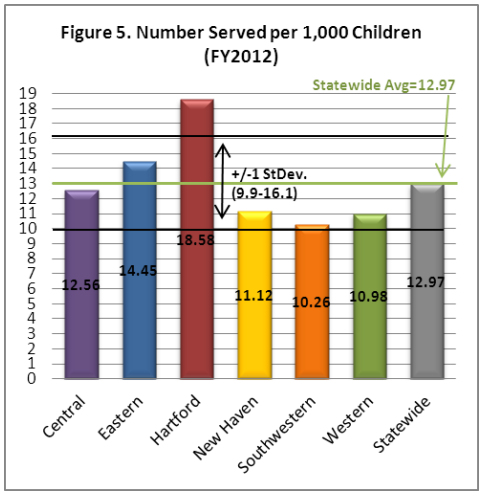
In FY2012, the PIC worked with collaborators to produce twelve monthly reports, four quarterly reports, and this annual report summarizing performance indicator results and other activities (visit chdi.org for all reports). Each quarter, site visits were conducted and performance improvement plans were developed with the six primary service area teams and their satellite offices or subcontractors. Individualized consultation helped EMPS providers identify best practice areas and areas in need of quality improvement, develop strategies for monitoring data and using it for management, and address identified areas of concern. Many providers focused on developing consistency on primary indicators of service access (e.g., episode volume) and service quality (e.g., mobility, response time); however, a few providers began to target clinical and administrative processes in their quarterly performance improvement plans (e.g., assessing acuity at intake, achieving timely completion of discharge paperwork). During FY2012, there were a total of 29 performance improvement goals developed. Of those goals, 62% were achieved and 73% improved or achieved the goal.

Data on performance measures and quality improvement activities are reviewed below along with clinical outcomes and special data analysis requests in FY2012.

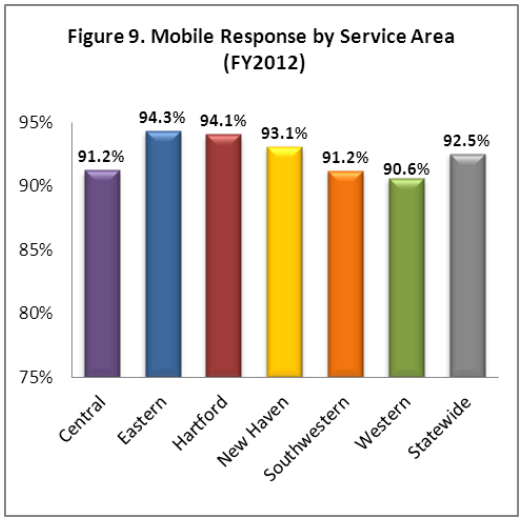
Call Volume: **In FY2012, there were 13,814 calls to 211 for crisis stabilization, including 10,560 that became EMPS episodes of care.** The total number of calls this year was 12.6% higher than FY2011 (12,244 calls), 30.1% higher than FY2010 (10,135 calls), and about 176% higher than FY2009 (estimated 5,000 calls). Most calls (76.5%) were transferred to an EMPS provider for a response; a slightly lower percentage than FY2011 (77.2%). In addition, 10.9% of calls were sent to EMPS for crisis response follow-up and 6.9% were transferred to EMPS for information follow-up. Remaining calls were handled by 211 only as information and referral (4.0%) or as transfers to 911 (1.7%) (see figure below).



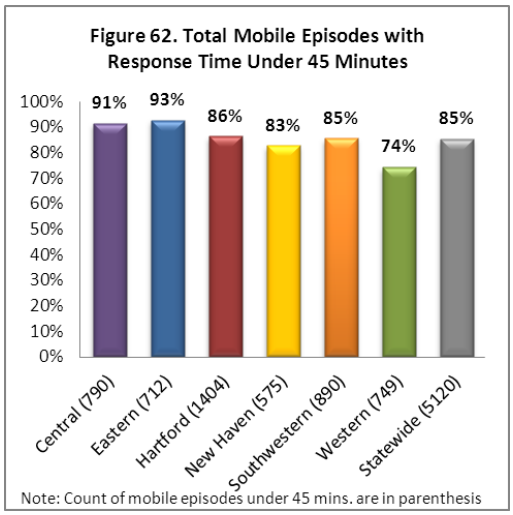
Of the 13,814 calls received, 10,560 resulted in new episodes of care entered into PSDCRS. A "service reach rate" examines total episodes relative to the population of children (based on 2010 census data) in a given catchment area (see figure below). Service reach rates are calculated statewide, for each service area, and for each individual provider. The statewide service reach rate for FY2012 was 12.97 EMPS episodes per 1,000 children (the rate was 11.23 in FY2011, based on 2000 census data). The Hartford service area had the highest service reach rate (18.58 per 1,000) which was about 1.8 standard deviations above the group mean. The lowest service reach was in the Southwestern service area (10.26 episodes per 1,000). No service areas were one or more standard deviations below the statewide mean. Connecticut's EMPS service reach rate is significantly higher than two comparable mobile crisis services in other states, based on data obtained from their program directors in 2011. Milwaukee's Mobile Urgent Treatment Team (MUTT) has an annual service reach rate of 5.05 episodes per 1,000 children, and the King County Children's Crisis Outreach Response System (CCORS; Greater Seattle) has an annual service reach rate of 2.39 episodes per 1,000 children.



Mobility Rate: Mobile responsiveness is a key feature of EMPS service delivery. Early in FY2010, DCF worked with other EMPS stakeholders to establish a 90% mobility benchmark. The EMPS PIC examines all episodes in which 211 recommended a mobile or deferred mobile response and determines the percentage that actually received a mobile or deferred mobile response from an EMPS provider. **In FY2012, the statewide mobility rate of 92.5% was the highest to date.** Mobility was higher than FY2011 (90.3%), FY2010 (83.6%) and FY2009 (estimated at 50%). **For the first time, all six service areas had an annual mobility rate that was above the 90% benchmark.** The highest rate was in the Eastern region (94.3%) and the lowest was in the Western region (90.6%). The range in mobility rates across all six service areas was only 3.7 percentage points which was much lower than FY2011 (8.6 percentage points) and FY2010 (15.8 percentage points). This suggests better overall mobility and better consistency statewide (see figure below).



Response Time: Since FY2010, the benchmark for response time is that at least 80% of all mobile responses will be provided in 45 minutes or less. **In FY2012, statewide achievement of the response time benchmark was 85%** (compared to 86% in FY2011 and 62% in FY2010) (See Figure 5). Five of six service areas achieved the benchmark, with service area performance ranging from 74% (Western) to 93% (Eastern). **The median response time this year was 29 minutes** (28 minutes in FY2011). Response times have been consistently at or above expectations the last two fiscal years despite substantial growth in episode volume.



Clinical Outcomes

Ohio Scales: The Ohio Scales are intended to be completed at intake and discharge by parents and EMPS clinicians, typically for stabilization follow-up episodes in which children and families are seen in person for multiple sessions over a timeframe of up to six weeks. Statewide, approximately 3,032 clinician-report and 898 parent-report Ohio Scales were completed at intake and discharge. The total number of completed clinician-report measures is higher than last year (2,758 in FY2011) but the number of completed parent-report measures was significant lower (1,334 in FY2011), despite a higher overall number of EMPS episodes. **In FY2012, EMPS clinicians completed the Ohio Scales for 90% of episodes at intake and 84% at discharge.** These rates are lower than FY2011 (93% at intake and 90% at discharge). This pattern of lower completion rates was more pronounced for parent-report measures, especially at discharge. In FY2012, **parents completed Ohio Scales 65% at intake and 26% at discharge,** which was significantly lower than FY2011 (70% at intake and 44% at discharge). Lower completion rates are likely due to a combination of interrelated factors including higher call volume, shorter LOS, more unplanned discharges, and less-than-desired compliance among providers.

Despite inconsistent completion rates, there are sufficient numbers of completed measures at intake and discharge to examine pre-post changes. Even though the measure was designed to assess treatment outcomes for longer-term models of intervention such as outpatient care, **there were significant and positive changes on all domains of the Ohio Scales in FY2012** (see Table 1). In FY2012, these positive changes were highly significant, even more so than in past years, as indicated by higher t-score values.

Although the changes were statistically significant, the four measures changed by an average of 4.53 points (compared to 2.95 in FY2011), so it is important to also examine clinically meaningful change. For EMPS, clinically meaningful change on the Ohio Scales Functioning scale is a change of at least 5 points and a score of 50 or higher at discharge; and on the problem severity scale, a change of at least 5 points and a score of 25 or lower at discharge. Using these definitions, there was clinically meaningful change on functioning for 2.5% of youth (n=22) according to parent-report and 1.1% of youth (n=32) according to clinician-report. Findings on problem severity were stronger. There was clinically

meaningful change on problem severity for 28.7% of youth (n=258) according to parent-report and 27.4% of youth (n=831) according to clinician-report.

Table 1. Statewide Ohio Scale Scores (based on paired intake and discharge scores)	**N**	**Mean (intake)**	**Mean (discharge)**	**t-score**	**Sig.**	**% Clinically Meaningful Change**
Parent Functioning Score	880	42.19	46.38	10.32	p < .001	2.5%
Worker Functioning Score	3032	42.56	45.84	23.68	p < .001	1.1%
Parent Problem Severity Score	898	29.44	23.83	-13.94	p < .001	28.7%
Worker Problem Severity Score	3037	30.38	25.35	-31.0	p < .001	27.4%

Global Assessment of Functioning (GAF): Statewide, the average GAF score at intake was 43.99 and the average score at discharge was 47.25, a statistically significant difference and another indicator of improved overall functioning.

Special Data Analysis Requests

The EMPS PIC worked with DCF, EMPS providers, and other stakeholders to examine PSDCRS data submissions and answer a number of important questions related to EMPS service delivery, quality, outcomes, and systems-related issues. Many of these special data requests were generated throughout the year in response to questions from DCF, EMPS providers, and other stakeholders. This information was used to shape EMPS practice as well as systems-level decision-making. A few examples are described below.

Length of Stay (LOS) Outliers: Using PSDCRS data submissions, the PIC identified LOS outliers (cases that had been open for an excessive period of time) and worked with each provider to close the case if it was open past the 45 day window, or provide a discharge date if one had not been entered for a closed case. There were a small number of such outliers, but many had been open for a long period of time. In nearly all cases this was due to discharge dates not being entered into PSDCRS in a timely manner. Due at least in part to this effort, this year there was a lower percentage of discharged cases that exceeded the 45 day treatment window.

School utilization of EMPS: We supplied EMPS providers with data to help them identify schools in their area that were underutilizing their services in order to suggest targeted outreaches.

Racial/Ethnic Proportionality of EMPS Utilization: We examined the reported racial and ethnic backgrounds of youth served by EMPS in each service area and compared that to the percentages of racial and ethnic groups in the general child population. The results indicated that EMPS served a higher percentage of African American and Hispanic youth than would be expected from their representation in the general population. We also analyzed racial/ethnic proportionality of EMPS referrals from Hartford area schools and discovered similar findings.

Hourly Breakdown of EMPS Referrals: We examined the data for patterns of EMPS utilization in one hour intervals. The statewide findings indicated that the highest utilization occurs between 9am and 11am, and again between 2pm and 5pm (consistent with the approximate beginning and end of the school day). The data also indicated that between 10pm and 9am (non-mobile hours), about half of all calls occurred in the one hour interval between 8am and 9am, corresponding with the beginning of the school day. This analysis helped providers plan staffing coverage and helped DCF understand patterns of utilization that would inform contracting and staffing decisions.

Percentage of Youth Referred to Inpatient Hospitalization: We examined each provider's rate of referral to inpatient hospitals in order to determine significant differences across sites and implications for practice. We found differences across sites that helped to inform site-specific technical assistance supporting inpatient diversion.

Standardized Training and Technical Assistance

The EMPS PIC is responsible for designing and delivering a standardized training curriculum that addresses the core competencies related to delivering EMPS in the community. Providers are required by contract to ensure that their clinicians attend these trainings. There were ten training modules in FY2012, including two new additions:

1. Crisis Assessment, Planning, and Intervention
2. Crisis Wraparound Principles
3. Violence Risk Assessment
4. Suicide Risk Assessment
5. Traumatic Stress and Trauma-Informed Care
6. Cultural and Linguistic Competence
7. Strengths-Based Assessment and Identification of Natural Supports
8. Worker Safety, Vicarious Trauma, and Self-Care
9. **Emergency Certificates (added in FY2012)**
10. **Assessing and Managing Suicide Risk (added in FY2012)**

Evaluation forms indicated that participants were generally highly satisfied and that the learning objectives were consistently met. Evaluation findings are being used to inform changes for FY2013.

In FY2012:

- 39 training sessions were offered. There have been 114 trainings in the last three years.
- 147 staff members were trained this year. To date 251 EMPS staff members have completed one or more trainings.
- 76 individuals have completed all of the initial 8 trainings and 49 individuals have completed all 10 modules.
- The Traumatic Stress and Trauma-Informed Care training was transitioned from being led by a non-EMPS trainer to being co-trained by two EMPS managers. Currently, 5 of 10 trainings modules are led by peers--EMPS managers or community-based agency clinicians.
- The Cultural and Linguistic Competence training module is being led by Ellen Boynton from the DMHAS Office of Multicultural Affairs.

In addition to these formal training sessions, EMPS providers also received periodic consultation and technical assistance to address data collection and entry issues; for using data to enhance EMPS access and service quality; and to inform management and clinician supervision. We continue to explore ways to reduce redundancy in content and increase efficiency of delivering the training curriculum, especially in light of further increases in episode volume. For example, we are considering combining some trainings and offering video- or webinar-based trainings for selected modules.

Collaborations among EMPS Partners

There were numerous collaborations among DCF, the EMPS PIC, EMPS provider organizations, the Connecticut Behavioral Health Partnership (CTBHP), 211-United Way, FAVOR, and other stakeholders. Activities in this area include:

- *Monthly meetings*: Monthly meetings include the EMPS PIC, DCF, EMPS providers, 211-United Way, and the CTBHP. Meetings focus on discussing a broad range of EMPS practice and policy issues.
- *EMPS Medicaid utilization review*: PSDCRS data were provided to the CTBHP monthly to help them track utilization of EMPS services by children and families enrolled in Medicaid.
- *EMPS emergency department referrals*: PSDCRS data were provided to CTBHP to help them track inpatient diversions and referrals for follow-up from emergency departments and inpatient hospitalization.
- *Collaboration on CTBHP Performance Incentives*. The EMPS PIC and providers consulted with CTBHP as they developed their annual performance incentives relating to reducing rates of inpatient hospitalization among youth.
- *Client and referrer satisfaction*: 211-United Way and the EMPS PIC worked together to measure and report family and referrer satisfaction with EMPS services.
- *Responding to Children of Arrested Caregivers Together (REACT)*: This initiative has worked to develop a model for responding to children in the event that they witness caregiver arrest. The best practice model brings together DCF investigators, local police, and EMPS providers. The initiative involved EMPS Managers from both the Western and

Eastern regions of the EMPS network to serve as co-trainers for delivering the CIT-Youth curriculum to their respective police departments.

- *The School Based Diversion Initiative (SBDI)*: SBDI is a school-based initiative that seeks to reduce rates of school-based arrest, expulsion, and out of school suspension through professional development, revisions to school disciplinary policies, and access to mental health services and supports in the school and community (with particular emphasis on access to EMPS).
- *The CT Suicide Advisory Board*: Collaborate on purchase and dissemination of a teen suicide prevention presentation toolkit.
- *Annual meetings*: EMPS providers, DCF, 211-United Way, the EMPS PIC, and other stakeholders attended one of two year-end annual meetings; one each in the Northern and Southern parts of the state. The annual meetings were held to review findings and celebrate accomplishments throughout the year.

Model Development and Promotion

EMPS stakeholders continue to work toward standardized EMPS practice across the provider network, and to establish Connecticut's EMPS program as a recognized statewide and national best practice. Activities in this area are summarized below.

EMPS workgroups: DCF, EMPS providers, and the PIC conduct collaborative workgroups to create or revise documents that support standardized EMPS practice. In FY2012, the workgroup focused on developing guidelines in two areas. First, the workgroup developed a form and guidelines for issuing Emergency Certificates, which allows EMPS to order emergency transport to a hospital in the event that a child is a danger to himself or others as a result of suicidal ideation, homicidal ideation, or a severe psychiatric disability. The second area was to develop guidelines for providing follow-up EMPS care beyond the initial response. Both documents are nearly finalized. Further revisions were also made to the EMPS Practice Standards to reflect developments in these two areas.

Family engagement special incentive: This year, all six service areas were awarded mini-grant from the EMPS PIC to develop and implement a family engagement plan, the goal of which was to identify and engage parents to join the EMPS team as advisors and partners in EMPS service delivery and quality improvement activities. The results of the initiative show that 69 family members (including 10 youth) were involved statewide. Examples of activities undertaken through this initiative include: participation on the QI team; consulting on EMPS documentation and intake practices; co-training and co-presenting with EMPS in the community; and revising agency websites to be more "family friendly."

Substance Abuse and Mental Health Services Administration (SAMHSA) Service to Science Initiative and Mini-Subcontract: SAMHSA selected EMPS as a promising practice and provided free consultation and technical assistance to help EMPS apply enhanced evaluation and model development strategies to move it toward the status of an evidence-based practice. With consultation from SAMHSA, we were able to identify goals and strategies to pursue throughout the year. The EMPS PIC at CHDI also worked with DCF to apply for a competitive grant to continue to develop evaluation goals. This one year grant was awarded to CHDI beginning in February 2012. The goals are: 1) develop standardized practice documents including a model of clinical follow-up care; 2) identify and pilot new outcome and risk and protective factors measures for youth with substance abuse and behavioral health problems; and 3) publish findings in a peer-reviewed journal.

Staffing Survey: In FY2012, we developed a survey for EMPS managers to determine staffing patterns and approaches in order to identify and spread best practices across all EMPS sites.

Training Needs Assessment: Near the end of FY2012, we disseminated an online survey to assess ongoing training needs in order to inform changes for FY2013.

Marketing and Promotion: A number of marketing and promotional initiatives were undertaken this year. DCF and the PIC worked together to develop consistent branding and logos across all EMPS materials and to create bags, tumblers, water bottles, pad folios, and other materials to broadly market across the state. The EMPS PIC worked with 211-United Way and the CT Suicide Advisory Board to purchase presentation materials related to youth suicide prevention. Marketing materials (posters, brochures, wallet cards) were distributed to EMPS sites for community outreach events. Staff from the EMPS PIC shared a booth with the Connecticut Association for the Benefit of Law Enforcement (CABLE) at the annual law enforcement Expo to promote use of EMPS by law enforcement.

Presentations: The EMPS model and associated findings was presented at local, state, and national meetings and conferences this year. A few examples include the 24th Annual Children's Mental Health Research and Policy Conference (March 2011; Tampa FL); the First Biennial Global Implementation Conference (Washington DC; August 2011); The Connecticut Psychological Association Annual Meeting (February 2012; Rocky Hill CT); The Connecticut Suicide Advisory Board (February 2012; Rocky Hill CT); and the Connecticut Behavioral Health Partnership Clinical Operations Subcommittee (October 2011; Rocky Hill CT).

Publications: CHDI published two reports on the EMPS PIC this year, highlighting the PIC as an effective framework for quality improvement in children's mental health. The first publication was part of CHDI's IMPACT series, meant to spread ideas and information to promote the health of Connecticut's children (http://www.chdi.org/pic-impact). The second publication was an Issue Brief on EMPS and the PIC approach (http://www.chdi.org/download.php?id=587).

Goals for Fiscal Year 2013

FY2012 was another successful year for EMPS providers, the EMPS PIC, and other stakeholders. There remain several areas of EMPS practice requiring further attention. Recommended goals for FY2013 are summarized below.

A. Quality Improvement

EMPS providers demonstrated outstanding performance on key indicators related to service volume, mobility, and response times. In FY2013, EMPS providers will maintain this excellent performance.

1. All providers will enhance access to community-based mental health services and supports by increasing EMPS episode volume. This will be accomplished through outreach, meetings, and engagement of schools, local police, and families that may benefit from EMPS intervention.
2. Each service area will continue to post mobility at or above the 90% benchmark
3. Each service area will respond to crises in 45 minutes or less for at least 80% of mobile episodes
4. Increase Ohio Scales completion rates

B. Standardized Training

1. Increase the number of modules that are trained by EMPS managers or supervisors
2. Create efficiencies in the training curriculum by condensing training modules and converting to video- or webinar-based formats where possible and fiscally feasible
3. Identify and implement at least one new training module consistent with interests and training needs identified in the recent (FY2012) training needs assessment

C. Developing the EMPS Clinical Model

1. Complete SAMHSA-funded study of acuity and follow-up care
2. Finalize the following documents: Emergency Certificates (form and guidelines documents); Follow-Up Care; Practice Standards; Standardized Assessment.
3. Develop a protocol for measuring fidelity to the newly developed EMPS model of care
4. Collect and report data on use of emergency certificates
5. Publish at least one paper on EMPS in a peer-reviewed journal

Section I: EMPS Statewide/Service Area Dashboard

Figure 1. Total Call Volume by Call Type (FY2012)

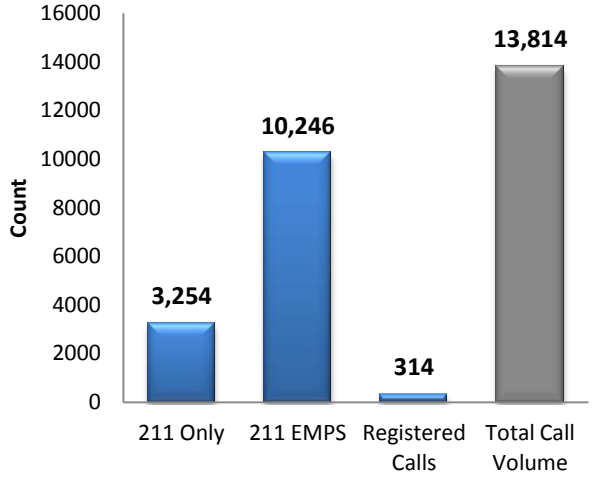


Figure 2. Total Call Volume per Quarter by Call Type

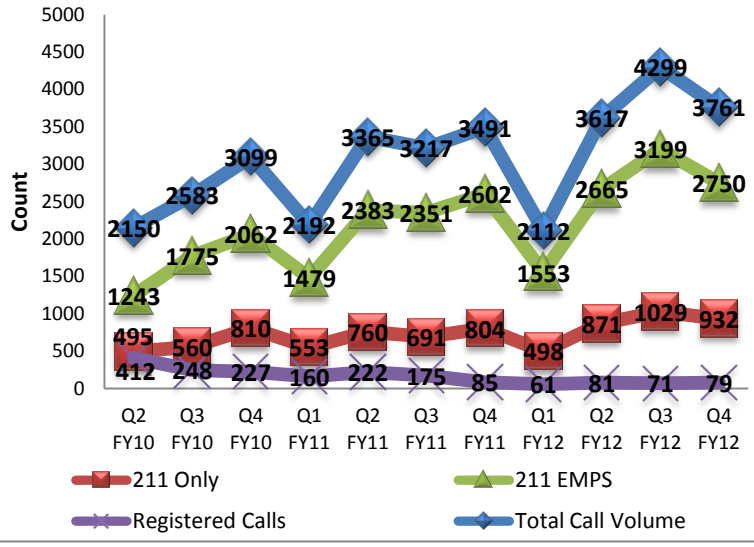


Figure 3. EMPS Episodes by Service Area (N=10,560)

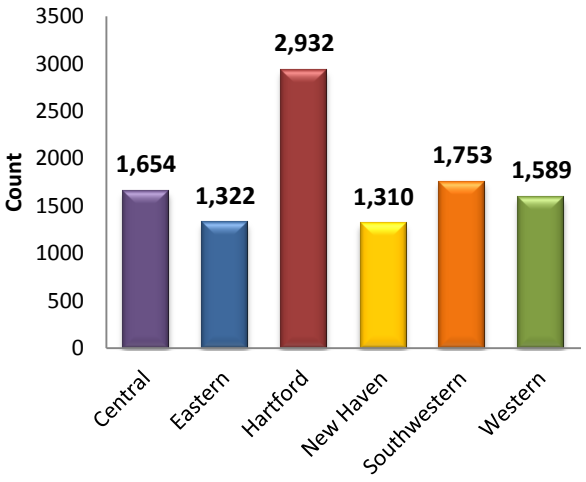


Figure 4. EMPS Episodes per Quarter by Service Area

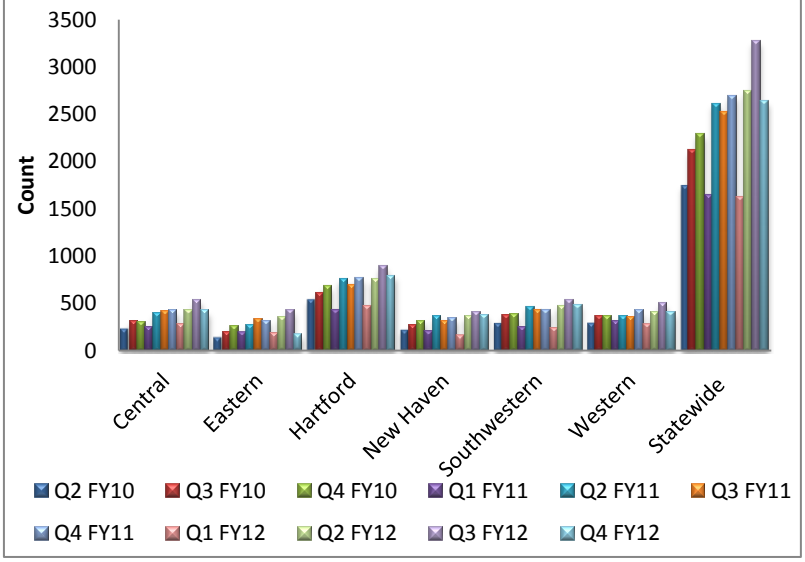


Figure 5. Number Served per 1,000 Children (FY2012)

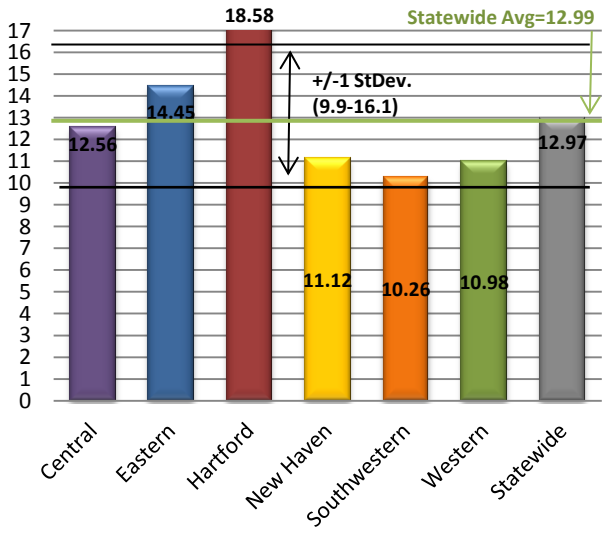


Figure 6. Number Served per 1,000 Children per Quarter by Service Area

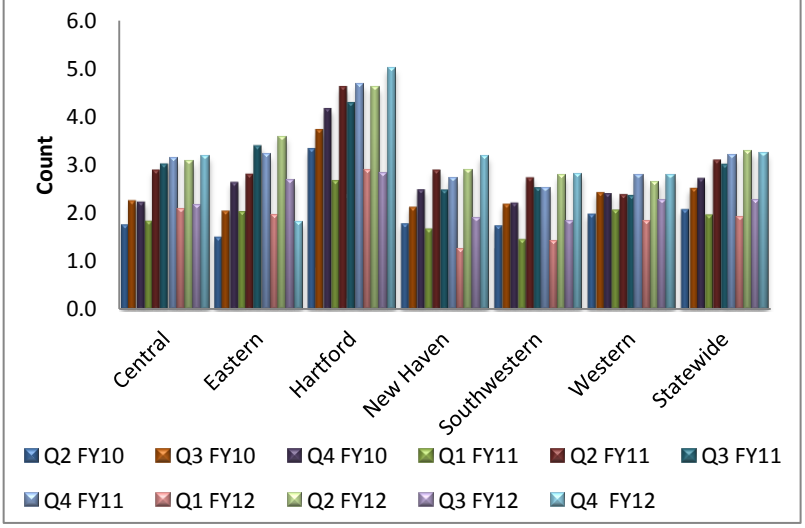


Figure 7. Number Served per 1,000 Children in Poverty (FY2012)

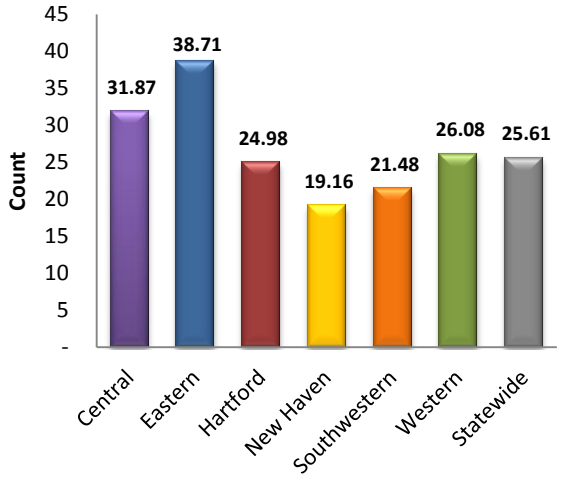


Figure 8. Number Served per 1,000 Children in Poverty per Quarter by Service Area

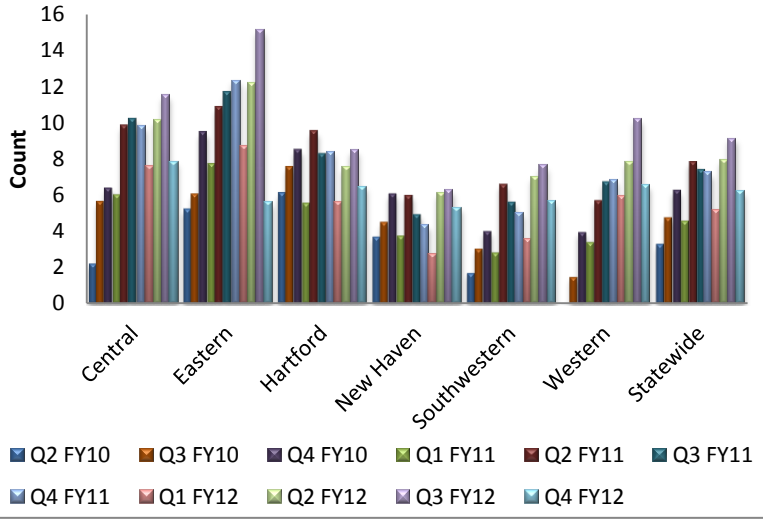


Figure 9. Mobile Response by Service Area (FY2012)

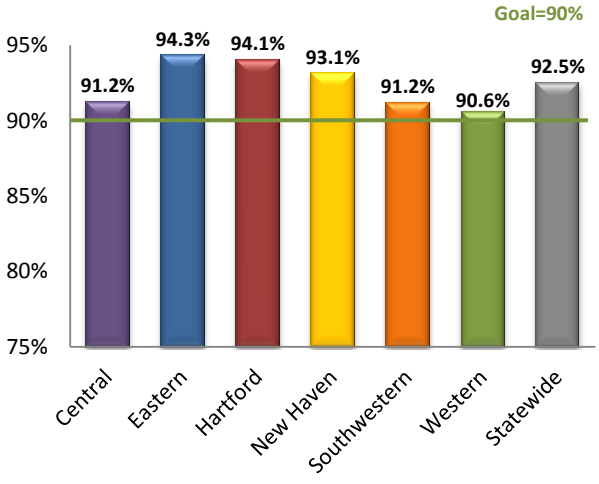


Figure 10. Mobile Response per Quarter by Service Area

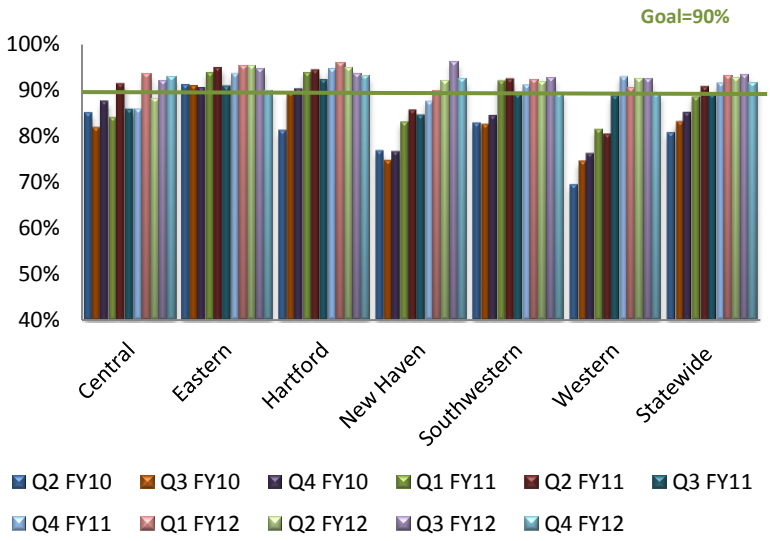
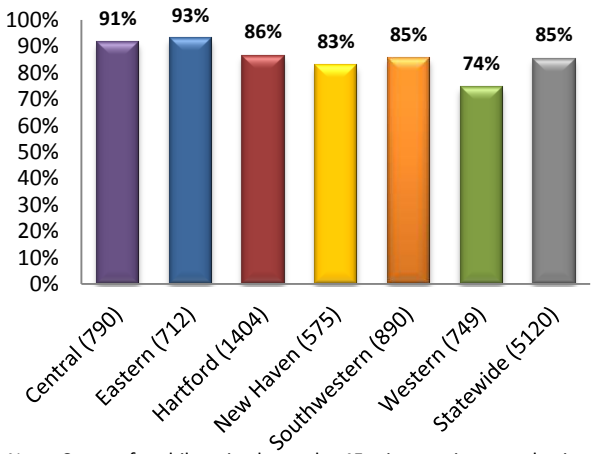
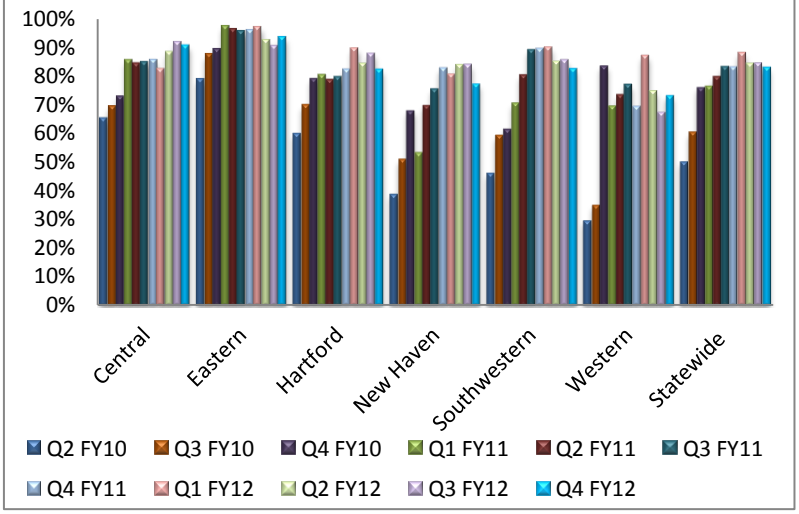


Figure 11. Total Mobile Episodes with Response Time Under 45 Minutes (FY2012)



Note: Count of mobile episodes under 45 mins. are in parenthesis

Figure 12. Total Mobile Episodes with Response Time Under 45 Minutes per Quarter by Service Area



Section II: Episode Volume

Figure 13. Total Call Volume by Call Type

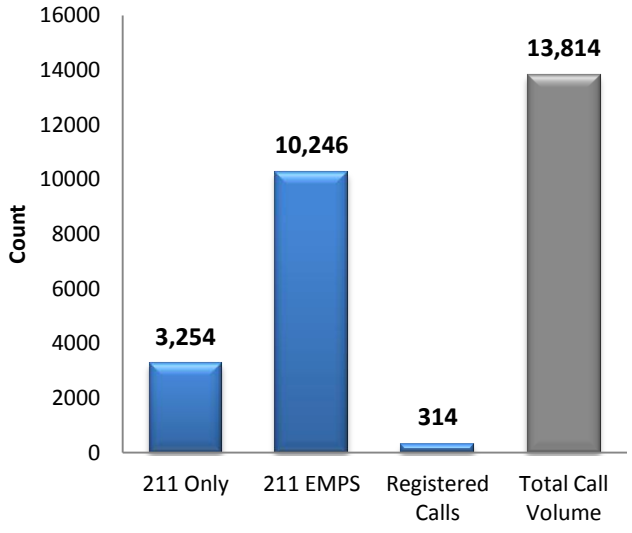
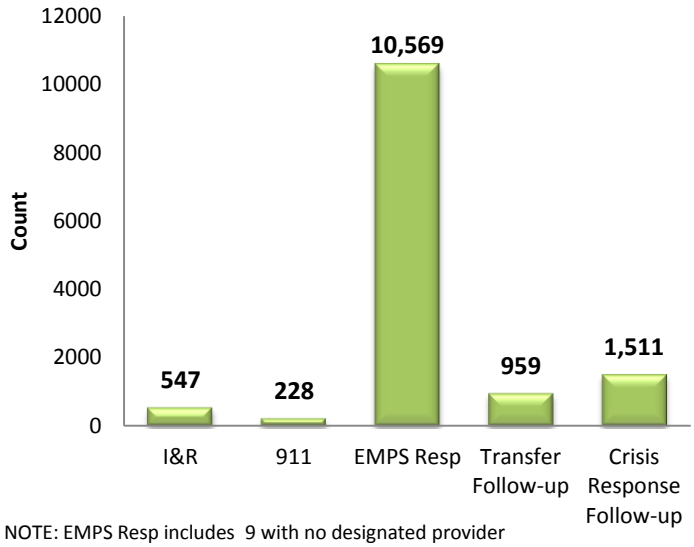


Figure 14. Statewide 211 Disposition Frequency



NOTE: EMPS Resp includes 9 with no designated provider

Figure 15. EMPS Response Episodes by Provider (Total Episodes=10,560)

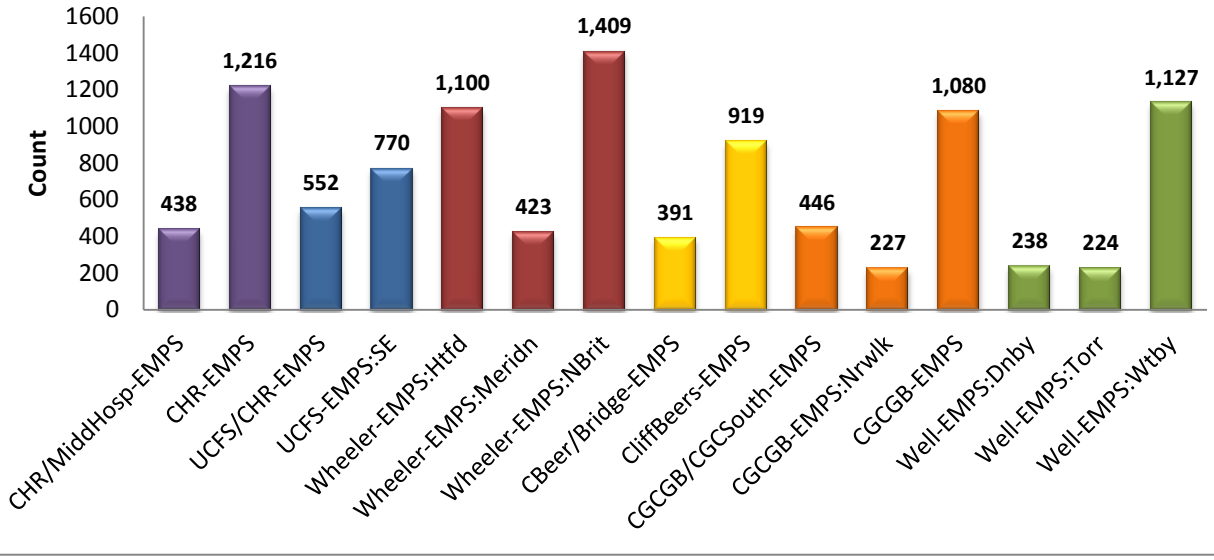


Figure 16. Number Served Per 1,000 Children by Provider (FY2012)

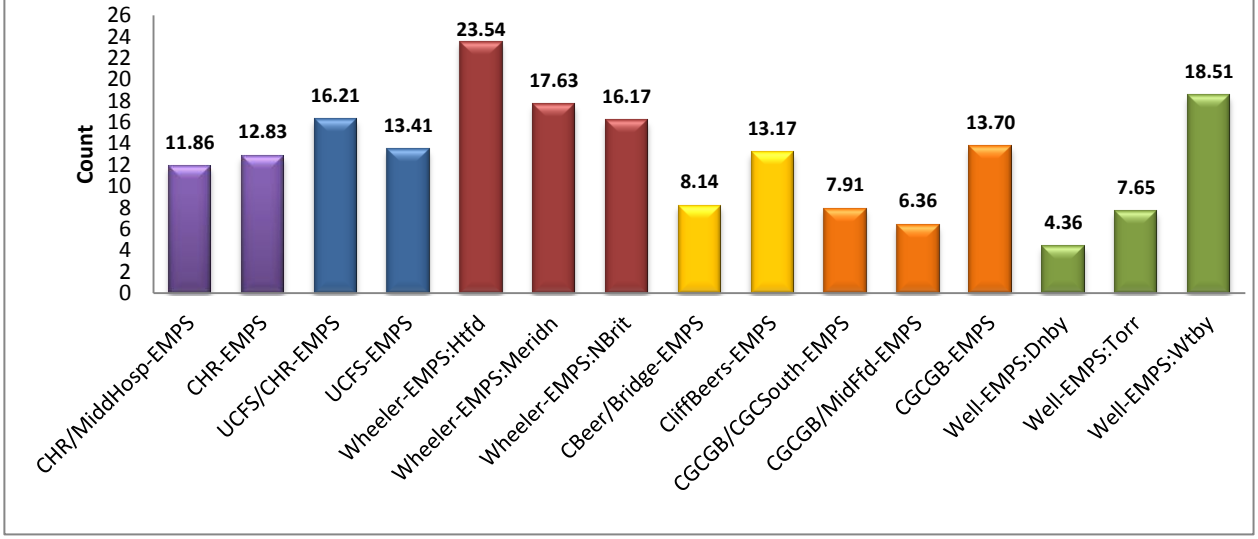


Figure 17. Episode Intervention Types by Service Area

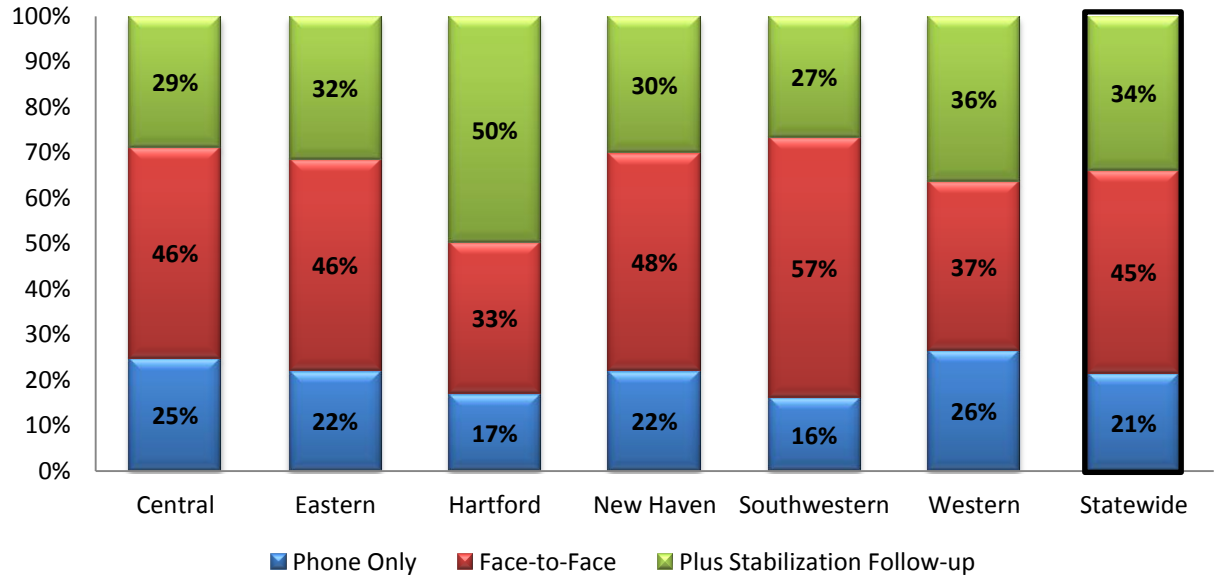
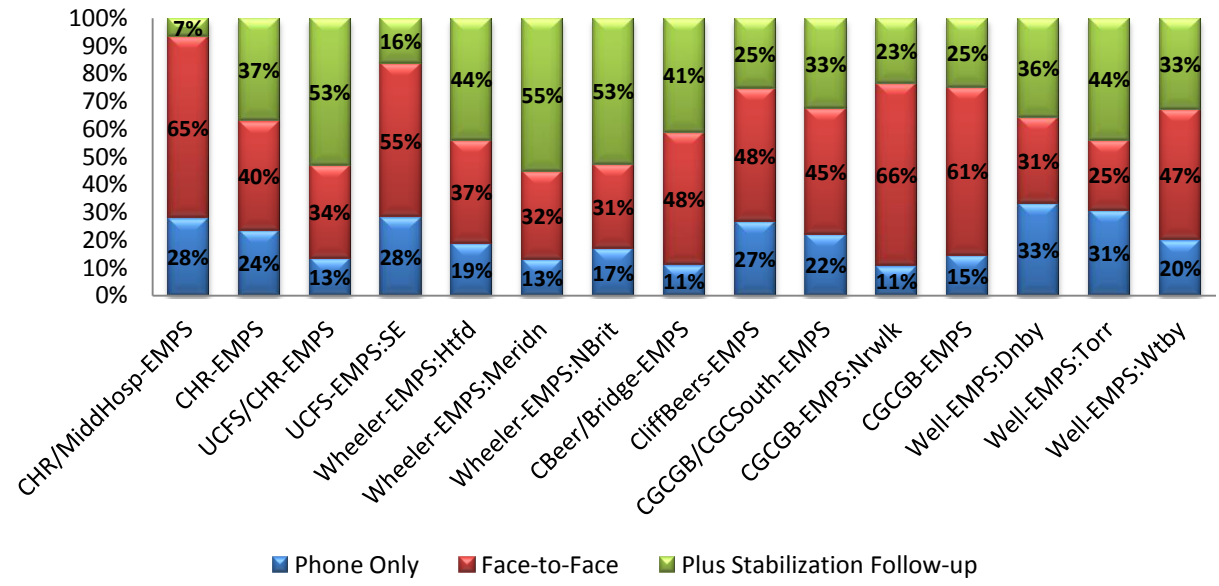


Figure 18. Episode Intervention Types by Provider



Section III: Demographics

Figure 19. Gender of Children Served Statewide

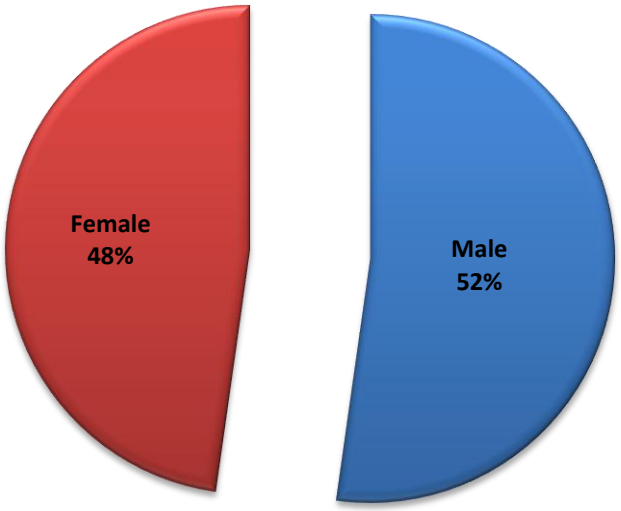


Figure 20. Age Groups of Children Served Statewide (N=8,346)

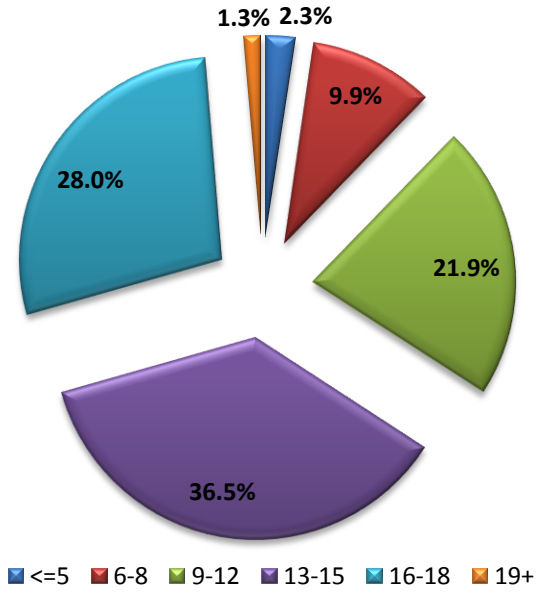


Figure 21. Ethnic Background of Children Served Statewide (N=9,778)

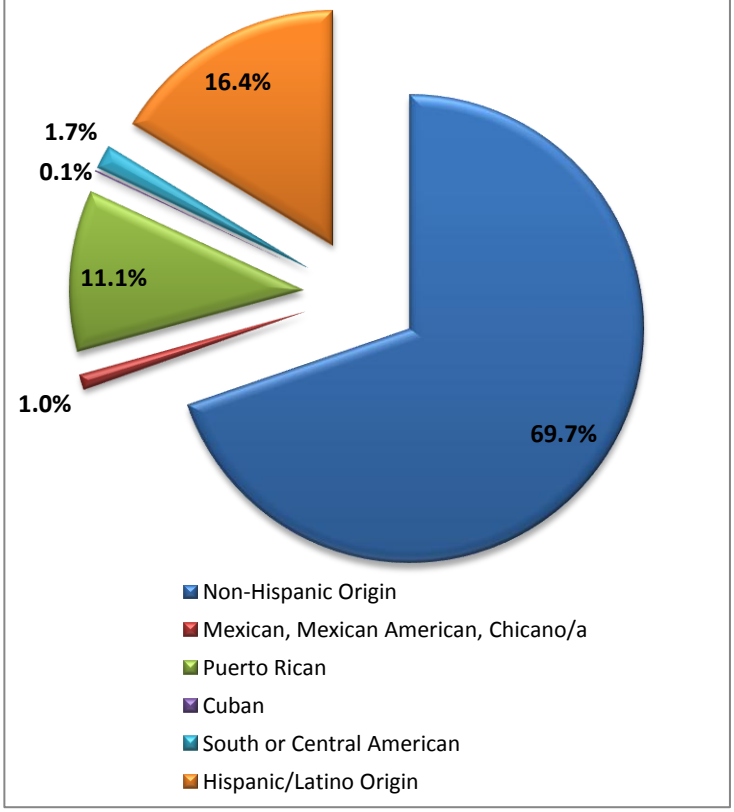
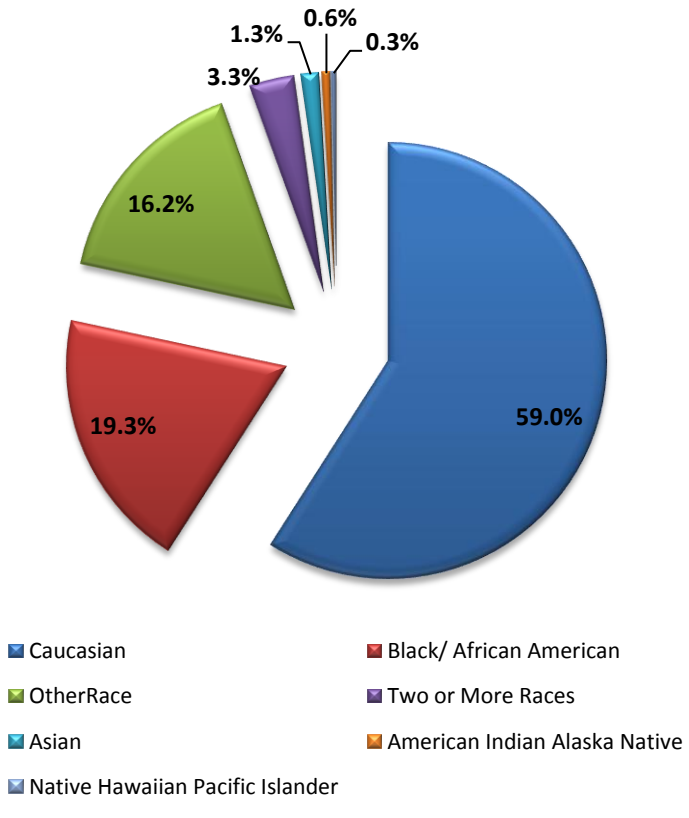


Figure 22. Race of Children Served Statewide (N=10,109)



Note: According to the U.S. Census Bureau, "[P]eople who identify their origin as Spanish, Hispanic, or Latino may be of any race…[R]ace is considered a separate concept from Hispanic origin (ethnicity) and, wherever possible, separate questions should be asked on each concept."

Figure 23. Client's Type of Health Insurance at Intake Statewide

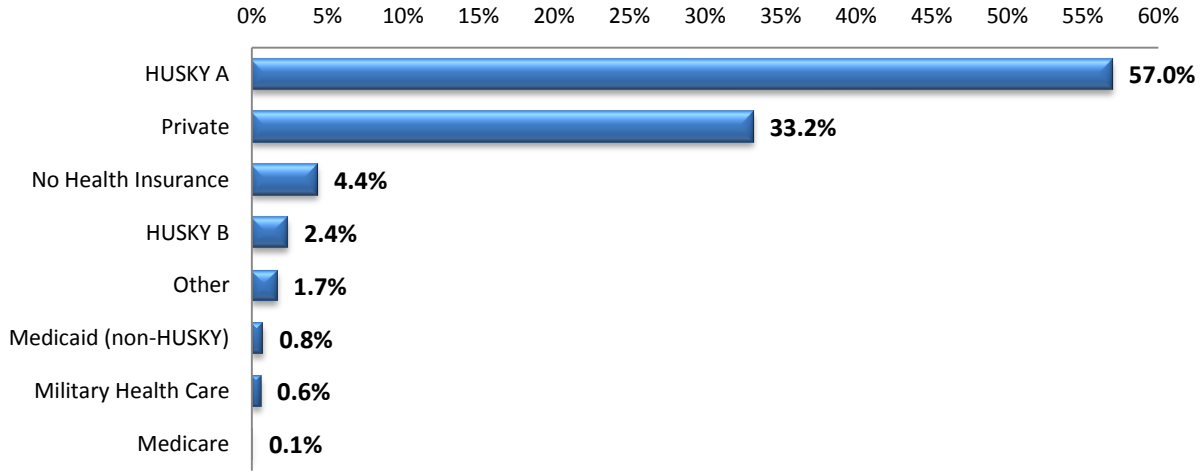
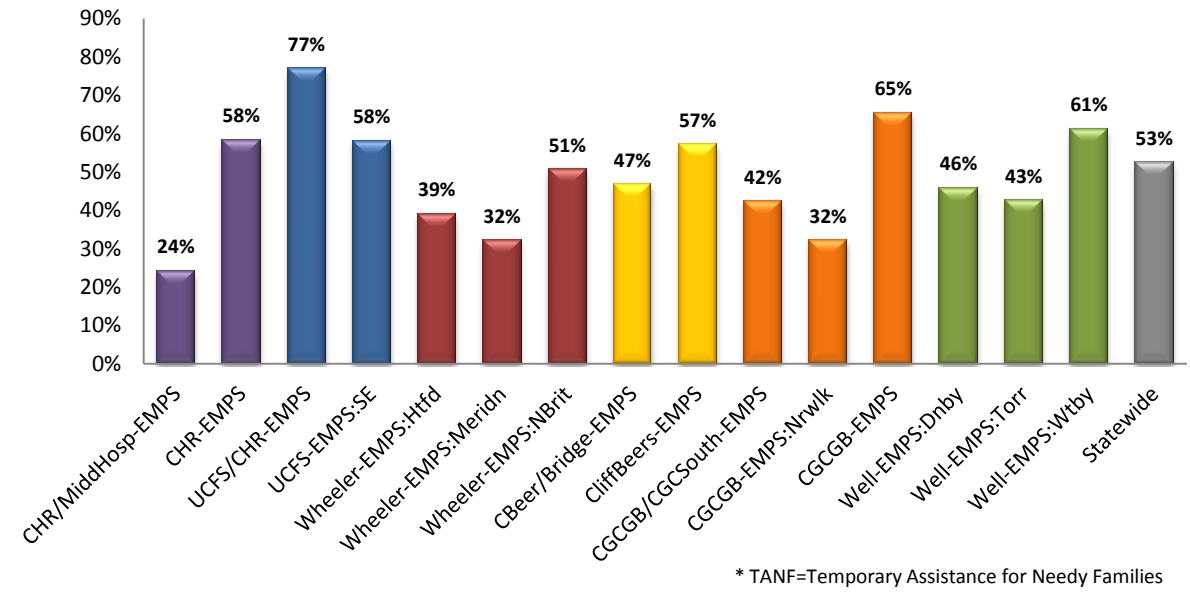
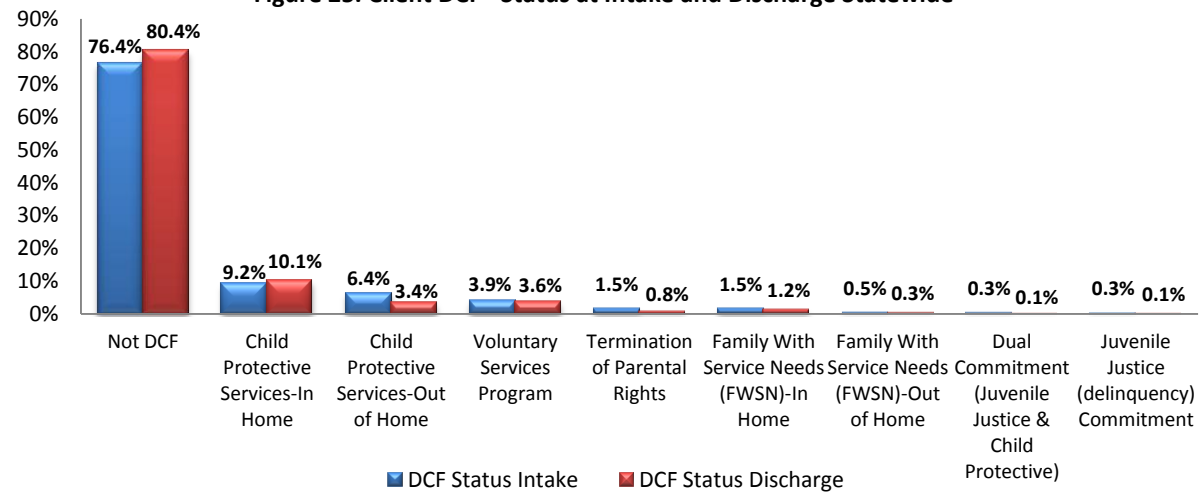


Figure 24. Families that Answered "Yes" TANF* Eligible by Provider



* TANF=Temporary Assistance for Needy Families

Figure 25. Client DCF* Status at Intake and Discharge Statewide



*DCF=Department of Children and Families

Section IV: Clinical Functioning

Figure 26. Top Six Client Primary Presenting Problems by Service Area

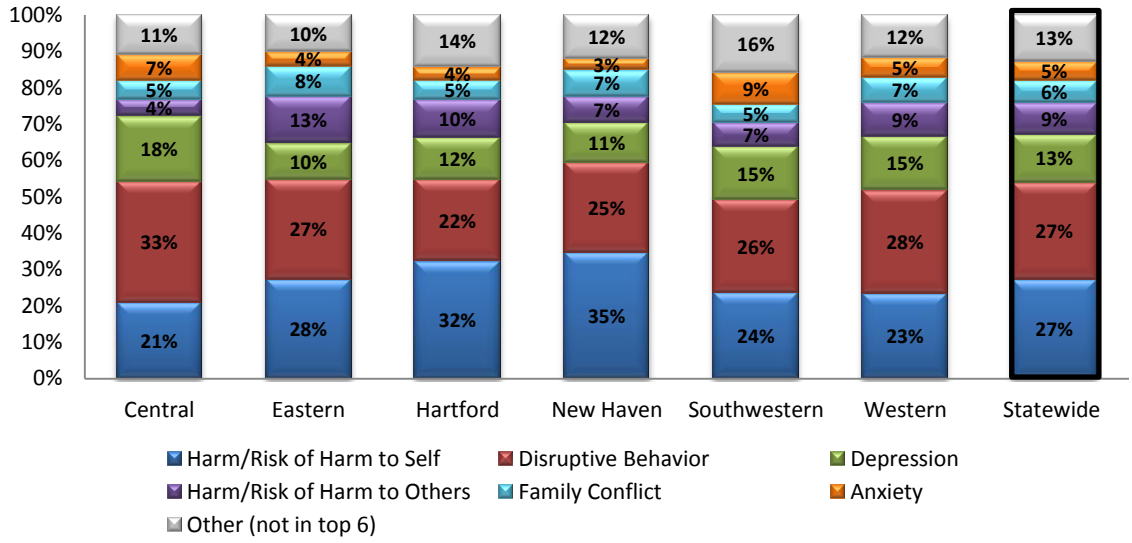
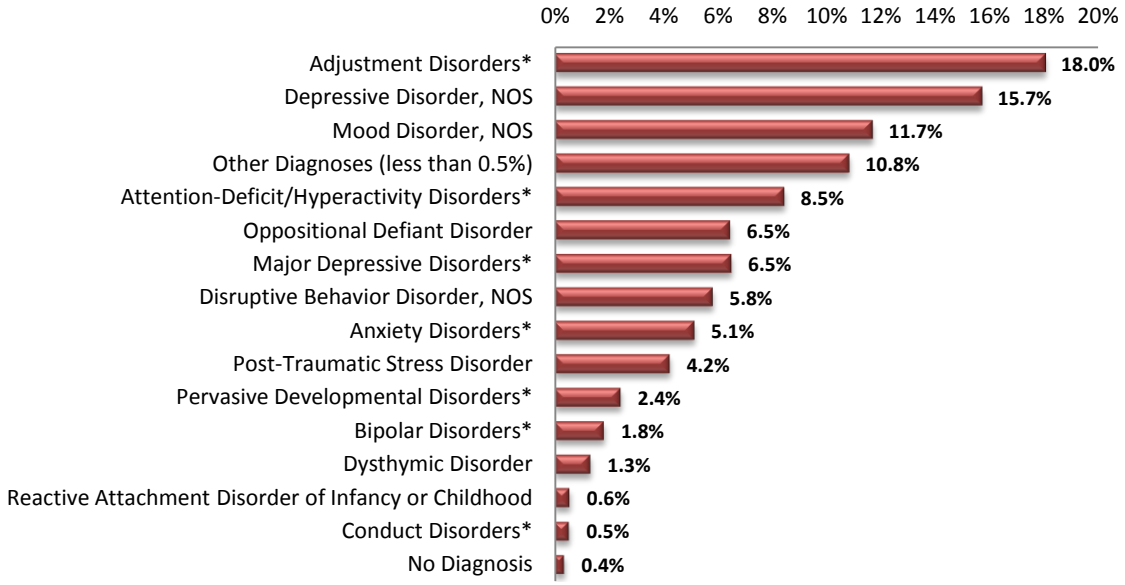
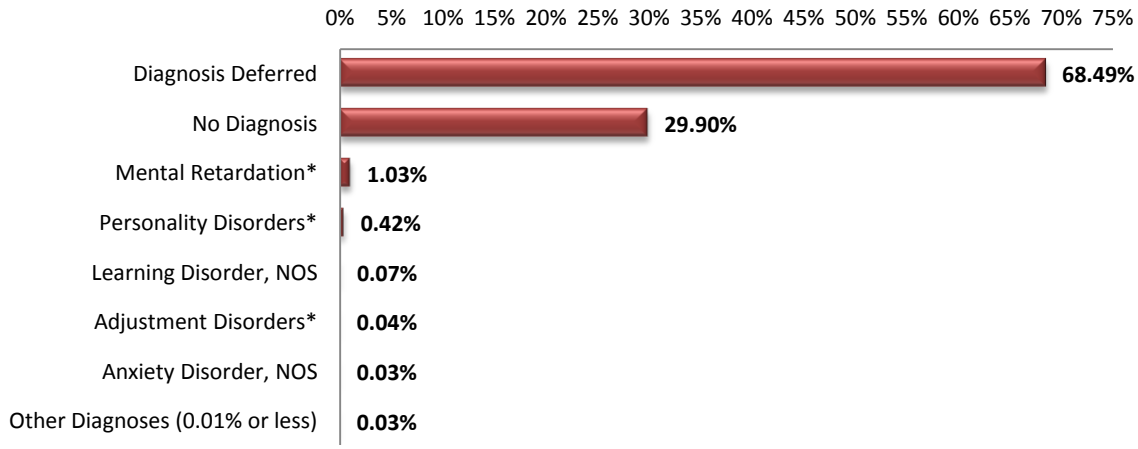


Figure 27. Distribution of Client Axis I Primary Diagnosis at Intake Statewide



*multiple diagnostic codes combined within category (see "Appendix B" for list)

Figure 28. Distribution of Client Axis II Primary Diagnosis at Intake Statewide



*multiple diagnostic codes combined within category (see "Appendix B" for list)

Figure 29. Distribution of Client Axis III Diagnosis at Intake Statewide

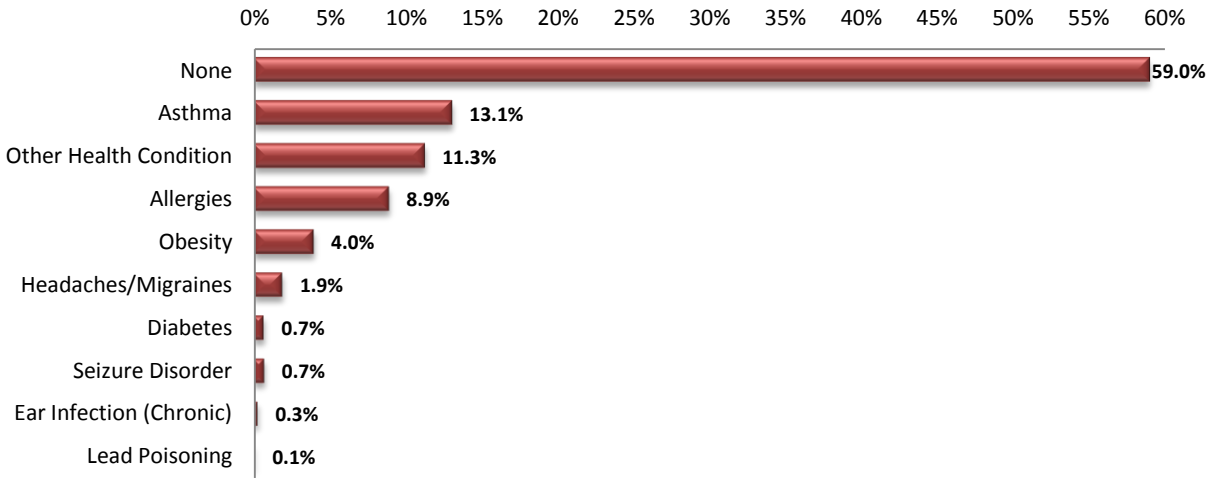


Figure 30. Distribution of Client Axis IV Diagnosis at Intake Statewide

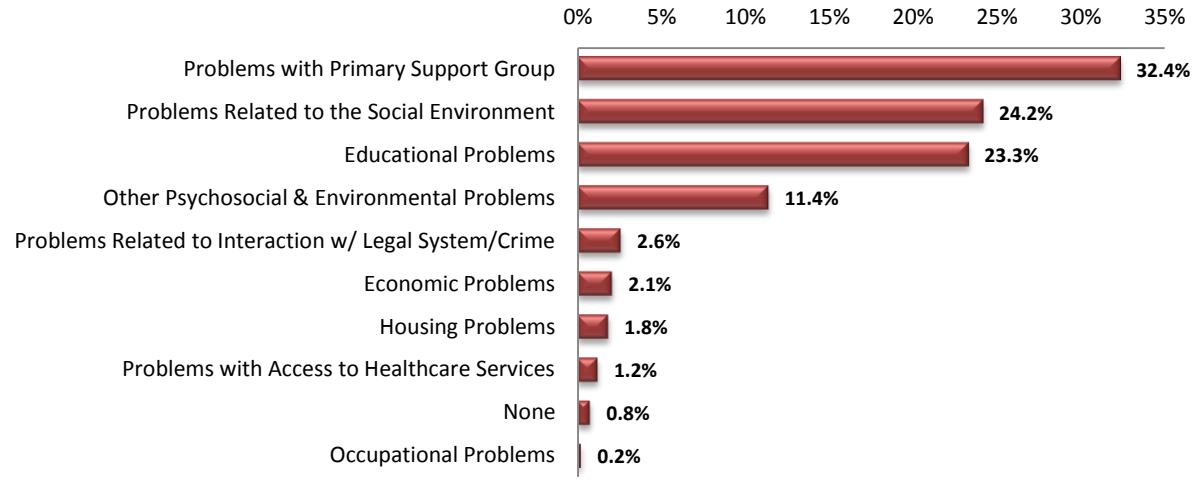
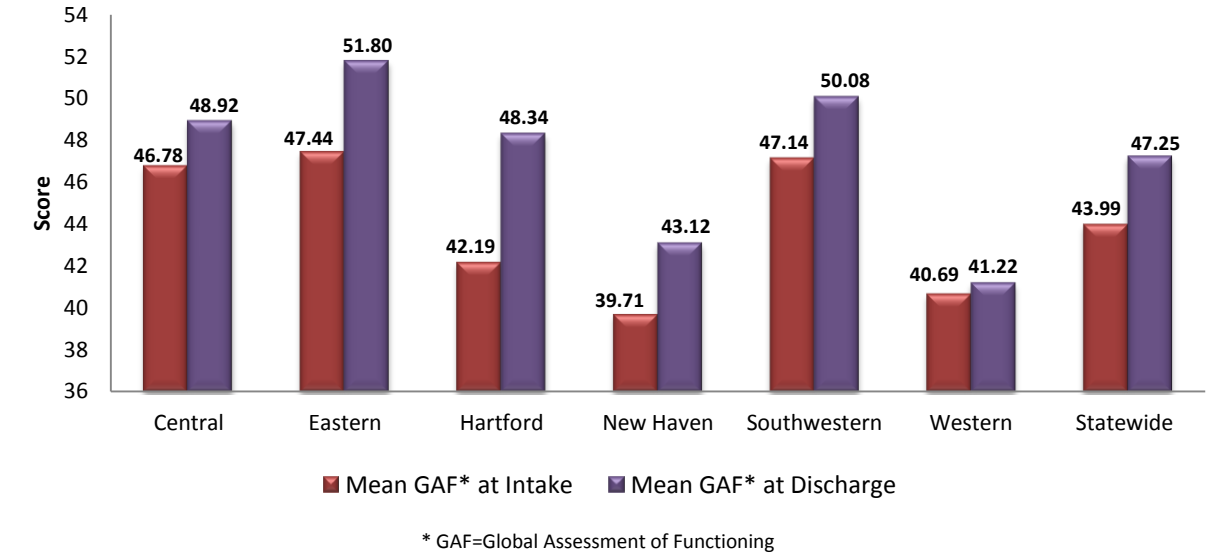
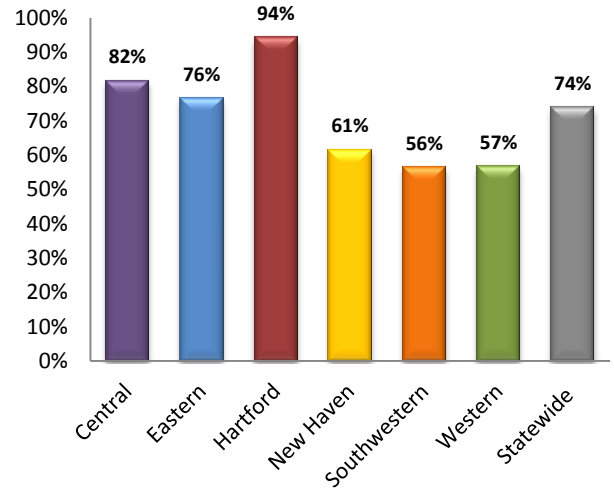


Figure 31. Mean Client Axis V Diagnosis (GAF*) at Intake and Discharge by Service Area



* GAF=Global Assessment of Functioning

Figure 32. Children Meeting SED* Criteria by Service Area



*SED= Serious Emotional Disturbance for definition see Appendix A

Figure 33. Children with Trauma Exposure Reported at Intake by Service Area

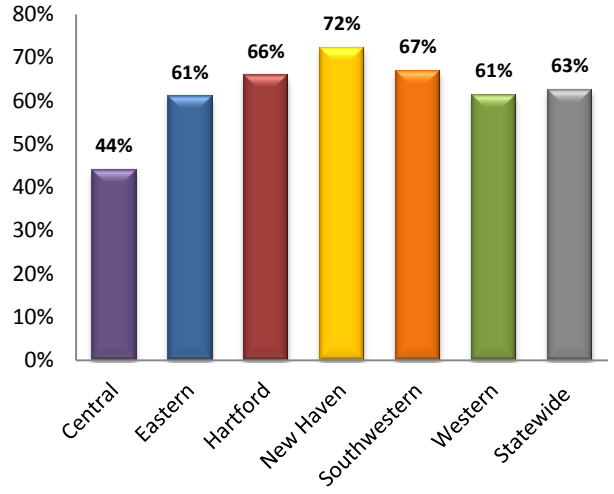
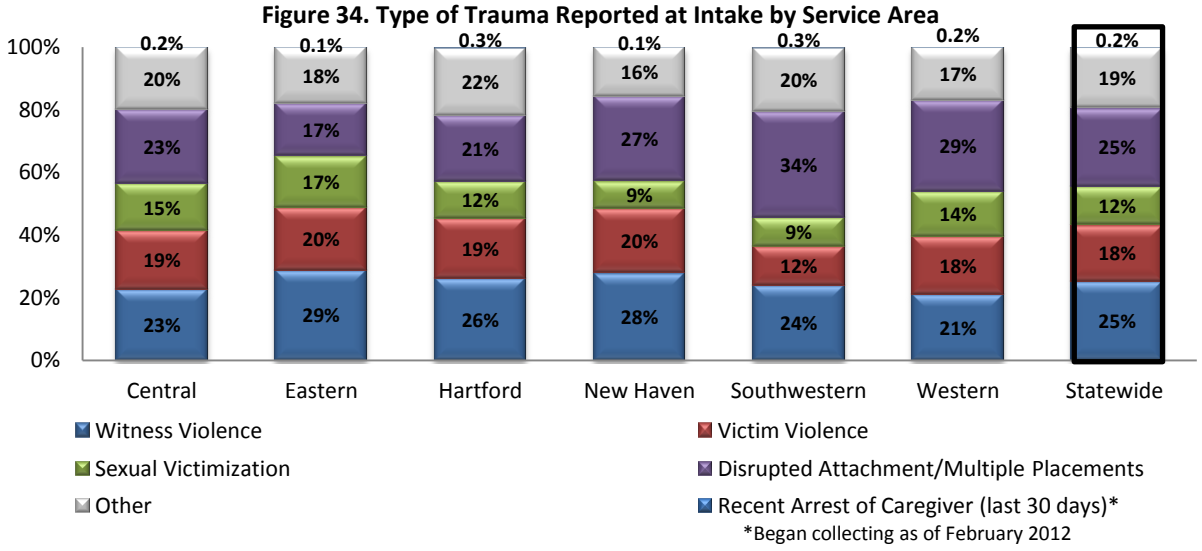


Figure 34. Type of Trauma Reported at Intake by Service Area



*Began collecting as of February 2012

Figure 35. Clients Evaluated in an Emergency Dept. One or More Times in the Six Months Prior to and During an Episode of Care

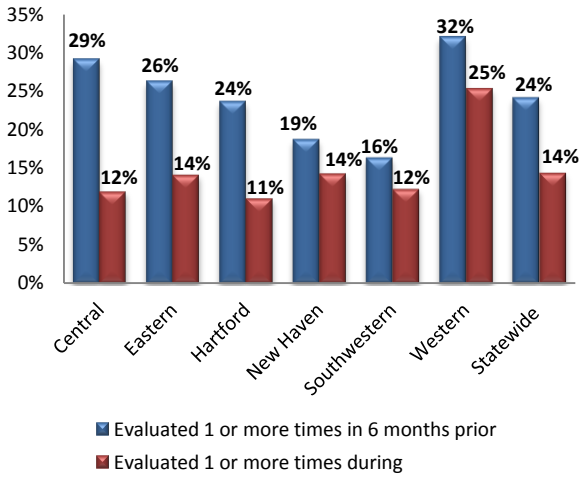


Figure 36. Clients Admitted to a Hospital (Inpatient) for Psychiatric or Behavioral Health Reasons One or More Times in His/Her Lifetime, in Six Months Prior to and During the Episode of Care

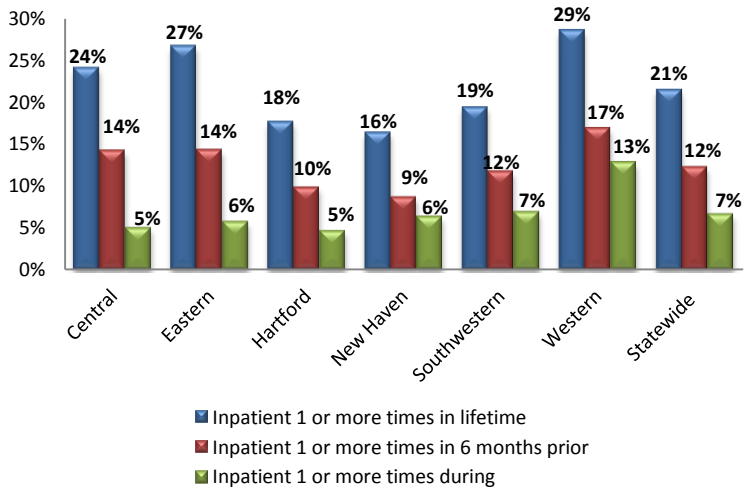
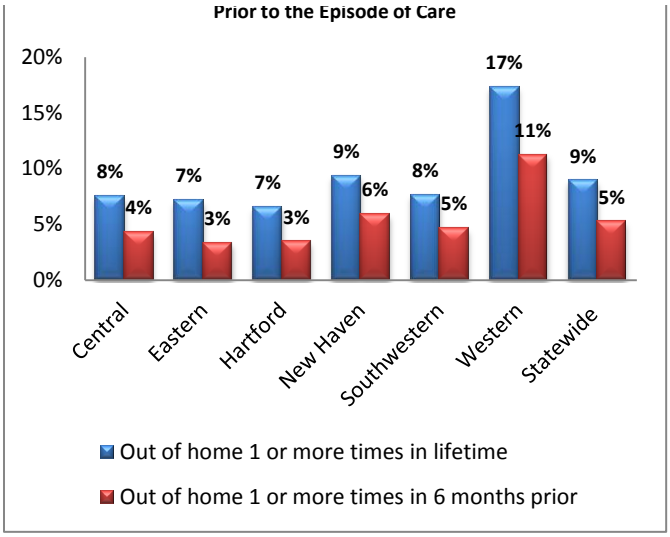
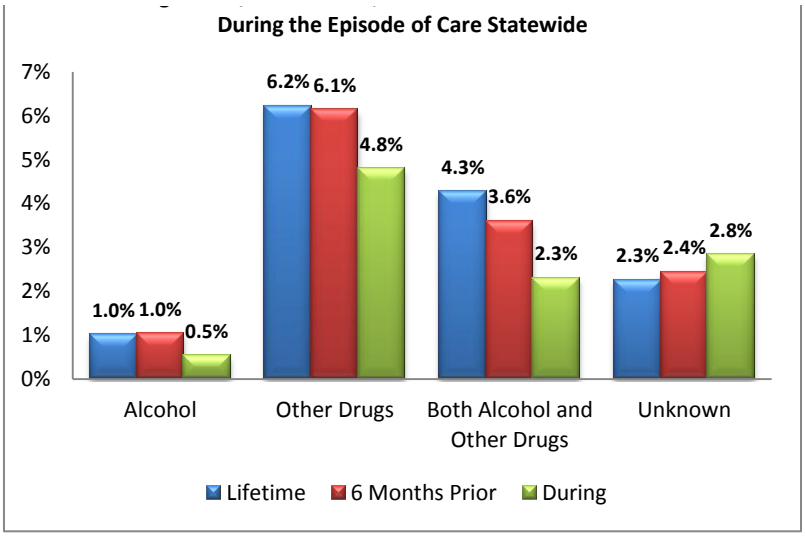


Figure 37. Clients Placed in an Out of Home Setting One or More Times in His/Her Lifetime and in the Six Months Prior to the Episode of Care

Figure 38. Client Reported Problems with Alcohol and/or Drugs in His/Her Lifetime, in the Six Months Prior to and


Prior to the Episode of Care
20%
15%
10%
5%
0%
8%
4%
7%
3%
7%
3%
9%
6%
8%
5%
17%
11%
9%
5%
Central
Eastern
Hartford
New Haven
Southwestern
Western
Statewide
Out of home 1 or more times in lifetime
Out of home 1 or more times in 6 months prior


During the Episode of Care Statewide
7%
6%
5%
4%
3%
2%
1%
0%
1.0%
1.0%
0.5%
6.2%
6.1%
4.8%
4.3%
3.6%
2.3%
2.3%
2.4%
2.8%
Alcohol
Other Drugs
Both Alcohol and Other Drugs
Unknown
Lifetime
6 Months Prior
During

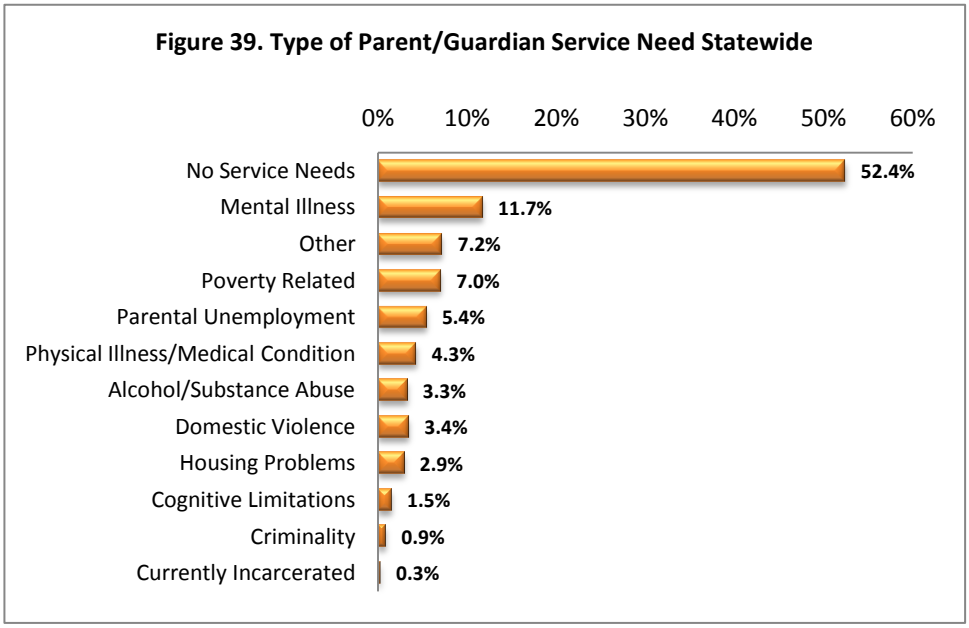


Figure 39. Type of Parent/Guardian Service Need Statewide
0%
10%
20%
30%
40%
50%
60%
No Service Needs
52.4%
Mental Illness
11.7%
Other
7.2%
Poverty Related
7.0%
Parental Unemployment
5.4%
Physical Illness/Medical Condition
4.3%
Alcohol/Substance Abuse
3.3%
Domestic Violence
3.4%
Housing Problems
2.9%
Cognitive Limitations
1.5%
Criminality
0.9%
Currently Incarcerated
0.3%

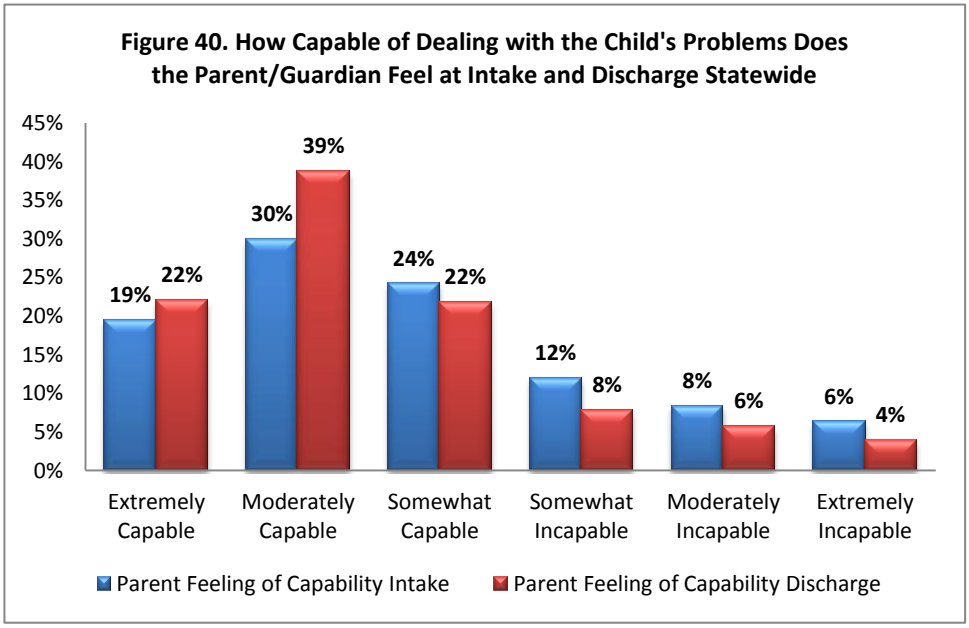


Figure 40. How Capable of Dealing with the Child's Problems Does the Parent/Guardian Feel at Intake and Discharge Statewide
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
19%
22%
30%
39%
24%
22%
12%
8%
8%
6%
6%
4%
Extremely Capable
Moderately Capable
Somewhat Capable
Somewhat Incapable
Moderately Incapable
Extremely Incapable
Parent Feeling of Capability Intake
Parent Feeling of Capability Discharge

Figure 41. Client's Suspended or Expelled from School in the Six Months Prior to and During the Episode of Care

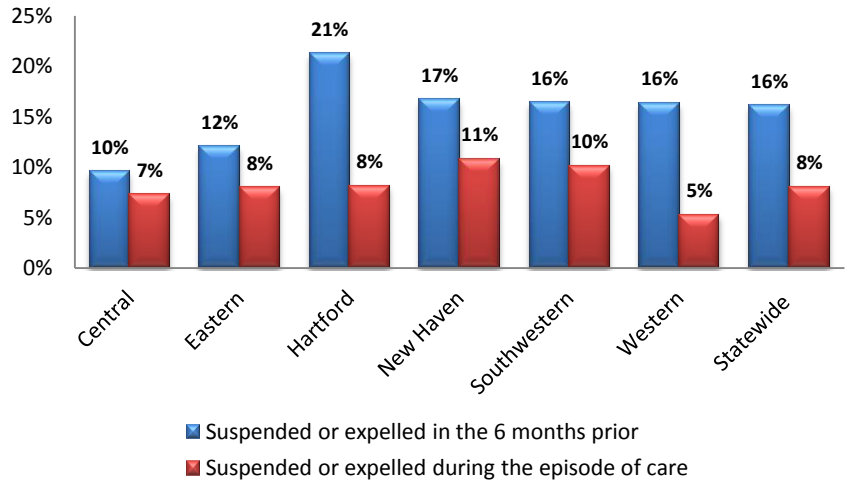


Figure 42. Statewide Parent/Guardian Rating of Client's Attendance at School During the Episode of Care (compared to pre-admission)

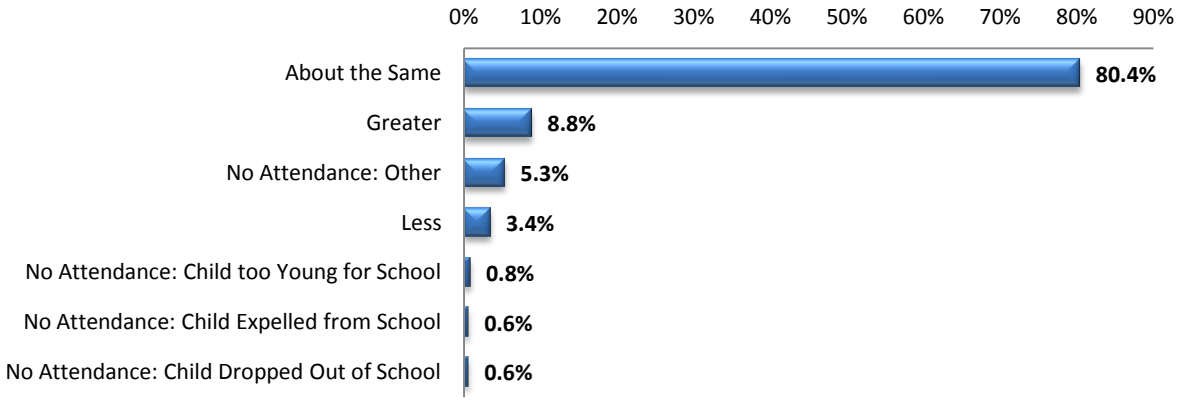
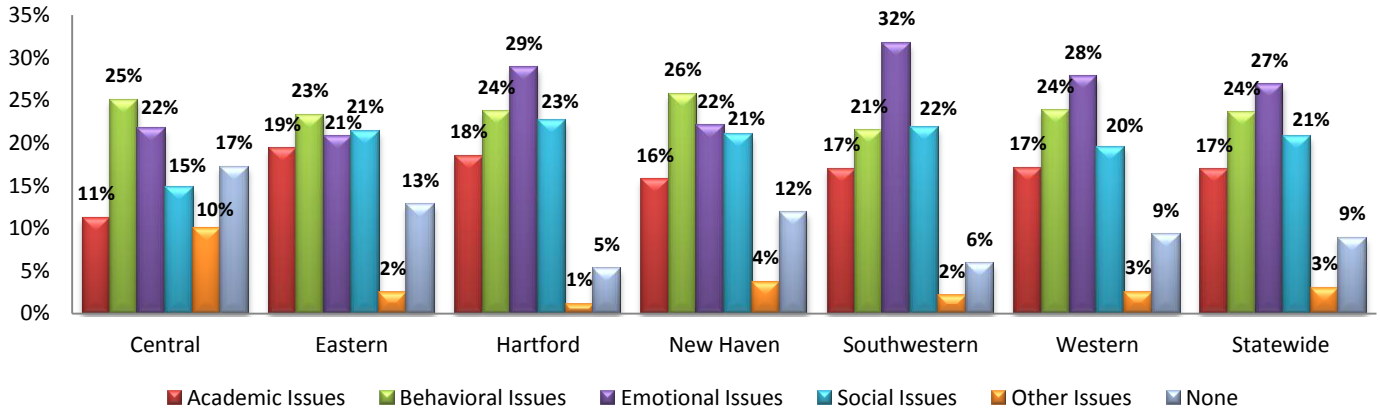
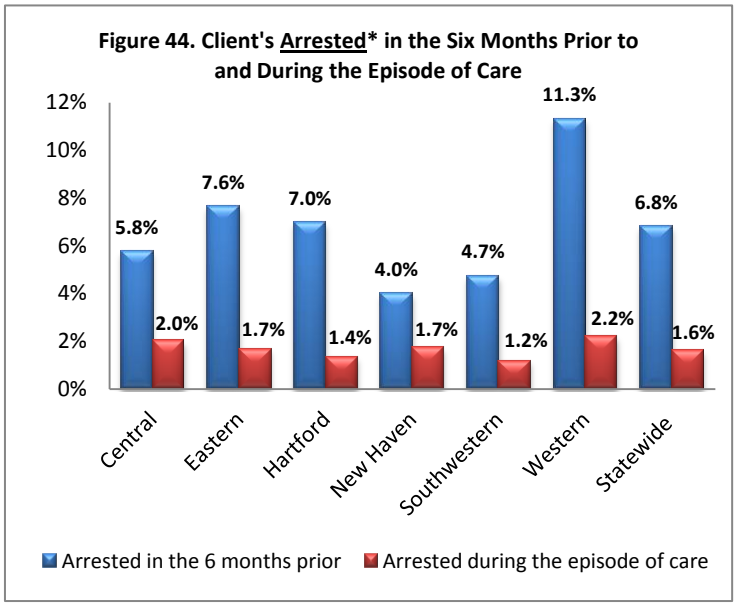
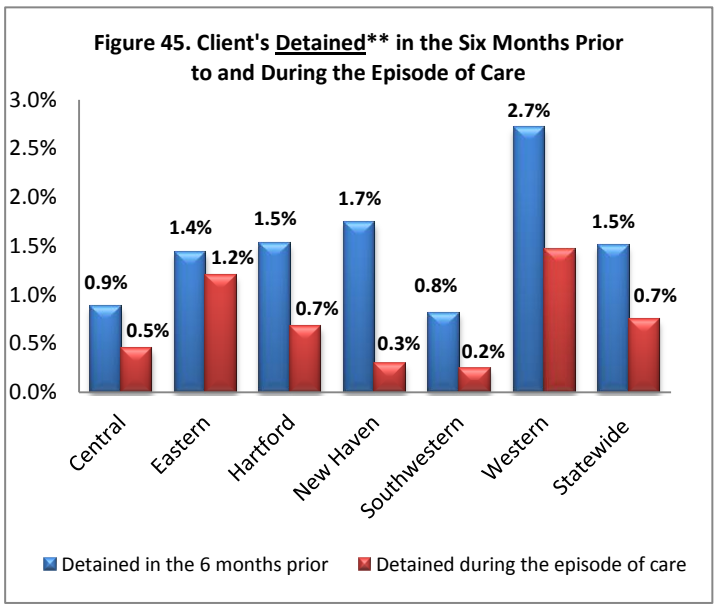


Figure 43. School Issues at <u>Intake</u> that have a Negative Impact on Client's Functioning at School by Service Area







*Arrested refers to any arrest, regardless of whether it resulted in formal arraignment or adjudication.

**Detained is intended to indicate instances in which the youth has been removed from the community and institutionally confined for legal reasons.

Section V: Referral Sources

Figure 46. Referral Sources Statewide

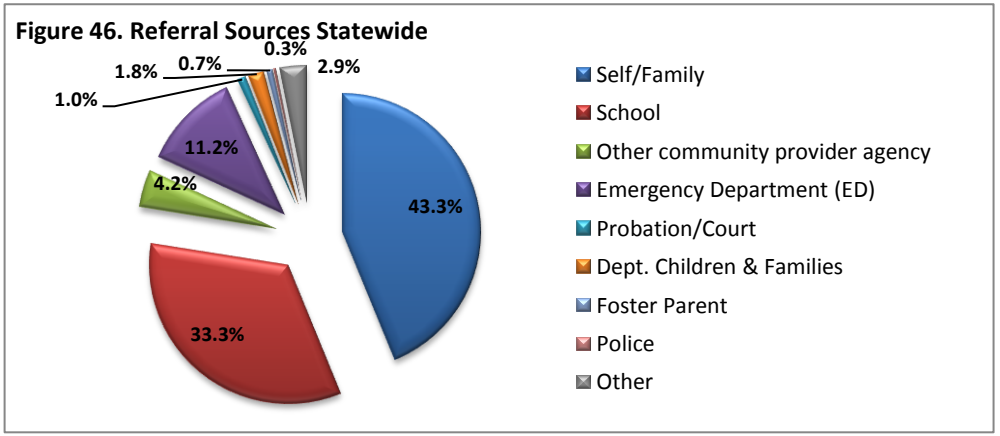
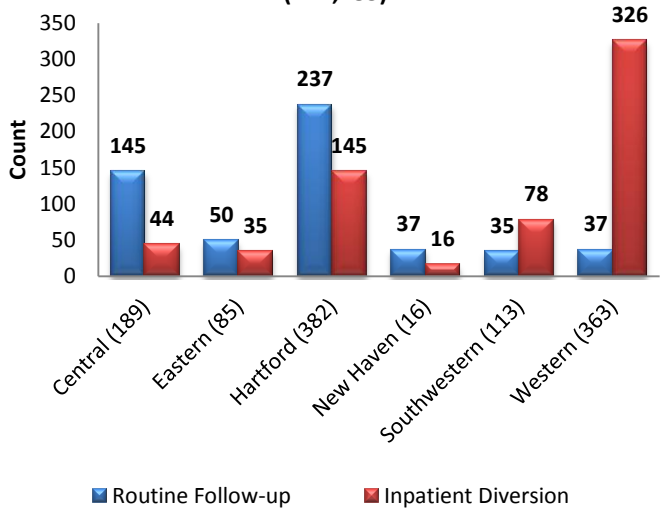


Table 1. Referral Sources (FY2011)

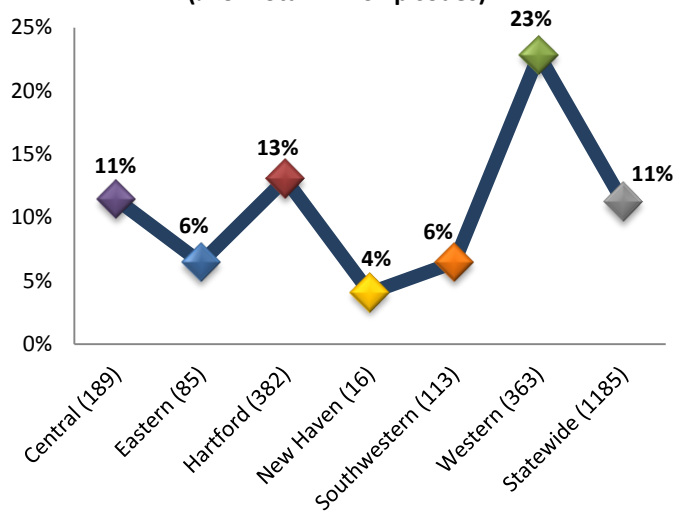
	Self/Family	School	Emergency Department (ED)	Other Community Provider	Dept. of Children & Families (DCF)	Probation/Court	Foster Parent	Physician	Congregate Care Facility	Other Program within Agency	Psychiatric Hospital	Info-Line (211)	Police	Family Advocate	Other State Agency	Community Natural Support
STATEWIDE	43.3%	33.3%	11.2%	4.2%	1.8%	1.0%	0.7%	0.7%	0.6%	1.2%	0.9%	0.3%	0.3%	0.2%	0.03%	0.09%
CENTRAL	48.2%	27.4%	11.4%	4.7%	1.9%	0.6%	0.9%	0.8%	0.6%	1.5%	1.5%	0.0%	0.4%	0.1%	0.0%	0.1%
CHR/MiddHosp-EMPS	47.3%	27.9%	12.8%	6.4%	1.1%	1.1%	0.2%	0.9%	1.4%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%
CHR-EMPS	48.5%	27.3%	10.9%	4.1%	2.1%	0.4%	1.2%	0.7%	0.3%	2.0%	1.6%	0.0%	0.5%	0.2%	0.0%	0.1%
EASTERN	48.8%	32.5%	6.4%	5.2%	1.0%	0.4%	0.5%	0.9%	0.4%	2.3%	0.9%	0.0%	0.2%	0.5%	0.0%	0.0%
UCFS/CHR-EMPS	44.7%	29.0%	5.8%	10.5%	1.4%	0.5%	0.5%	1.3%	0.4%	4.7%	0.9%	0.0%	0.2%	0.0%	0.0%	0.0%
UCFS-EMPS	51.7%	35.1%	6.9%	1.4%	0.6%	0.3%	0.5%	0.6%	0.4%	0.6%	0.9%	0.0%	0.1%	0.8%	0.0%	0.0%
HARTFORD	40.7%	34.1%	13.0%	3.8%	1.9%	1.6%	0.5%	0.8%	0.4%	1.2%	1.6%	0.0%	0.0%	0.2%	0.0%	0.1%
Wheeler-EMPS:Htfd	32.8%	41.2%	13.9%	5.3%	1.5%	0.8%	0.5%	0.7%	0.2%	0.6%	2.1%	0.0%	0.0%	0.2%	0.0%	0.2%
Wheeler-EMPS:Meridn	36.9%	46.6%	8.3%	2.1%	2.8%	0.7%	0.7%	0.9%	0.0%	0.5%	0.2%	0.0%	0.0%	0.2%	0.0%	0.0%
Wheeler-EMPS:NBrit	48.0%	24.8%	13.8%	3.1%	2.0%	2.5%	0.6%	0.8%	0.6%	1.9%	1.7%	0.0%	0.0%	0.1%	0.0%	0.0%
NEW HAVEN	46.3%	37.8%	4.0%	5.9%	1.3%	0.3%	1.4%	0.5%	0.1%	1.2%	0.2%	0.2%	0.2%	0.5%	0.0%	0.1%
CBeer/Bridge-EMPS	38.6%	42.7%	2.6%	9.0%	1.5%	0.3%	0.8%	0.3%	0.0%	3.3%	0.3%	0.0%	0.0%	0.8%	0.0%	0.0%
CliffBeers-EMPS	49.6%	35.7%	4.7%	4.6%	1.2%	0.3%	1.6%	0.7%	0.1%	0.3%	0.2%	0.3%	0.2%	0.3%	0.0%	0.1%
SOUTHWESTERN	42.0%	39.0%	6.4%	3.5%	2.7%	1.2%	0.5%	0.6%	0.2%	1.0%	0.3%	1.3%	1.0%	0.1%	0.0%	0.1%
CGCGB/CGCSouth-EMPS	46.9%	35.4%	0.7%	4.7%	0.9%	0.4%	0.2%	0.9%	0.2%	2.0%	0.9%	5.2%	1.3%	0.0%	0.0%	0.2%
CGCGB/MidFfd-EMPS	39.6%	47.6%	1.3%	5.7%	2.6%	0.4%	0.0%	0.4%	0.0%	0.4%	0.0%	0.0%	1.3%	0.4%	0.0%	0.0%
CGCGB-EMPS	40.6%	38.6%	9.9%	2.6%	3.5%	1.7%	0.6%	0.6%	0.3%	0.6%	0.1%	0.0%	0.7%	0.1%	0.0%	0.1%
WESTERN	37.4%	28.6%	22.8%	3.1%	1.8%	1.1%	0.8%	0.7%	1.8%	0.4%	0.3%	0.1%	0.3%	0.3%	0.2%	0.2%
Well-EMPS:Dnby	61.3%	22.7%	0.8%	3.4%	5.5%	3.4%	0.4%	1.3%	0.4%	0.0%	0.0%	0.0%	0.4%	0.4%	0.0%	0.0%
Well-EMPS:Torr	48.2%	30.8%	2.2%	6.3%	1.3%	0.4%	1.8%	0.4%	6.7%	0.0%	0.4%	0.0%	0.9%	0.4%	0.0%	0.0%
Well-EMPS:Wtby	30.2%	29.4%	31.6%	2.5%	1.1%	0.8%	0.6%	0.6%	1.2%	0.6%	0.4%	0.2%	0.2%	0.3%	0.3%	0.3%

Figure 47. Type of Emergency Dept. Referral (n=1,185)



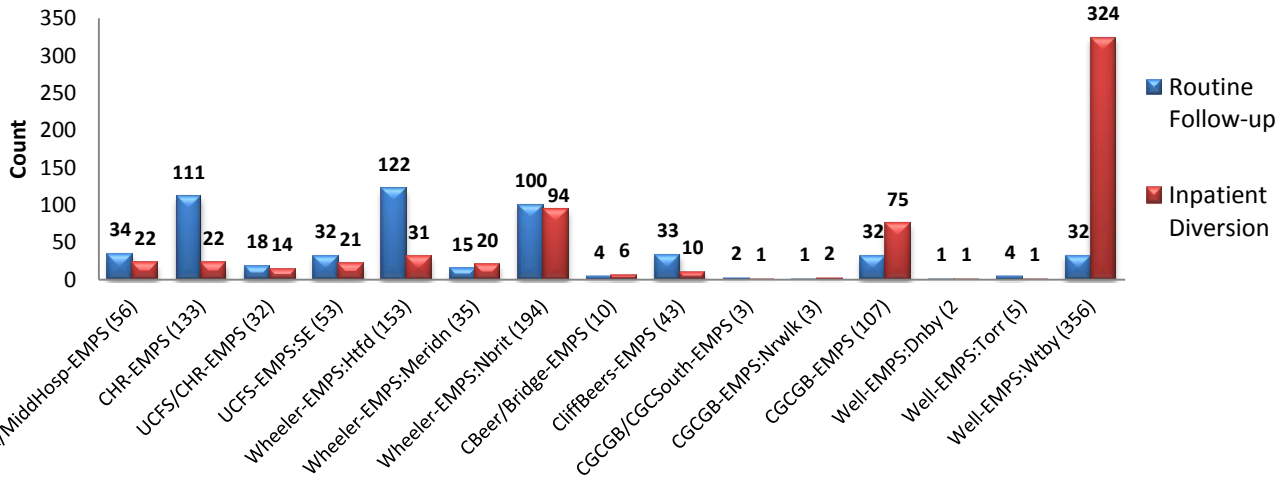
Note: Count total ED referrals are in parenthesis

Figure 48. Emergency Dept. Referral (% of Total EMPS Episodes)



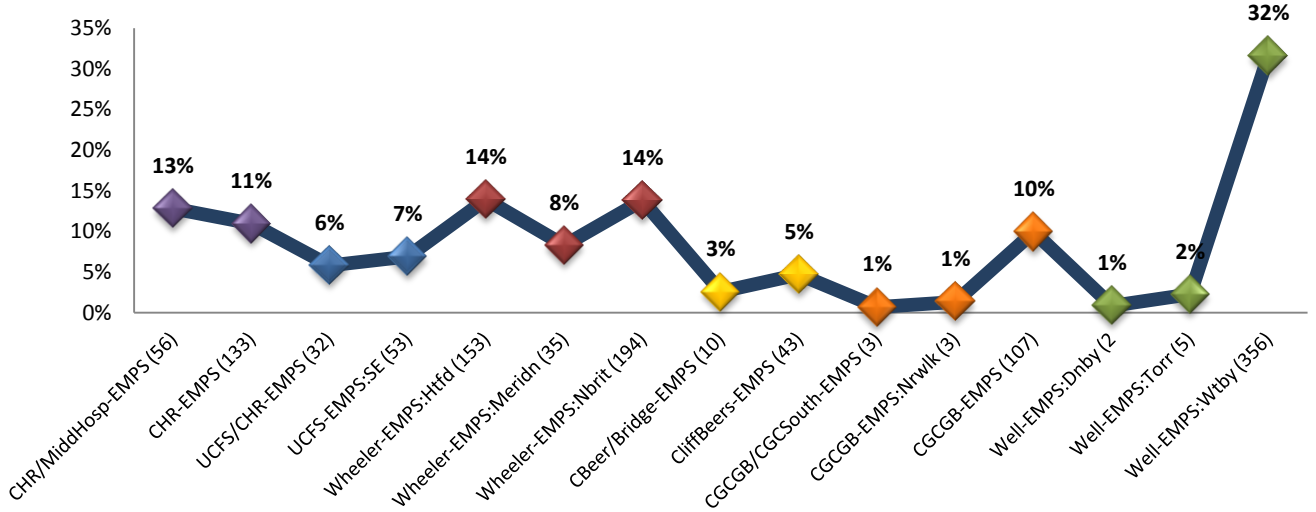
Note: Count total ED referrals are in parenthesis

Figure 49. Type of Emergency Dept. Referral by Provider



Note: Count total ED referrals are in parenthesis

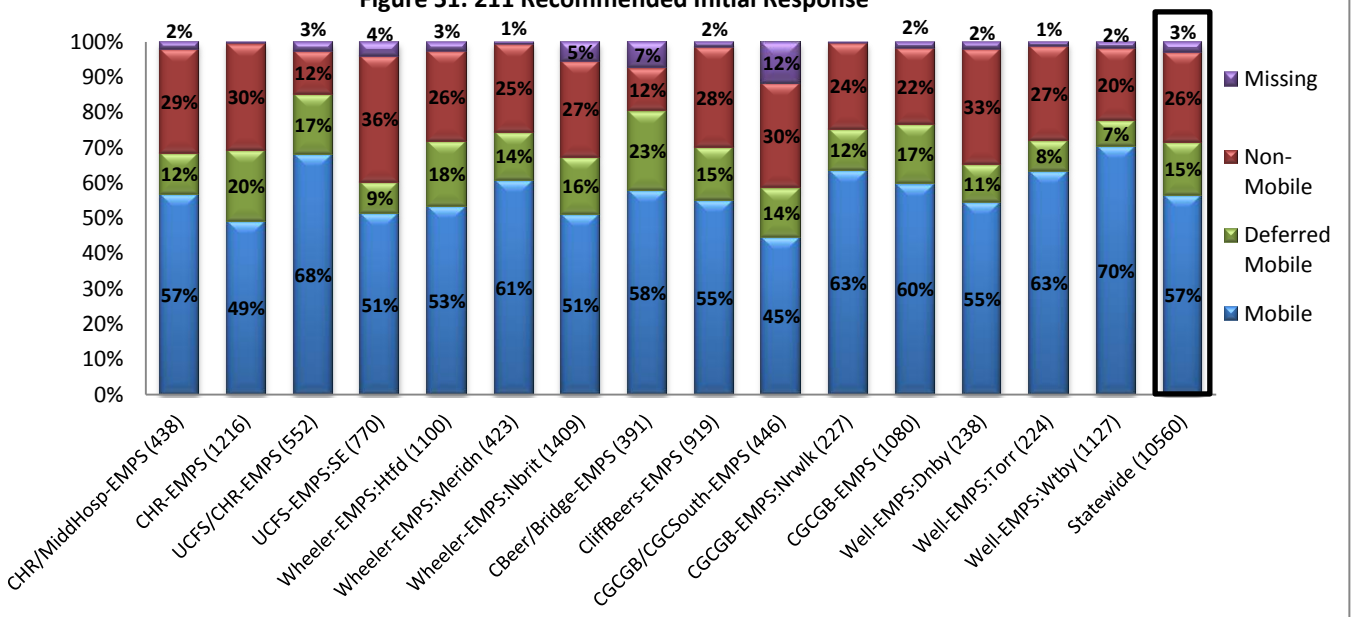
Figure 50. Emergency Dept. Referral (% of Total EMPS Episodes) by Provider



Note: Count total ED referrals are in parenthesis

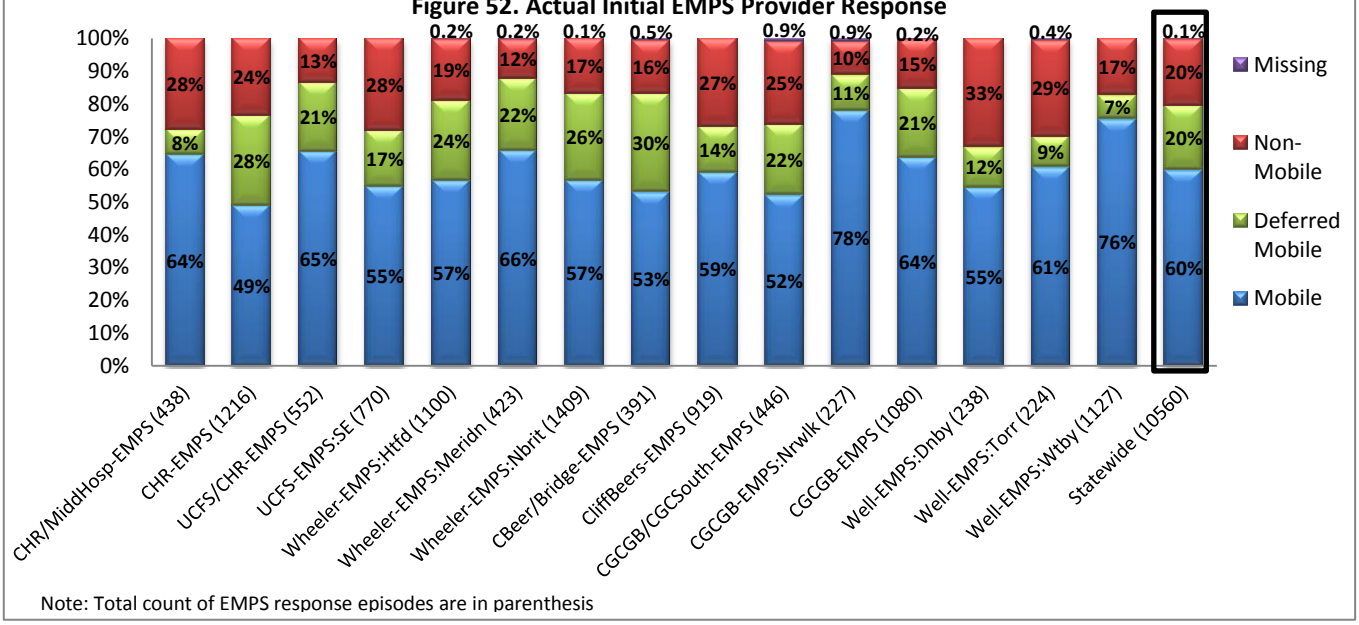
Section VI: 211 Recommendations and EMPS Response

Figure 51. 211 Recommended Initial Response



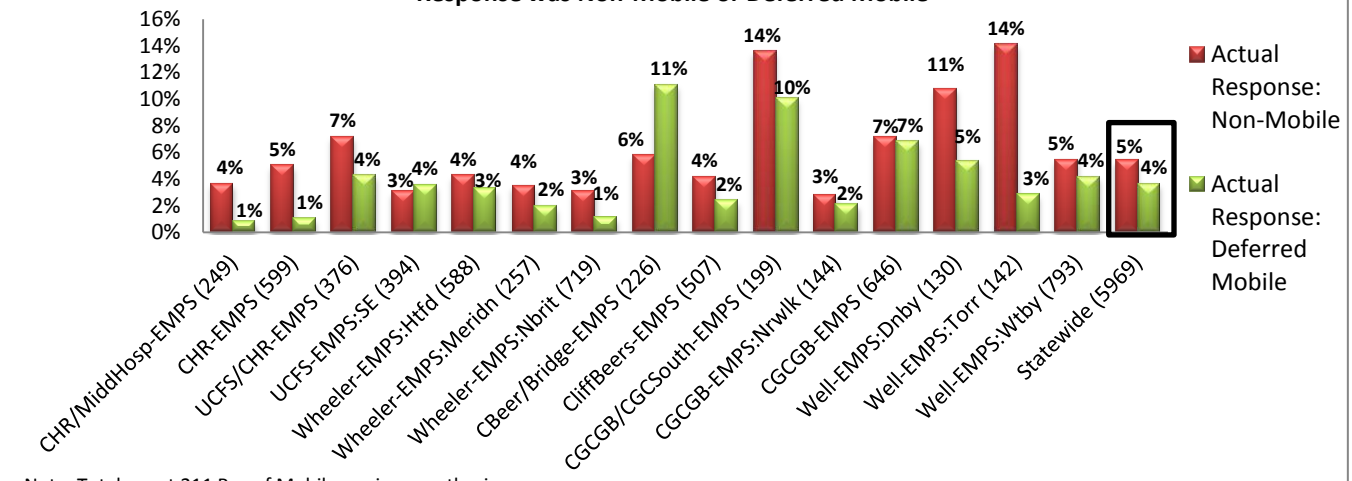
Note: Total count of EMPS response episodes are in parenthesis

Figure 52. Actual Initial EMPS Provider Response



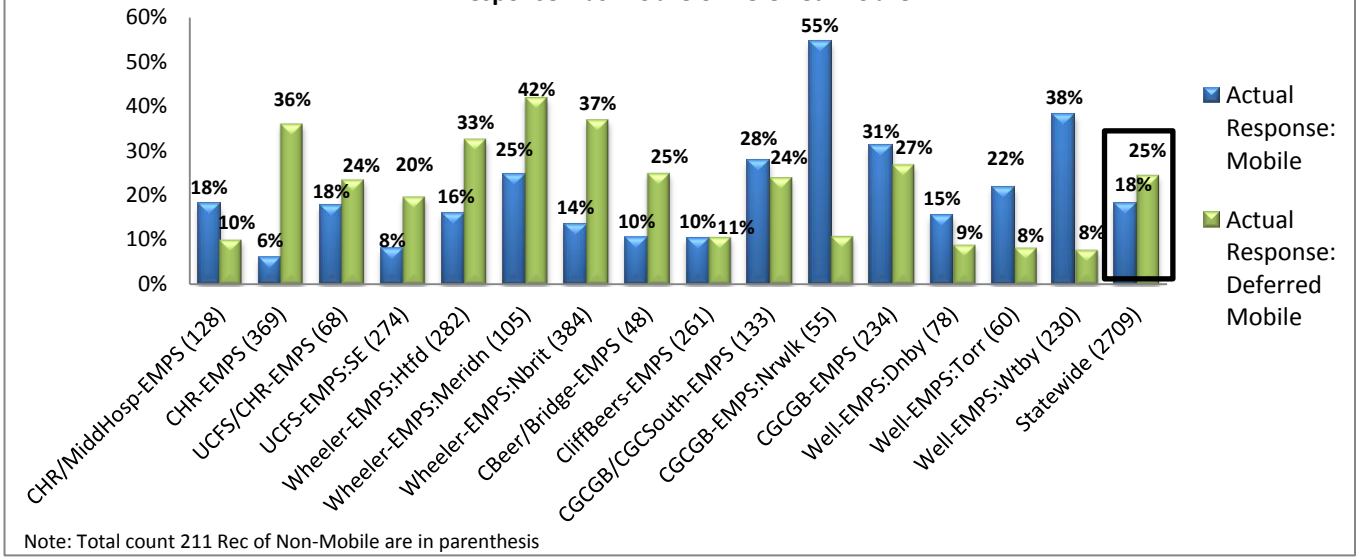
Note: Total count of EMPS response episodes are in parenthesis

Figure 53. 211 Recommended Mobile Response Where Actual EMPS Response was Non-Mobile or Deferred Mobile



Note: Total count 211 Rec of Mobile are in parenthesis

Figure 54. 211 Recommended Non-Mobile Response Where Actual EMPS Response was Mobile or Deferred Mobile



Note: Total count 211 Rec of Non-Mobile are in parenthesis

Figure 55. Mobile Response by Service Area

Goal=90%

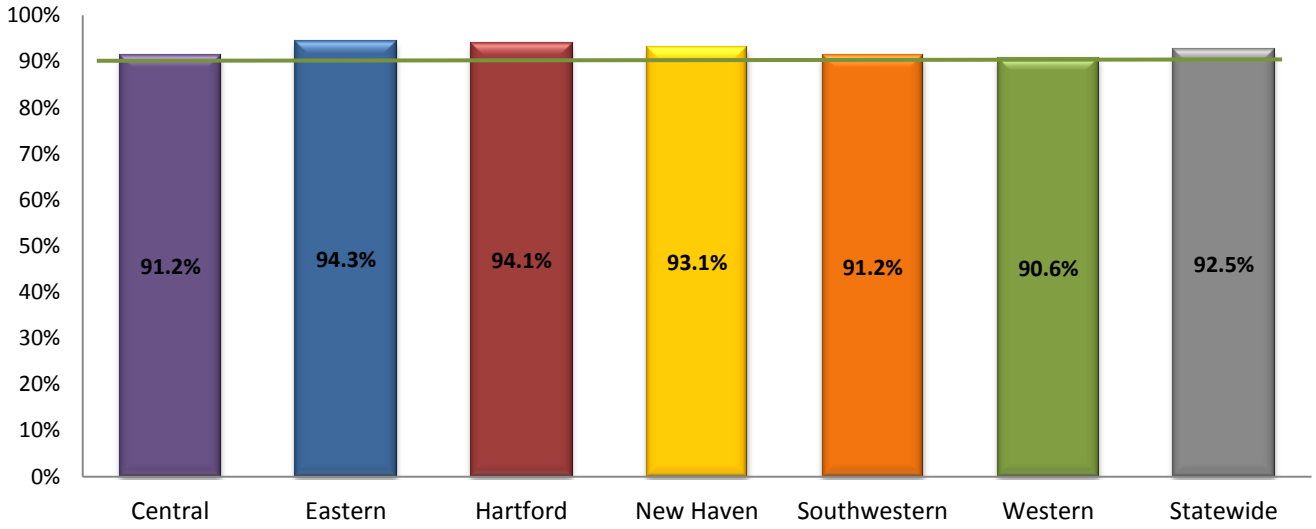


Figure 56. Mobile Response by Provider

Goal=90%

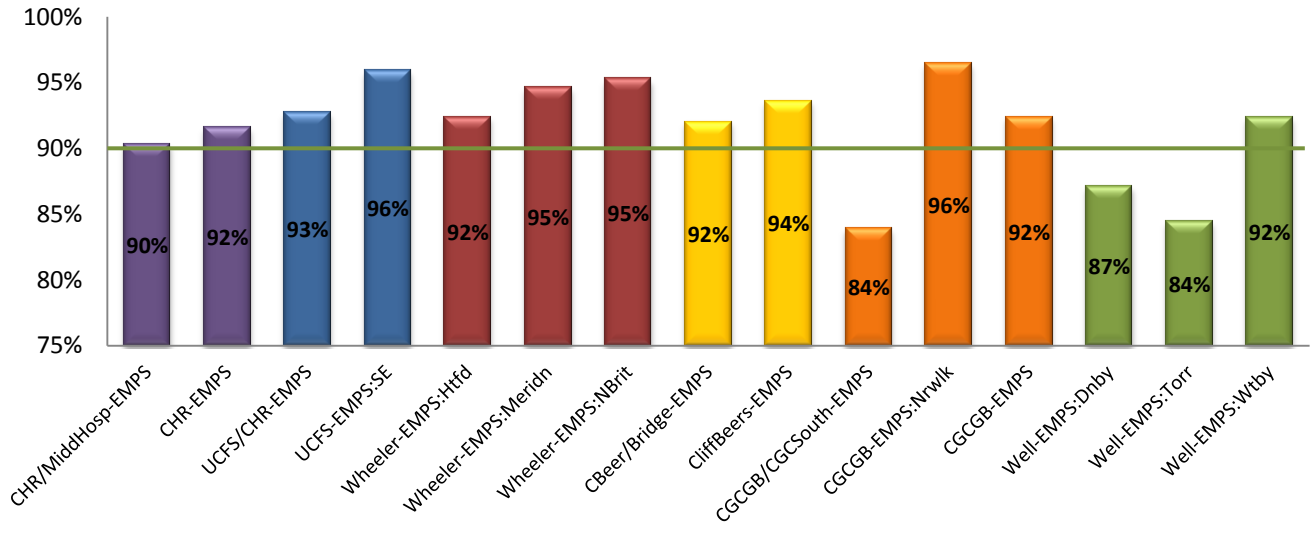


Figure 57. EMPS First Contact Mobile Site by Service Area

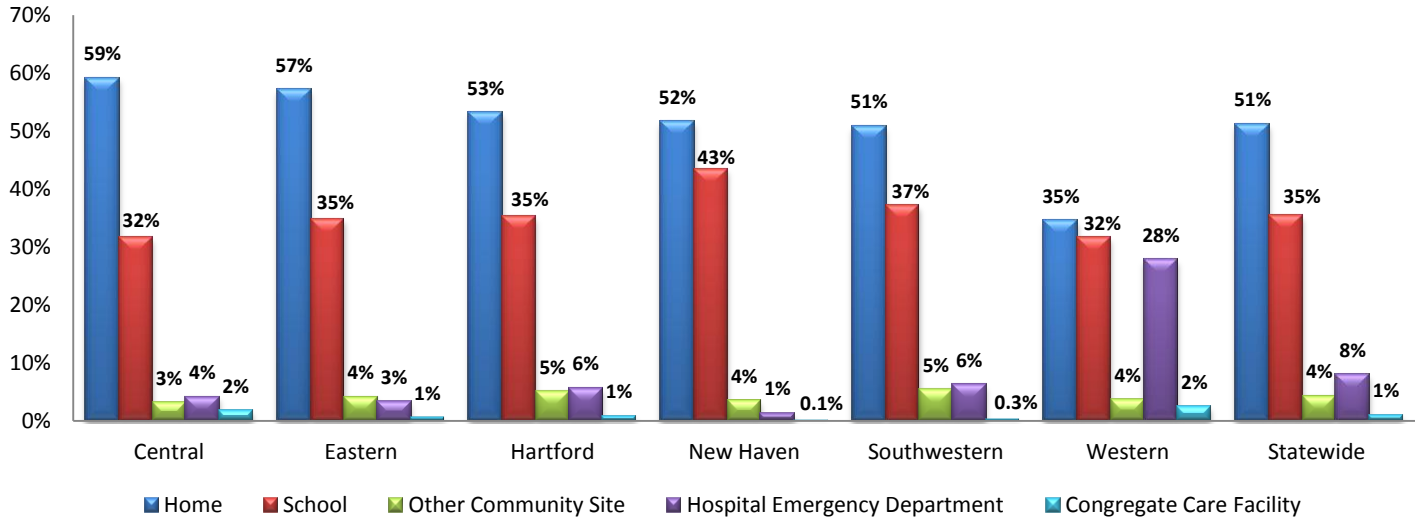
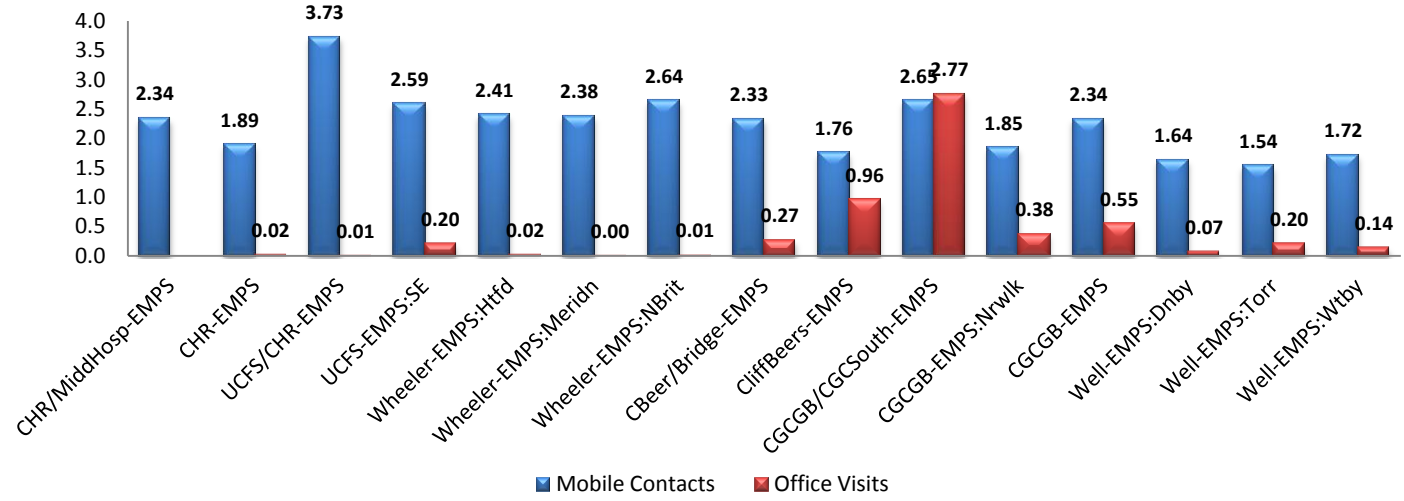
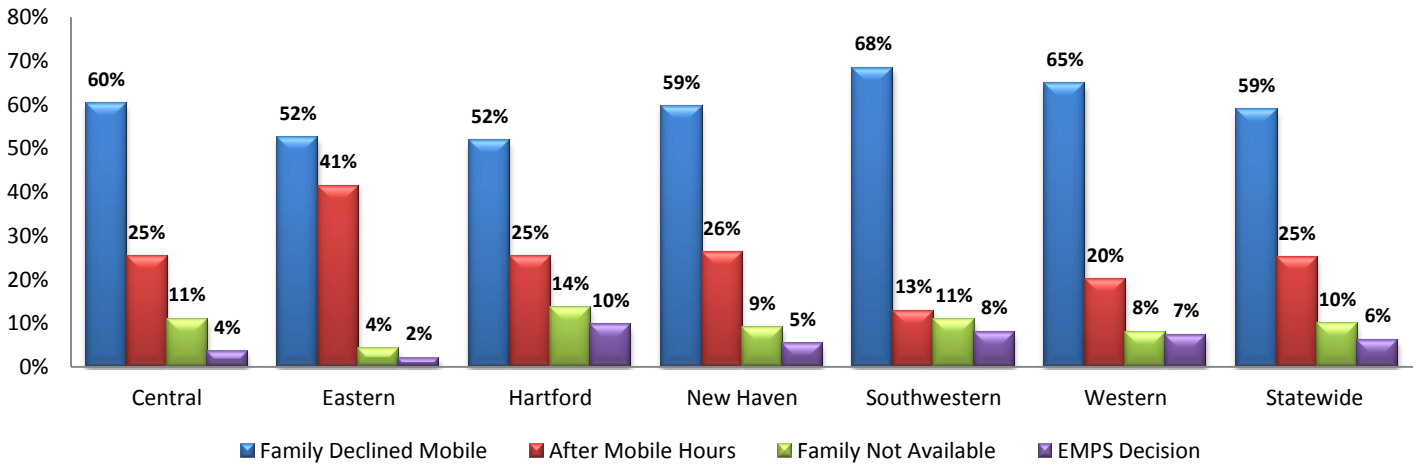


Figure 58. Mean of Mobile Contacts and Office Visists Occurring During an Episode of Care by Provider



Note: Only episodes with a Crisis Response of Plus Stabilization Follow-up are included.

Figure 59. EMPS Non-Mobile Reason by Service Area



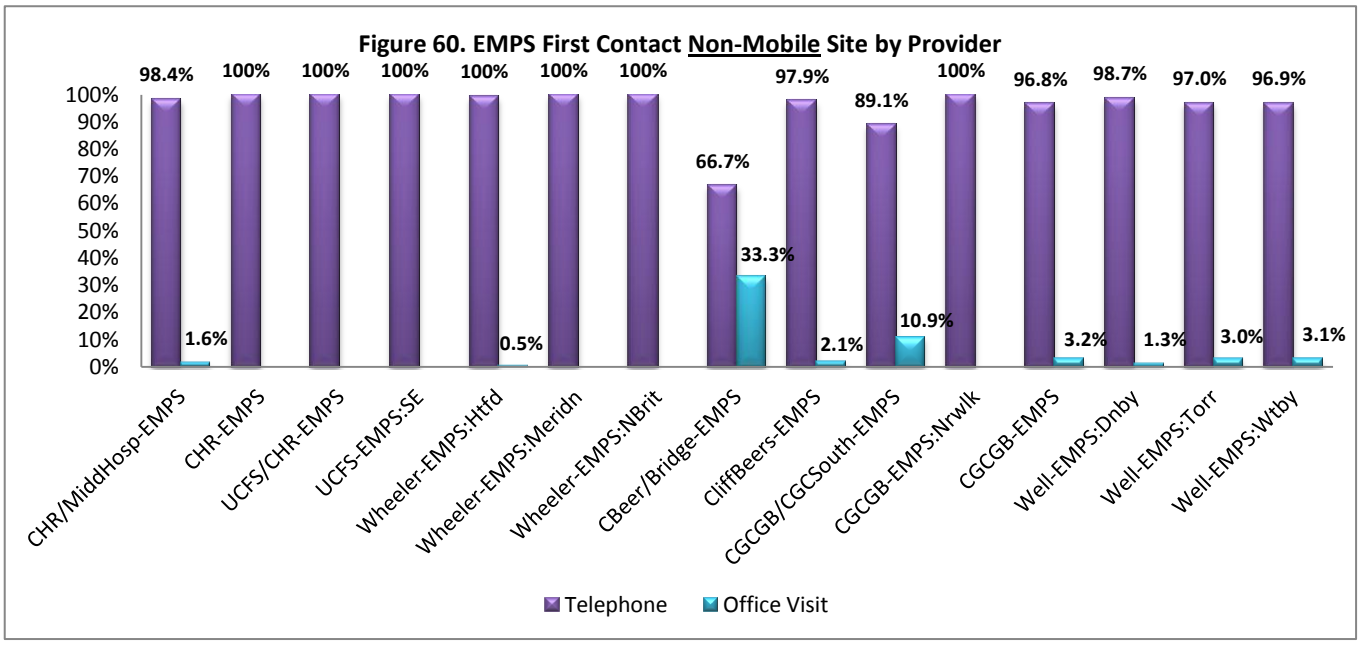
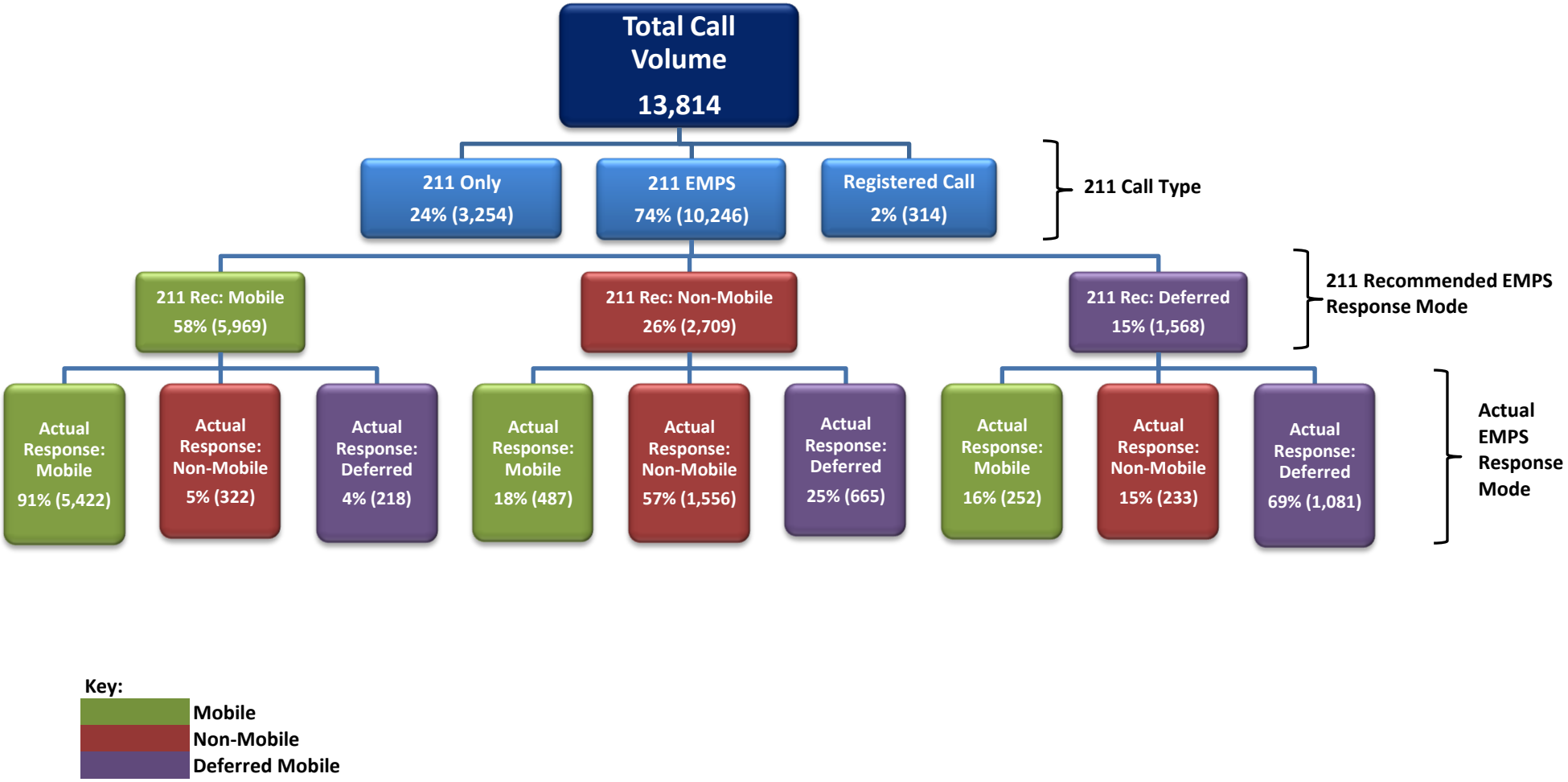


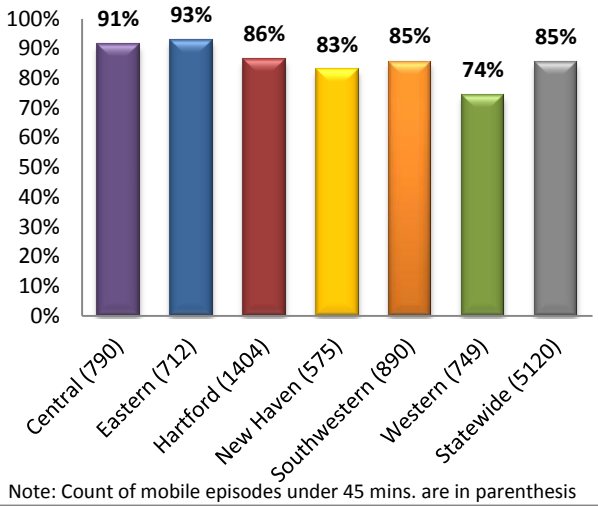
Figure 60. EMPS First Contact Non-Mobile Site by Provider
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
98.4%
1.6%
100%
100%
100%
100%
0.5%
100%
100%
66.7%
33.3%
97.9%
2.1%
89.1%
10.9%
100%
96.8%
3.2%
98.7%
1.3%
97.0%
3.0%
96.9%
3.1%
CHR/MiddHosp-EMPS
CHR-EMPS
UCFS/CHR-EMPS
UCFS-EMPS:SE
Wheeler-EMPS:Htfd
Wheeler-EMPS:Meridn
Wheeler-EMPS:NBrit
CBeer/Bridge-EMPS
CliffBeers-EMPS
CGCGB/CGCSouth-EMPS
CGCGB-EMPS:Nrwlk
CGCGB-EMPS
Well-EMPS:Dnby
Well-EMPS:Torr
Well-EMPS:Wtby
Telephone
Office Visit

Figure 61. Breakdown of Call Volume by Call Type and Response Mode



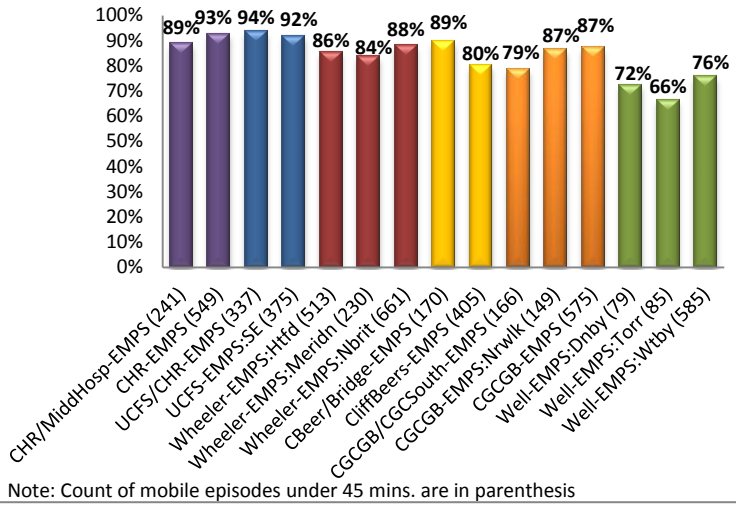
Section VII: Response Time

Figure 62. Total Mobile Episodes with Response Time Under 45 Minutes



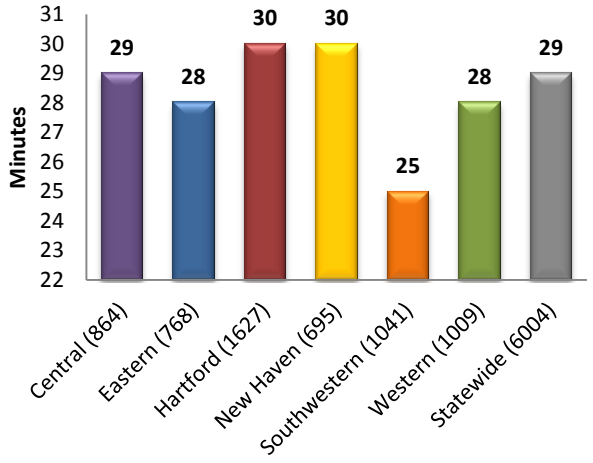
Note: Count of mobile episodes under 45 mins. are in parenthesis

Figure 63. Total Mobile Episodes with Response Time Under 45 Minutes by Provider



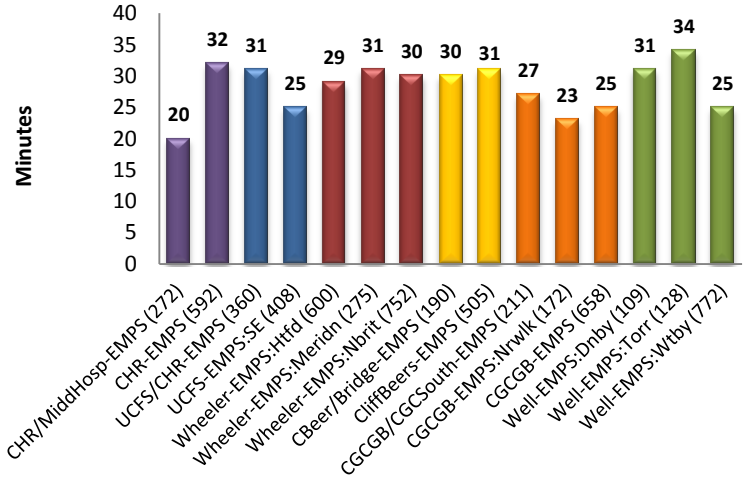
Note: Count of mobile episodes under 45 mins. are in parenthesis

Figure 64. Median Mobile Response Time by Service Area in Minutes



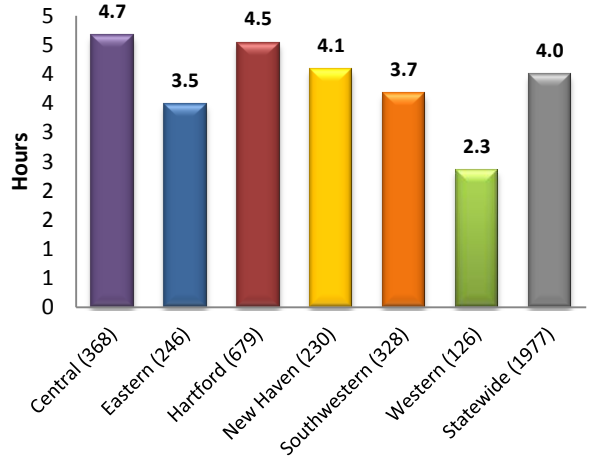
Note: Count of mobile EMPS response episodes in parenthesis

Figure 65. Median Mobile Response Time by Provider in Minutes



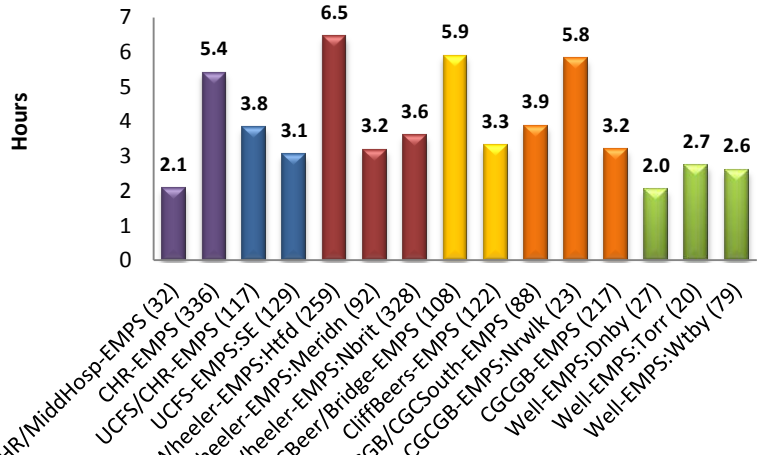
Note: Count of mobile EMPS response episodes are in parenthesis

Figure 66. Median Deferred Mobile Response Time by Service Area in Hours



Note: Count of deferred mobile EMPS response episodes in parenthesis

Figure 67. Median Deferred Mobile Response Time by Provider in Hours



Note: Count of deferred mobile EMPS response episodes in parenthesis

Section VIII: Length of Stay and Discharge Information

Table 2. Length of Stay for Discharged Episodes of Care in Days

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
		Discharged Episodes for FY2012									*N of Discharged Episodes for FY2012*					
		Mean			Median			Percent			N used Mean/Median			N used for Percent		
		LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45
1	**STATEWIDE**	**0.8**	**6.0**	**22.1**	**0.0**	**1.0**	**18.0**	**9%**	**27%**	**6%**	**2107**	**4466**	**3677**	**195**	**1222**	**205**
2	**Central**	**0.9**	**9.4**	**22.4**	**0.0**	**5.0**	**21.0**	**15%**	**46%**	**5%**	**408**	**740**	**450**	**61**	**340**	**21**
3	**CHR/MiddHosp-EMPS**	**2.0**	**0.0**	**13.5**	**1.0**	**3.0**	**12.0**	**35%**	**26%**	**0%**	**122**	**286**	**29**	**43**	**74**	**0**
4	**CHR-EMPS**	**0.4**	**12.8**	**23.0**	**0.0**	**7.0**	**22.0**	**6%**	**59%**	**5%**	**286**	**454**	**421**	**18**	**266**	**21**
5	**Eastern**	**0.1**	**1.5**	**22.4**	**0.0**	**1.0**	**21.0**	**1%**	**1%**	**1%**	**292**	**611**	**416**	2	**5**	**3**
6	**UCFS/CHR-EMPS**	**0.1**	**1.2**	**22.3**	**0.0**	**0.0**	**20.5**	**1%**	**1%**	**1%**	**74**	**186**	**292**	**1**	**2**	**2**
7	**UCFS-EMPS**	**0.1**	**1.6**	**22.7**	**0.0**	**1.0**	**21.0**	**0%**	**1%**	**1%**	**218**	**425**	**124**	**1**	**3**	**1**
8	**Hartford**	**0.8**	**4.3**	**20.9**	**0.0**	**2.0**	**18.0**	**11%**	**19%**	**5%**	**494**	**970**	**1398**	**53**	**189**	**72**
9	**Wheeler-EMPS:Htfd**	**1.4**	**5.6**	**24.0**	**0.0**	**2.0**	**22.0**	**17%**	**28%**	**9%**	**204**	**410**	**453**	**35**	**114**	**43**
10	**Wheeler-EMPS:Meridn**	**0.7**	**3.7**	**16.9**	**0.0**	**1.0**	**14.0**	**17%**	**15%**	**2%**	**54**	**133**	**228**	**9**	**20**	**4**
11	**Wheeler-EMPS:NBrit**	**0.3**	**3.3**	**20.1**	**0.0**	**2.0**	**17.0**	**4%**	**13%**	**3%**	**236**	**427**	**717**	**9**	**55**	**25**
12	**New Haven**	**1.1**	**8.1**	**27.2**	**0.0**	**2.0**	**26.0**	**12%**	**38%**	**10%**	**285**	**603**	**355**	**33**	**229**	**36**
13	**CBeer/Bridge-EMPS**	**1.2**	**3.3**	**21.5**	**0.0**	**0.0**	**17.0**	**7%**	**19%**	**5%**	**43**	**183**	**145**	**3**	**34**	**7**
14	**CliffBeers-EMPS**	**1.1**	**10.2**	**31.1**	**0.0**	**4.5**	**30.0**	**12%**	**46%**	**14%**	**242**	**420**	**210**	**30**	**195**	**29**
15	**Southwestern**	**0.9**	**9.0**	**28.4**	**0.0**	**3.0**	**29.0**	**9%**	**41%**	**8%**	**281**	**962**	**438**	**26**	**392**	**33**
16	**CGCGB/CGCSouth-EMPS**	**0.0**	**3.0**	**34.3**	**0.0**	**0.0**	**36.0**	**0%**	**8%**	**22%**	**99**	**185**	**126**	**0**	**14**	**28**
17	**CGCGB-EMPS:Nrwlk**	**1.3**	**8.8**	**24.1**	**1.0**	**6.0**	**21.0**	**29%**	**53%**	**6%**	**24**	**143**	**53**	**7**	**76**	**3**
18	**CGCGB-EMPS**	**1.4**	**10.7**	**26.4**	**0.0**	**5.0**	**28.0**	**12%**	**48%**	**1%**	**158**	**634**	**259**	**19**	**302**	**2**
19	**Western**	**0.7**	**2.5**	**17.1**	**0.0**	**0.0**	**14.0**	**6%**	**12%**	**6%**	**347**	**580**	**620**	**20**	**67**	**40**
20	**Well-EMPS:Dnby**	**0.8**	**2.6**	**16.2**	**0.0**	**0.0**	**14.0**	**6%**	**15%**	**3%**	**78**	**74**	**78**	**5**	**11**	**2**
21	**Well-EMPS:Torr**	**0.2**	**3.8**	**18.2**	**0.0**	**1.0**	**16.0**	**6%**	**20%**	**6%**	**69**	**56**	**96**	**4**	**11**	**6**
22	**Well-EMPS:Wtby**	**0.8**	**2.3**	**17.0**	**0.0**	**0.0**	**12.0**	**6%**	**10%**	**7%**	**200**	**450**	**446**	**11**	**45**	**32**

Note: Blank cells indicate no data was available for that particular inclusion criteria

Definitions:

LOS: Phone	Length of Stay in Days for Phone Only
LOS: FTF	Length of Stay in Days for Face To Face Only
LOS: Stab.	Length of Stay in Days for Stabilization Plus Follow-up Only
Phone > 1	Percent of episodes that are phone only that are greater than 1 day
FTF > 5	Percent of episodes that are face to face that are greater than 5 days
Stab. > 45	Percent of episodes that are stabilization plus follow-up that are greater than 45 days

Table 3. Length of Stay for Open Episodes of Care in Days

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
		*Episodes Still in Care**									*N of Episodes Still in Care**					
		Mean			Median			Percent			N used Mean/Median			N used for Percent		
		LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45
1	STATEWIDE	39.5	30.8	30.7	31.5	24.0	23.0	100%	91%	21%	8	82	150	8	75	31
2	Central	32.0	30.4	27.7	32.0	24.0	25.0	100%	100%	16%	1	25	25	1	25	4
3	CHR/MiddHosp-EMPS										0	0	0	0	0	0
4	CHR-EMPS	32.0	30.4	27.7	32.0	24.0	25.0	100%	100%	16%	1	25	25	1	25	4
5	Eastern			9.0			9.0			0%	0	0	2	0	0	0
6	UCFS/CHR-EMPS										0	0	0	0	0	0
7	UCFS-EMPS			9.0			9.0			0%	0	0	2	0	0	0
8	Hartford	26.0	15.5	17.6	26.0	14.5	17.5	100%	83%	0%	2	6	46	2	5	0
9	Wheeler-EMPS:Htfd		26.0	19.5		26.0	22.5		100%	0%	0	2	28	0	2	0
10	Wheeler-EMPS:Meridn	2.0		13.0	2.0		17.0	100%		0%	1	0	3	1	0	0
11	Wheeler-EMPS:NBrit	50.0	10.3	15.1	50.0	10.0	16.0	100%	75%	0%	1	4	15	1	3	0
12	New Haven	13.0	40.8	36.3	13.0	44.0	20.5	100%	95%	35%	2	19	34	2	18	12
13	CBeer/Bridge-EMPS		22.5	36.0		14.0	32.0		100%	36%	0	4	14	0	4	5
14	CliffBeers-EMPS	13.0	45.7	36.5	13.0	50.0	18.5	100%	93%	35%	2	15	20	2	14	7
15	Southwestern		28.9	36.1		22.0	29.0		83%	32%	0	29	22	0	24	7
16	CGCGB/CGCSouth-EMPS		41.9	43.0		38.0	29.5		100%	39%	0	15	18	0	15	7
17	CGCGB-EMPS:Nrwlk		17.6			18.0			80%		0	5	0	0	4	0
18	CGCGB-EMPS		13.7	5.3		16.0	4.0		56%	0%	0	9	4	0	5	0
19	Western	68.7	18.3	50.0	82.0	23.0	36.0	100%	100%	38%	3	3	21	3	3	8
20	Well-EMPS:Dnby	93.0		49.8	93.0		36.0	100%		40%	1	0	5	1	0	2
21	Well-EMPS:Torr		6.0	76.5		6.0	76.5		100%	50%	0	1	2	0	1	1
22	Well-EMPS:Wtby	56.5	24.5	46.2	56.5	24.5	35.0	100%	100%	36%	2	2	14	2	2	5

* Data includes episodes still in care with referral dates from July 1, 2011 to June 30, 2012.

Note: Blank cells indicate no data was available for that particular inclusion criteria

Definitions:

LOS: Phone	Length of Stay in Days for Phone Only
LOS: FTF	Length of Stay in Days for Face To Face Only
LOS: Stab.	Length of Stay in Days for Stabilization Plus Follow-up Only
Phone > 1	Percent of episodes that are phone only that are greater than 1 day
FTF > 5	Percent of episodes that are face to face that are greater than 5 days
Stab. > 45	Percent of episodes that are stabilization plus follow-up that are greater than 45 days

Figure 68. Top Five Reasons for Client Discharge Statewide

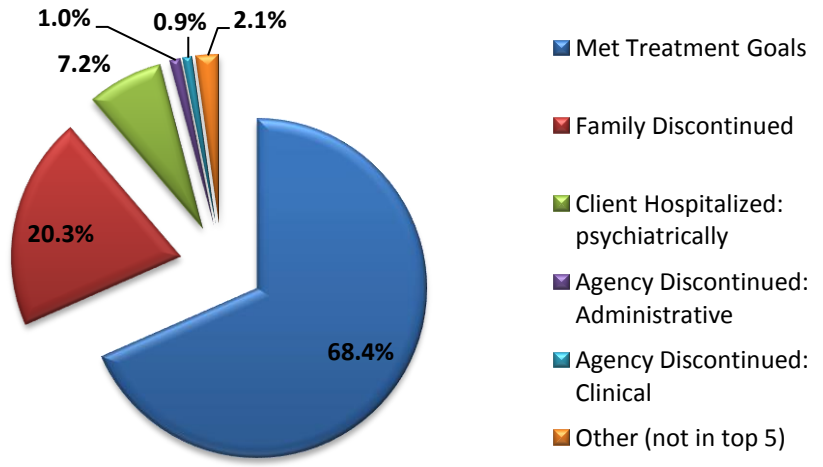


Figure 69. Top Five Places Clients Live at Discharge Statewide

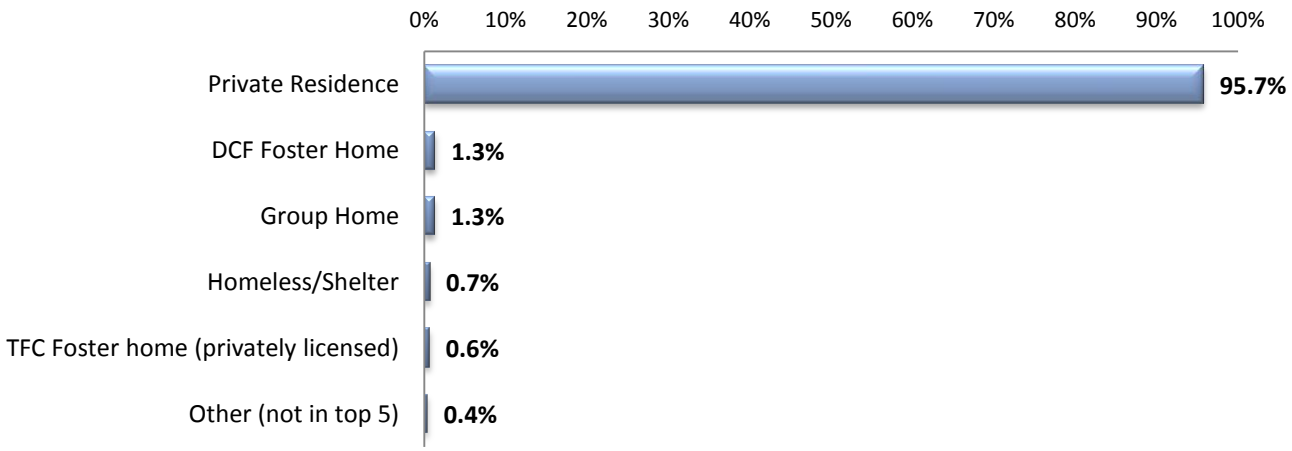
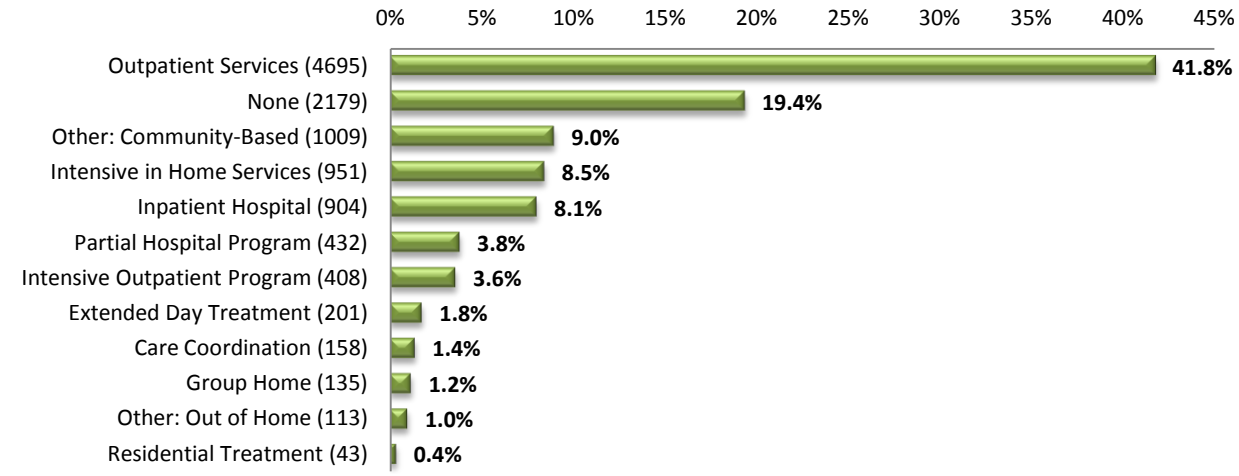


Figure 70. Type of Services Client Referred* to at Discharge Statewide (N=11,228)



Note: Count for each type of service referral* is in parenthesis

* Data include clients referred to more than one type of service

Table 4. Ohio Scales Scores by Service Area

Service Area	*N (paired ' intake & discharge)*	*Mean (paired ' intake)*	*Mean (paired ' discharge)*	*Mean Difference (paired ' cases)*	*t-score*	*Sig.*
STATEWIDE						
Parent Functioning Score	880	42.19	46.38	4.19	10.32	**
Worker Functioning Score	3032	42.56	45.84	3.28	23.68	**
Parent Problem Score	898	29.44	23.83	-5.61	-13.94	**
Worker Problem Score	3037	30.38	25.35	-5.03	-31.0	**
Central						
Parent Functioning Score	218	42.36	42.42	0.06	0.14	
Worker Functioning Score	409	45.82	48.19	2.37	7.10	**
Parent Problem Score	219	29.73	28.59	-1.14	-2.76	**
Worker Problem Score	410	25.16	21.71	-3.45	-9.90	**
Eastern						
Parent Functioning Score	253	39.41	45.84	6.43	7.58	**
Worker Functioning Score	409	40.08	44.53	4.45	10.21	**
Parent Problem Score	265	31.77	23.87	-7.90	-9.24	**
Worker Problem Score	410	34.65	27.36	-7.29	-12.61	**
Hartford						
Parent Functioning Score	146	43.28	49.71	6.43	5.84	**
Worker Functioning Score	1125	42.58	45.24	2.66	12.33	**
Parent Problem Score	148	29.35	20.87	-8.48	-8.49	**
Worker Problem Score	1126	30.65	25.87	-4.78	-19.05	**
New Haven						
Parent Functioning Score	166	45.60	49.77	4.17	3.98	**
Worker Functioning Score	280	43.13	45.97	2.84	5.39	**
Parent Problem Score	168	26.72	19.88	-6.84	-6.51	**
Worker Problem Score	280	29.63	23.93	-5.70	-9.23	**
Southwestern						
Parent Functioning Score	42	43.02	50.86	7.84	4.10	**
Worker Functioning Score	298	42.78	48.33	5.55	10.71	**
Parent Problem Score	43	26.98	20.58	-6.40	-3.76	**
Worker Problem Score	299	28.65	22.41	-6.24	-10.65	**
Western						
Parent Functioning Score	55	40.44	42.09	1.65	1.34	
Worker Functioning Score	511	41.42	44.77	3.35	12.49	**
Parent Problem Score	55	27.60	27.24	-0.36	-0.29	
Worker Problem Score	512	31.98	28.01	-3.97	-13.50	**

paired' = Number of cases with both intake and discharge scores

† .05-.10
*** P < .05**
****P < .01**

Section IX: Client & Referral Source Satisfaction

Table 5. Client and Referrer Satisfaction for 211 and EMPS*

211 Items	Q1 FY12 Clients (n=59)	Q2 FY12 Clients (n=68)	Q3 FY12 Clients (n=79)	Q4 FY12 Clients (n=131)	Q1 FY12 Referrers (n=57)	Q2 FY12 Referrers (n=61)	Q3 FY12 Referrers (n=69)	Q4 FY12 Referrers (n=64)
The 211 staff answered my call in a timely manner	4.80	4.88	4.96	4.90	4.81	4.76	4.89	4.94
The 211 staff was courteous	4.85	4.94	4.98	4.89	4.88	4.81	4.92	4.98
The 211 staff was knowledgeable	4.78	4.85	4.95	4.89	4.60	4.70	4.90	4.95
My phone call was quickly transferred to the EMPS provider	4.64	4.71	4.90	4.86	4.71	4.60	4.84	4.95
Sub-Total Mean: 211	**4.77**	**4.85**	**4.95**	**4.88**	**4.75**	**4.72**	**4.89**	**4.96**
EMPS Items								
EMPS responded to the crisis in a timely manner	4.70	4.83	4.81	4.87	4.67	4.60	4.93	5.00
The EMPS staff was respectful	4.84	4.94	4.84	4.88	4.79	4.85	4.96	5.00
The EMPS staff was knowledgeable	4.75	4.85	4.83	4.87	4.71	4.69	4.92	5.00
The EMPS staff spoke to me in a way that I understood	4.84	4.90	4.87	4.87	X	X	X	X
EMPS helped my child/family get the services needed or made contact with my current service provider (if you had one at the time you called EMPS)	4.59	4.74	4.74	4.72	X	X	X	X
The services or resources my child and/or family received were right for us	4.55	4.60	4.68	4.76	X	X	X	X
The child/family I referred to EMPS was connected with appropriate services or resources upon discharge from EMPS	X	X	X	X	4.31	4.37	4.75	4.84
Overall, I am very satisfied with the way that EMPS responded to the crisis	4.77	4.67	4.69	4.78	4.60	4.60	4.81	4.91
Sub-Total Mean: EMPS	**4.72**	**4.79**	**4.78**	**4.82**	**4.62**	**4.62**	**4.87**	**4.95**
Overall Mean Score	**4.74**	**4.81**	**4.84**	**4.84**	**4.68**	**4.66**	**4.88**	**4.95**

* All items collected by 211, in collaboration with the PIC and DCF; measured on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree)

Client Comments:

- Extremely pleased with services and with the follow up they have provided so far.
- I was impressed with the rapidity of the response. I felt people took me seriously and it was comforting. The clinician knew what to look for and got to the issues quickly. She was so kind - these kind of people are really the heroes of the world. We are following the plan she laid down for us.
- Father said he is very happy with the entire service and is glad the word is getting out about EMPS.
- Very pleased with the follow-up actions they have recommended.

- Very unhappy with service--the EMPS staff only spoke to my son and never to me when they arrived.
- I feel I should not have had to repeat all of my information over again to the 211 staff since I have called before.
- I felt that the clinician, while helpful, did not have a lot of resources at her disposal. I think this service is more beneficial to those families who do not have much of any connection with any other type of mental health/crisis services.
- I was very upset with EMPS because I feel they did not take into consideration the safety of my family and my own concerns. i do not plan on ever using EMPS again.

Referrer Comments:

- I use them all the time and am always very pleased with their response.
- Within the hour of making a phone call someone was at the office. It was phenominal. It's great to know that they are there if we need them.
- Great experience. The provider said the intervention was helpful and very professional.
- I was very impressed with the service and found it extremely helpful.
- Very satisfied with the services - our school uses EMPS quite a bit.

- I felt that I literally had to spell everything out to the 211 staffperson.
- School social worker said she likes the service but gets frustrated with feeling she has to give all demographic information when child is in crisis.
- I was not at all happy with 211 -- I waited a very long time to be connected to the EMPS staff and finally disconnected the call. I ended up calling that office on my own and spoke to a clinician myself. The entire process is very cumbersome. However, I was satisfied with the EMPS services once I was in contact with them.
- I have been dealing with EMPS for a while and am in general not happy with the services. I feel that too many inappropriate questions are asked and that the response time is never adequate.

Figure 71. Parent/Guardian Satisfaction with the Mental Health Services their Child has Received by Service Area

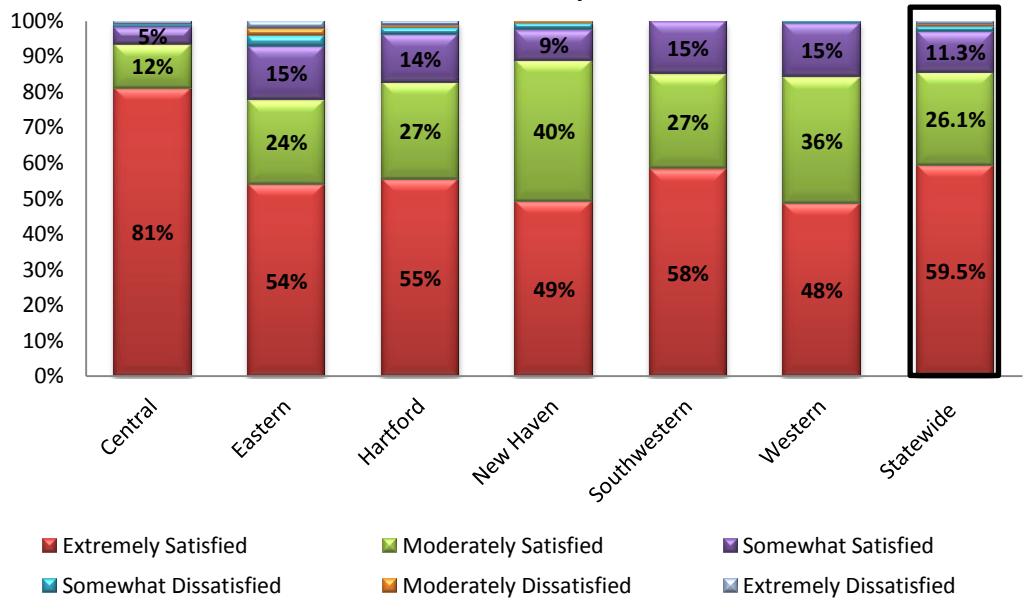
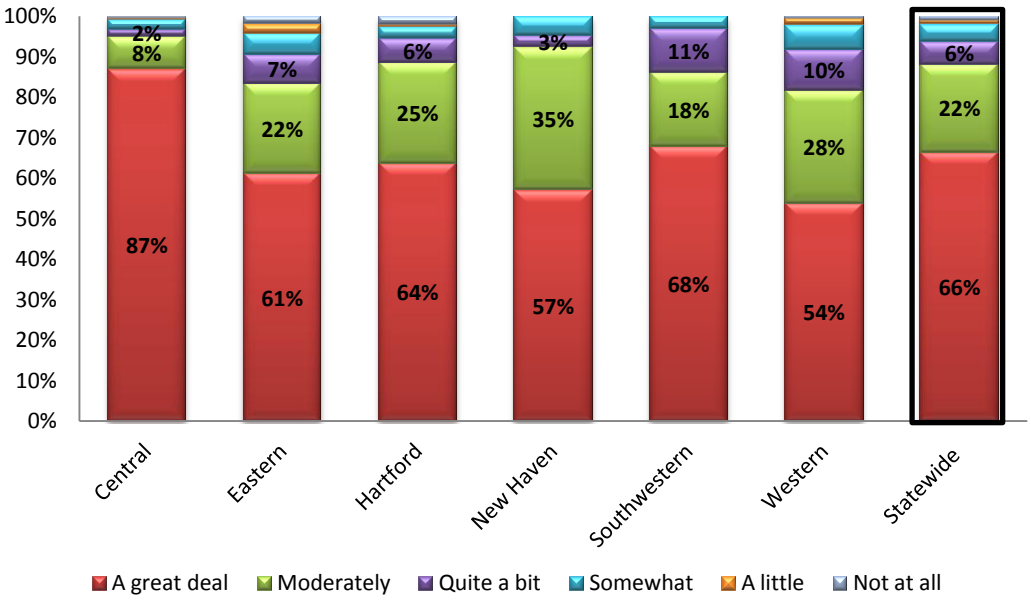


Figure 72. Parent/Guardian Rating of the Extent to Which the Child's Treatment Plan Included their Ideas about their Child's Treatment Needs by Service Area



Section X: Training

Table 6. Training Modules Completed for All Active Staff* by Provider

	Crisis Wrap	Crisis API	Str Based	Suicide	Trauma	Violence	C&L Care	Safety	Emerg. Certificate	All 9 Trainings Completed	All 9 Completed for Full-Time Staff Only
Statewide (153)*	64%	69%	65%	68%	68%	69%	64%	71%	55%	36%	56%
CHR/MiddHosp-EMPS (6)*	83%	100%	67%	100%	100%	100%	83%	100%	100%	67%	100%
CHR-EMPS (11)*	82%	100%	91%	82%	73%	91%	82%	91%	73%	64%	100%
UCFS/CHR-EMPS (5)*	80%	100%	80%	100%	80%	100%	80%	100%	40%	40%	50%
UCFS-EMPS (11)*	82%	82%	82%	73%	82%	82%	82%	82%	45%	45%	83%
Wheeler-EMPS:Htfd (20)*	65%	80%	75%	75%	80%	75%	60%	75%	55%	25%	45%
Wheeler-EMPS:Meridn (11)*	82%	73%	91%	73%	82%	91%	73%	82%	82%	55%	86%
Wheeler-EMPS:Nbrit (14)*	79%	93%	93%	100%	86%	93%	86%	93%	86%	71%	90%
CBeer/Bridge-EMPS (6)*	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%
CliffBeers-EMPS (14)*	43%	50%	50%	71%	57%	57%	57%	43%	14%	0%	0%
CFGC/Stmfrd(6)*	50%	33%	17%	67%	50%	67%	33%	67%	0%	0%	0%
CFGC-Nrwlk (3)*	100%	100%	67%	67%	100%	100%	67%	67%	67%	67%	67%
CFGC-Brdgprt (14)*	64%	64%	64%	64%	64%	79%	64%	79%	36%	29%	100%
Well-EMPS:Dnby (1)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Well-EMPS:Torr (2)*	50%	50%	50%	50%	50%	50%	100%	100%	50%	50%	50%
Well-EMPS:Wtby (29)*	41%	66%	62%	55%	69%	52%	69%	76%	79%	31%	69%
Full-Time Staff Only (91)	77%	79%	79%	80%	84%	82%	82%	87%	67%	54%	

Note: Count of active staff for each provider is in parenthesis

* Includes all active full-time, part-time and per diem staff. Some active staff are new, and have not yet had the opportunity to attend several training modules.

Training Title Abbreviations:

Crisis Wrap = Crisis Wraparound

Crisis API = Crisis Assessment, Planning and Intervention

Str Based = Strengths-Based Assessment and Utilizing the System of Care

Suicide = Assessing and Intervening with Suicidal and Self-Injurious Youth

Trauma = Traumatic Stress and Trauma Informed Care

Violence = Violence Assessment and Prevention

C&L Care = Culturally and Linguistically Competent Care

Safety = Worker Safety and Self Care

Emerg. Certificate=Emergency Certificate

Section XI: Ohio Scales Completion

Figure 73. Ohio Scales Collected at Intake by Provider

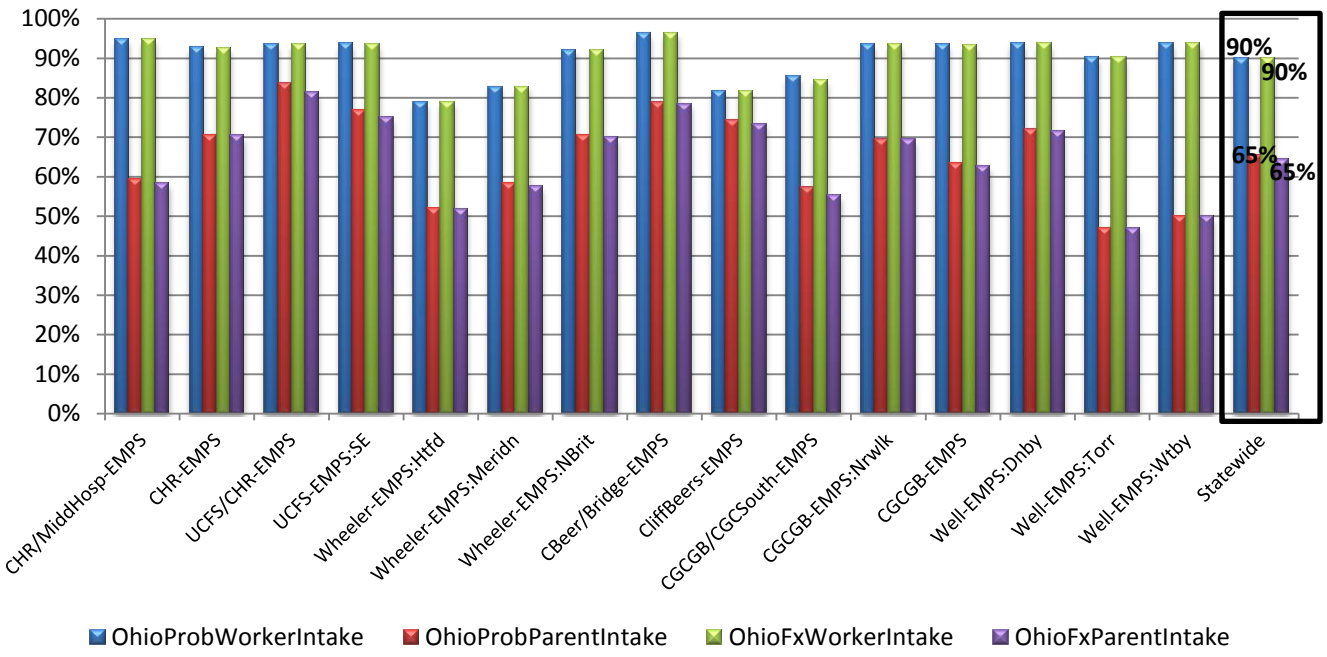
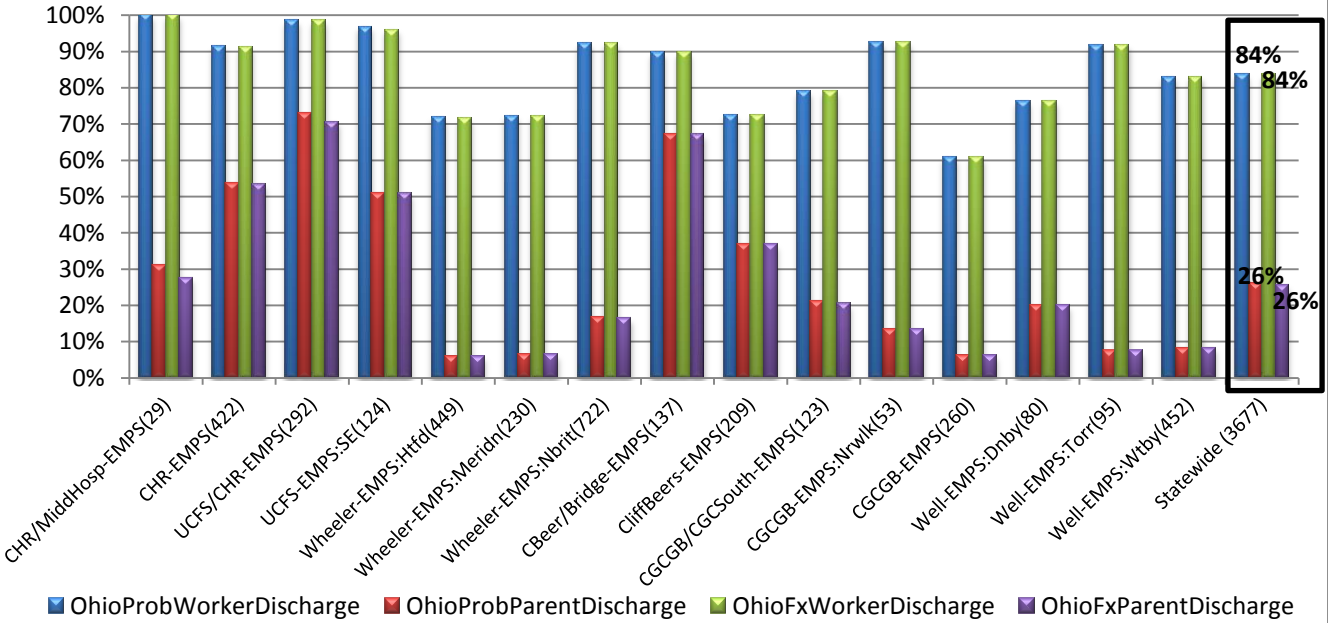


Figure 74. Ohio Scales Collected at Discharge by Provider



Note: Count number of expected Ohio Scales completed at discharge in parenthesis

Section XII: Provider Community Outreach

Table 7. Number of Times Provider Performed Formal Outreach to the Community

Provider	Q1 FY12	Q2 FY12	Q3 FY12	Q4 FY12
CHR/MiddHosp-EMPS	5	6	8	6
CHR-EMPS	10	11	6	7
UCFS/CHR-EMPS	14	9	4	1
UCFS-EMPS:SE	11	9	6	11
Wheeler-EMPS:Htfd	7	6	2	3
Wheeler-EMPS:Meridn	6	5	5	2
Wheeler-EMPS:NBrit	6	5	3	7
CBeer/Bridge-EMPS	6	11	0	4
CliffBeers-EMPS	5	6	2	7
CGCGB/CGCSouth-EMPS	15	10	4	2
CGCGB-EMPS:Nrwlk	14	13	14	3
CGCGB-EMPS	12	9	5	7
Well-EMPS:Dnby	8	8	11	5
Well-EMPS:Torr	13	8	15	11
Well-EMPS:Wtby	8	9	13	14
Statewide	140	125	98	90

Note: Formal outreach refers to: 1) In person presentations lasting 30 minutes or more, using the EMPS PowerPoint slides and including distribution to attendees of marketing materials and other EMPS resources; 2) Outreach presentations that are in person that include workshops, conferences, or similar gatherings in which EMPS is discussed for at least an hour or more; 3) Outreach presentations that are not in person which may include workshops, conferences, or similar gatherings in which the EMPS marketing video, banner, and table skirt are set up for at least 2 hours with marketing materials made available to those who would like them; 4) The EMPS PIC considers other outreaches for inclusion on a case-by-case basis, as requested by EMPS providers.

Appendix A: Description of Calculations

Section I: Primary EMPS Performance Indicators and Monthly Trends

•Figures 1 and 2 tabulate the total number of calls by 211-Only, 211-EMPS, or Registered Calls.
•Figures 3 and 4 calculate the total number of EMPS episodes for the specified time frame for the designated service area.
•Figures 5 and 6 show the number of children served by EMPS per 1,000 children. This is calculated by summing the total number of episodes for the specified service area multipled by 1,000; this result is then divided by the total number of youth in that particular service area as reported by U.S. Census data.
•Figures 7 and 8 determine the number of children served by EMPS that are TANF eligible out of the total number of children in that service area that are eligible for free or reduced lunch[1]. This is calculated by selecting only those episodes that are coded as face-to-face or plus stabilization follow-up divided by the total number of youth receiving free or reduced lunch[1] in that service area.
•Figures 9 and 10 isolate the total number of episodes that 211 recommended to be mobile or deferred mobile. This number of episodes is then divided by the total number of episodes that the EMPS response mode (what actually happened) was either mobile or deferred mobile. Multiply this result by 100 in order to get a percentage.
•Figures 11 and 12 isolate the total number of episodes that were coded as EMPS response mode mobile that had a response time under 45 minutes divided by the total number of episodes that were coded as EMPS response mode mobile. Response time is calculated by substracting the episode First Contact Date Time from the Call Date Time. In this calculation, 10 minutes is substracted from the original response time for the average 211 call.

Section II: Episode Volume

•Figure 13 tabulates the total number of calls by 211-Only, 211-EMPS, or Registered Calls.
•Figure 14 shows the 211 disposition of all calls received by service area.
•Figure 15 shows the 211 disposition EMPS response by provider.
•Figure 16 show the number served per 1,000 children by provider, uses the same calculation as Figure 5.
•Figure 17 is a stacked bar chart that represents the percent of episodes that have a crisis response of phone only, face-to-face, or plus stabilization follow-up. Each percentage is calculated by counting the number of episodes in the respective category (i.e., phone only) divided by the total number of episodes coded for crisis response for that specified service area.
•Figure 18 calculates the same percentage as Figure 17 and is shown by provider.

Section III: Demographics

•Figure 19 shows the percentage of male and female children served.
•Figure 20 Age group percentages include only episodes with a Crisis Response of "Face-to-face" or "Plus stabilization follow-up".
•Figure 21 shows the percentage of children from various ethnic backgrounds.
•Figure 22 breaks out the percentages of the races of children served.
• Figure 23 is calculated by taking the count of each type of health insurance reported at intake, dividing by total count collected for each area and that number is multiplied by 100 for the percent.
• Figure 24 is calculated by taking the count of "yes" TANF responses for each provider, dividing that by the total count answered for each provider and multiplying that number by 100 for the percent.
• Figure 25 is calculated by taking the count of each DCF status category reported at intake, dividing

[1] United States Department of Agriculture, Food and Nutrition Service, "*Eligibility Manual for School Meals, January 2008",* http://www.fns.usda.gov/cnd/Lunch/.

• Figure 26 shows the percentages for the top six primary presenting problems by service area.
• Figure 27 is calculated by taking the count of each Axis I primary diagnostic category reported at intake, dividing by total count collected and that number is multiplied by 100 to get the percent.
• Figure 28 is calculated by taking the count of each Axis II primary diagnostic category reported at intake, dividing by total count collected and that number is multiplied by 100 to get the percent.
• Figure 29 is calculated by taking the count of each Axis III diagnostic category reported at intake, dividing by total count collected and that number is multiplied by 100 to get the percent.
• Figure 30 is calculated by taking the count of each Axis IV diagnostic category reported at intake, dividing by total count collected and that number is multiplied by 100 to get the percent.
• Figure 31 represents the average Axis V at **intake and discharge**. Intake data filtered on an "EMPS Response Mode" of mobile or deferred mobile, face-to-Face or plus stabilization follow-up "Crisis Response" and data entered for Axis V at Intake. Discharge data filtered on an "EMPS Response Mode" of mobile or deferred mobile, plus stabilization follow-up "Crisis Response" and data entered for Axis V at discharge.
• Figure 32 shows the percentage of children meeting SED criteria. Serious Emotional Disturbance is defined by the federal statute as applying to a child with a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM), and whose condition results in functional impairment, substantially interfering with one or more major life activities or the ability to function effectively in social, familial, and educational contexts.
• Figure 33 is calculated by taking the count of "yes" responses to trauma history at intake filtered on specified service area, a "Crisis Response" of face-to-face or plus stabilization follow-up divided by the total count trauma answered (e.g., yes + no) by service area multiplied by 100.
• Figure 34 is calculated by taking the count of the individual type of trauma filtered on identified service area, "Crisis Response" of face-to-face or plus stabilization follow-up for the episodes that indicated a trauma history divided by the total of yes responses to trauma history by service area multiplied by 100.
• Figure 35 is calculated by taking the number of clients evaluated in an ED 1 or more times for category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for 6 months prior and Plus Stabilization Follow-up for During divided by the total answered for category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for 6 months prior and Plus Stabilization Follow-up for During multiplied by 100.
• Figure 36 is calculated by taking the number of clients admitted (inpatient) 1 or more times for category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for lifetime, 6 months prior and Plus Stabilization Follow-up for During divided by the total answered for category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for lifetime, 6 months prior and Plus Stabilization Follow-up for During multiplied by 100.
• Figure 37 is calculated by taking the number of clients placed in an out of home setting 1 or more times for each category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for lifetime and 6 months prior divided by the total answered for each category using the same filters then multiplied by 100.
• Figure 38 is calculated by taking the number of clients who reported problems with alcohol and/or drugs for each category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for lifetime, 6 months prior and during divided by the total answered for each category using the same filters then multiplied by 100.
• Figure 39 shows the percentages of types of parent/guardian service needs statewide.
• Figure 40 shows the parent reported feeling of capability for dealing with the child's problems at intake and discharge in the state.
• Figure 41 shows the percent of client's suspended or expelled in the six months prior to and during the episode of care. Calculated by using the count answered in each category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for six months prior and Plus Stabilization for During divided by the total number answered filtered on "Crisis Response" of Face-to-Face or Plus

Section V: Referral Sources

•Figure 46, and Table 1 are percentage break outs of referral sources across the state.
•Figure 47 counts the number of ED referrals (i.e., routine follow-up or in-patient diversion) by service area.
•Figure 48 calculates the percent of EMPS response episodes that are ED referrals by service area. This is calculated by counting the total number of ED referrals for the specified service area divided by the total number of EMPS response episodes for that service area .
•Figures 49 and 50 use the same calculation as 47 and 48 respectively, but are brokedown by provider.

Section VI: 211 Recommendations and EMPS Response

•Figure 51 is a count of the 211 recommended response mode (i.e., mobile, non-mobile, deferred mobile) by provider .
•Figure 52 is contrasted by Figure 51 that shows a count of the actual EMPS response mode (i.e., mobile, non-mobile, deferred mobile) by provider.
•Figure 53 and 54 show the percent of 211 recommended response of mobile and non-mobile episodes where the actual EMPS response was different than the recommended.
•Figure 55 is the same graph as Figure 9.
•Figure 56 uses the same calculation as Figure 9 but shows the percent mobile response (mobile & deferred mobile) by provider.

Section VII: Response Time

•Figure 62 is the same graph as shown in Figure 11.
•Figure 63 uses the same calculation as Figure 11 but shows the percent of mobile episodes with response time under 45 minutes by provider.
•Figure 64 arranges the response time for those episodes that are coded as EMPS response mode-mobile and arranges the response time in ascending order by service area and selects the response time in the middle.
•Figure 65 uses the same calculation as Figure 64 but is categorized by provider.
•Figure 66 arranges the response time for those episodes that were coded as EMPS response mode -deferred mobile and arranges the response time in ascending order by service area and then selects the response time in the middle.
•Figure 67 uses the same calculation as Figure 66but is categorized by provider.

Section VIII: Length of Stay and Discharge Information

•Table 2 shows the mean, median and percent length of stay statewide, by service area and by

provider for both discharged episodes for the current reporting period and cumulative (since January 1, 2010) discharged episodes of care broken into the various crisis response categories (phone only, face-to-face and stabilization plus follow-up). LOS: Phone means Length of Stay in Days for Phone Only. LOS: FTF means Length of Stay in Days for Face To Face. LOS: Stab. means Length of Stay in Days for Stabilization Plus Follow-up. Phone > 1 is defined as the percent of episodes that are phone only that are greater than 1 day. FTF > 5 is defined as the percent of episodes that are face to face that are greater than 5 days. Stab. > 45 is defined as the percent of episodes that are stabilization plus follow-up that are greater than 45 days. Blank cells in the table indicate no data was available for that particular criteria.

- Table 3 shows total number of episodes used to calculate mean, median and percent in Table 2.
- Table 4 shows the mean, median, percent and total number for length of stay statewide, by service area and by provider for open episodes of care broken into the various crisis response categories (phone only, face-to-face and stabilization plus follow-up. These cases do not have an episode end date at the time of the data download and therefore an episode end date equal to the last day of the reporting period was used in order to calculate length of stay data.
- Figure 68 shows the top five reasons for client discharge statewide. To calculate this percentage take the count answered for each category and divide by the total number answered for "Reason for Discharge" then multiply by 100.
- Figure 69 represents the statewide percentages of the top 5 places where clients live at discharge. To calculate the percentage, count of episodes in each category that have a "Crisis Response" of plus stabilization follow-up and have an end date divided by the total count of episodes with a "Crisis Response" of plus stabilization follow-up with an end date with data entered for "Living situation at discharge" multiplied by 100.

Section VIII: Length of Stay and Discharge Information (continued)

- Figure 70 shows percentages for the types of services clients were referred to at discharge. Calculated by taking the count answered in each category, dividing by total count answered and multiplying by 100 to get the percent.
- Table 5 shows the number and mean of Ohio Scales scores for paired intakes (filtered for only mobile and deferred mobile responses, as well as, a crisis response of face-to-face or plus stabilization follow-up) and paired discharges (filtered for only mobile and deferred mobile responses, as well as, a crisis response of plus stabilization follow-up). Paired is the number of cases with both intake and discharge Ohio scores. The mean difference for paired cases is also shown which is the mean of paired discharges minus the mean of paired intakes. Any significance of change in the Ohio score is noted next to the mean difference.

Section IX: Client and Referral Source Satisfaction

- Table 6 shows the mean outcomes of the client and referral source satisfaction survey collected for 211 and EMPS. All items are measured on a scale of 1 (strongly disagree) to 5 (strongly agree).

Section X: Training Attendance

- Table 7 calculates the percent of staff that attended trainings by dividing actual number of trainings over expected number of trainings.

Section XI: Ohio Scales Completion

- Figure 73 calculates the percent of Ohio intake scales by dividing actual over expected. The

numerator is calculated by counting the number of Ohio intake scales for only those episodes that have been coded as crisis response face-to-face OR crisis response stabilization plus follow-up AND for those episodes that are coded as EMPS response mode either mobile OR deferred mobile (what actually happened). This is divided by the total number of expected Ohio intake scales which is calculated by counting the total number of episodes that are coded as crisis response face-to-face OR crisis response stabilization plus follow-up AND for those episodes that are coded as EMPS response mode either mobile OR deferred mobile (what actually happened).

- Figure 74 calculates the actual percent of Ohio discharge scales by dividing actual over expected. The numerator is calculated by counting the number of Ohio discharge scales for only those episodes that have been coded as crisis response stabilization plus follow-up AND are coded as EMPS response mode either mobile OR deferred mobile AND has an episode end date. This is divided by the total number of expected Ohio discharge scales which is calculated by counting the total number of episodes that are coded as crisis response stabilization plus follow-up AND are coded as EMPS response mode either mobile OR deferred mobile AND has an episode end date.

Section XII: Provider Community Outreach

- Table 8 is a count of community outreach performed by each provider during each quarter.

Appendix B: List of Diagnostic Codes[2] Combined

Adjustment Disorders:
309.0 - Adjustment Disorder w/ Depressed Mood
309.24 - Adjustment Disorder with Anxiety
309.28 - Adjustment Disorder w/ Mixed Anxiety & Depressed Mood
309.3 - Adjustment Disorder with Disturbance of Conduct
309.4 - Adjustment Disorder w/ Mixed Disturbance of Emotions & Conduct
309.9 - Adjustment Disorder Unspecified

Anxiety Disorders:
300.00 - Anxiety Disorder, NOS
300.01 - Panic Disorder without Agoraphobia
300.02 - Generalized Anxiety Disorder
300.21 - Panic Disorder with Agoraphobia
300.22 - Agoraphobia without History of Panic Disorder
300.23 - Social Phobia
300.29 - Specific Phobia

Attention Deficit/Hyperactivity Disorders:
314.00 - Attention Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
314.01 - Attention Deficit/Hyperactivity Disorder, Combined Type
314.01 - Attention Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
314.9 - Attention Deficit/Hyperactivity Disorder NOS

Bipolar Disorders:
296.0 Bipolar I Disorder, Single Manic Episode, Unspecified
296.01 Bipolar I Disorder, Single Manic Episode, Mild
296.02 Bipolar I Disorder, Single Manic Episode, Moderate
296.03 Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features
296.04 Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features
296.05 Bipolar I Disorder, Single Manic Episode, In Partial Remission
296.06 Bipolar I Disorder, Single Manic Episode, In Full Remission
296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
296.4 Bipolar I Disorder, Most Recent Episode Manic, Unspecified
296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild
296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate
296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features
296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
296.5 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild
296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate
296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
296.6 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.61 Bipolar I Disorder, Most Recent Episode Mixed, Mild
296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate
296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features

[2] "*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*", Numerical Listing of DSM-IV-TR Diagnoses and Codes, http://www.psychiatryonline.com.

Bipolar Disorders (continued):
296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
296.65 Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
296.66 Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
296.7 Bipolar I Disorder, Most Recent Episode Unspecified
296.80 Bipolar Disorder NOS
296.89 Bipolar II Disorder

Conduct Disorders:
312.81 Conduct Disorder, Childhood-Onset Type
312.82 Conduct Disorder, Adolescent-Onset Type
312.89 Conduct Disorder, Unspecified Onset

Mental Retardation:
317 Mild Mental Retardation
318.0 Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation
319 Mental Retardation, Severity Unspecified

Major Depressive Disorders:
296.2 Major Depressive Disorder, Single Episode, Unspecified
296.21 Major Depressive Disorder, Single Episode, Mild
296.22 Major Depressive Disorder, Single Episode, Moderate
296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
296.24 Major Depressive Disorder, Single Episode, Severe With Psychotic Features
296.25 Major Depressive Disorder, Single Episode, In Partial Remission
296.26 Major Depressive Disorder, Single Episode, In Full Remission
296.3 Major Depressive Disorder, Recurrent, Unspecified
296.31 Major Depressive Disorder, Recurrent, Mild
296.32 Major Depressive Disorder, Recurrent, Moderate
296.33 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features
296.35 Major Depressive Disorder, Recurrent, In Partial Remission
296.36 Major Depressive Disorder, Recurrent, In Full Remission

Personality Disorders:
301.0 Paranoid Personality Disorder
301.20 Schizoid Personality Disorder
301.22 Schizotypal Personality Disorder
301.4 Obsessive-Compulsive Personality Disorder
301.50 Histrionic Personality Disorder
301.6 Dependent Personality Disorder
301.7 Antisocial Personality Disorder
301.81 Narcissistic Personality Disorder
301.82 Avoidant Personality Disorder
301.83 Borderline Personality Disorder
301.9 Personality Disorder NOS

Pervasive Developmental Disorders:
299.00 Autistic Disorder
299.10 Childhood Disintegrative Disorder
299.80 Asperger's Disorder
299.80 Pervasive Developmental Disorder NOS
299.80 Rett's Disorder

Appendix C: Tables

Table 8. Percent Type of Health Insurance at Intake (relates to Figure 23)

	HUSKY A	Private	No Health Insurance	Other	HUSKY B	Medicaid (non-HUSKY)	Health Care	Military	Medicare
STATEWIDE	57.0%	33.2%	4.4%	1.7%	2.4%	0.8%	0.6%	0.1%	
CENTRAL	49.3%	43.0%	4.0%	1.6%	1.7%	0.2%	0.2%	0.0%	
CHR/MiddHosp-EMPS	40.6%	50.0%	1.6%	3.9%	2.6%	1.0%	0.3%	0.0%	
CHR-EMPS	52.2%	40.6%	4.8%	0.8%	1.4%	0.0%	0.2%	0.0%	
EASTERN	55.7%	35.0%	2.7%	1.8%	1.6%	0.1%	3.1%	0.0%	
UCFS/CHR-EMPS	58.9%	35.1%	3.0%	0.6%	1.5%	0.2%	0.6%	0.0%	
UCFS-EMPS	53.0%	34.9%	2.4%	2.8%	1.7%	0.0%	5.2%	0.0%	
HARTFORD	59.6%	30.2%	4.9%	2.5%	2.0%	0.4%	0.4%	0.1%	
Wheeler-EMPS:Htfd	68.6%	15.8%	8.8%	4.8%	1.5%	0.1%	0.1%	0.1%	
Wheeler-EMPS:Meridn	55.2%	35.1%	3.8%	3.1%	1.6%	0.9%	0.3%	0.0%	
Wheeler-EMPS:NBrit	55.1%	37.8%	2.7%	0.9%	2.4%	0.4%	0.5%	0.1%	
NEW HAVEN	56.0%	37.6%	2.9%	0.6%	1.7%	0.6%	0.5%	0.0%	
CBeer/Bridge-EMPS	44.3%	48.4%	3.5%	0.9%	1.2%	0.9%	0.9%	0.0%	
CliffBeers-EMPS	62.7%	31.4%	2.5%	0.5%	2.0%	0.5%	0.3%	0.0%	
SOUTHWESTERN	57.1%	30.5%	6.3%	0.3%	5.0%	0.6%	0.0%	0.2%	
CGCGB/CGCSouth-EMPS	49.2%	40.8%	7.5%	0.6%	0.3%	1.6%	0.0%	0.0%	
CGCGB-EMPS:Nrwlk	40.6%	46.7%	9.1%	0.0%	3.0%	0.0%	0.0%	0.5%	
CGCGB-EMPS	63.4%	23.4%	5.2%	0.3%	7.1%	0.3%	0.0%	0.2%	
WESTERN	61.6%	27.2%	4.1%	2.6%	1.7%	2.7%	0.1%	0.0%	
Well-EMPS:Dnby	32.9%	54.2%	7.1%	3.2%	1.3%	1.3%	0.0%	0.0%	
Well-EMPS:Torr	49.0%	35.1%	6.0%	6.6%	2.6%	0.7%	0.0%	0.0%	
Well-EMPS:Wtby	68.5%	21.3%	3.3%	1.9%	1.6%	3.3%	0.1%	0.0%	

Table 9. Type of Trauma Reported at Intake (relates to Figure 34)

	Witness Violence	Victim Violence	Sexual Victimization	Multiple Placements	Attachment / Disrupted	Caregiver (last 30 days)*	Recent Arrest of	Other
STATEWIDE	25%	18%	12%	25%	0.2%	19%		
CENTRAL	23%	19%	15%	23%	0.2%	20%		
CHR/MiddHosp-EMPS	15%	14%	12%	33%	0.0%	27%		
CHR-EMPS	24%	20%	16%	22%	0.2%	19%		
EASTERN	29%	20%	17%	17%	0.1%	18%		
UCFS/CHR-EMPS	21%	13%	19%	15%	0.0%	32%		
UCFS-EMPS	35%	25%	15%	18%	0.2%	7%		
HARTFORD	26%	19%	12%	21%	0.3%	22%		
Wheeler-EMPS:Htfd	24%	16%	10%	25%	0.3%	25%		
Wheeler-EMPS:Meridn	24%	18%	13%	17%	0.4%	28%		
Wheeler-EMPS:NBrit	28%	23%	13%	19%	0.3%	17%		
NEW HAVEN	28%	20%	9%	27%	0.1%	16%		
CBeer/Bridge-EMPS	23%	22%	14%	18%	0.8%	23%		
CliffBeers-EMPS	29%	20%	8%	28%	0.0%	14%		
SOUTHWESTERN	24%	12%	9%	34%	0.3%	20%		
CGCGB/CGCSouth-EMPS	30%	22%	14%	22%	0.6%	12%		
CGCGB-EMPS:Nrwlk	29%	13%	7%	11%	0.0%	40%		
CGCGB-EMPS	22%	10%	9%	41%	0.2%	18%		
WESTERN	21%	18%	14%	29%	0.2%	17%		
Well-EMPS:Dnby	21%	18%	15%	17%	0.0%	29%		
Well-EMPS:Torr	20%	17%	12%	35%	0.0%	17%		
Well-EMPS:Wtby	21%	19%	15%	30%	0.3%	15%		

Table 10. Reasons for Client Discharge (relates to Figure 54)

	Met Treatment Goals	Family Discontinued	Client Hospitalized: Psychiatrically	Agency Discontinued: Administrative	Agency Discontinued: Clinical	Child Requires Other Out of Home Care	Family Moved	Child Ran Away	Client Incarcerated	Client Hospitalized: Medically	No Payment Source	Age (too old)
STATEWIDE	68.4%	20.3%	7.2%	1.0%	0.9%	0.6%	0.6%	0.4%	0.2%	0.2%	0.06%	0.03%
CENTRAL	76.2%	14.3%	7.0%	0.2%	0.2%	0.4%	0.5%	0.6%	0.1%	0.3%	0.32%	0.00%
CHR/MiddHosp-EMPS	65.9%	23.0%	9.3%	0.2%	0.0%	0.7%	0.0%	0.2%	0.2%	0.5%	0.00%	0.00%
CHR-EMPS	80.0%	11.0%	6.2%	0.2%	0.3%	0.3%	0.7%	0.7%	0.1%	0.2%	0.43%	0.00%
EASTERN	75.3%	15.9%	7.5%	0.2%	0.2%	0.1%	0.3%	0.1%	0.2%	0.3%	0.00%	0.00%
UCFS/CHR-EMPS	70.1%	16.4%	12.0%	0.4%	0.0%	0.0%	0.6%	0.0%	0.0%	0.6%	0.00%	0.00%
UCFS-EMPS	79.0%	15.5%	4.3%	0.1%	0.3%	0.1%	0.1%	0.1%	0.3%	0.1%	0.00%	0.00%
HARTFORD	60.7%	30.1%	4.8%	1.3%	1.2%	0.3%	0.9%	0.3%	0.3%	0.1%	0.00%	0.00%
Wheeler-EMPS:Htfd	53.3%	37.8%	3.9%	2.8%	0.5%	0.4%	0.7%	0.3%	0.4%	0.0%	0.00%	0.00%
Wheeler-EMPS:Meridn	59.3%	32.7%	5.3%	1.0%	0.2%	0.2%	1.0%	0.2%	0.0%	0.0%	0.00%	0.00%
Wheeler-EMPS:NBrit	66.7%	23.4%	5.4%	0.1%	2.1%	0.3%	1.1%	0.4%	0.3%	0.2%	0.00%	0.00%
NEW HAVEN	72.1%	13.5%	5.6%	3.8%	1.8%	1.8%	0.7%	0.2%	0.1%	0.4%	0.00%	0.00%
CBeer/Bridge-EMPS	79.5%	14.0%	3.5%	0.8%	0.3%	0.8%	1.1%	0.0%	0.0%	0.0%	0.00%	0.00%
CliffBeers-EMPS	69.0%	13.2%	6.5%	5.0%	2.5%	2.2%	0.6%	0.3%	0.1%	0.6%	0.00%	0.00%
SOUTHWESTERN	71.0%	17.1%	7.9%	0.5%	1.2%	1.0%	0.7%	0.3%	0.0%	0.2%	0.00%	0.06%
CGCGB/CGCSouth-EMPS	69.7%	15.2%	5.9%	1.2%	3.9%	2.4%	1.2%	0.2%	0.0%	0.2%	0.00%	0.00%
CGCGB-EMPS:Nrwlk	63.1%	21.2%	12.9%	0.5%	0.5%	1.4%	0.5%	0.0%	0.0%	0.0%	0.00%	0.00%
CGCGB-EMPS	73.2%	16.9%	7.7%	0.2%	0.3%	0.4%	0.6%	0.4%	0.0%	0.3%	0.00%	0.09%
WESTERN	63.1%	21.2%	12.3%	0.6%	0.5%	0.6%	0.4%	0.7%	0.2%	0.3%	0.07%	0.13%
Well-EMPS:Dnby	61.7%	23.9%	11.3%	0.0%	0.4%	0.0%	0.9%	1.3%	0.0%	0.4%	0.00%	0.00%
Well-EMPS:Torr	59.7%	29.2%	4.6%	0.9%	0.5%	2.8%	0.5%	0.9%	0.0%	0.9%	0.00%	0.00%
Well-EMPS:Wtby	64.0%	19.1%	14.0%	0.6%	0.6%	0.3%	0.3%	0.5%	0.3%	0.1%	0.09%	0.18%

Table 11. Type of Services Client Referred to at Discharge (relates to Figure 56)

	Outpatient Services	None	Intensive In-Home Services	Other: Community-Based	Inpatient Hospital	Partial Hospital Program	Intensive Outpatient Program	Extended Day Treatment	Care Coordination	Group Home	Other: Out-of-Home	Residential Treatment
STATEWIDE	41.8%	19.4%	8.5%	9.0%	8.1%	3.8%	3.6%	1.8%	1.4%	1.2%	1.0%	0.4%
CENTRAL	32.8%	36.5%	6.5%	4.0%	6.7%	6.8%	2.3%	0.6%	2.0%	0.8%	0.9%	0.1%
CHR/MiddHosp-EMPS	39.1%	31.4%	2.0%	4.8%	8.8%	5.5%	1.5%	1.8%	1.8%	2.4%	0.9%	0.0%
CHR-EMPS	30.5%	38.4%	8.2%	3.7%	5.9%	7.3%	2.6%	0.2%	2.0%	0.2%	0.9%	0.1%
EASTERN	36.7%	14.5%	6.7%	17.3%	8.8%	10.6%	1.3%	0.8%	1.0%	0.7%	1.0%	0.5%
UCFS/CHR-EMPS	32.9%	4.3%	5.6%	26.9%	11.9%	11.1%	2.5%	1.0%	1.7%	0.7%	1.3%	0.3%
UCFS-EMPS	40.4%	24.4%	7.8%	8.1%	5.9%	10.1%	0.3%	0.6%	0.3%	0.8%	0.8%	0.8%
HARTFORD	46.3%	19.5%	9.8%	7.7%	5.1%	1.7%	2.5%	4.0%	0.8%	0.8%	1.5%	0.3%
Wheeler-EMPS:Htfd	36.6%	33.8%	8.2%	8.4%	3.3%	1.9%	1.7%	2.4%	0.5%	0.2%	2.8%	0.4%
Wheeler-EMPS:Meridn	53.8%	12.4%	7.1%	10.8%	6.7%	1.8%	4.1%	2.2%	0.4%	0.4%	0.0%	0.2%
Wheeler-EMPS:NBrit	51.0%	11.2%	11.9%	6.3%	5.9%	1.5%	2.6%	5.7%	1.2%	1.3%	1.1%	0.3%
NEW HAVEN	40.1%	13.3%	9.1%	15.1%	6.0%	4.4%	6.1%	1.7%	2.0%	0.3%	1.3%	0.7%
CBeer/Bridge-EMPS	48.7%	14.0%	17.9%	4.1%	6.0%	1.0%	6.7%	0.0%	0.3%	0.0%	0.8%	0.5%
CliffBeers-EMPS	37.0%	13.0%	6.1%	18.9%	6.0%	5.6%	5.9%	2.3%	2.6%	0.4%	1.5%	0.8%
SOUTHWESTERN	53.2%	15.1%	6.4%	4.9%	7.8%	0.5%	6.8%	1.2%	2.7%	0.6%	0.5%	0.2%
CGCGB/CGCSouth-EMPS	59.6%	16.1%	5.3%	5.7%	5.7%	1.4%	2.5%	0.2%	2.1%	0.9%	0.5%	0.0%
CGCGB-EMPS:Nrwlk	46.0%	17.3%	5.1%	6.8%	11.8%	0.0%	5.1%	5.1%	0.8%	1.3%	0.4%	0.4%
CGCGB-EMPS	52.3%	14.2%	7.2%	4.2%	7.8%	0.3%	8.8%	0.8%	3.4%	0.4%	0.5%	0.2%
WESTERN	36.5%	16.4%	11.2%	7.4%	16.8%	1.6%	3.7%	0.4%	0.4%	4.5%	0.3%	0.7%
Well-EMPS:Dnby	48.5%	15.5%	6.0%	9.4%	13.3%	0.9%	4.7%	0.0%	0.0%	0.0%	0.9%	0.9%
Well-EMPS:Torr	42.4%	11.8%	10.9%	9.6%	9.6%	3.1%	2.2%	0.9%	1.3%	7.9%	0.0%	0.4%
Well-EMPS:Wtby	32.9%	17.6%	12.4%	6.6%	19.0%	1.4%	3.8%	0.4%	0.3%	4.7%	0.3%	0.7%

Table 12. Performance Improvement Plan Goals and Results for Fiscal Year 2012

Service Area	Performance Goals and Relevant Quarter(s)	Goal Achieved	Positive Progress	No Positive Progress
Central	1. A Maximum of 5% of children will exceed 45 days due to discharge planning delays (Q1)	Q1		
	2. Increase parent participation to 2 to 3 parents (Q2) AND in EMPS trainings & Committees (Q3)	Q2		Q3
	3. Increase mobility rate to 90% for the service area (Q1, Q3)	Q1, Q3		
	4. Increase staff training compliance (Q2, Q3, Q4)	Q4	Q2, Q3	
	5. Complete 75% of parent Ohio's at admission & discharge (Q1, Q2, Q3, Q4)		Q1, Q3, Q4	Q2
	6. Complete 95% of worker Ohio's for problem severity at admission & discharge (Q1, Q2, Q3, Q4)	Q1	Q3	Q2, Q4
	7. Crisis response plus stabilization will be achieved at 50% for episodes that receive a face-to-face evaluation (Q4)		Q4	
Eastern	1. Family & clinician complete YSS-F for cases seen over 4 weeks (Q1, Q2)		Q1, Q2	
	2. At UCFS, families & clinicians will complete YSS-F, for cases seen over 4 weeks, 60% of the time (Q3)	Q3		
	3. At UCFS, 80% of cases will be completed and signed within 4 weeks of closing (Q1, Q2)		Q1, Q2	
	4. At CHR, 80% of cases will be completed and signed within 2 weeks of closing (Q1, Q2)		Q1, Q2	
	5. UCFS will randomly pick 20 files, and CHR 15 files, to analyze and evaluate for followup services (Q3)		Q3	
	6. Use tool-monitor followup; UCFS to randomly pick 20 files & CHR 15 files; read notes & fill out form (Q4)	Q4		
Hartford	1. Maintain % of youth categorized as "Crisis Resp Plus Stabilization" w/ LOS greater than 45 days at 5% for New Britain (Q1, Q2)	Q1, Q2		
	2. Increase # of episodes for current quarter as compared to the same quarter last year (Q1, Q2, Q3, Q4)	Q2, Q3, Q4		Q1
	3. Increase mobile response time under 45 mins. to 85% for Hartford & Meriden (Q1, Q2)	Q2	Q1	
	4. Increase parent completeion of the Ohio Scales at discharge for all 3 sites (Q2, Q3 by 25%, Q4 by 15%)		Q2	Q3, Q4
	5. Begin to analyze & gather baseline data for followup visits in relation to client's acuity level (Q2, Q3)	Q2, Q3		
	6. Come up w/ working definitions of acuity levels and train EMPS managers (Q4)	Q4		
	7. Increase mobile response time under 45 mins. to 87% for all 3 sites (Q3, Q4)		Q3, Q4	
New Haven	1. Increase and maintain mobility rate of 90% (Q1, Q2)	Q2	Q1	
	2. Increase referrals from New Haven area police departments (Q3)	Q3		
	3. Review parameters of EMPS services, including voluntary nature of services for families resistant to discharge planning (Q4)	Q4		
	4. Resume efforts w/ Yale ED in response to recent requests for on-site evals (Q4)	Q4		
	5. Increase outreach activity, to summer camps/recreational orgs (i.e. boys & Girls Clubs, Solar Youth, etc.). Bridges to provide outreach to Milford area recreational organizations under-utilizing EMPS. (Q4)		Q4	
	6. Identify actual LOS delays vs documented LOS delays (Q4)	Q4		
Southwestern	1. Meet mobility rate of 90% in all 3 sites & the service area as a whole (Q1, Q2, Q3, Q4)	Q1, Q2, Q3, Q4		
	2. Maintain response time under 45 mins to at least 80% in all 3 sites & the service area as a whole (Q1, Q2)	Q1	Q2	
	3. Reach 2.0 episodes per 1,000 for each program and as a service area (Q1, Q2, Q3, Q4)		Q2	Q1, Q3, Q4
	4. All 3 sites to discharge episodes w/in the 6 wk LOS standard w/ no more than 5% over 45 days (Q3, Q4)		Q4	Q3
Western	1. Maintain mobility rate at 90% (Q1, Q2, Q3, Q4)	Q1, Q2, Q3	Q4	
	2. Responses under 45 minutes (Q1, Q2 - 85% and Q3, Q4 - 80%)	Q1	Q4	Q2, Q3
	3. Increase number of outreaches: 2 wk/full time staff; 1 per wk part time staff (Q1, Q3, Q4)		Q3	Q1, Q4
	4. Increase number of referrals/episodes per 1,000 (Q2, Q3, Q4)	Q2, Q3		Q4

Total Goals=34; Number of goals achieved (during at least one quarter): 21 of 34 (62%); Number of goals with positive progress (during at least one quarter): 20 of 34 (59%)