Mobile Crisis Intervention Services
Performance Improvement Center (PIC)

Annual Report: Fiscal Year 2017
July 1, 2016 – June 30, 2017

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This report was prepared by the

Mobile Crisis Intervention Services

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The Mobile Crisis Intervention Services Performance Improvement Center
is housed at the
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Table of Contents

Executive Summary

Fiscal Year 2017 Annual Report
Executive Summary

Mobile Crisis Intervention Services (Mobile Crisis), formerly known as the Emergency Mobile Psychiatric Services, is a mobile intervention service for children and adolescents experiencing a behavioral or mental health crisis. Mobile Crisis is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1. The statewide Mobile Crisis network is comprised of more than 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. Mobile Crisis is implemented by six primary contractors, each of whom may have satellite offices or subcontracted agencies. This Fiscal Year, a total of 14 Mobile Crisis sites collectively provided coverage for every town and city in Connecticut.

The Mobile Crisis 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 services for children and families. Since August 2009, the PIC has provided data analysis, reporting, and quality improvement; standardized workforce development; and standardized practice development. The PIC is responsible for submitting monthly, quarterly, and annual reports that summarize findings on key indicators of Mobile Crisis service access, quality, and outcomes and to take a lead role on quality improvement activities. DCF also charges the PIC with taking the lead on practice development and outcomes evaluation activities.

The FY2017 Annual Report summarizes results from Mobile Crisis data entry into the Provider Information Exchange (PIE), DCF's web-based data entry system, as well as other activities and results relevant to Mobile Crisis implementation. **This year, Mobile Crisis continued to demonstrate strong results in service access, quality, outcomes, and workforce development.** Achievement of positive results is due to strong collaborations among various partners including DCF, Mobile Crisis providers, the PIC and its subcontractors, 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 2017 (FY2017; July 1, 2016 to June 30, 2017), and when appropriate, includes comparisons to previous years. The report is organized according to the following sections:

- Call and Episode Volume
- Characteristics of Children and Families Served
- Performance Measures and Quality Improvement
- Standardized Training and Technical Assistance
- Collaboration among Mobile Crisis Intervention Services Partners
- Model Development and Promotion
- Goals for Fiscal Year 2017

Call and Episode Volume

In FY2017, there were 18,021 calls to 211 requesting crisis intervention, which is 7.3% higher call volume than FY2016 (16,789 calls), 8.3% higher than FY2015 (16,644 calls), 0.1% higher than FY2014 (18,002 calls), 15.7% higher than FY 2013 (15,574 calls), 30.5% higher than FY 2012 (13,814 calls), 46.9% higher than FY2011 (12,266 calls), and 77.8% higher than FY2010 (10,135 calls). These numbers are significantly higher than when the PIC began tracking data in FY2009 (estimated 5,000 calls). Of the 18,021 calls this year, 13,488 (74.8%) resulted in calls sent to Mobile Crisis Intervention Services for a response, an 8.4% increase from FY2015 (12,478).

Characteristics of Children and Families Served

Demographic Characteristics

For all Mobile Crisis episodes, data were entered into PIE to capture demographic characteristics, case characteristics, and clinical functioning characteristics of the youth and families that were served.

Gender: Among all Mobile Crisis episodes of care, 51.7% were for boys and 48.3% were for girls.

Age: The highest percentage of children served by Mobile Crisis were 13 to 15 years old (33.2%) and 9 to 12 years old (27.4%). An additional 23.0% of children were 16 years old or older and the remaining 15.6% of children were 8 years old or younger.

Ethnic Background: Most families (67.6%) reported non-Hispanic ethnicity. Of the 32.4% of children from a Hispanic ethnic background, most reported their ethnicity as "Hispanic/Latino" (17.1%) or "Puerto Rican" (13.3%).

Racial Background: Many children served by Mobile Crisis reported "White" (62.0%) racial background, followed by "Black/African-American" (23.0%), and "Other Race" (12.1%).

Health Insurance Status: **Most children served by Mobile Crisis were covered by public insurance sources** including Husky A (63.5%) and Husky B (1.6%). Private insurance coverage was reported for 28.9% of youth served and about 2.0% of children served by Mobile Crisis this year had no insurance coverage, which is lower than FY2016 (2.6%).

Temporary Assistance for Needy Families (TANF) eligibility: Statewide, **41% of children were eligible for TANF**. Across all 14 Mobile Crisis sites, the percentages of TANF eligible families served ranged from 25% (Well-EMPS:Dnby) to 53% (Wheeler-EMPS: Meridn).

Case Characteristics

Referral Source: **Most children were referred by schools (41.8%), parents or family members (39.6%), or emergency departments (8.7%)**. Compared to FY2016, higher percentage of youth were referred from schools, while the percent referred from self/family was lower.

Mean Mobile/Office Visits: In FY2017, the average Mobile Crisis episode included 2.22 sessions. The average number of mobile contact sessions per episode was 2.07 sessions (range 1.42 to 2.91 sessions across 14 Mobile Crisis sites). The average number of in-office sessions was 0.26 sessions (range 0.00 to 0.88 sessions across 14 Mobile Crisis sites). Consistent with the Mobile Crisis model and practice standards, all 14 Mobile Crisis provider sites had a higher average number of mobile sessions per episode than office sessions. Compared to FY2016, there was a slight increase in office visits per episode of care.

Length of Stay (LOS): In FY 2017, the median LOS was 17.0 days, and the mean LOS was 21.1 days among discharged episodes of care coded as "Stabilization Follow-Up." The mean LOS has stayed relatively consistent the last few years (22.6 days in FY2016, 20.8 days in FY2015, 21.5 days in FY2014, 20.3 days in FY2013, 22.1 days in FY2012, 24.5 days in FY2011, and 26.4 days in FY2010). In FY2017, Mobile Crisis providers continued to manage LOS and ensure that data on start and end dates were accurately entered into PIE. These efforts resulted in **8% of episodes exceeding the 45 day LOS benchmark** for "Stabilization Follow-up" episodes. This exceeds the 5% benchmark. This was a decrease from FY2016 (10.0%), and higher than FY2015 (7.0%), FY2014 (7.0%), FY2013 (5.0%) FY2012 (6.0%), and FY2011 (7.0%), but lower than FY2010 (11.6%). In FY2017, the median LOS for episodes coded as "Face-to-Face" was 3.0 days, and for "Phone Only" episodes the median LOS was 0 days.

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 (29%); Disruptive Behavior (26%); Depression (13%); Harm/Risk of Harm to Others (7%); Anxiety (7%)**; and **Family Conflict (5%).** All other presenting problems combined accounted for 13% of referrals. These percentages are very similar to FY2016, FY2015 and FY2014.

Diagnosis: In FY2016, the primary diagnoses at intake were restructured according to new DSM-5 guidelines. The five most common primary diagnoses at intake were Depressive Disorder (28.6%); Adjustment Disorder (17.0%); Conduct Disorders (12.8%); Attention Deficit/Hyperactivity Disorder (10.3%); Anxiety Disorder (9.7%); and Trauma Disorders (6.9%).

Trauma exposure: Statewide, **62% of children served by Mobile Crisis reported one or more trauma exposures**, compared to 65% of children served by Mobile Crisis in FY2016, 67% in FY2015, 64% in FY2014, 65% in FY2013, 63% in FY2012, and 61% in FY2011. Across service areas this year, the percentage of youth reporting trauma exposure ranged from 57% (Central and Southwestern area) to 72% (New Haven service area). Among those with trauma exposure, the most common types were disrupted attachment/multiple placements (25%), witnessing violence (23%), being a victim of violence (16%), and sexual victimization (13%).

DCF Involvement: At intake, **most children (83.0%) served by Mobile Crisis were not involved with DCF**, a higher rate than FY2016 (82.0%), FY2015 (81.0%), FY2013 (81.7%) and FY2012 (76.4%) but a slightly lower rate than FY2014 (82.4%). The most common types of DCF involvement at intake were CPS in-home services (6.8%), CPS out-of-home services (3.8%), and the Voluntary Services program (1.4%). These rates are similar to results from FY2016.

Juvenile Justice Involvement: Statewide, 4.4% of children served by Mobile Crisis had been arrested in the six months prior to the Mobile Crisis episode, slightly lower than FY2016 (4.5%). It is also lower than FY2015 (5.1%), FY2014 (5.4%), an increase from FY2013 (2.5%), but lower than FY2012 (6.8%) and FY2011 (7.9%). Moreover, 1.8% of youth were arrested during the Mobile Crisis episode, which is slightly higher than FY2016 (1.5%).

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 (33%), behavioral (26%), social (22%), and academic problems (17%). Statewide, 14% of youth served by Mobile Crisis had been suspended or expelled in the six months prior to the Mobile Crisis episode.

Alcohol and Other Drug (AOD) Use Problems: In terms of lifetime prevalence of AOD use, 0.5% reported alcohol use, 5.3% reported other drugs, and 2.3% reported both alcohol and other drug use.

Emergency Department and Inpatient Hospital Utilization: Statewide, 8.7% of all referrals to Mobile Crisis came from hospital EDs, compared to 8.6% in FY2016, 9.2% in FY2015, 10.6% in FY2014, 10.1% in FY2013, 11.2% in FY2012, and 12.0% in FY2011. In addition, in FY2017, 17% of episodes were evaluated in an ED one or more times during the current Mobile Crisis episode of care, compared to 17% in FY2016 and FY2015, 20% in FY2014, 17% in FY2013, 14% in FY2012, and 15% in FY2011. In addition, 7% of Mobile Crisis episodes experienced an inpatient admission, which was 1% lower than FY2016 (8%).

Performance Measures and Quality Improvement

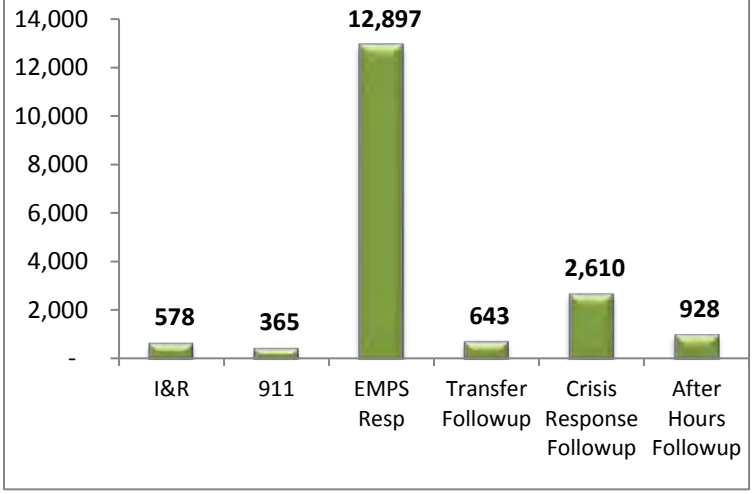
In FY2017, the PIC worked with collaborators to produce monthly reports, quarterly reports, and this annual report summarizing indicators of access, service quality, performance, and outcomes (visit www.chdi.org or www.empsct.org for all reports). Site visits were conducted with providers and performance improvement plans were developed with the six primary service area teams and, when applicable, their satellite offices or subcontractors. Individualized consultation helped Mobile Crisis providers identify best practice areas and areas in need of improvement and develop strategies for

addressing areas in need of improvement. Primary indicators of service access and quality were the focus of many sites' performance improvement plans, but sites increasingly examined other indicators of service and programmatic quality including clinical and administrative processes. During FY2017 there were a total of 112 performance improvement goals developed. Of those goals, 21% were achieved and an additional 74% of the goals saw improvement. Only 5% of goals developed had no positive progress (see Table 12 for a summary of sites' performance improvement plans).

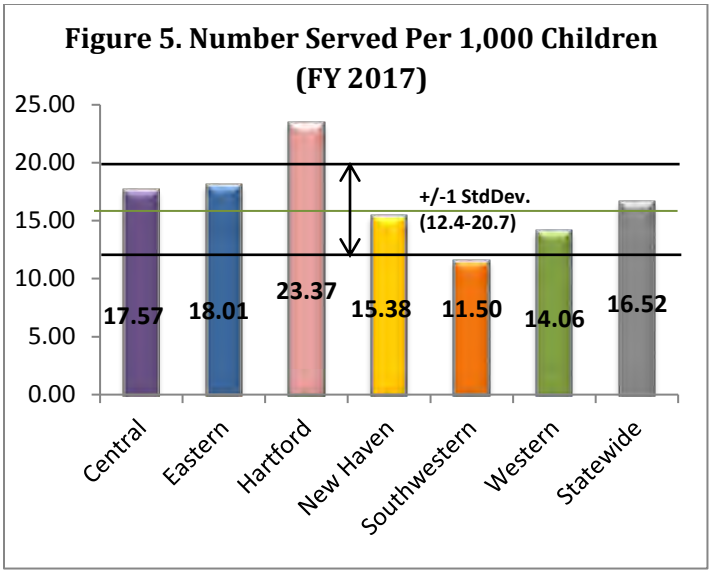
Data on performance measures and quality improvement activities are reviewed below along with clinical outcomes and special data analysis requests in FY2017.

Call Volume: **In FY2017, there were 18,021 calls to 211 and Mobile Crisis for crisis intervention,** which is 7.3% higher than FY2016 (16,789), 0.8% higher than FY2015, 0.1% higher call volume than FY 2014 (18,002 calls). These calls resulted in **13,461 Mobile Crisis episodes of care,** 8.4% more than FY2016. Most calls (74.8%) were transferred to a Mobile Crisis provider for a response, which is lower than FY2016 (74.0%) and FY2015 (74.9%) and higher than FY2014 (64.2%) and FY2013 (69.7%), but lower than FY2012 (76.5%) and FY2011 (77.2%). In addition 14.4% of calls in FY2017 were sent to Mobile Crisis for crisis response follow-up and 5.1% were transferred to Mobile Crisis for after-hours follow-up. The remaining calls were handled by 211 only as information and referral (3.2%) or as transfers to 911 (2.0%).

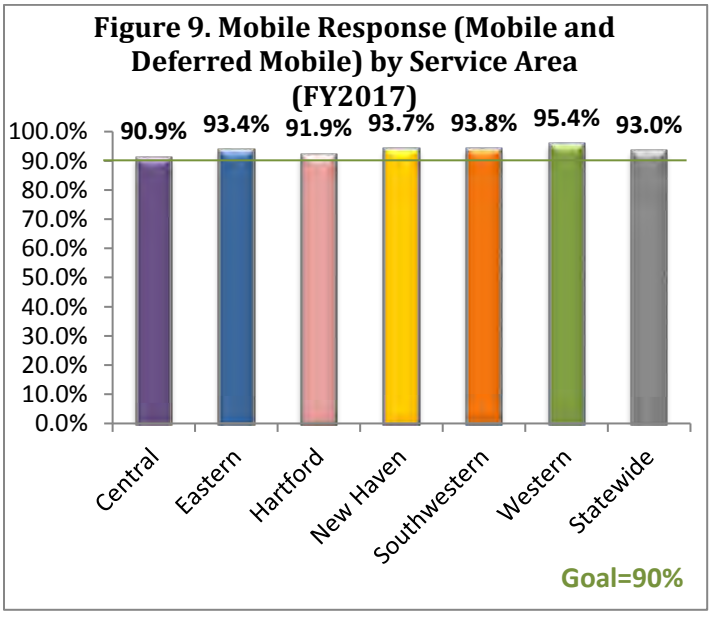
Figure 14. Statewide 211 Call Disposition



A "service reach rate" examines total episodes relative to the population of children (based on 2010 U.S. Census data) in a given catchment area (see Figure 5 below). Service reach rates are calculated statewide, for each service area, and for each individual provider. The statewide service reach rate for FY2017 was 16.52 per 1,000 children compared to 15.24 episodes per 1,000 children in FY2016, 15.31 in FY2015, 15.19 in FY2014, 13.25 in FY2013, 12.97 in FY2012, and 11.23 in FY2011. The Hartford service area had the highest service reach rate (23.37 per 1,000 children) which was more than 1 standard deviation above the statewide mean. The lowest service reach rate was in the Southwestern service area (11.50 episodes per 1,000), which was less than one standard deviation below the statewide mean.

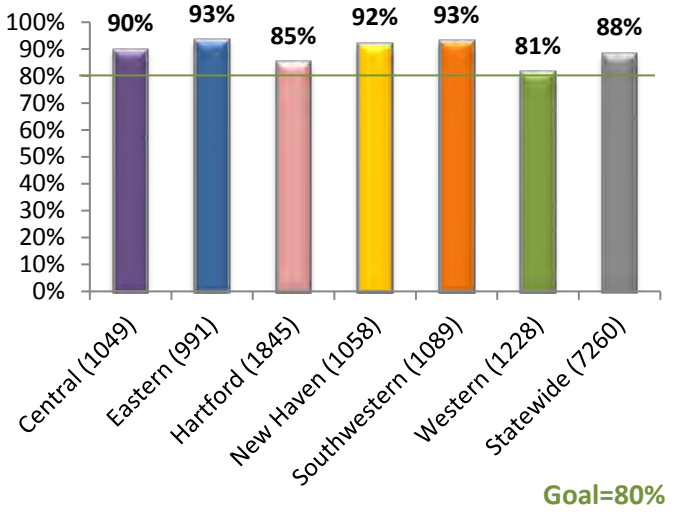


Mobility Rate: Mobile responsiveness is a key feature of Mobile Crisis service delivery. Since PIC implementation, the established mobility benchmark has been 90%. The Mobile Crisis PIC examines all episodes for which 211 recommended a mobile or deferred mobile response and determines the percentage of those episodes that actually received a mobile or deferred mobile response from a Mobile Crisis provider. **In FY2017, the statewide mobility rate was 93.0%** which was above the 90% benchmark. The statewide mobility rate this year was one of the highest recorded mobility rates since FY2009 [FY2016 (92.5%), FY2015 (92.4%), FY2014 (91.7%), FY2013 (91.9%), FY2012 (92.5%), FY2011 (90.3%), FY2010 (83.6%), and FY2009 (estimated at 50%)]. **All six service areas had an annual mobility rate above the 90% benchmark.** The highest rate was in the Western region (95.4%) and the lowest was in the Central service area (90.9%). The range in mobility rates across all six service areas was 4.5 percentage points which was lower than FY2016 (7.2 percentage points), higher than FY2015 (4.1 percentage points), lower than FY2014 (8.1 percentage points) and FY2013 (9 percentage points), but higher than FY2012 (3.7 percentage points). Continued year-to-year increases in Mobile Crisis utilization rates impacts sites' ability to respond to requests for mobile response; however, the Mobile Crisis program continues to add clinicians to its network of providers and to respond to this challenge with excellent overall mobility.



Response Time: The benchmark for response time is that at least 80% of all mobile responses will be provided in 45 minutes or less. **This year, 88% of all mobile responses were made within the 45 minute benchmark.** For the past two fiscal years (FY2016 and FY2015), the rate was 89%, which is the highest annual rate achieved to date (FY2014 (87%), FY2013 (88%), FY2012 (85%), FY2011 (86%), and FY2010 (62%)). All six service areas achieved the benchmark, with service area performance ranging from 93% (Central) to 81% (Western). **The median response time this year was 27 minutes, which was two minutes more than FY2016**. Statewide response time performance has been consistently above expectations the last four fiscal years despite growth in episode volume.

Figure 11. Total Mobile Episodes with a Response Time Under 45 Minutes by Service Area (FY2017)



Clinical Outcomes

Ohio Scales: The Ohio Scales are intended to be completed at intake and discharge by parents and Mobile Crisis 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 45 days. Statewide, 3,025 clinician-report and 236 parent-report Ohio Scales were completed at intake and discharge. **In FY2017, Mobile Crisis clinicians completed the Ohio Scales for 81% of episodes at intake and 79% at discharge.** Clinician completion rate at intake were lower than FY2016 (84%) and rates at discharge were lower than FY2016 (86%). In FY2017, **parents completed the Ohio Scales at the rate of 43% at intake and 5% at discharge,** both of which were lower than FY2016. Throughout the year, providers have been working with their clinicians to improve their parent Ohio Scale completion rate. By including Ohio Scale completion as a part of every providers' PIP, additional training provided by DCF and providers, and constant emphasis on the importance of these scales, the numbers have increased.

Even though the Ohio Scales were designed to assess treatment outcomes for longer-term models of intervention such as outpatient care, pre-post changes indicate **statistically significant and positive changes on all domains of the Ohio Scales** (see Table 4) at the statewide-level. It is important to note that low completion rates (especially for parent-report measures at discharge) present a potential threat to the validity of these results.

Examining "clinically meaningful change" is another way to view Ohio Scales results. Clinically meaningful change on the Ohio Scales Functioning scale is a change of at least 8 points and a score of 50 or higher at discharge; and on the problem severity scale, a change of at least 10 points and a score of 25 or lower at discharge. Using these definitions, there was clinically meaningful change on Functioning for 11.4% of youth according to parent-report and 8.4% of youth

according to clinician-report. There was clinically meaningful change on Problem Severity for 18.7% of youth according to parent-report and 10.2% of youth 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	236	39.53	40.92	1.91	$p < 0.1$	11.4%
Worker Functioning Score	3025	43.84	45.66	11.46	$p < 0.01$	8.4%
Parent Problem Severity Score	235	24.58	20.15	-7.21	$p < 0.01$	18.7%
Worker Problem Severity Score	3005	27.90	25.27	-16.87	$p < 0.01$	10.2%

Special Data Analysis Requests

The Mobile Crisis PIC examined PIE and other data submissions and answered a number of important questions related to Mobile Crisis service delivery, access, quality, outcomes, and systems-related issues. Many of these special data requests were generated throughout the year in response to questions from DCF, Mobile Crisis providers, and other stakeholders. This information was used to shape Mobile Crisis practice as well as systems-level decision-making. Several examples are described below.

Results Based Accountability (RBA): Historically, the Mobile Crisis PIC has helped identify appropriate indicators for RBA reporting and has reported on these indicators in the annual report. In Q2 FY2016, Mobile Crisis PIC integrated the statewide RBA report card into quarterly reports to enhance the capacity for DCF and statewide stakeholders to monitor performance on a more regular basis. In FY2017, the Mobile Crisis PIC also provided each Mobile Crisis provider with their own site specific RBA.

Mobile Crisis Analyses Supporting Related Initiatives: Mobile Crisis data analyses were conducted to support two related initiatives taking place in select Connecticut communities. School referrals to Mobile Crisis and episode-level data were examined to support the School-Based Diversion Initiative (SBDI) and Connecticut Department of Mental Health and Addiction Services Safe Schools/Healthy Students Diffusion Project.

Advancing Quality Improvement Standards: The Mobile Crisis PIC examined benchmarks (e.g., mobility, response time) disaggregated by referral source, at the statewide, service area, and provider levels. This allowed sites to assess areas for quality improvement among subgroups of Mobile Crisis recipients.

Hourly Breakdown of Mobile Crisis Utilization: In order to inform possible changes to Mobile Crisis hours of mobility, the Mobile Crisis PIC analyzed the time of day of 211 calls that resulted in a Mobile Crisis episode, using data from FY2014 and FY2015. The findings from this analysis indicated that 5.2% of 211 calls that resulted in a Mobile Crisis episode occurred between 10:00 pm to 8:00 am. The results from FY2014 and FY2015 helped inform the decision to expand Mobile Crisis mobile hours, effective March 1, 2016, to 6:00 am to 10:00 pm on weekdays. In FY2017, we still continue to monitor the hourly breakdown of mobile crisis utilization.

Statewide Committee Reporting: The Racial and Ethnic Disparities (RED) Committee, formerly known as Disproportionate Minority Contact (DMC), requested the PIC t*o* examine response time and referral sources for school districts in Connecticut, particularly Alliance School Districts. Among the top five schools, the response time and mobility were well above their designated benchmarks. The JJPOC Diversion Workgroup requested information about Mobile Crisis referrals, child demographic information for youth served, presenting problems and diagnosis by race to inform juvenile justice reform efforts.

Standardized Workforce Development and Technical Assistance

The Mobile Crisis PIC is responsible for designing and delivering a standardized workforce development and training curriculum that addresses the core competencies related to delivering Mobile Crisis services in the community. Providers are required by contract to ensure that their clinicians attend these trainings. CHDI contracts with Wheeler Clinic's CT Clearinghouse to coordinate the many logistics associated with implementing training events throughout the year. There were eleven regular training modules and one special training module offered in FY2017.

The 11 regular training modules included:

1. 21st Century Culturally Responsive Mental Health Care
2. Crisis Assessment, Planning and Intervention
3. Disaster Behavioral Health Response Network
4. Emergency Certificate Training
5. Strengths-Based Crisis Planning
6. Overview of Intellectual Development Disabilities and Positive Behavioral Supports
7. Traumatic Stress and Trauma-Informed Care
8. Assessing Violence Risk in Children and Adolescents
9. Question, Persuade and Refer
10. Columbia Suicide Severity Rating Scale (online training)
11. Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT)

The special module was Applied Suicide Intervention Skills Training (ASIST).

Evaluation forms indicated that participants were generally highly satisfied with the training modules and that the learning objectives were consistently met. Evaluation findings continue to be used to inform changes for FY2018. Highlights from the Mobile Crisis PIC training component include the following:

- 36 training modules were held,
- There were 143 unique Mobile Crisis training participants in FY2017,
- There have been 256 trainings in the eight years of Mobile Crisis PIC implementation, involving 559 Mobile Crisis staff members that have completed one or more trainings during that time.

In addition to these formal workforce development sessions, Mobile Crisis providers also received periodic consultation and technical assistance to address data collection and entry issues; for using data to enhance Mobile Crisis access and service quality; and to inform management and clinical supervision. In our efforts to reduce redundancy in content and increase efficiency of delivering the training curriculum, especially in light of continued high episode volume, we still continue to offer Columbia Suicide Severity Rating Scale (CSSRS) as an online training module.

Collaborations among Mobile Crisis Partners

There were numerous collaborations among DCF, the Mobile Crisis PIC, Mobile Crisis 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 representatives from the Mobile Crisis PIC, DCF, Mobile Crisis managers and supervisors, 211-United Way, the CTBHP, and other stakeholders. The meetings are held to review Mobile Crisis practice and policy issues.
- *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. The initiative

emphasizes enhanced school utilization of Mobile Crisis as a "front end" diversion to school-based arrest, which disproportionately affects students with behavioral health needs.

- *Client and Referrer Satisfaction*: 211-United Way and the Mobile Crisis PIC worked together to measure and report family and referrer satisfaction with Mobile Crisis services.
- *Workforce Development Enhancement:* The Mobile Crisis PIC, CT Clearinghouse, DCF, and Mobile Crisis personnel collaborated and added a new trauma module for FY2018 on Autism Spectrum Disorder. We will continue to provide QPR and A-SBIRT as in-house trainings.
- *Annual Meetings:* Mobile Crisis Providers, clinicians, DCF and other stakeholders attended the year-end annual meeting at the CT Hospital Association. The purpose of annual meetings were to recognize Mobile Crisis accomplishments throughout the year and to provide a training on "Addressing Self-Care Needs for Individuals and Teams in Large Scale Community Events" by Dr. Jessica Welt.
- *MOA Development with School Districts*: Mobile Crisis PIC staff provided technical assistance and support to Mobile Crisis managers to develop MOAs with School Districts as one element of Connecticut Public Act 13-178. Staff from 211-United Way sent outreach mailings to school administrators, and the Mobile Crisis PIC facilitated contact between Mobile Crisis providers and school personnel. Staff from 211-United Way posted MOA information and signed MOAs on their website (http://www.empsct.org/moa/). Additionally, a brief Mobile Crisis video highlighting the mutual benefits that students and schools receive by collaborating with Mobile Crisis service providers was developed and disseminated to school administrators.

Model Development and Promotion

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

Presentations: The Mobile Crisis model and associated findings were presented at local, state, and national meetings and conferences this year. Examples include a presentation to the 30th Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health and a national webinar entitled, "Mobile Crisis Service Delivery: An Examination on Utilization by Race and Ethnicity." In addition, Jeffrey Vanderploeg co-facilitated SAMHSA TA sessions in New Jersey, in collaboration with the National TA Center for Children's Behavioral Health at the University of Maryland. In December 2016 and April 2017, he also consulted with multiple state and communities to disseminate Connecticut's Mobile Crisis model. Mobile Crisis held consultation calls with a mobile crisis manager in Kent County, MI which launched a new service based on Connecticut's model. In January 2017, Jeffrey Vanderploeg was invited by the State of Michigan Department of Health and Human Services to present on the CT model as they have added a requirement for mobile crisis services to their Medicaid State Plan. Jeffrey Vanderploeg collaborated on a presentation at the American Psychiatric Association annual conference in San Diego on Mobile Crisis. He also provided project management and collaboration on a Children's Fund of Connecticut study awarded to the University of Connecticut School of Social Work to examine emergency department and inpatient utilization among youth served by Mobile Crisis. Mobile Crisis was also featured as part of a presentation at the CT Association of School Based Health Center's annual conference in May 2017. In November 2016, Jeffrey Vanderploeg also published an article on the CT Mobile Crisis model in Children and Youth Services review.

Goals for Fiscal Year 2017

FY2017 was another successful year for Mobile Crisis providers, the Mobile Crisis PIC, and all stakeholders involved in the Connecticut Mobile Crisis Intervention Services. Mobile Crisis providers demonstrated very good performance on key indicators related to service volume, mobility, and response times. In FY2017, Mobile Crisis providers are expected to maintain this excellent performance; however, there remain several areas of Mobile Crisis practice requiring further attention. Recommended goals for FY2018 are summarized below.

A. Quality Improvement

1. Continue to maintain volume by engaging in outreach activities, meetings, presentations.
2. Continue to focus on reaching schools, local police, and families that may benefit from Mobile Crisis.
3. Each service area will post mobility at or above the 90% benchmark.
4. Each service area will respond to crises in 45 minutes or less for at least 80% of mobile episodes.
5. Increase Ohio Scales completion rates.
6. Mobile Crisis providers will submit Performance Improvement Plans each quarter with goals in service access, service quality, and outcomes, as well as goals relating to efficient and effective clinical and administrative practices.

B. Standardized Training

1. Maintain or increase the number of training modules that are led by Mobile Crisis managers or supervisors.
2. Consider alternative training approaches to ensure that clinicians complete all training modules in a timely manner.
    - Implementation of Mobile Crisis Training Institute Week during which time most or all modules will be offered during this lower-volume time of year. This will supplement, not replace, existing offerings.
    - Implementation of a web-based Mobile Crisis training module to improve access and decrease cost for service providers.

C. Developing the Mobile Crisis Clinical Model

1. The PIC will publish one or more papers in peer-reviewed journals and present on Mobile Crisis at local, regional, state, and national conferences.
2. The PIC will work with DCF to provide consultation to one or more states seeking to develop or enhance their state's mobile crisis program.
3. Examine the role of Mobile Crisis in reducing emergency department utilization among youth presenting with primary behavioral health concerns.

D. Support the implementation of Connecticut Public Act 13-178 components that pertain to Mobile Crisis

1. Increase the number of signed MOAs between Mobile Crisis providers and School Districts.
2. Support Mobile Crisis expansion to our service providers' staff by utilizing data to inform how best to increase effective service delivery, including cost-effectiveness analyses, hourly breakdown of Mobile Crisis utilization, and evaluating growth in quarterly service area performance goals.
3. Enhance collaboration between Mobile Crisis and community-based mental health care agencies, school-based health centers, and the contracting authority for each local or regional board of education through the state to improve access to timely behavioral health care for children and youth.

SFY 2017 Annual RBA Report Card: EMPS Mobile Crisis Services

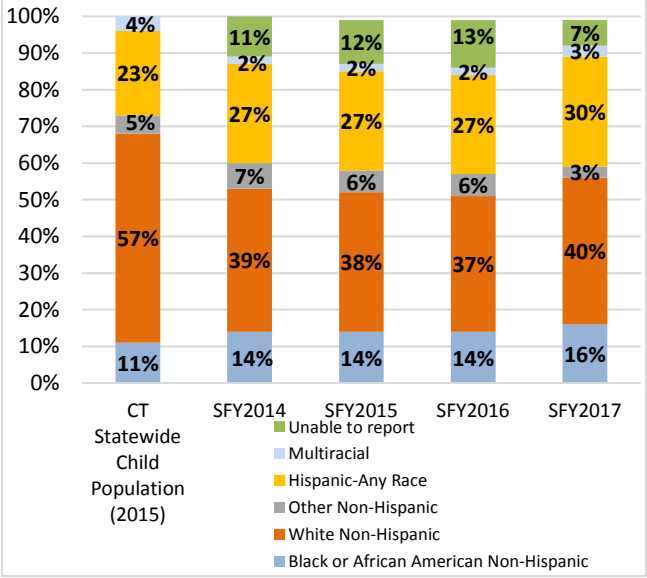
Quality of Life Result: Connecticut's children will live in stable environments, safe, healthy and ready to lead successful lives.

Contribution to the Result: The Mobile Crisis services provide an alternative, community based intervention to youth visits to hospital emergency rooms, inpatient hospitalizations and police calls that could remove them from their home and potentially negatively impact their growth and success. Mobile Crisis providers are expected to respond to all episodes of care. Partners with DCF include Child and Health Development Institute (CHDI) as the Performance Improvement Center.

Program Expenditures: Estimated SFY 2017	State Funding: $10,743,631

How Much Did We Do?

Total Call and Episode Volume



	FY2014	FY2015	FY2016	FY2017
Mobile Crisis Episode	12.376	12,478	12,419	13,488
211 Only	5,626	4,166	4,370	4,533
Total	18,002	16,644	16,789	18,021

Story Behind the Baseline: In SFY 2017, there were 18,021 total calls to the 211 Call center, which was 7.3% more than the SFY 2016 and the highest total in four years. The number of Mobile Crisis episodes in SFY 2017 was 13,488, 8.6% higher than SFY 2016 (12,419) and the highest total in the past 4 years. Each year the percentages of both Black and Hispanic children served is higher than the statewide population. Over the last fiscal year there has been a slight increase in the percentage of Black and White children served. Overall, Mobile Crisis use reflects increased community awareness of its availability and effectiveness.

Trend: ↑

How Much Did We Do?

Episodes Per Child

2014	DCF Child	Non-DCF Child	Total
1	757 (13.3%)	4952 (86.7%)	5,709
2	166 (16.9%)	817 (83.1%)	983
3	56 (20.1%)	223 (79.9%)	279
4 or more	36 (22.8%)	122 (77.2%)	158
2015	**DCF Child**	**Non-DCF Child**	**Total**
1	769 (13.9%)	4765 (86.1%)	5,534
2	238 (21.0%)	898 (79.0%)	1,136
3	81 (26.6%)	224 (73.4%)	305
4 or more	66 (31.4%)	144 (68.6%)	210
2016	**DCF Child**	**Non-DCF Child**	**Total**
1	792 (14.1%)	4806 (85.9%)	5,598
2	175 (20.4%)	682 (79.6%)	857
3	45 (18.8%)	195 (81.3%)	240
4 or more	47 (32.4%)	98 (67.6%)	145
2017	**DCF Child**	**Non-DCF Child**	**Total**
1	713 (12.8%)	4866 (87.2%)	5,579
2	166 (15.6%)	901 (84.4%)	1,067
3	58 (19.7%)	236 (80.3%)	294
4 or more	47 (23.4%)	154 (76.6%)	201

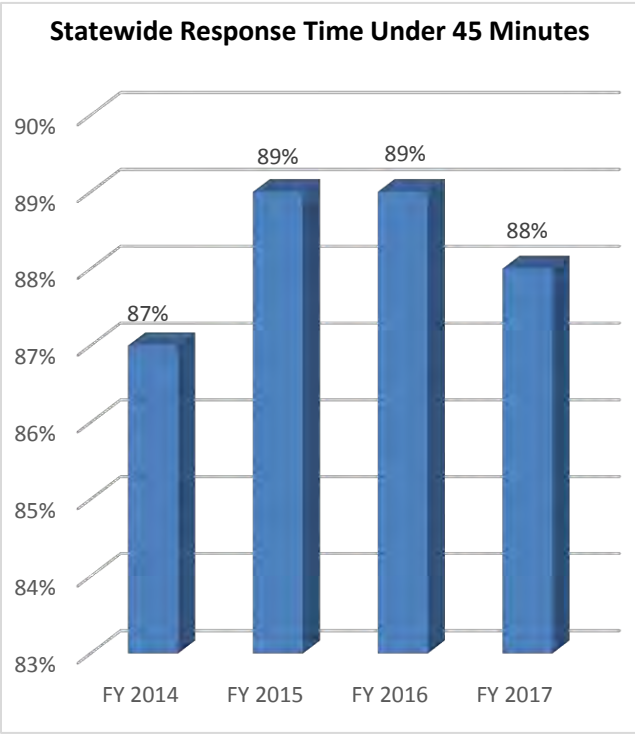
Story Behind the Baseline: In SFY 2017, of the 7,141* mobile crisis episodes of care 78.1% (5,579) only involved one response per child, and 93.1% (6,646) involved one or two responses, compared to 81.8% (5,598) and 94.4% (6,455) respectively for SFY 2016. This data indicates the effectiveness of Mobile Crisis in reducing the need for additional mobile crisis services. While the number of children with 4 or more episodes of care is relatively small the Mobile Crisis providers areworking on decreasing these numbers even further.

Trend: ↑

*Note: Only children with DCF/Non DCF status identified were reported.

How Well Did We Do?

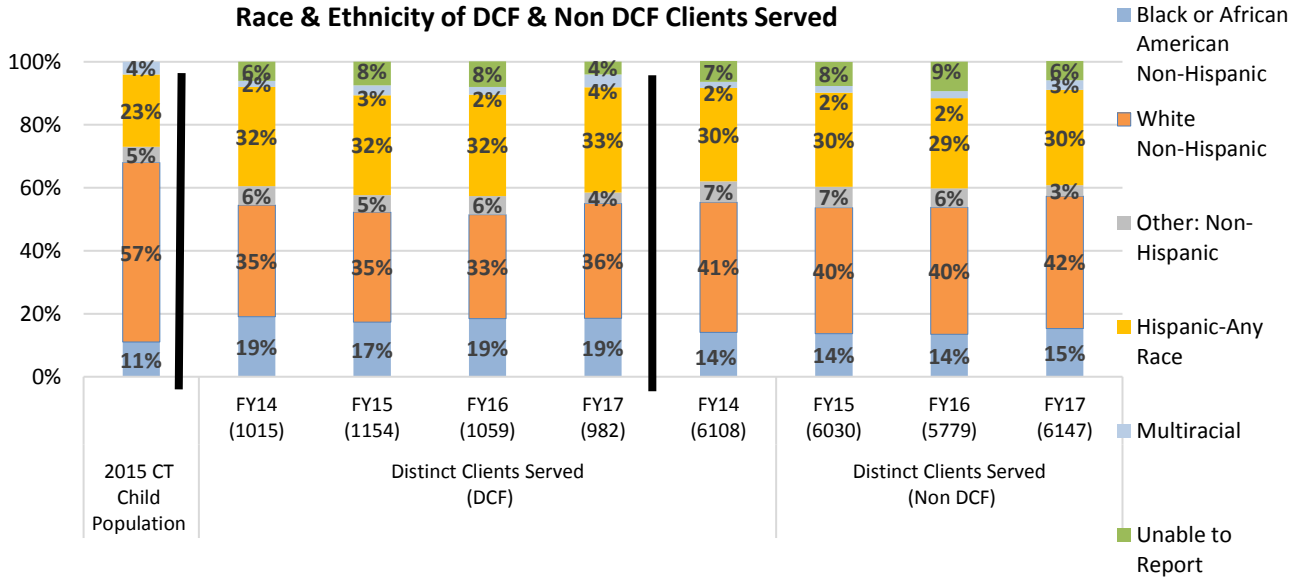
Statewide Response Time Under 45 Minutes



Story Behind the Baseline: Since SFY 2011 Mobile Crisis has consistently exceeded the 80% benchmark for a 45 minute or less mobile response to a crisis. For SFY 2017, 88% of all mobile responses were achieved within the 45 minute mark. The four year average for statewide response time is 88%. **The median response time for SFY 2017 was 27 minutes.** Mobile Crisis continues to quickly respond in 45 minutes or less to family homes, schools and other locations in the community to deal with child crises.

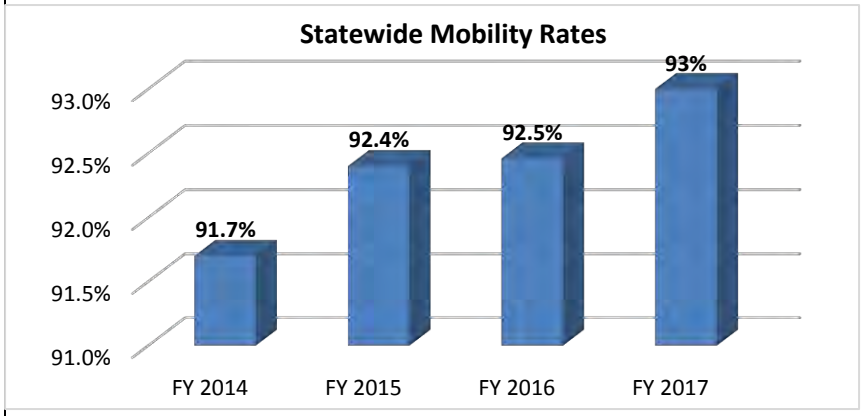
Trend: →

How Well Did We Do?



Story Behind the Baseline: Over the 4 years reviewed the race and ethnicity of non-DCF children utilizing Mobile Crisis is more consistent with the DCF population of children served, not the statewide child population. Over the 4 years reviewed Hispanic and Black DCF and Non-DCF involved children[1,2] access Mobile Crisis services at rates higher than the general population, while white DCF and Non-DCF involved children access the service at lower rates. Both Hispanic and Black DCF involved children utilize Mobile Crisis at higher rates than Non-DCF children, while White Non-DCF involved children utilize Mobile Crisis at higher rates than their DCF counterparts.[1]Note: Only children that had their DCF or non DCF status identified were reported. [2]Note: For the Distinct Clients served some had multiple episodes as identified above in Episodes per Child. **Trend:** →

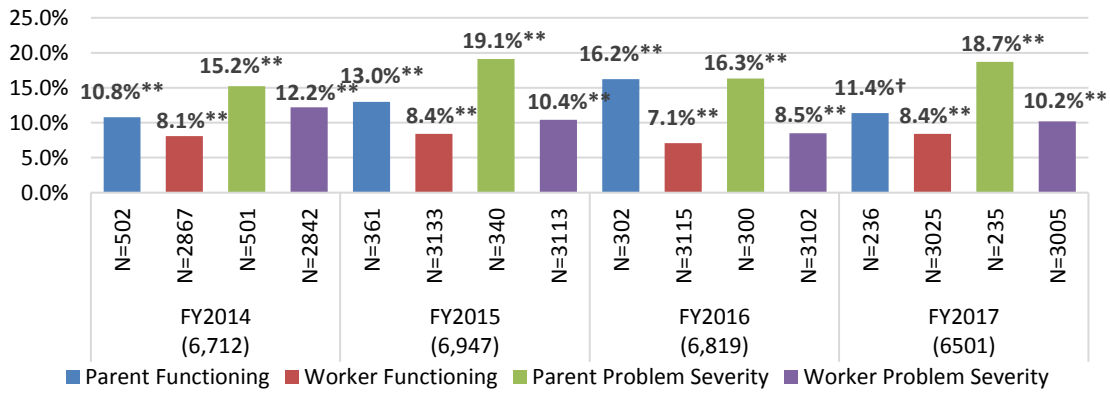
How Well Did We Do?



Story Behind the Baseline: Mobile responsiveness is a key feature of Mobile Crisis service delivery which has a 90% mobility benchmark. The statewide mobility rate was estimated at 50% prior to re-procurement of the service. In SFY 2017, the statewide mobility rate was 93.0%. Over the past 4 years the mobility rate has increased and this marks the seventh consecutive year in which statewide mobility has surpassed the 90% benchmark.

Trend: ↑

Is Anyone Better Off?



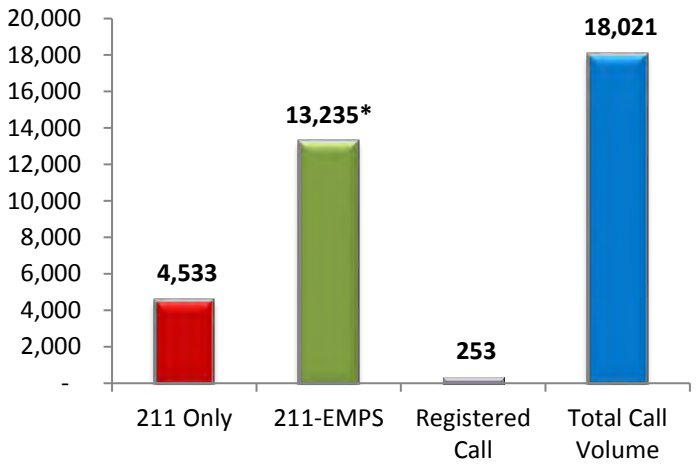
Story Behind the Baseline: The Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales), assessing behavioral health service outcomes has demonstrated clinically significant positive changes for children following a Mobile Crisis response. The parent ratings for SFY 2017 showed an average 11.4% improvement in child functioning and 18.7% decline in child problem severity following Mobile Crisis involvement.

Trend: ↑

[1]Note: Statewide Ohio Scales Scores are based on paired intake and discharge scores.[2]Note: Statistical Significance: † .05-.10; * P < .05; **P < 0.01

Section II: Mobile Crisis Statewide/Service Area Dashboard

Figure 1. Total Call Volume by Call Type



*Note: 26 episodes are Crisis-Response follow-up, 1 episode is Information and Referral

Figure 2. Total Call Volume per Quarter by Call Type

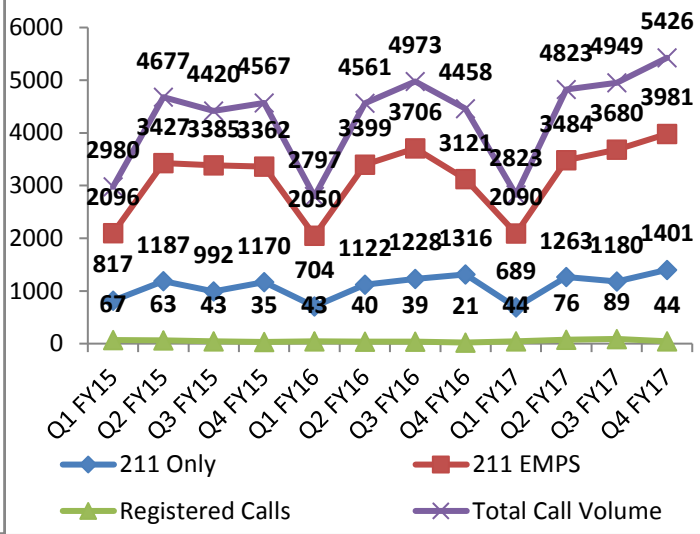
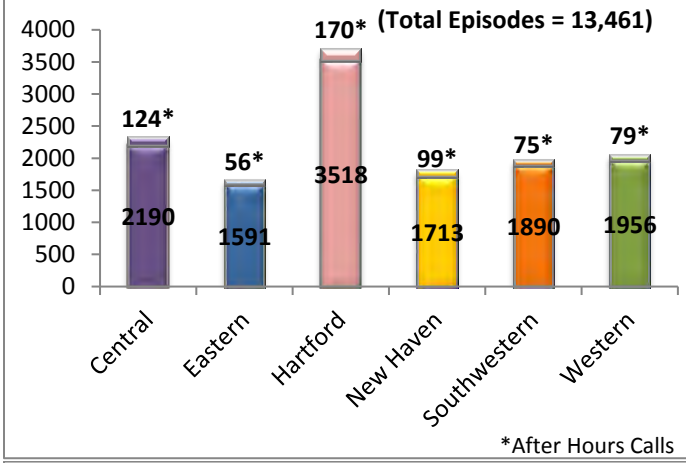


Figure 3. Mobile Crisis Response Episodes by Service Area



*After Hours Calls

Figure 4. Mobile Crisis Episodes per Quarter by Service Area

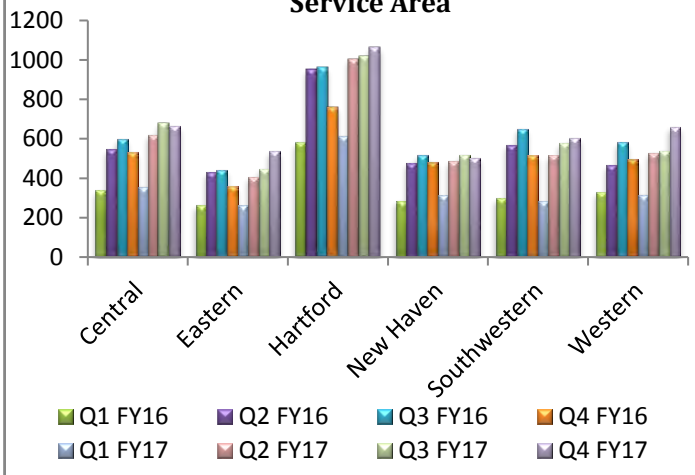


Figure 5. Number Served Per 1,000 Children (FY 2017)

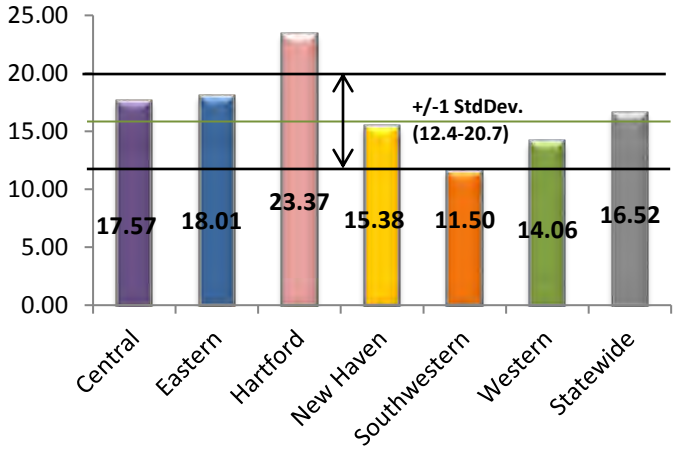


Figure 6. Number Served per 1,000 Children per Quarter by Service Area

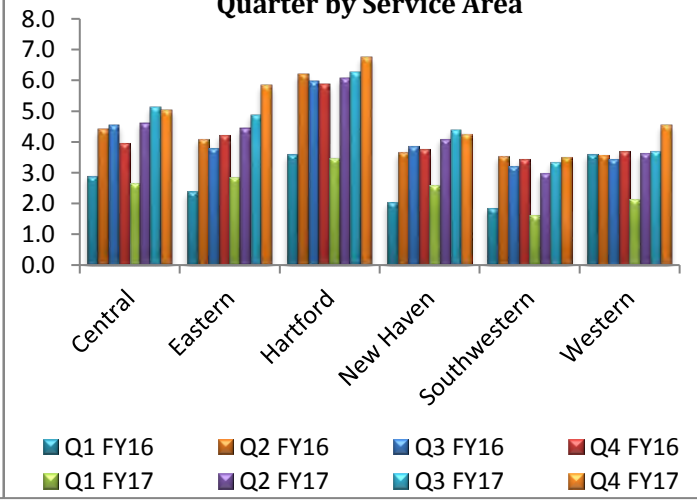


Figure 7. Number Served Per 1,000 Children in Poverty (FY2017)

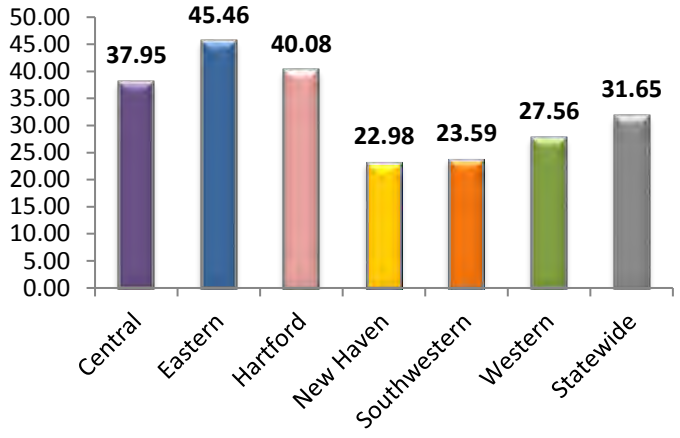


Figure 8. Number Served Per 1,000 Children in Poverty per Quarter by Service Area

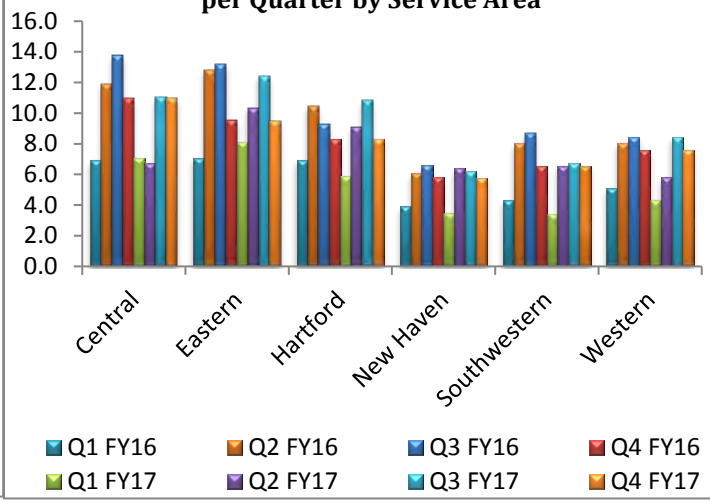


Figure 9. Mobile Response (Mobile and Deferred Mobile) by Service Area (FY2017)

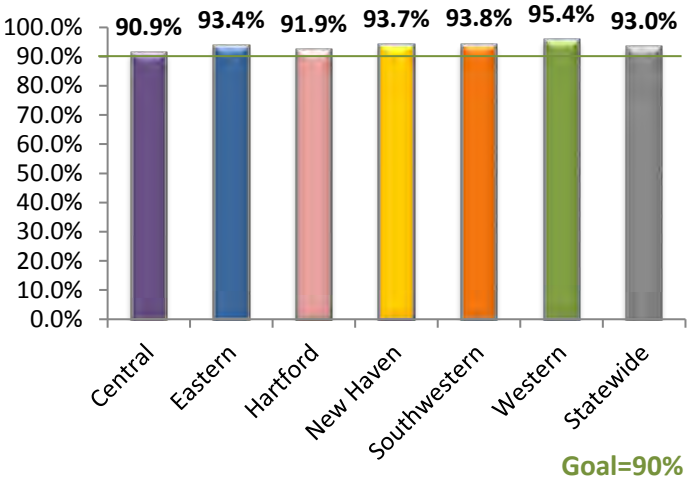


Figure 10. Mobile Response (Mobile and Deferred Mobile) by Service Area

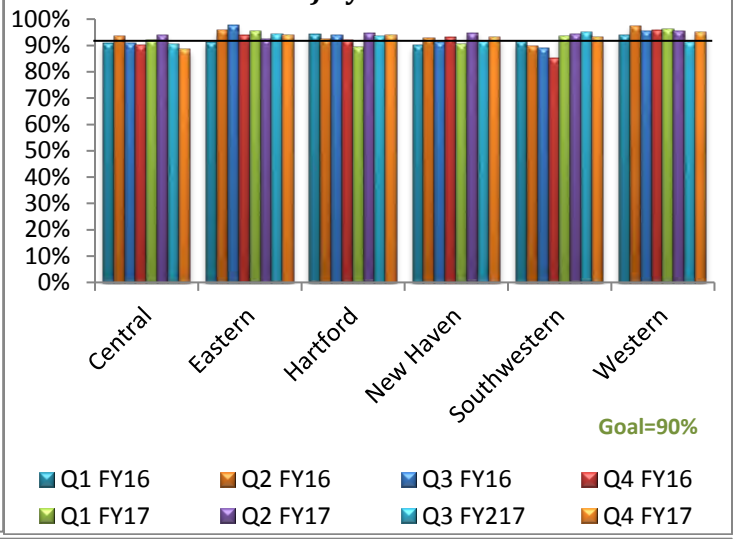


Figure 11. Total Mobile Episodes with a Response Time Under 45 Minutes by Service Area (FY2017)

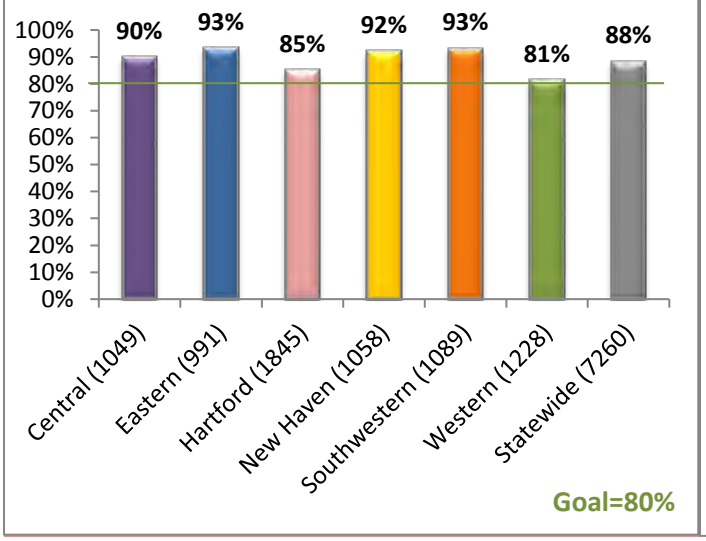
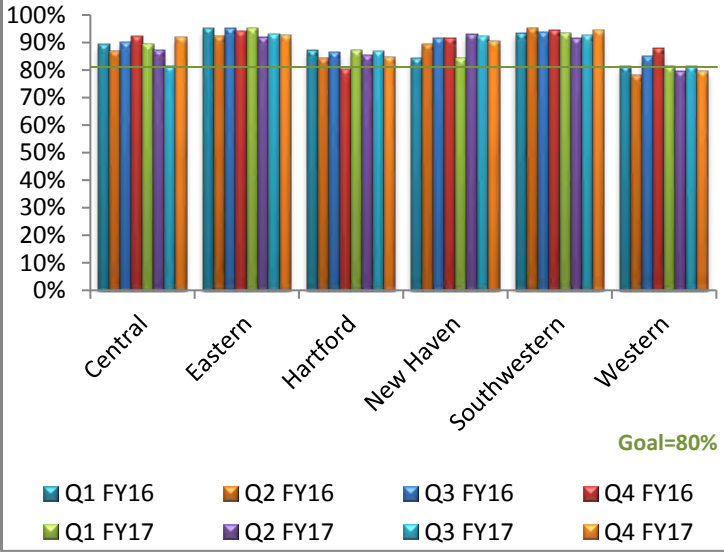


Figure 12. Total Mobile Episodes with a Response Time Under 45 Minutes per Quarter by Service Area



Section III: Mobile Crisis Volume

Figure 13. Total Call Volume by Call Type

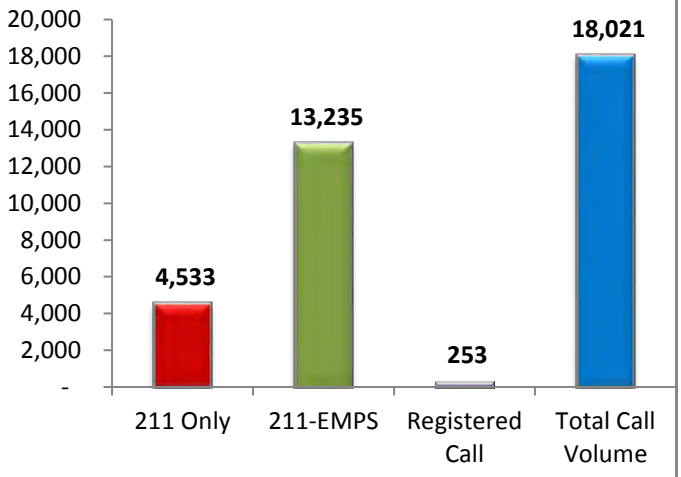


Figure 14. Statewide 211 Call Disposition

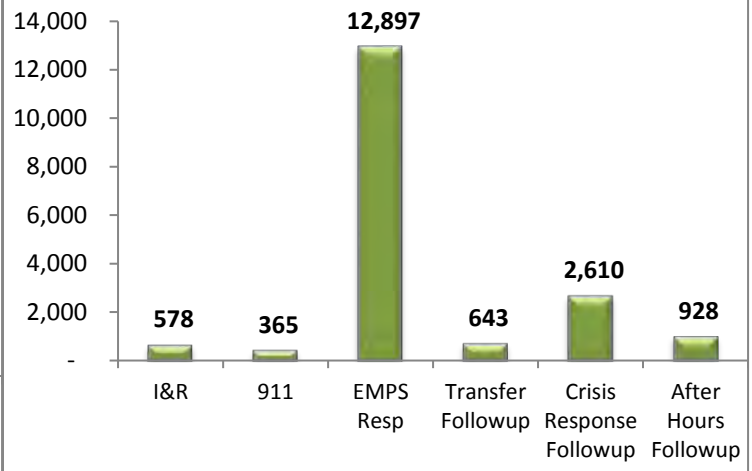


Figure 15. Mobile Crisis Response Episodes by Provider (Total Episodes = 13,461)

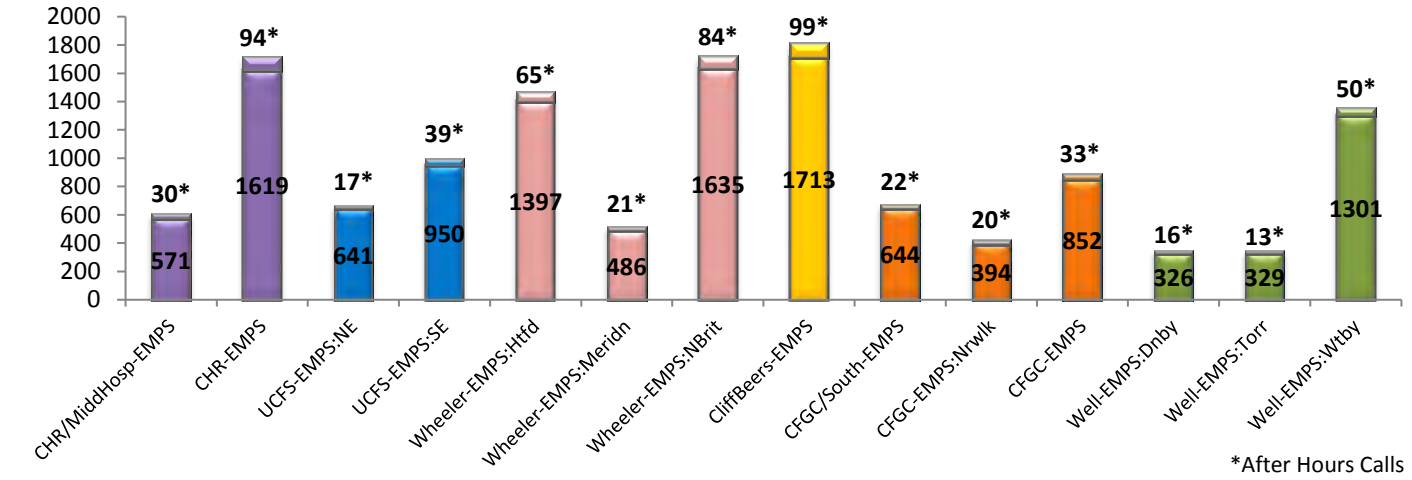


Figure 16. Number Served Per 1,000 Children by Provider (FY2017)

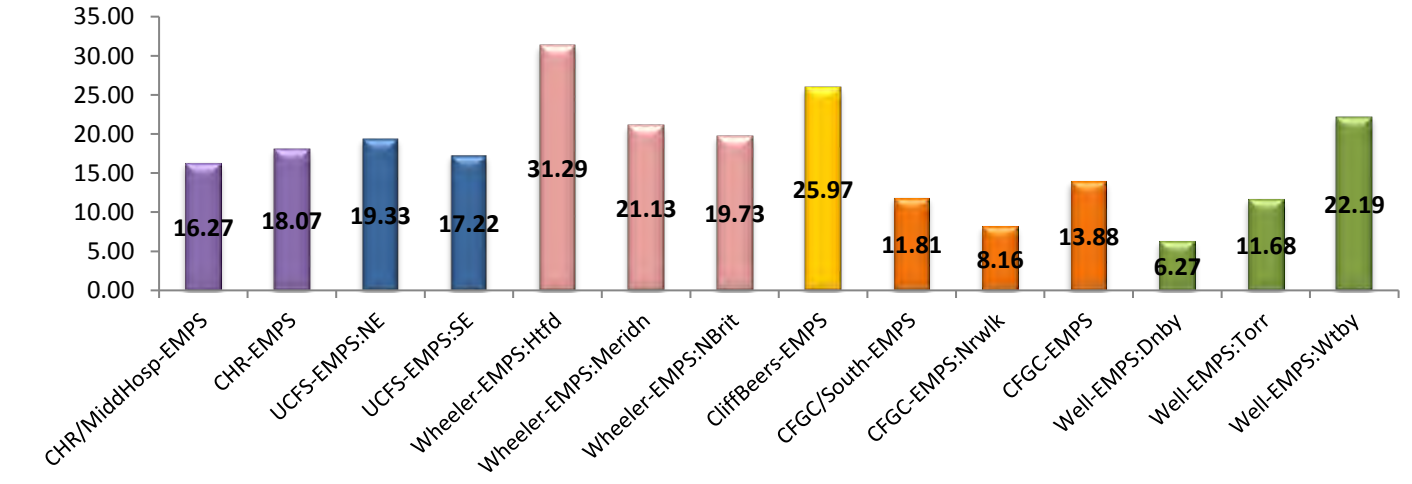


Figure 17. Episode Intervention Crisis Response Types by Service Area

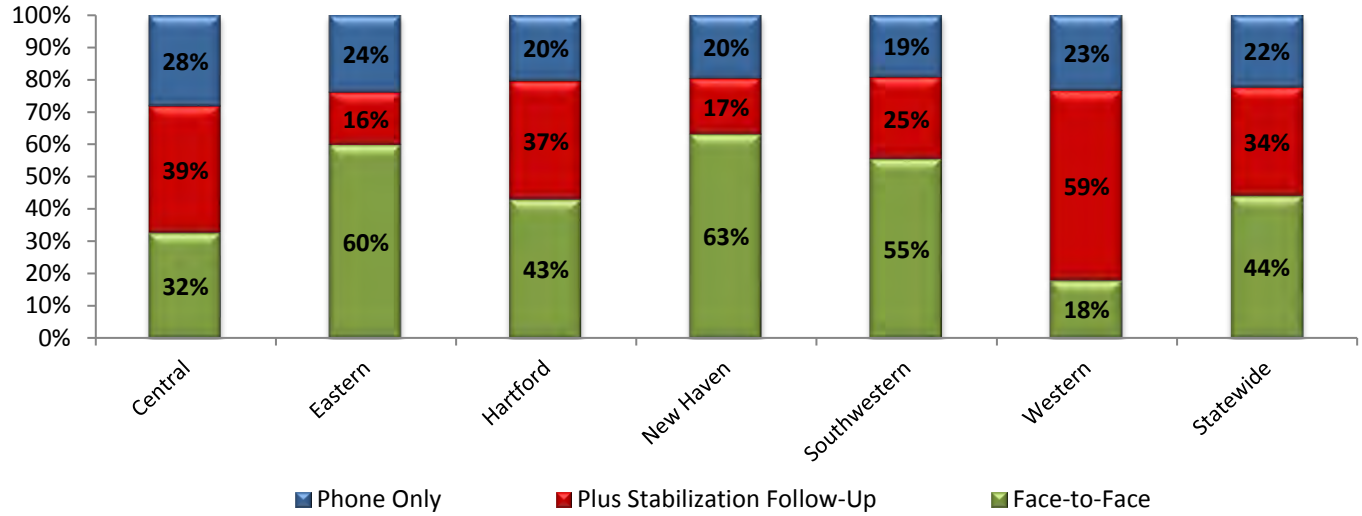
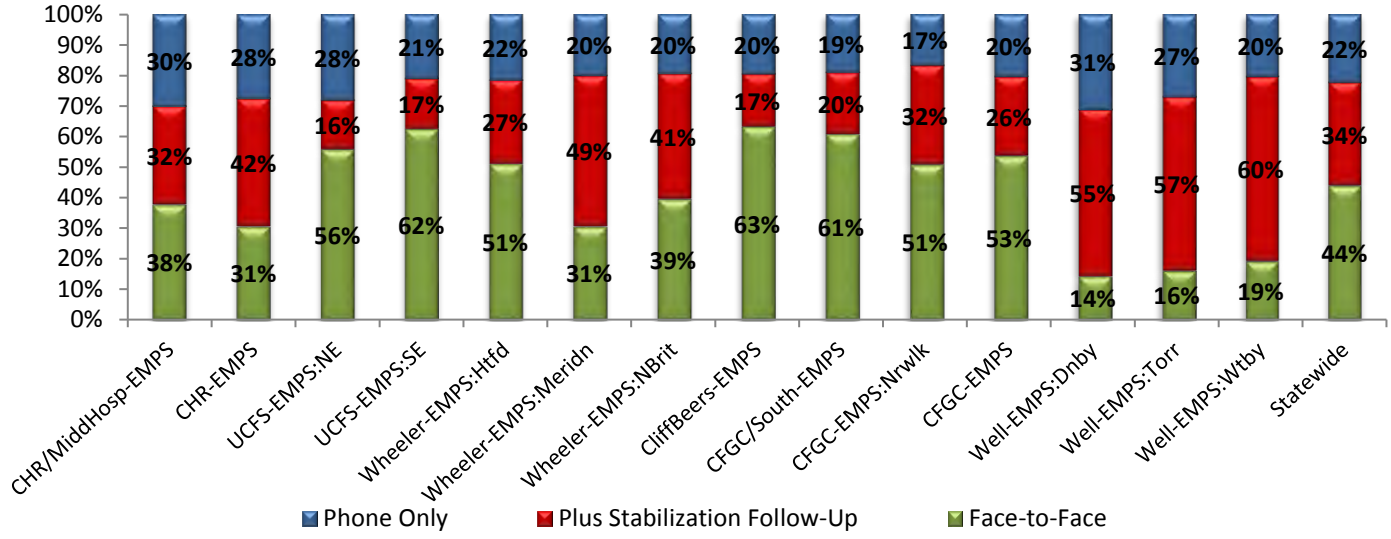


Figure 18. Episode Intervention Crisis Response Type by Provider



Section IV: Demographics

Figure 19. Gender of Children Served Statewide

(N = 13,461)

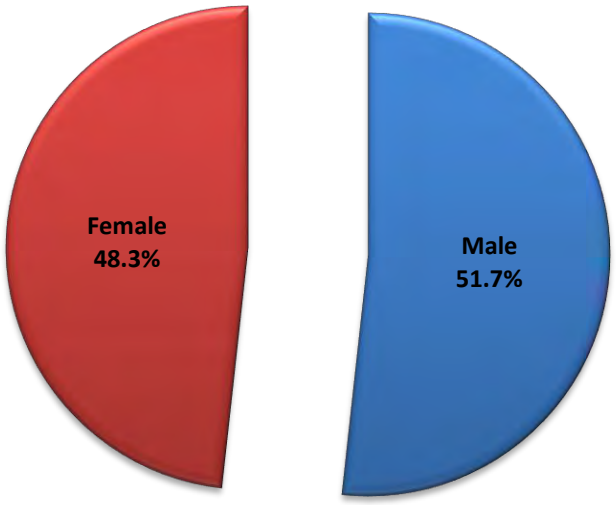


Figure 20. Age Groups of Children Served Statewide

(N = 13,461)

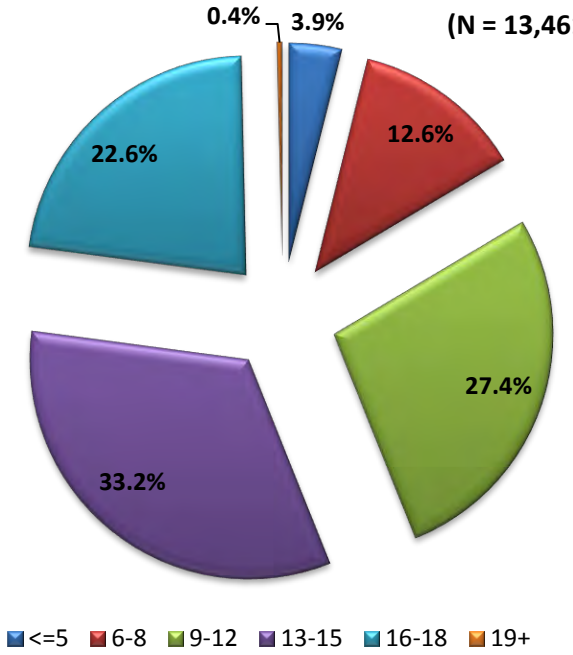


Figure 21. Ethnic Background of Children Served Statewide

(N = 12,756)

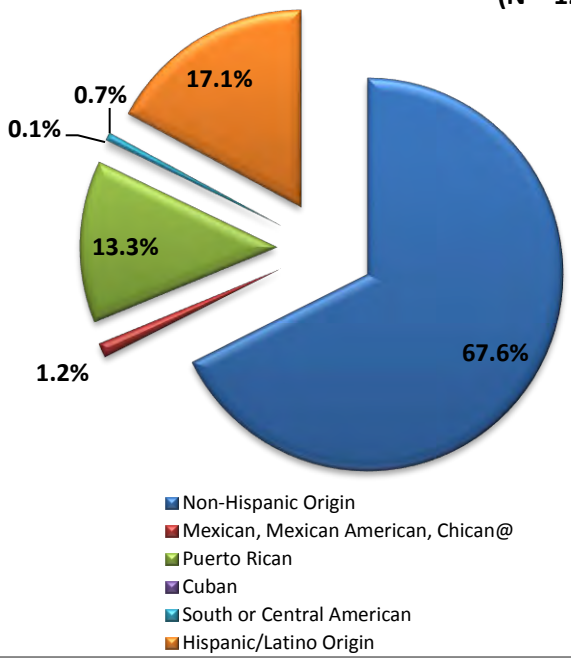
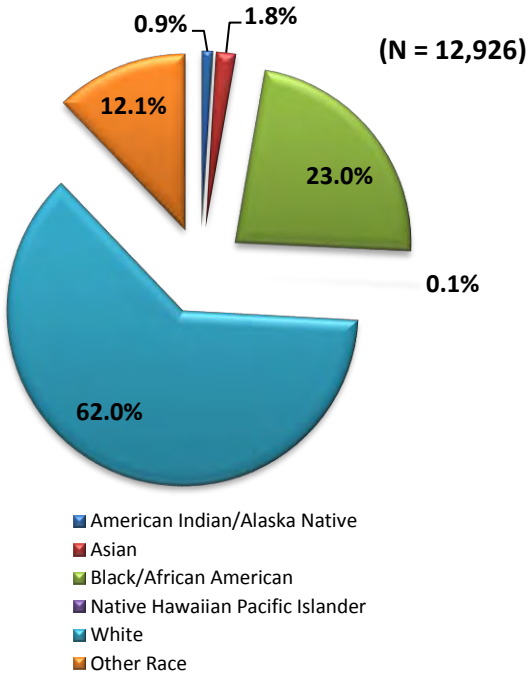


Figure 22. Race of Children Served Statewide

(N = 12,926)



Note: Clients may self-identify more than one Race.

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

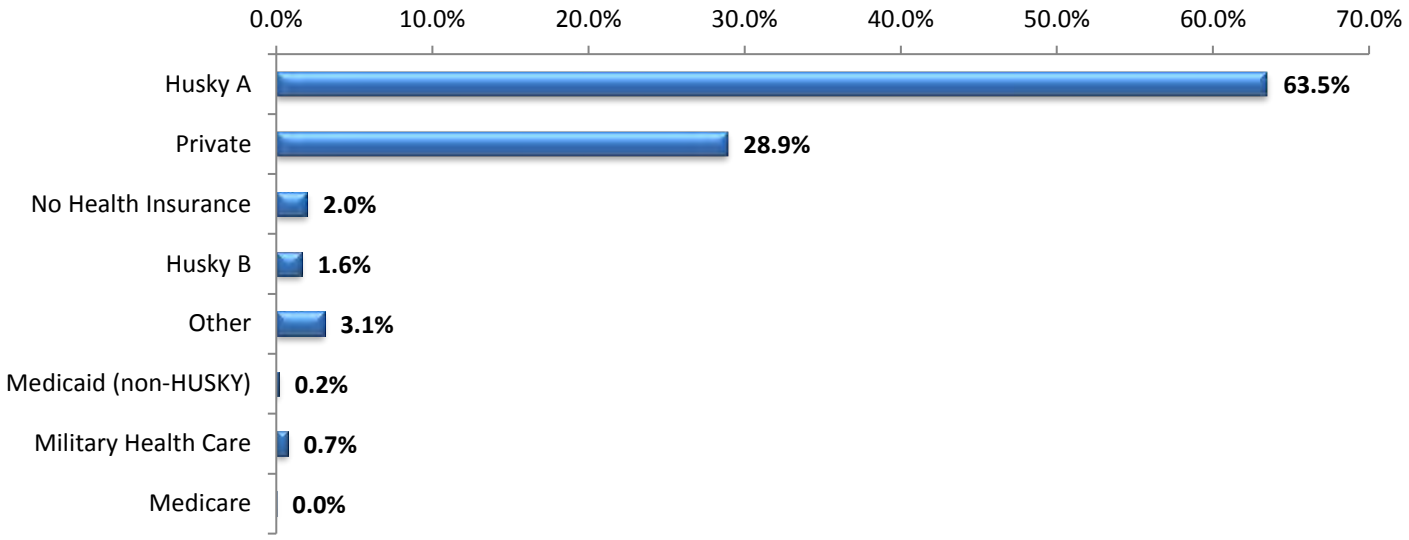
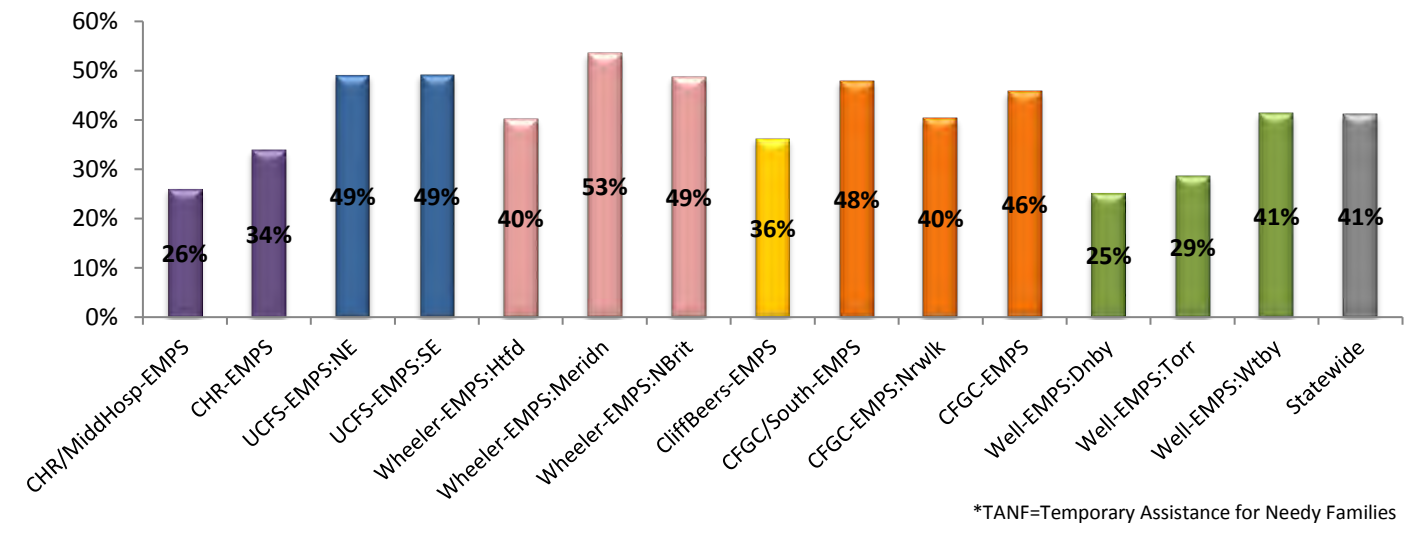
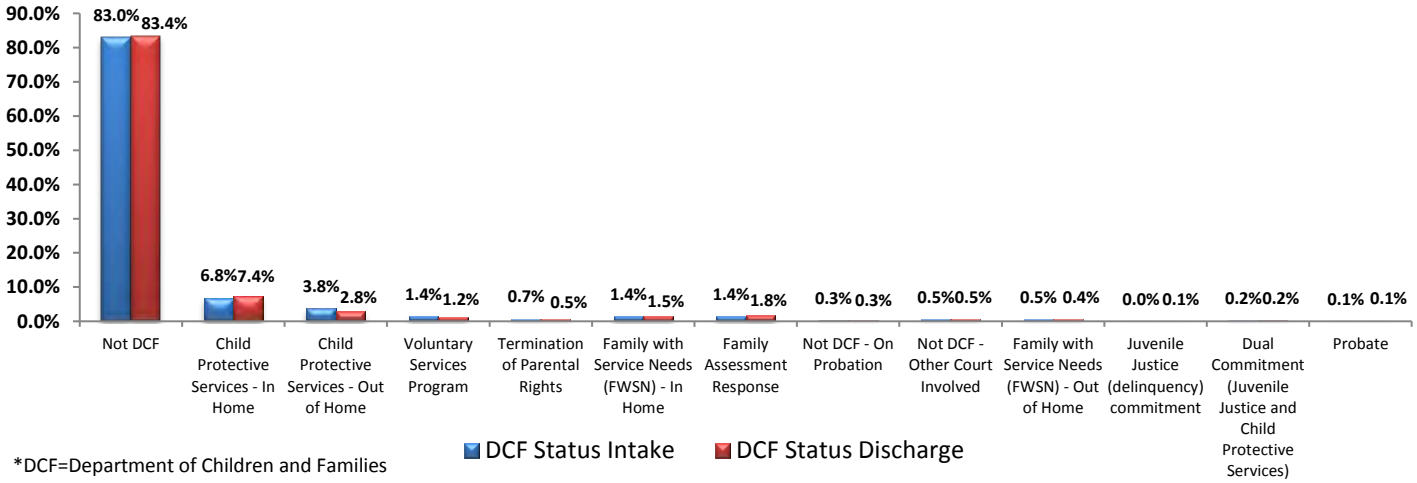


Figure 24. Families that Answered "Yes" TANF* Eligible



*TANF=Temporary Assistance for Needy Families

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



*DCF=Department of Children and Families

Section V: Clinical Functioning

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

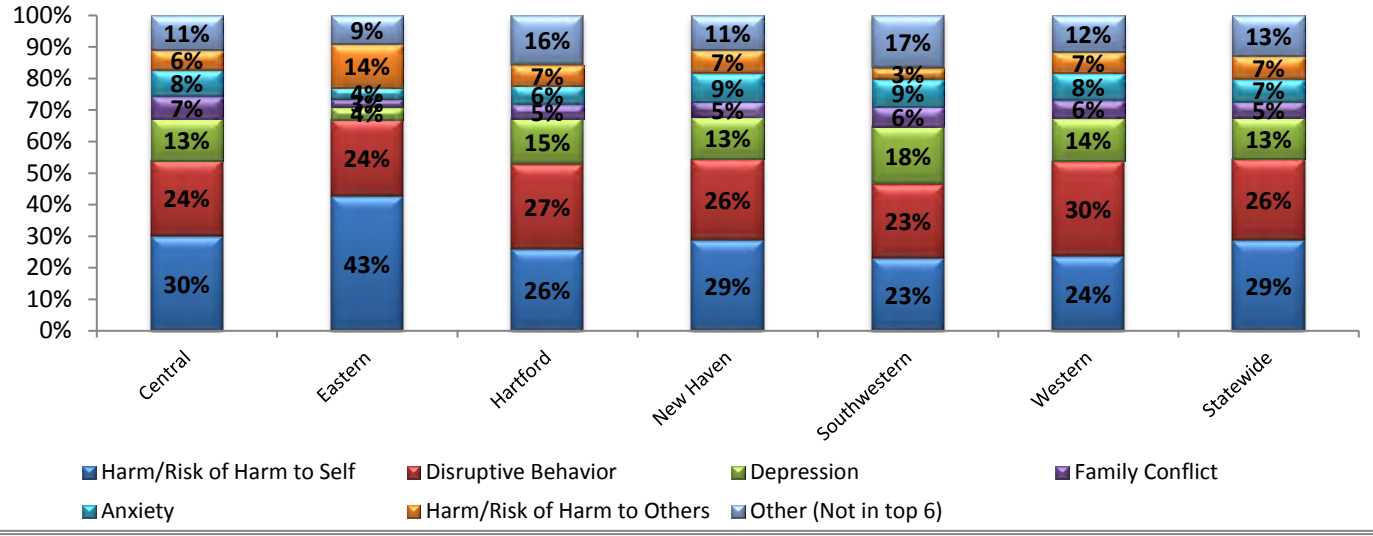
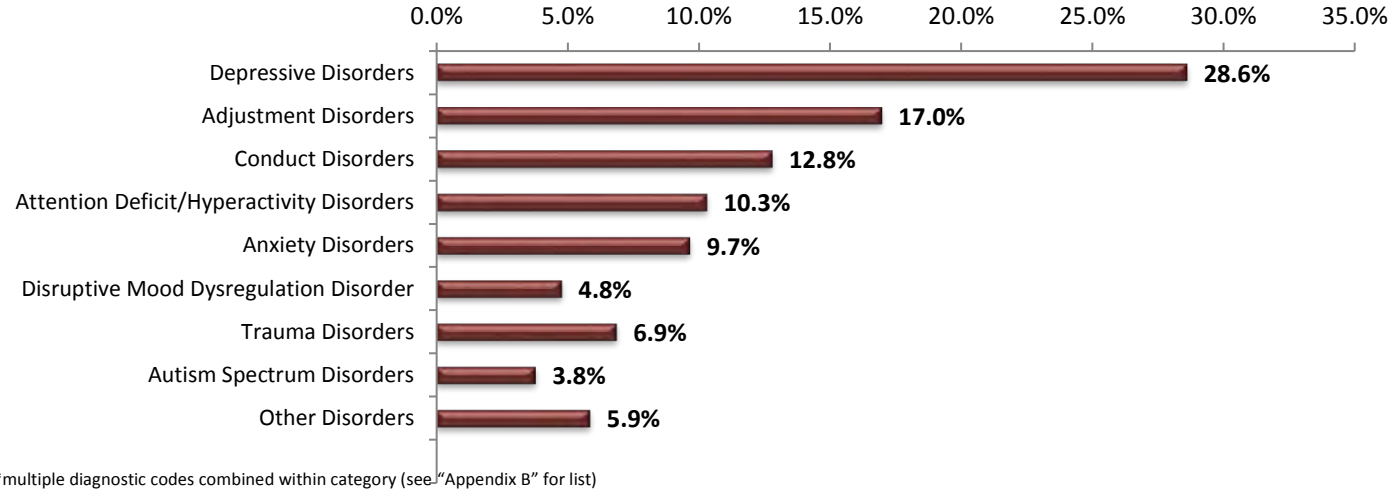


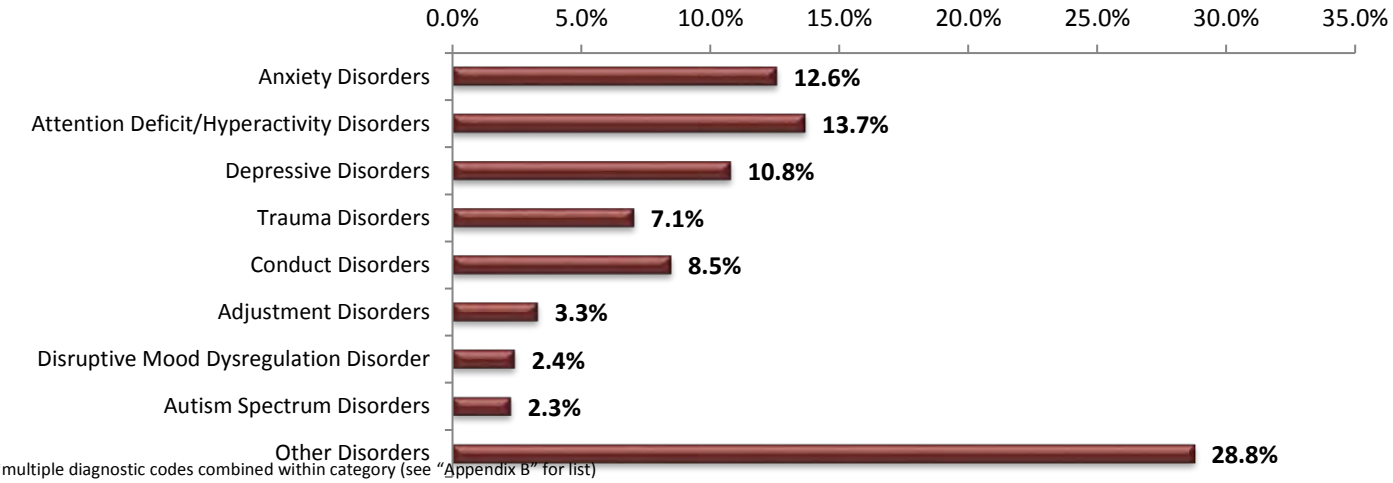
Figure 27. Distribution of Client Primary Diagnosis at Intake Statewide



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

Note: Excludes missing data

Figure 28. Distribution of Client Secondary Diagnosis at Intake Statewide



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

Note: Excludes missing data

Figure 29. Top 6 Client Primary Categories at Intake by Service Area

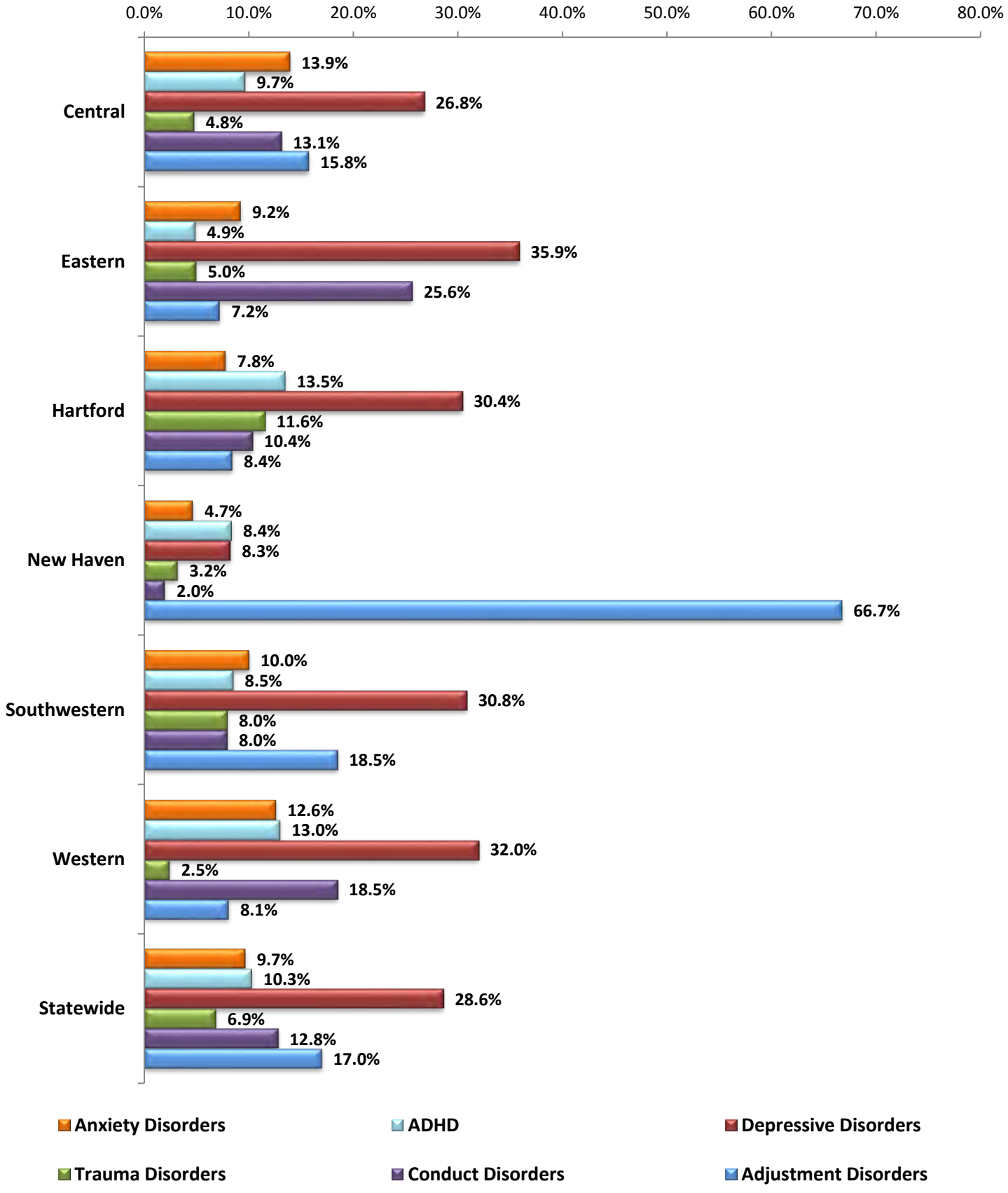


Figure 30. Top 6 Client Secondary Diagnostic Categories at Intake by Service Area

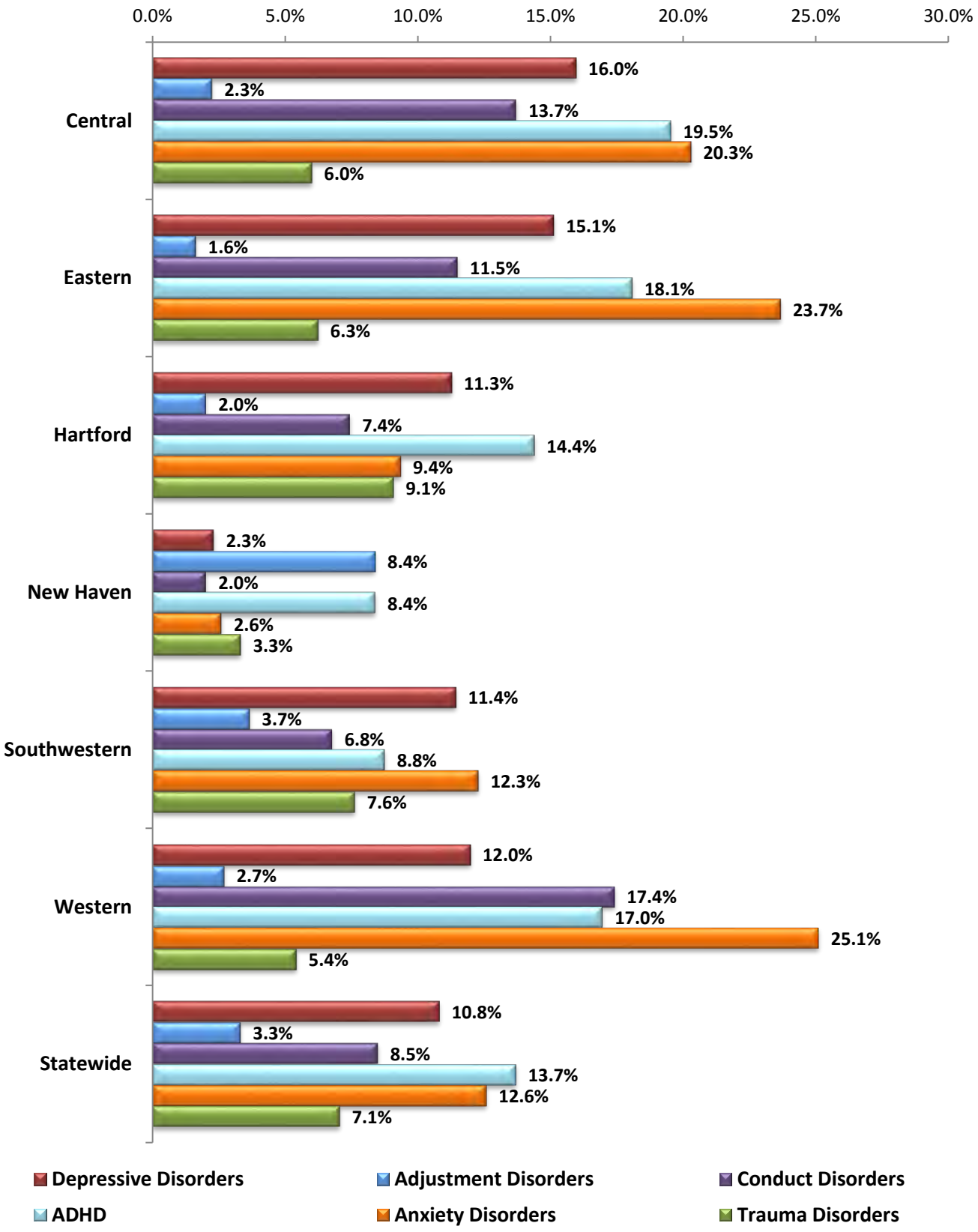


Figure 31. Children Meeting SED* Criteria by Service Area

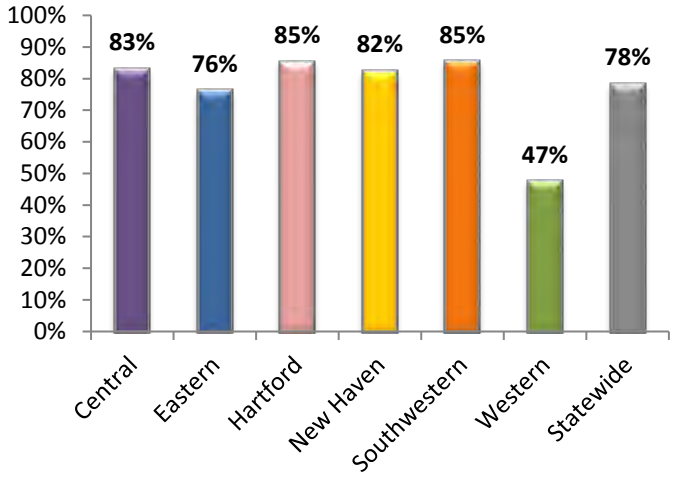


Figure 32. Children with Trauma Exposure Reported at Intake by Service Area

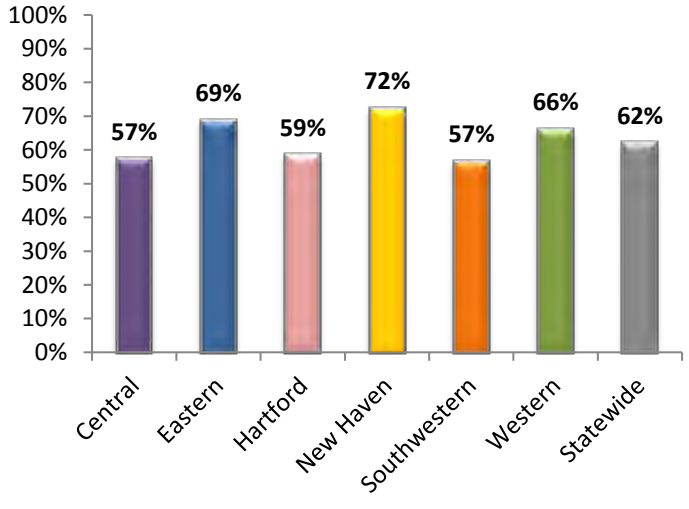


Figure 33. Type of Trauma Reported at Intake by Service Area

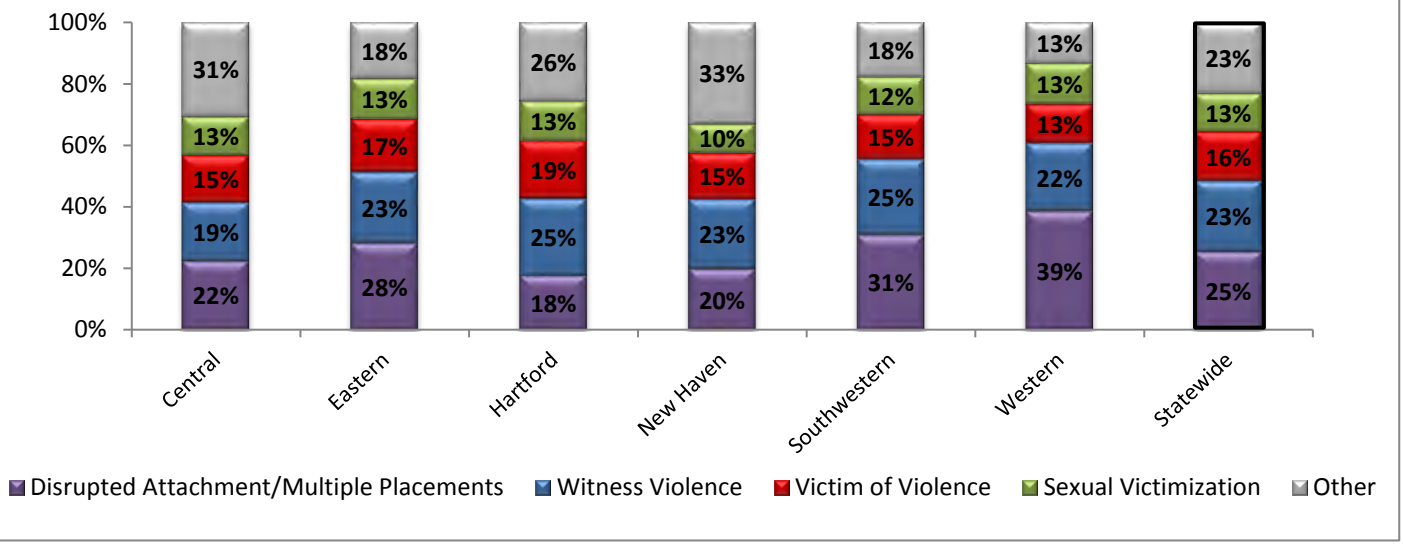


Figure 34. Clients Evaluated in an Emergency Dept. One or More Times in the Six Months Prior and During an Episode of Care

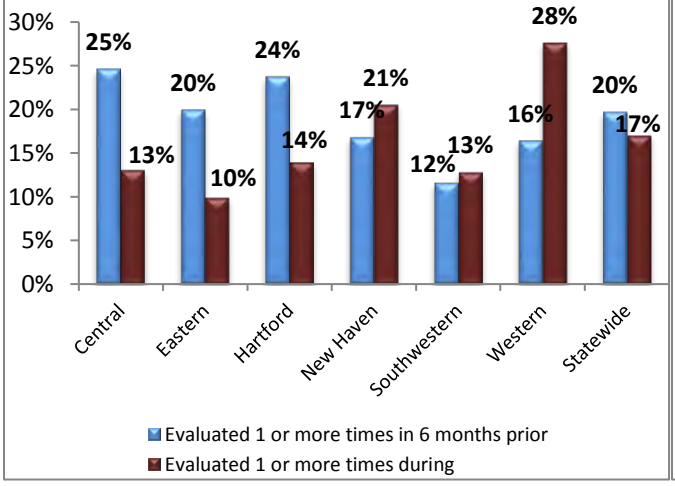


Figure 35. Clients Admitted to a Hospital (Inpatient) for Psychiatric or Behavioral Health Reasons One or More Times in His/Her Lifetime, in Six Months Prior and During the Episode of Care

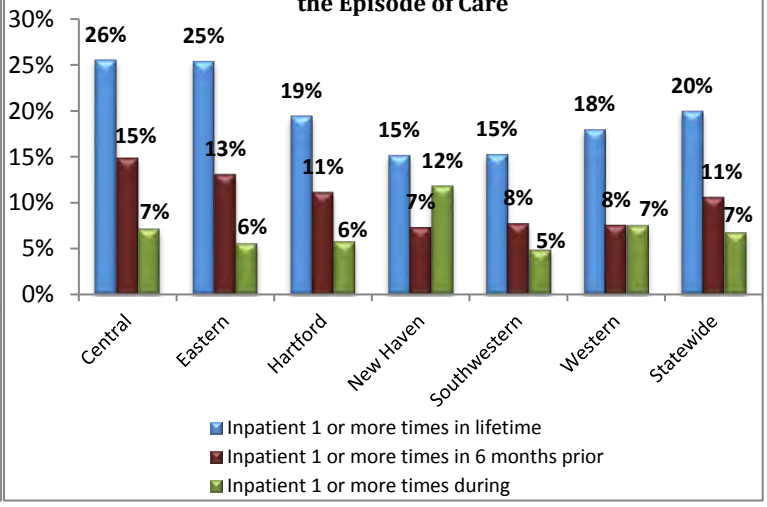


Figure 36. Clients Placed in an Out of Home Setting One or More Times in His/Her Lifetime and in the Six Months Prior to the Episode of Care

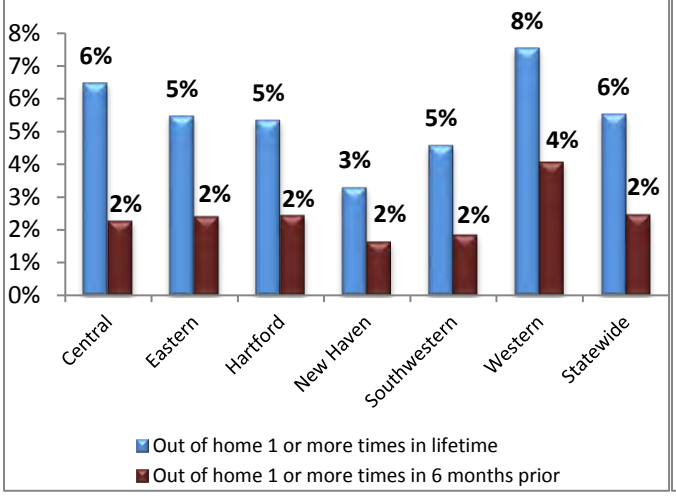


Figure 37. Clients Reported Problems with Alcohol and/or Drugs in His/Her Lifetime, in Six Months Prior to and During the Episode of Care

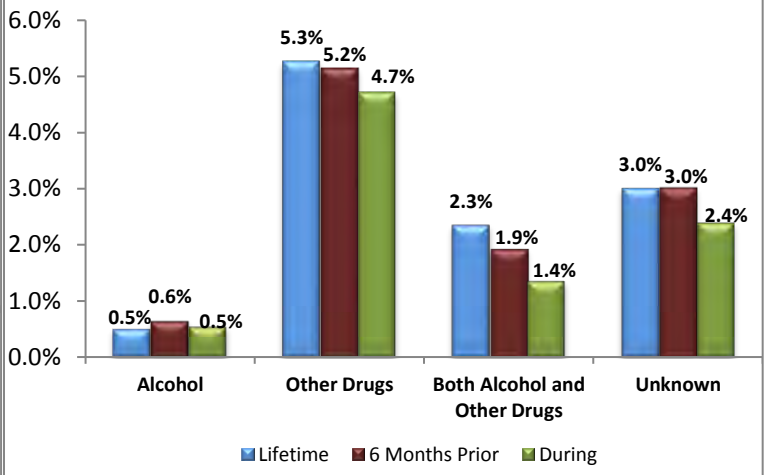


Figure 38. Type of Parent/Guardian Service Need Statewide

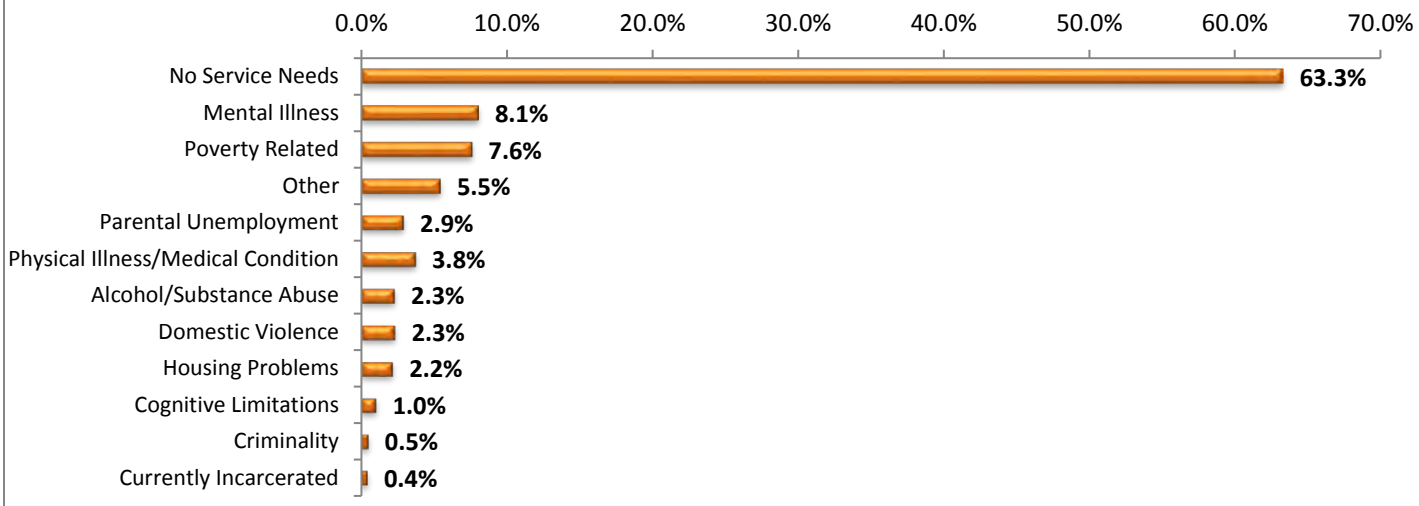


Figure 39. How Capable of Dealing with the Child's Problem Does the Parent/Guardian Feel at Intake and Discharge Statewide

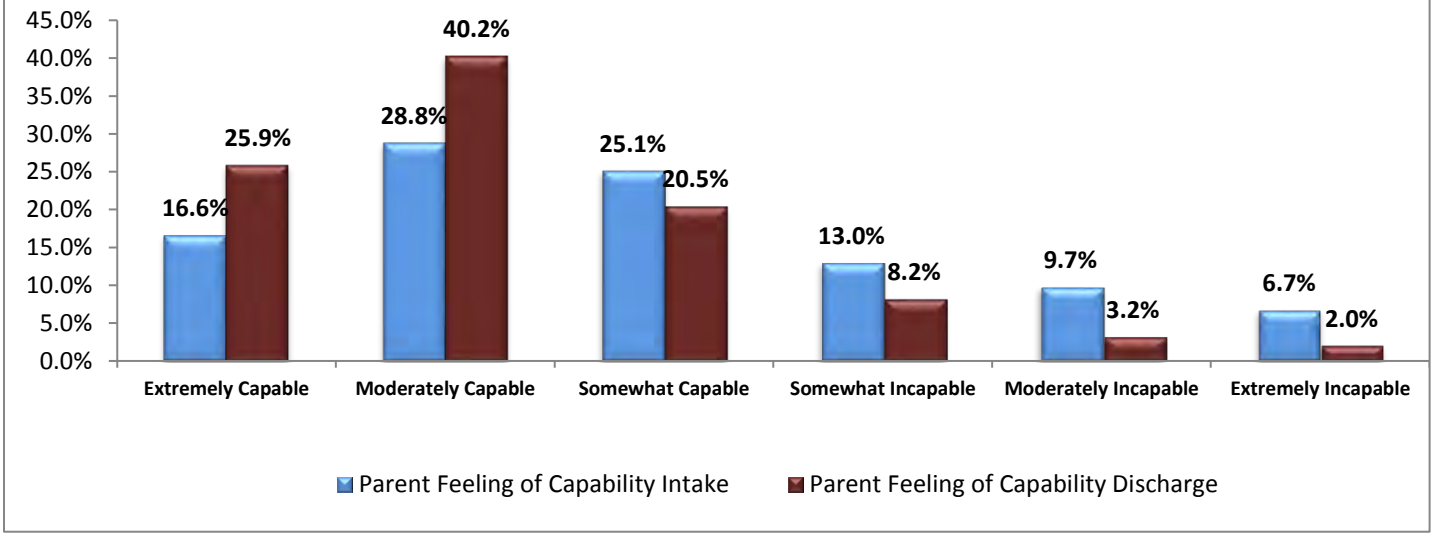


Figure 40. Client's Suspended or Expelled from School in the Six Months Prior to and During the Episode of Care

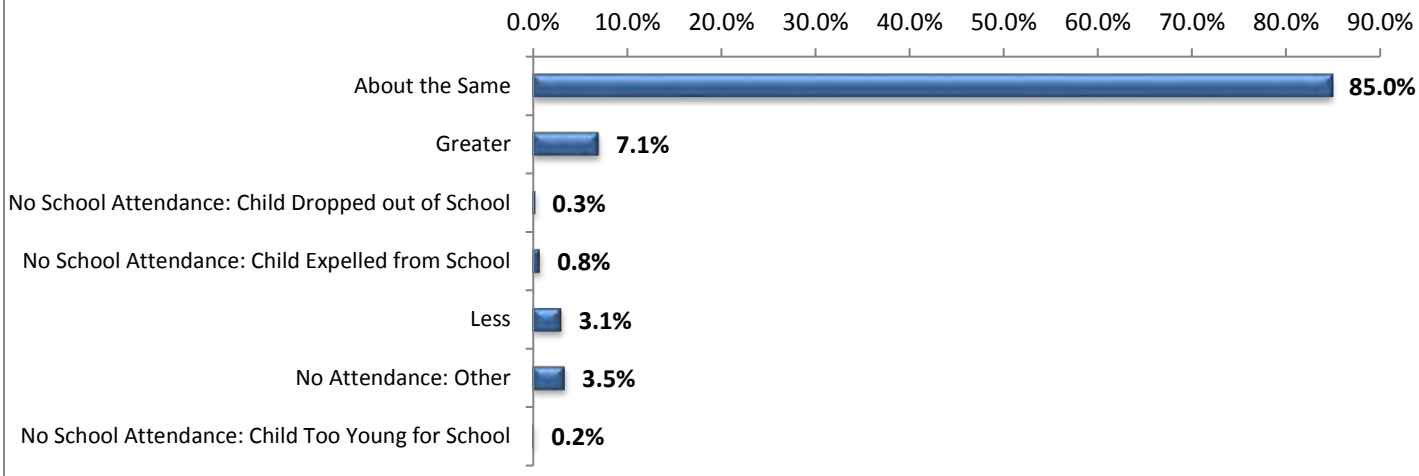


Figure 41. Statewide Parent/Guardian Rating of Client's Attendance at School During the Episode of Care (compared to pre-admission)

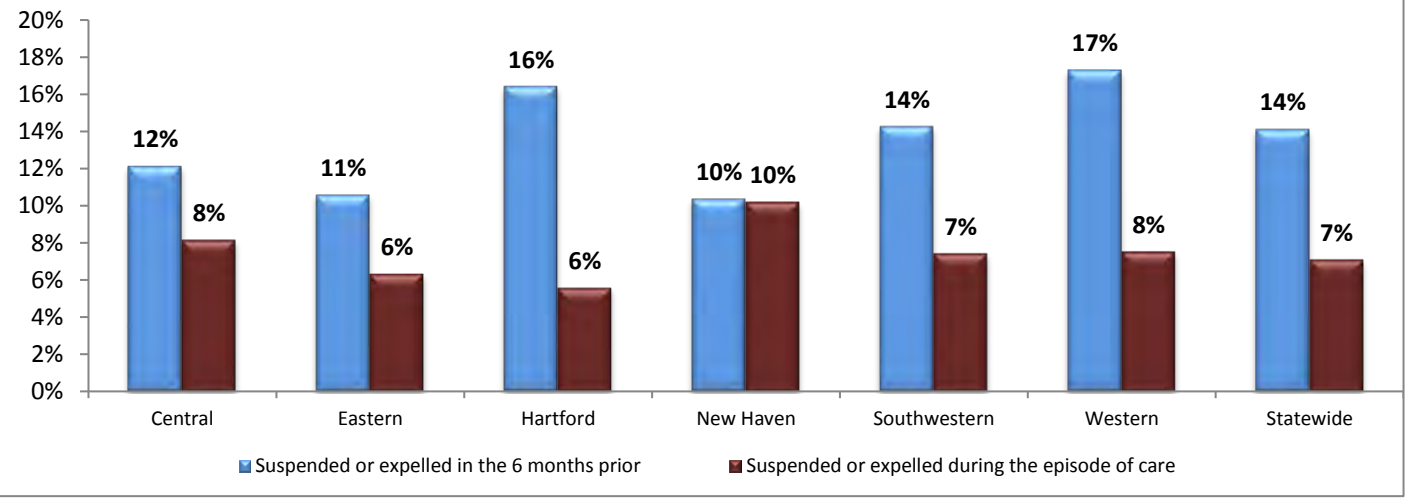


Figure 42. School Issues at Intake that have a Negative Impact on Client's Functioning at School by Service Area

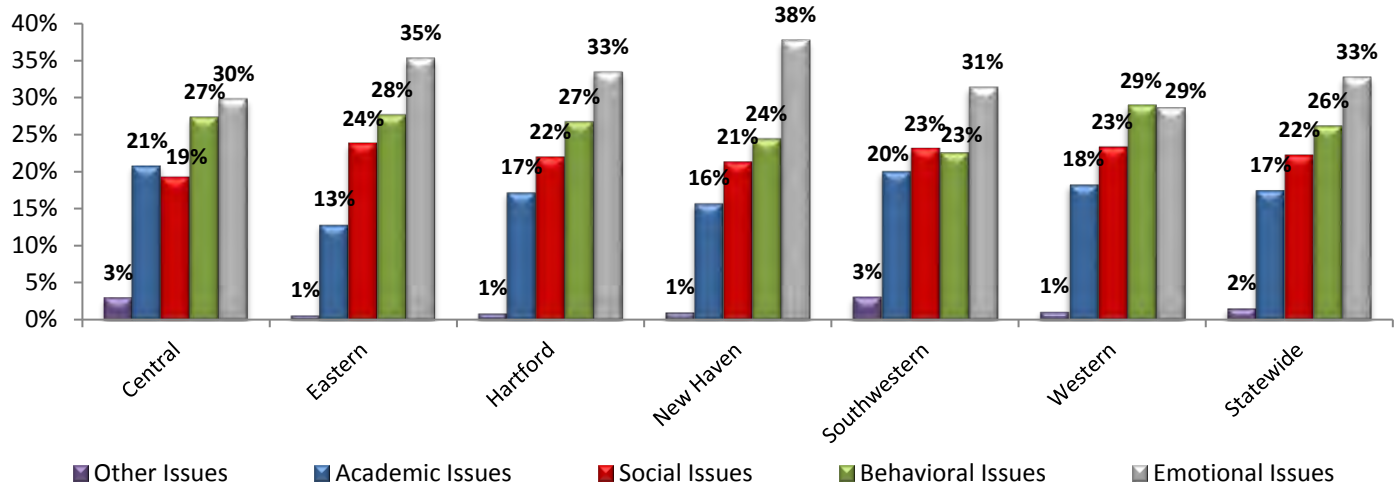
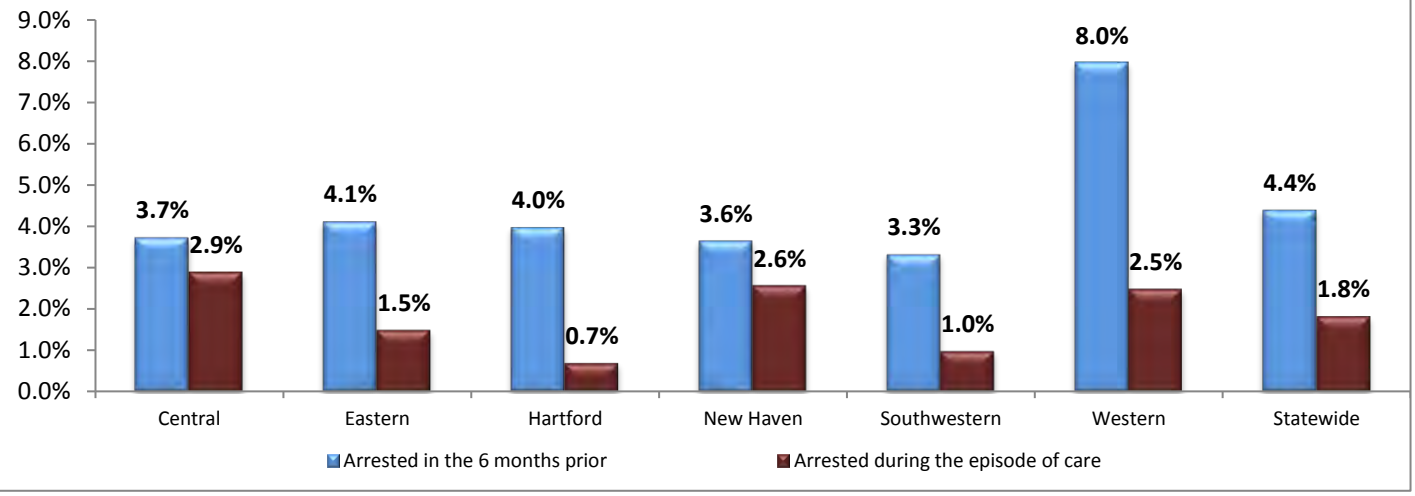
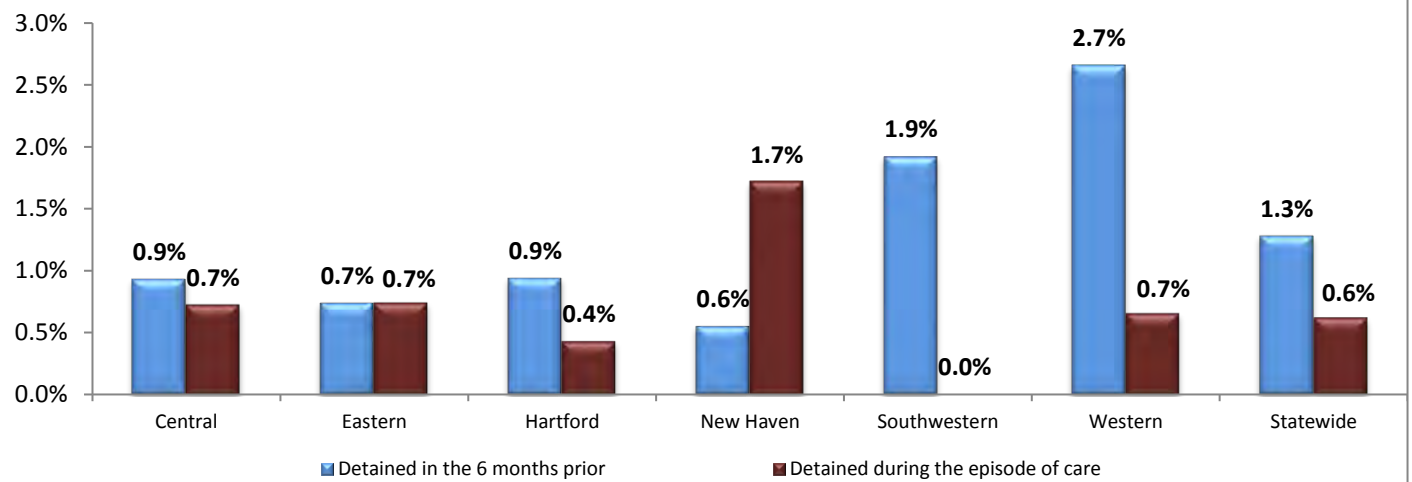


Figure 43. Clients Arrested* in the Six Months Prior to and During the Episode of Care



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

Figure 44. Clients Detained in the Six Months Prior to and During the Episode of Care**



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

Section VI: Referral Sources

Figure 45. Referral Sources Statewide

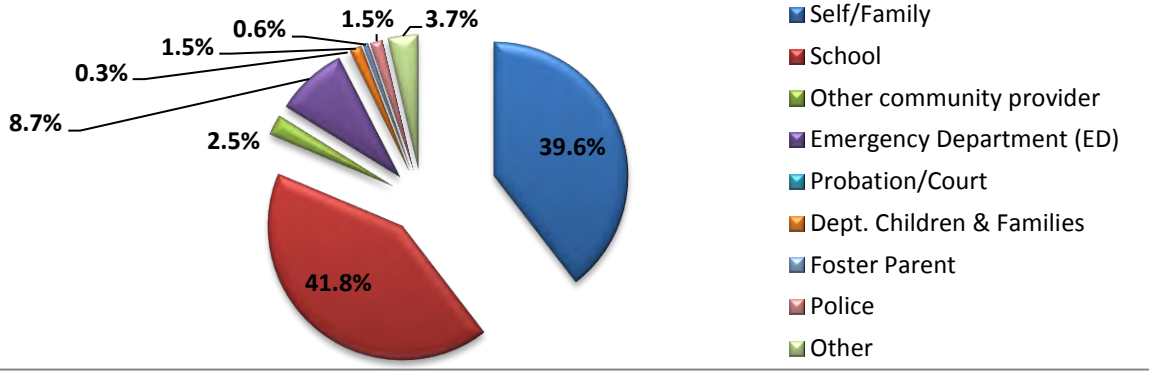
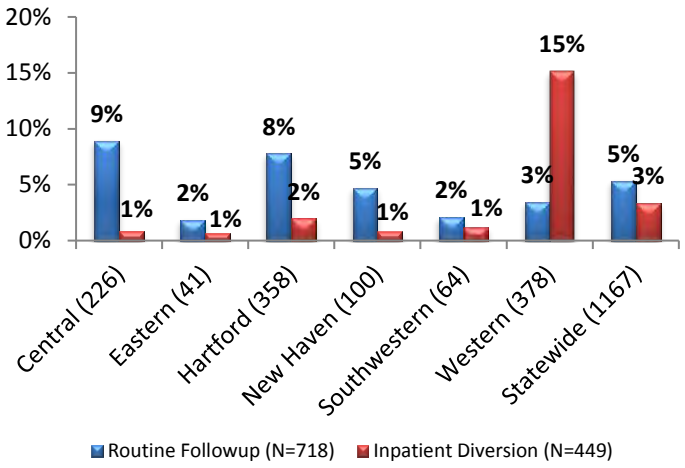


Table 1. Referral Sources (FY 2017)

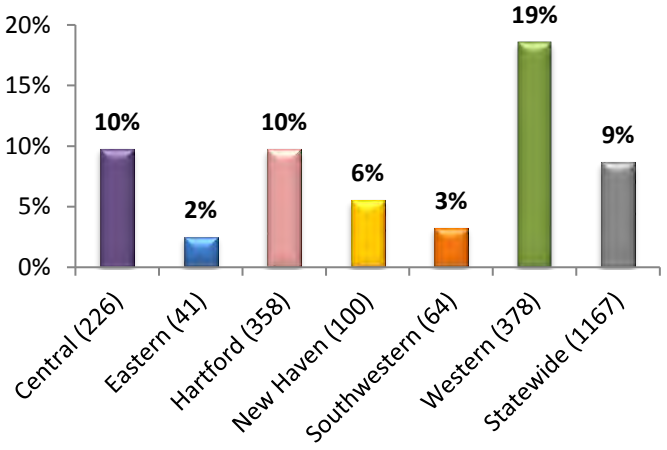
	Self/ Family	Family Adv.	School	Info-Line (211)	Other Prog. w/in Agency	Other Comm. Provider	Emer Dept. (ED)	Prob. or Court	Dept. of Child & Families (DCF)	Psych Hospital	Cong. Care Facility	Foster Parent	Police	Phys.	Comm. Nat. Supp.	Other State Agency
STATEWIDE	39.6%	0.2%	41.8%	0.0%	0.5%	2.5%	8.7%	0.3%	1.5%	1.8%	0.3%	0.6%	1.5%	0.6%	0.1%	0.1%
CENTRAL	39.5%	0.2%	33.1%	0.0%	0.4%	3.0%	9.8%	0.1%	1.3%	3.0%	0.4%	0.9%	7.3%	0.7%	0.1%	0.2%
CHR/MiddHosp-EMPS	41.9%	0.0%	36.9%	0.0%	0.7%	2.7%	12.8%	0.2%	1.3%	1.2%	0.7%	0.3%	0.2%	0.8%	0.3%	0.0%
CHR-EMPS	38.6%	0.2%	31.8%	0.1%	0.4%	3.1%	8.7%	0.1%	1.3%	3.7%	0.3%	1.1%	9.9%	0.6%	0.1%	0.2%
EASTERN	49.5%	0.1%	39.8%	0.0%	0.7%	2.0%	2.5%	0.2%	1.7%	1.1%	0.5%	1.0%	0.2%	0.5%	0.2%	0.0%
UCFS-EMPS:NE	53.8%	0.2%	35.7%	0.0%	0.6%	1.8%	2.0%	0.5%	2.1%	1.4%	0.0%	1.2%	0.0%	0.6%	0.2%	0.0%
UCFS-EMPS:SE	46.6%	0.1%	42.5%	0.0%	0.8%	2.1%	2.8%	0.0%	1.4%	0.9%	0.8%	0.8%	0.3%	0.5%	0.3%	0.0%
HARTFORD	37.5%	0.2%	41.6%	0.1%	0.7%	3.1%	9.7%	0.3%	1.6%	3.4%	0.4%	0.4%	0.1%	0.6%	0.1%	0.1%
Wheeler-EMPS:Htfd	28.1%	0.3%	47.9%	0.0%	0.3%	4.0%	11.3%	0.4%	1.1%	4.7%	0.3%	0.3%	0.1%	0.7%	0.2%	0.1%
Wheeler-EMPS:Meridn	40.2%	0.0%	46.2%	0.2%	1.0%	2.8%	6.9%	0.0%	1.4%	0.2%	0.0%	0.6%	0.0%	0.2%	0.2%	0.2%
Wheeler-EMPS:NBrit	44.7%	0.2%	35.0%	0.1%	0.8%	2.5%	9.2%	0.3%	2.2%	3.2%	0.7%	0.4%	0.2%	0.6%	0.1%	0.0%
NEW HAVEN	42.3%	0.2%	46.4%	0.0%	0.4%	1.7%	5.5%	0.3%	1.0%	0.2%	0.0%	0.6%	0.3%	0.9%	0.1%	0.1%
CliffBeers-EMPS	42.3%	0.2%	46.4%	0.0%	0.4%	1.7%	5.5%	0.3%	1.0%	0.2%	0.0%	0.6%	0.3%	0.9%	0.1%	0.1%
SOUTHWESTERN	41.2%	0.1%	48.6%	0.0%	0.6%	2.1%	3.3%	0.2%	2.0%	0.2%	0.1%	0.7%	0.7%	0.3%	0.2%	0.0%
CFGC/South-EMPS	39.3%	0.2%	52.9%	0.0%	1.2%	1.7%	1.4%	0.2%	1.4%	0.0%	0.0%	0.3%	1.1%	0.5%	0.2%	0.0%
CFGC-EMPS:Nrwlk	42.3%	0.0%	45.9%	0.0%	0.2%	1.9%	3.6%	0.2%	3.4%	0.5%	0.2%	0.5%	1.0%	0.2%	0.0%	0.0%
CFGC-EMPS	42.0%	0.1%	46.7%	0.0%	0.2%	2.6%	4.5%	0.1%	1.8%	0.1%	0.0%	1.1%	0.2%	0.2%	0.2%	0.0%
WESTERN	31.3%	0.2%	42.9%	0.0%	0.5%	2.1%	18.6%	0.5%	1.0%	0.9%	0.6%	0.4%	0.3%	0.4%	0.2%	0.1%
Well-EMPS:Dnby	46.2%	0.9%	46.2%	0.0%	0.3%	0.9%	1.5%	0.6%	1.2%	0.6%	0.0%	0.0%	0.9%	0.9%	0.0%	0.0%
Well-EMPS:Torr	37.7%	0.0%	44.2%	0.0%	0.3%	4.7%	5.3%	0.6%	0.9%	2.6%	2.0%	0.6%	0.0%	0.6%	0.6%	0.0%
Well-EMPS:Wtby	25.9%	0.1%	41.7%	0.0%	0.6%	1.7%	26.3%	0.4%	1.0%	0.5%	0.4%	0.5%	0.2%	0.3%	0.1%	0.1%

Figure 46. Type of Emergency Dept. Referral by Service Area (N = 1,167)



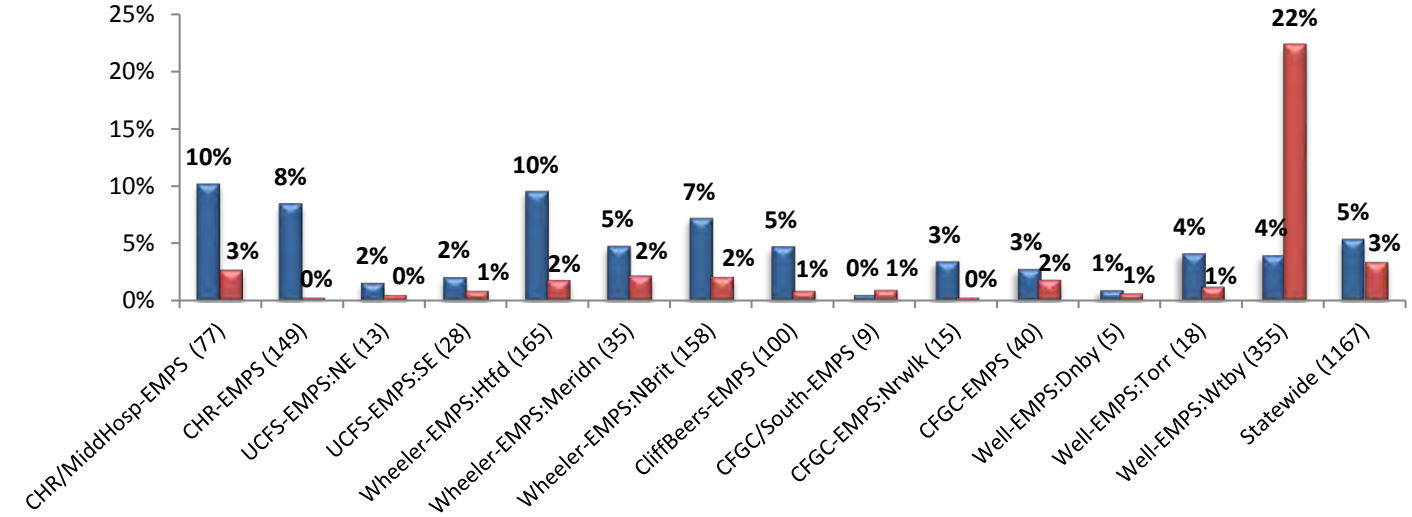
Note: Count total ED referrals are in parenthesis

Figure 47. Emergency Dept. Referral by Service Area (% of Total Mobile Crisis Episodes)



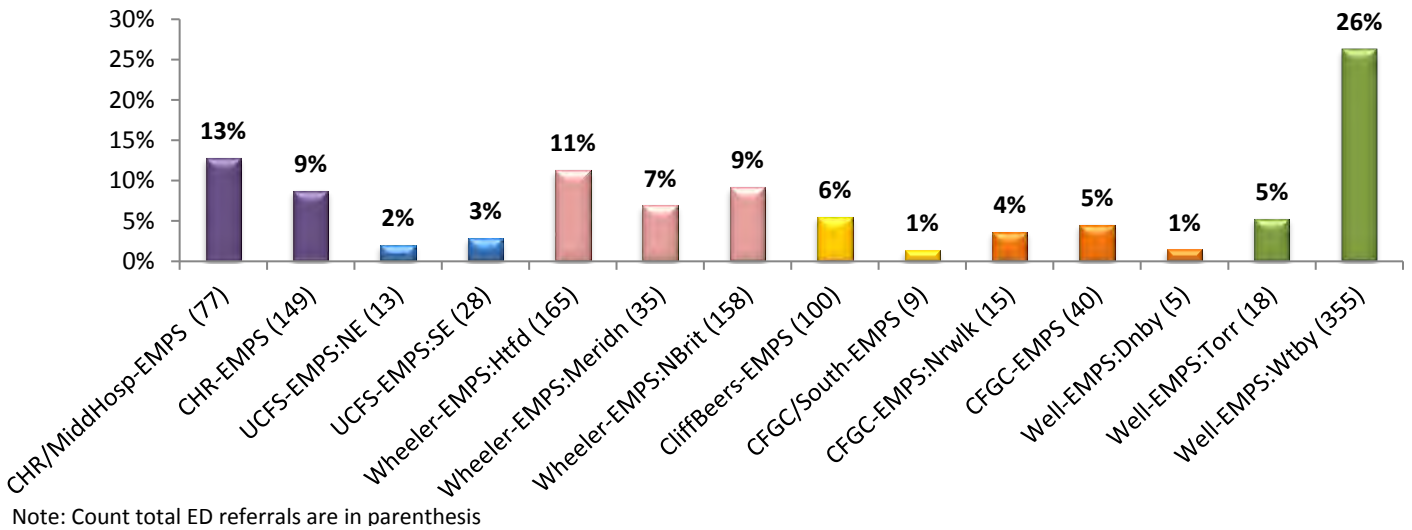
Note: Count total ED referrals are in parenthesis

Figure 48. Type of Emergency Department Referrals by Provider



Note: Count total ED referrals are in parenthesis

Figure 49. Emergency Dept. Referral (% of Total EMPS Episodes) by Provider



Note: Count total ED referrals are in parenthesis

Section VII: 211 Recommendations and Mobile Crisis Response

Figure 50. 211 Recommended Initial Response

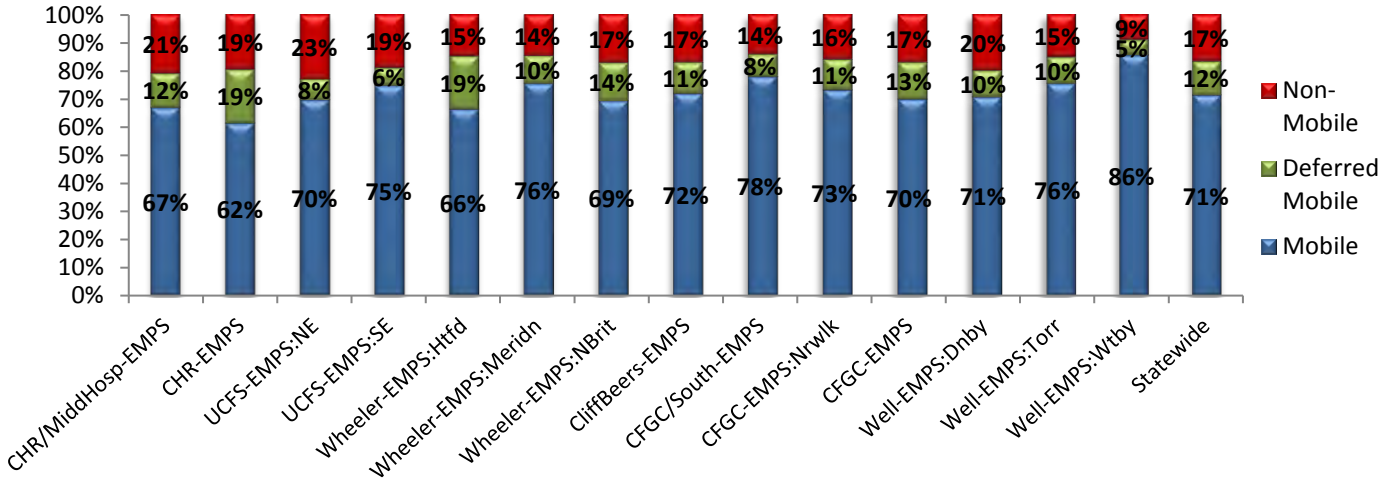


Figure 51. Actual Initial Mobile Crisis Provider Response

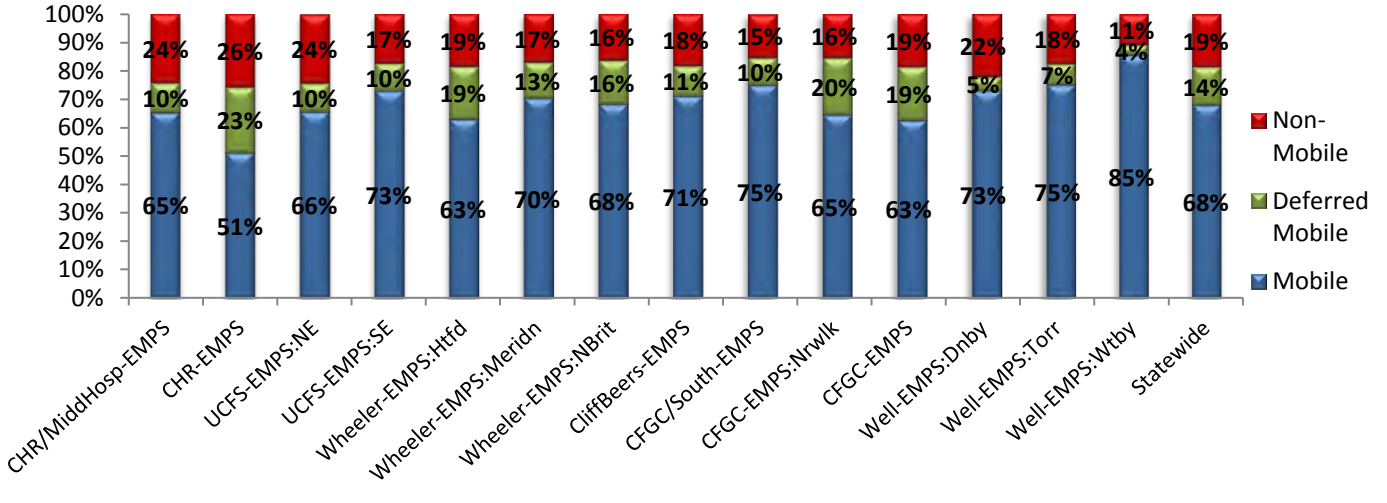


Figure 52. 211 Recommended <u>Mobile</u> Response Where Actual Mobile Crisis Response was Non-Mobile or Deferred Mobile

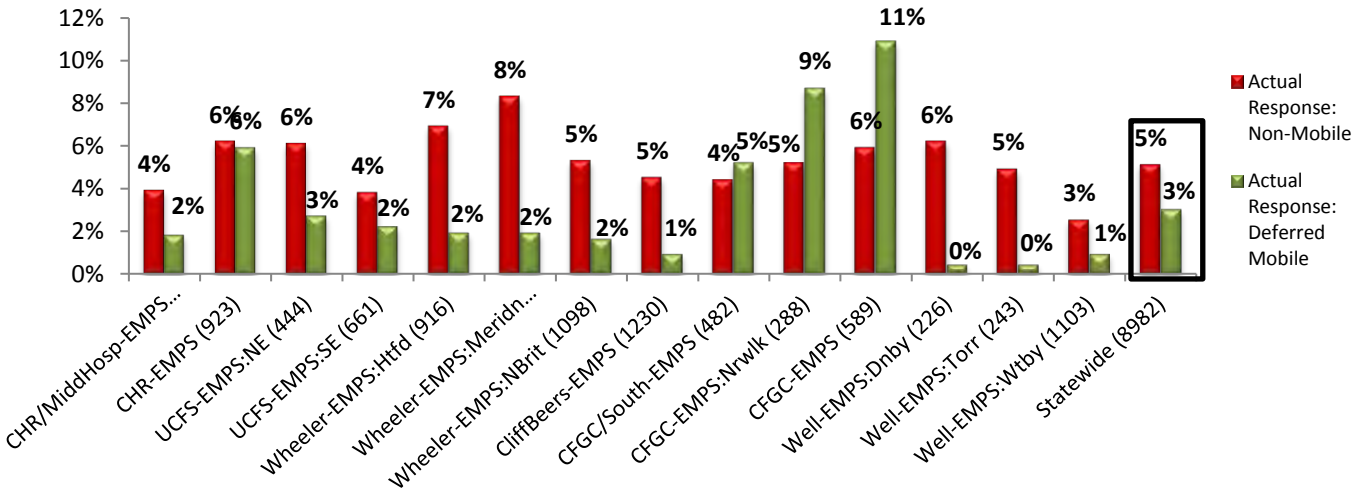


Figure 53. 211 Recommended Non-Mobile Response Where Actual Mobile Crisis Response was Mobile or Deferred Mobile

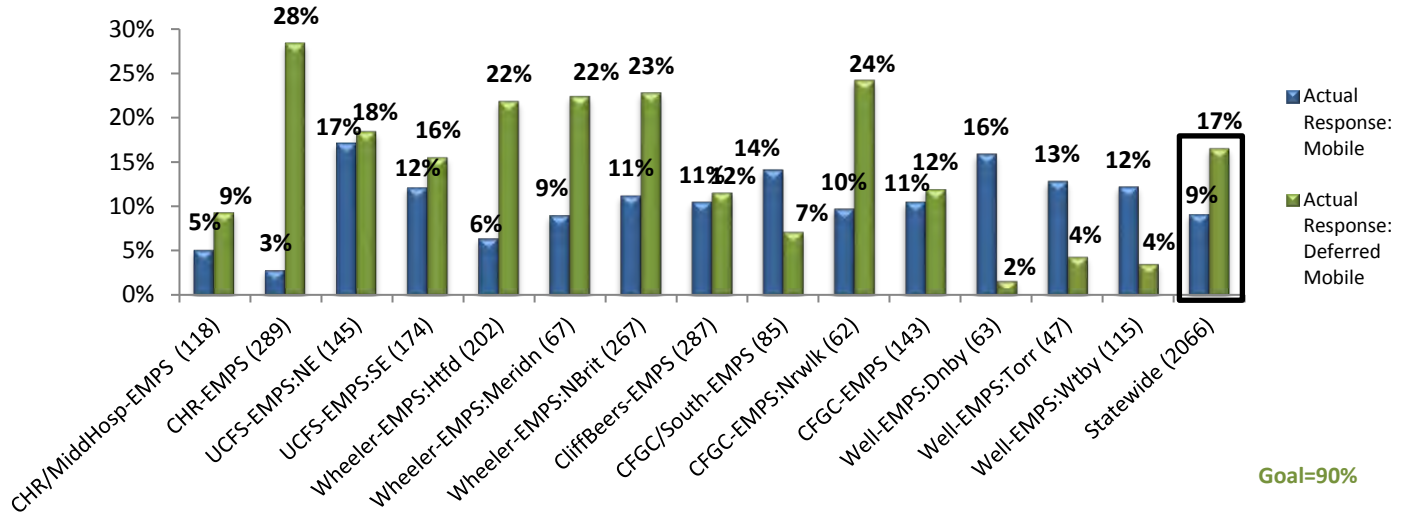


Figure 54. Mobile Response (Mobile & Deferred Mobile) By Service Area

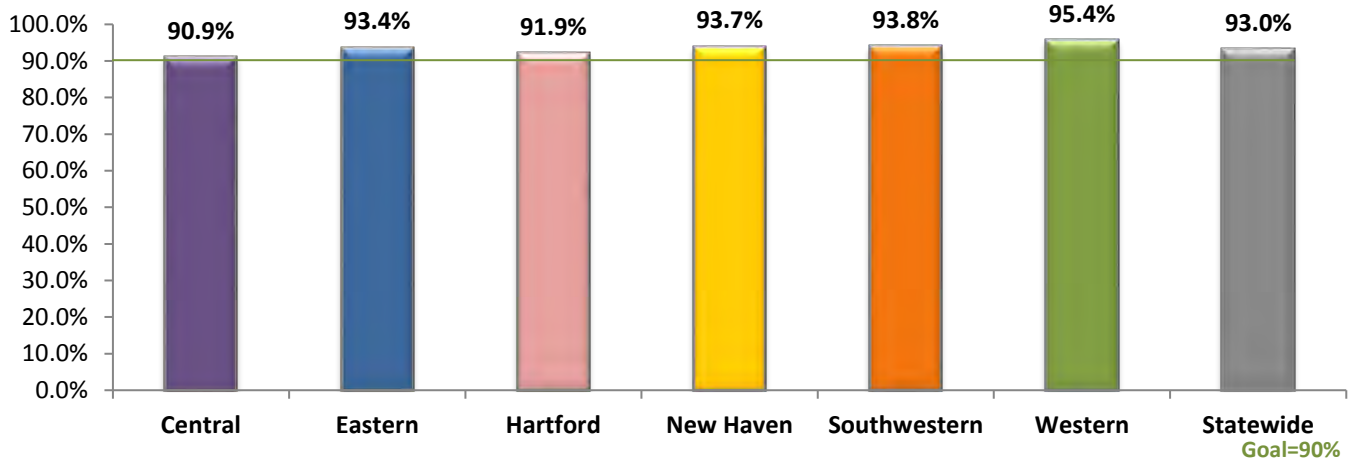


Figure 55. Mobile Response (Mobile & Deferred Mobile) By Provider

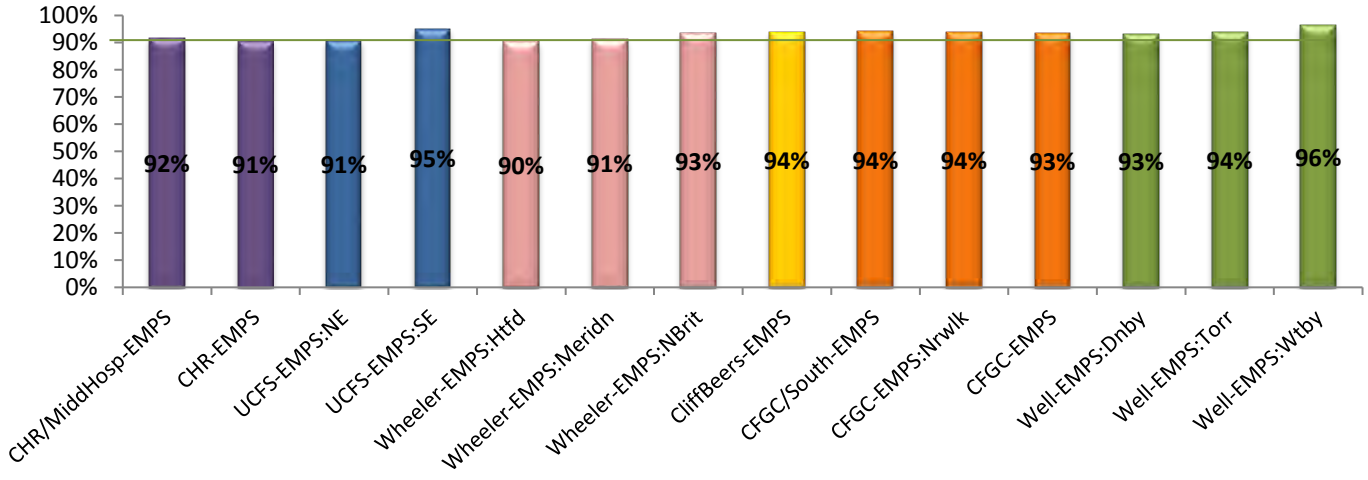


Figure 56. Mobile Crisis First Contact Mobile Site by Service Area

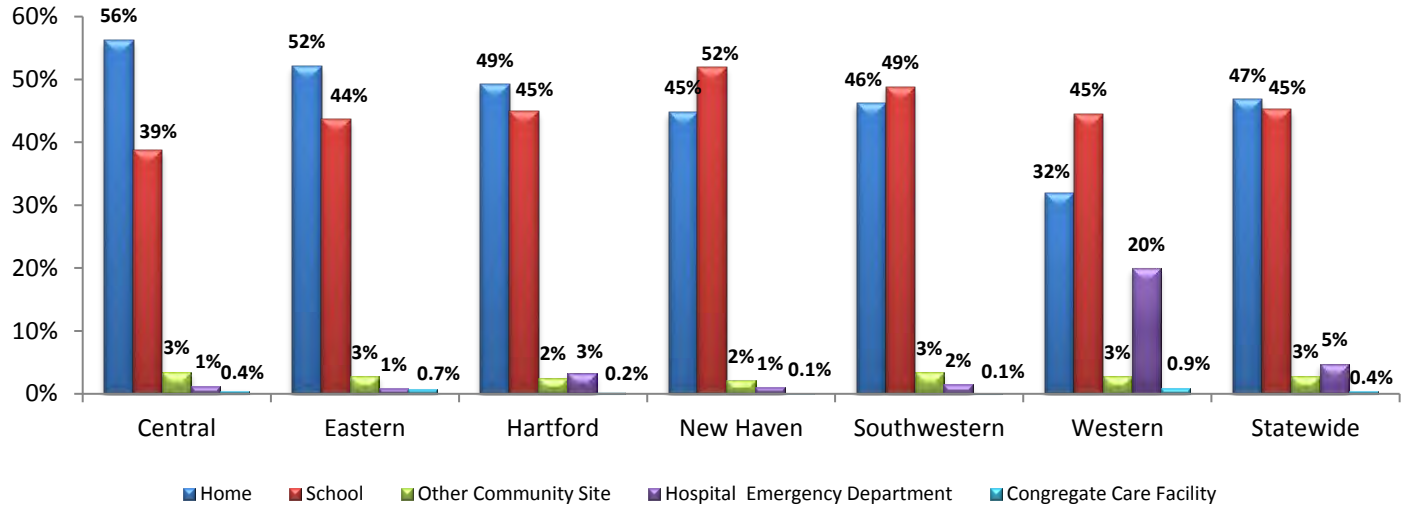
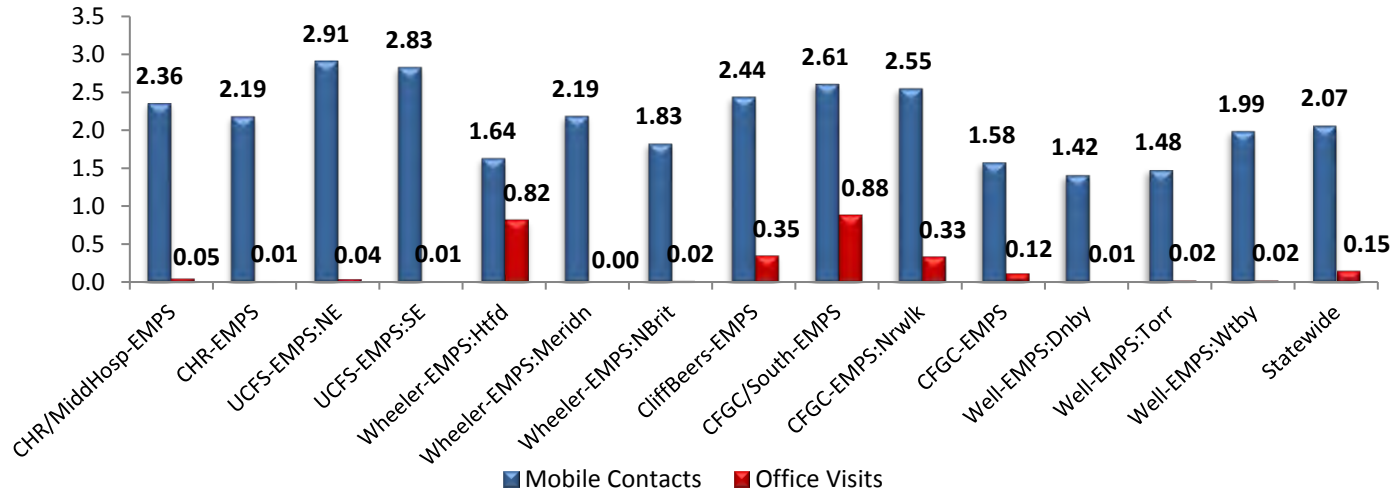


Figure 57. Mean Number of Mobile Contacts and Office Visits During an Episode of Care by Provider



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

Figure 58. Mobile Crisis Non-Mobile Reason by Service Area

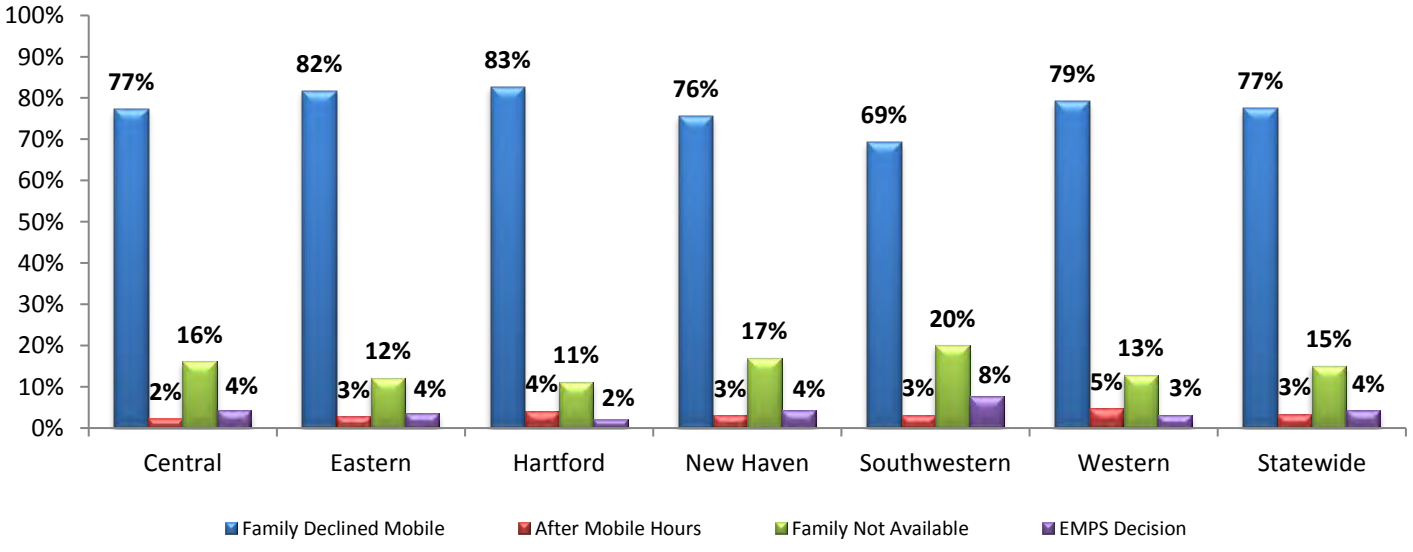


Figure 59. Mobile Crisis First Contact Non-Mobile Site by Provider

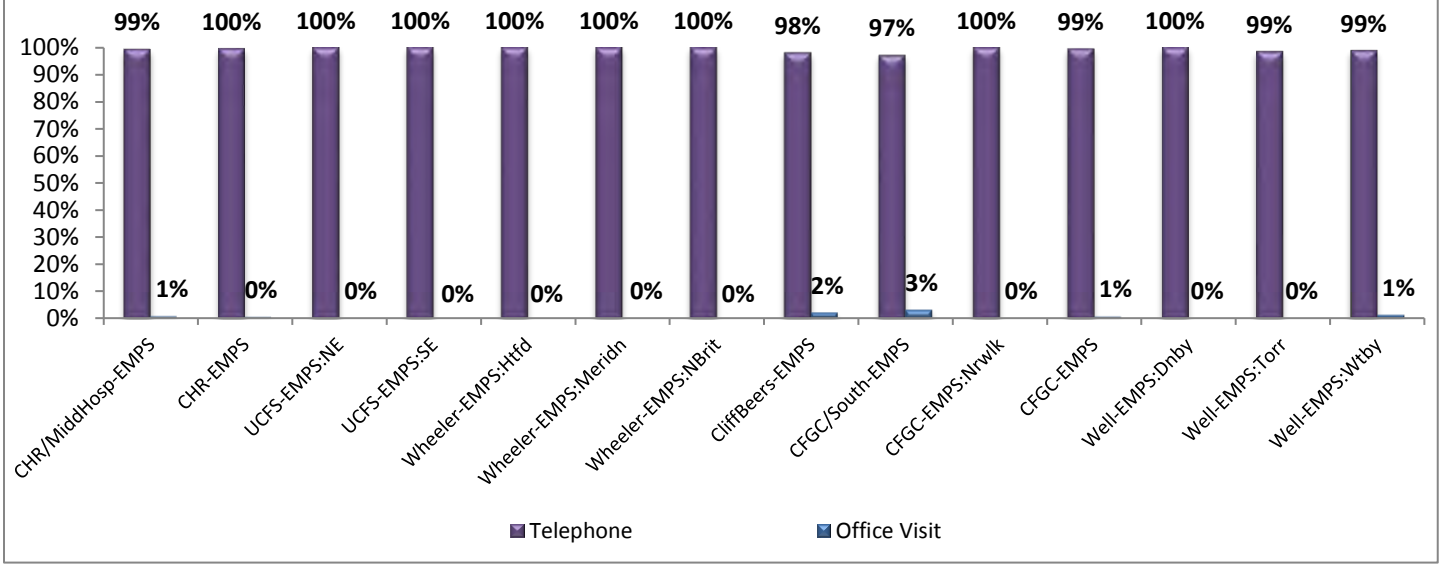
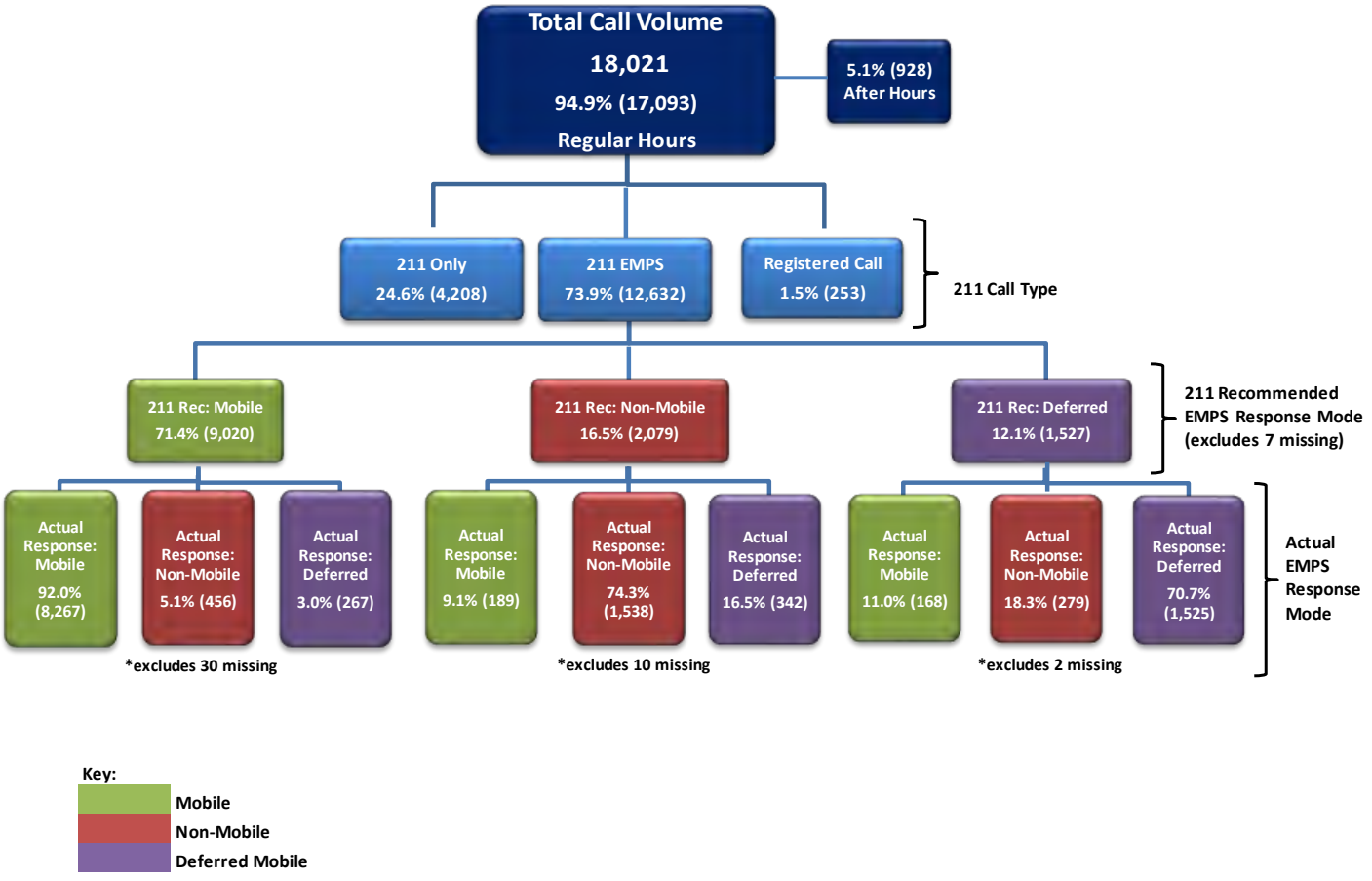
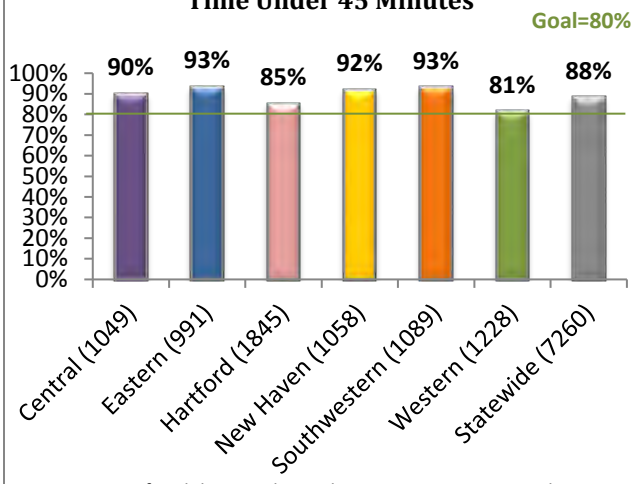


Figure 60. Breakdown of Call Volume by Call Type and Response Mode



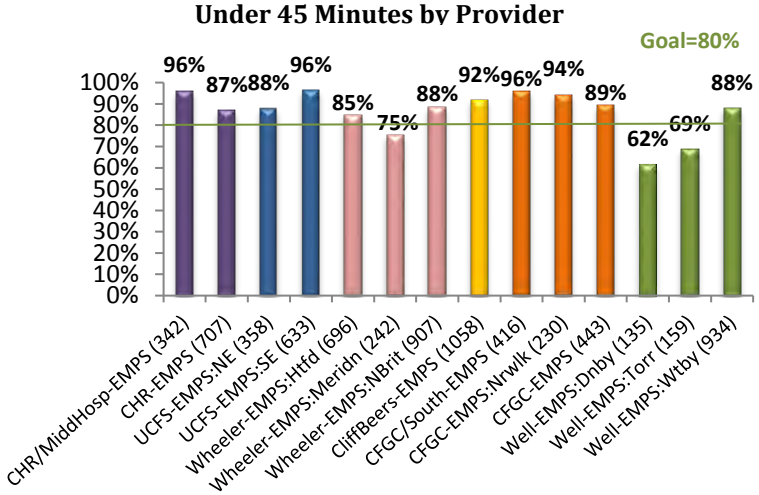
Section VIII: Response Time

Figure 61. Total Mobile Episodes with a Response Time Under 45 Minutes



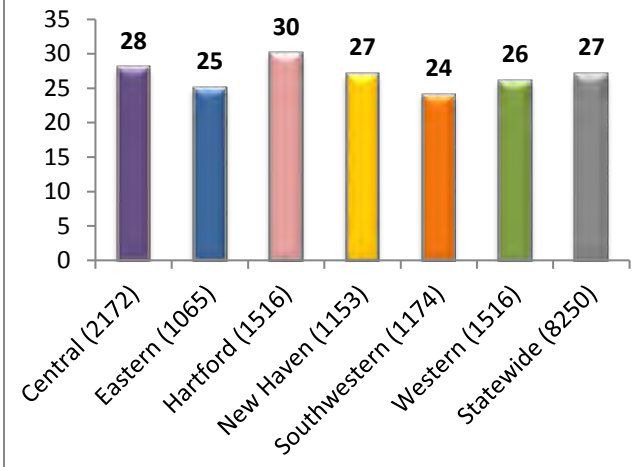
Note: Count of mobile episodes under 45 mins. are in parenthesis

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



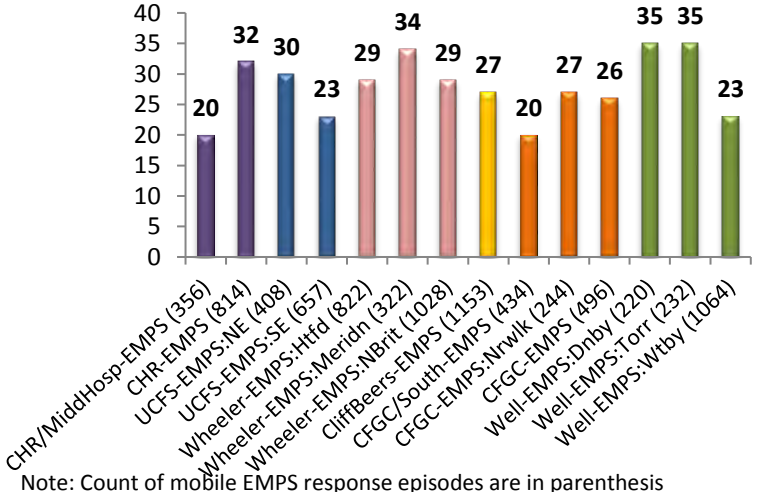
Note: Count of mobile episodes under 45 mins. are in parenthesis

Figure 63. Median Mobile Response Time by Service Area in Minutes



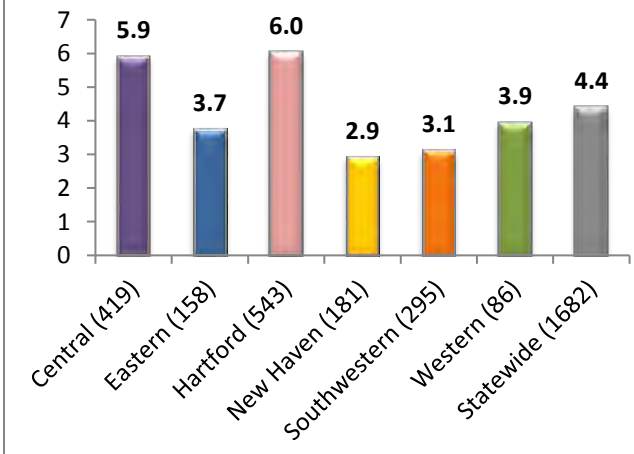
Note: Count of mobile EMPS response episodes are in parenthesis

Figure 64. Median Mobile Response Time by Provider in Minutes



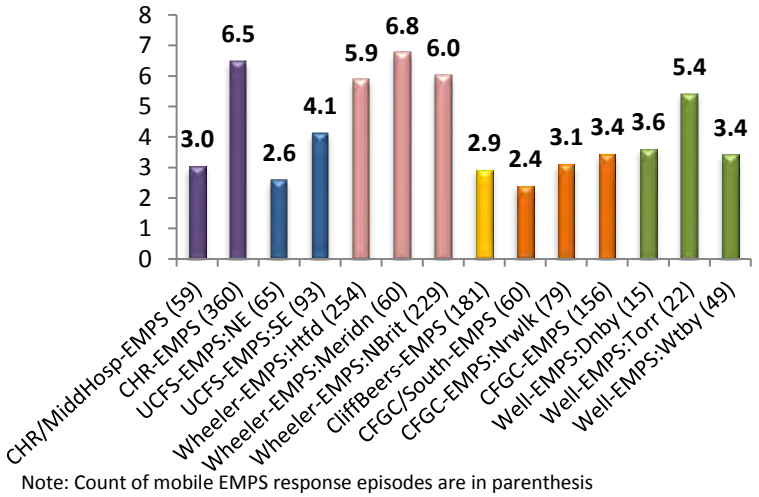
Note: Count of mobile EMPS response episodes are in parenthesis

Figure 65. Median Deferred Mobile Response Time by Service Area in Hours



Note: Count of mobile EMPS response episodes are in parenthesis

Figure 66. Median Deferred Mobile Response Time by Provider in Hours



Note: Count of mobile EMPS response episodes are in parenthesis

Section IX: 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 Current Reporting Period									***N of Discharged Episodes for FY2016***					
		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.	LOS: Phone	LOS: FTF	LOS: Stab.
1	**STATEWIDE**	**1.5**	**8.1**	**21.1**	**0.0**	**3.0**	**17.0**	**16%**	**37%**	**8%**	**2915**	**5554**	**4179**	**454**	**2076**	**314**
2	**Central**	**2.4**	**9.2**	**24.4**	**1.0**	**3.0**	**19.0**	**30%**	**42%**	**12%**	**647**	**725**	**858**	**197**	**308**	**102**
3	**CHR/MiddHosp-EMPS**	**3.6**	**4.1**	**14.2**	**2.0**	**2.0**	**12.0**	**58%**	**22%**	**1%**	**179**	**224**	**193**	**103**	**49**	**1**
4	**CHR-EMPS**	**2.0**	**11.5**	**27.4**	**1.0**	**6.0**	**21.0**	**20%**	**52%**	**15%**	**468**	**501**	**665**	**94**	**259**	**101**
5	**Eastern**	**0.2**	**2.3**	**21.7**	**0.0**	**2.0**	**19.0**	**4%**	**1%**	**4%**	**393**	**977**	**265**	**15**	**13**	**10**
6	**UCFS-EMPS:NE**	**0.1**	**2.2**	**22.2**	**0.0**	**2.0**	**19.5**	**3%**	**1%**	**5%**	**184**	**363**	**104**	**5**	**4**	**5**
7	**UCFS-EMPS:SE**	**0.2**	**2.4**	**21.4**	**0.0**	**2.0**	**18.0**	**5%**	**1%**	**3%**	**209**	**614**	**161**	**10**	**9**	**5**
8	**Hartford**	**1.5**	**11.4**	**17.8**	**0.0**	**7.0**	**15.0**	**14%**	**56%**	**5%**	**720**	**1369**	**1251**	**104**	**769**	**57**
9	**Wheeler-EMPS:Htfd**	**1.7**	**12.0**	**18.9**	**1.0**	**7.0**	**15.0**	**17%**	**56%**	**6%**	**295**	**575**	**341**	**50**	**323**	**22**
10	**Wheeler-EMPS:Meridn**	**2.2**	**7.7**	**18.2**	**0.0**	**5.0**	**15.0**	**12%**	**45%**	**5%**	**98**	**149**	**244**	**12**	**67**	**11**
11	**Wheeler-EMPS:NBrit**	**1.1**	**11.8**	**17.1**	**0.0**	**7.0**	**14.0**	**13%**	**59%**	**4%**	**327**	**645**	**666**	**42**	**379**	**24**
12	**New Haven**	**0.2**	**7.9**	**28.4**	**0.0**	**3.0**	**26.0**	**5%**	**43%**	**15%**	**352**	**1124**	**302**	**16**	**481**	**46**
13	**CliffBeers-EMPS**	**0.2**	**7.9**	**28.4**	**0.0**	**3.0**	**26.0**	**13%**	**43%**	**15%**	**352**	**1124**	**302**	**16**	**481**	**46**
14	**Southwestern**	**0.6**	**8.3**	**21.0**	**0.0**	**1.0**	**21.0**	**6%**	**38%**	**1%**	**376**	**1050**	**439**	**24**	**397**	**6**
15	**CFGC/South-EMPS**	**0.4**	**0.5**	**18.1**	**0.0**	**0.0**	**13.0**	**3%**	**2%**	**3%**	**128**	**403**	**120**	**4**	**7**	**4**
16	**CFGC-EMPS:Nrwlk**	**0.8**	**12.9**	**26.7**	**0.0**	**8.0**	**28.0**	**7%**	**67%**	**1%**	**69**	**207**	**129**	**5**	**139**	**1**
17	**CFGC-EMPS**	**0.8**	**13.2**	**18.9**	**0.0**	**7.0**	**17.0**	**8%**	**57%**	**1%**	**179**	**440**	**190**	**15**	**251**	**1**
18	**Western**	**3.4**	**8.6**	**19.9**	**0.0**	**3.0**	**16.0**	**23%**	**35%**	**9%**	**427**	**309**	**1064**	**98**	**108**	**93**
19	**Well-EMPS:Dnby**	**2.6**	**13.1**	**19.9**	**0.0**	**5.0**	**15.0**	**16%**	**46%**	**7%**	**93**	**37**	**154**	**15**	**17**	**11**
20	**Well-EMPS:Torr**	**3.9**	**8.8**	**17.5**	**0.0**	**2.0**	**15.0**	**20%**	**34%**	**4%**	**83**	**50**	**163**	**17**	**17**	**7**
21	**Well-EMPS:Wtby**	**3.6**	**7.8**	**20.5**	**0.0**	**3.0**	**16.0**	**26%**	**33%**	**10%**	**251**	**222**	**747**	**66**	**74**	**75**

* Discharged episodes, as of July 10, 2016, with end dates from July 1, 2016 to June 30, 2017.

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**	**150.4**	**131.2**	**106.4**	**121.0**	**108.5**	**92.0**	**100%**	**100%**	**100%**	**91**	**326**	**337**	**91**	**326**	**337**
2	**Central**	**72.2**	**88.6**	**97.8**	**67.0**	**83.5**	**85.0**	**100%**	**100%**	**100%**	**5**	**24**	**51**	**5**	**24**	**51**
3	**CHR/MiddHosp-EMPS**	**65.0**	**72.5**	**80.0**	**65.0**	**72.5**	**80.0**	**100%**	**100%**	**1%**	**1**	**2**	**1**	**1**	**2**	**1**
4	**CHR-EMPS**	**74.0**	**90.1**	**98.1**	**68.0**	**86.0**	**85.5**	**100%**	**100%**	**100%**	**4**	**22**	**50**	**4**	**22**	**50**
5	**Eastern**	**0.0**	**86.0**	**80.4**	**0.0**	**86.0**	**87.0**		**100%**	**100%**	**0**	**1**	**5**	**0**	**1**	**5**
6	**UCFS-EMPS:NE**	**0.0**	**0.0**	**82.0**	**0.0**	**0.0**	**82.0**			**100%**	**0**	**0**	**2**	**0**	**0**	**2**
7	**UCFS-EMPS:SE**	**0.0**	**86.0**	**79.3**	**0.0**	**86.0**	**87.0**		**100%**	**100%**	**0**	**1**	**3**	**0**	**1**	**3**
8	**Hartford**	**191.8**	**149.7**	**127.5**	**182.0**	**126.0**	**109.0**	**100%**	**100%**	**100%**	**31**	**203**	**90**	**31**	**203**	**90**
9	**Wheeler-EMPS:Htfd**	**182.5**	**152.5**	**140.4**	**158.0**	**130.0**	**133.0**	**100%**	**100%**	**100%**	**21**	**167**	**55**	**21**	**167**	**55**
10	**Wheeler-EMPS:Meridn**	**239.5**	**192.7**	**92.3**	**219.5**	**176.0**	**101.0**	**100%**	**100%**	**100%**	**4**	**6**	**3**	**4**	**6**	**3**
11	**Wheeler-EMPS:NBrit**	**192.5**	**125.3**	**108.8**	**177.5**	**90.5**	**88.5**	**100%**	**100%**	**100%**	**6**	**30**	**32**	**6**	**30**	**32**
12	**New Haven**	**262.3**	**90.7**	**95.4**	**239.0**	**79.0**	**99.0**	**100%**	**100%**	**100%**	**3**	**11**	**11**	**3**	**11**	**11**
13	**CliffBeers-EMPS**	**262.3**	**90.7**	**95.4**	**239.0**	**79.0**	**99.0**	**100%**	**100%**	**100%**	**3**	**11**	**11**	**3**	**11**	**11**
14	**Southwestern**	**94.0**	**107.0**	**85.2**	**94.0**	**100.0**	**81.0**	**100%**	**100%**	**100%**	**2**	**35**	**57**	**2**	**35**	**57**
15	**CFGC/South-EMPS**	**0.0**	**0.0**	**83.3**	**0.0**	**0.0**	**84.0**			**100%**	**0**	**0**	**13**	**0**	**0**	**13**
16	**CFGC-EMPS:Nrwlk**	**0.0**	**85.7**	**74.0**	**0.0**	**94.0**	**74.0**		**100%**	**100%**	**0**	**3**	**5**	**0**	**3**	**5**
17	**CFGC-EMPS**	**94.0**	**109.0**	**87.3**	**94.0**	**101.5**	**81.0**	**100%**	**100%**	**100%**	**2**	**32**	**39**	**2**	**32**	**39**
18	**Western**	**128.2**	**104.2**	**106.5**	**104.5**	**102.0**	**93.0**	**100%**	**100%**	**100%**	**50**	**52**	**123**	**50**	**52**	**123**
19	**Well-EMPS:Dnby**	**137.8**	**96.4**	**116.3**	**110.5**	**100.0**	**110.5**	**100%**	**100%**	**100%**	**14**	**12**	**30**	**14**	**12**	**30**
20	**Well-EMPS:Torr**	**124.8**	**108.4**	**112.2**	**102.0**	**98.0**	**105.0**	**100%**	**100%**	**100%**	**10**	**5**	**30**	**10**	**5**	**30**
21	**Well-EMPS:Wtby**	**124.3**	**106.3**	**99.0**	**100.5**	**105.0**	**87.0**	**100%**	**100%**	**100%**	**26**	**35**	**63**	**26**	**35**	**63**

* Data includes episodes still in care, as of July 10, 2016, with referral dates from July 1, 2015 to June 30, 2016.

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 67. Top Six Reasons for Client Discharge Statewide

(N =13,019)

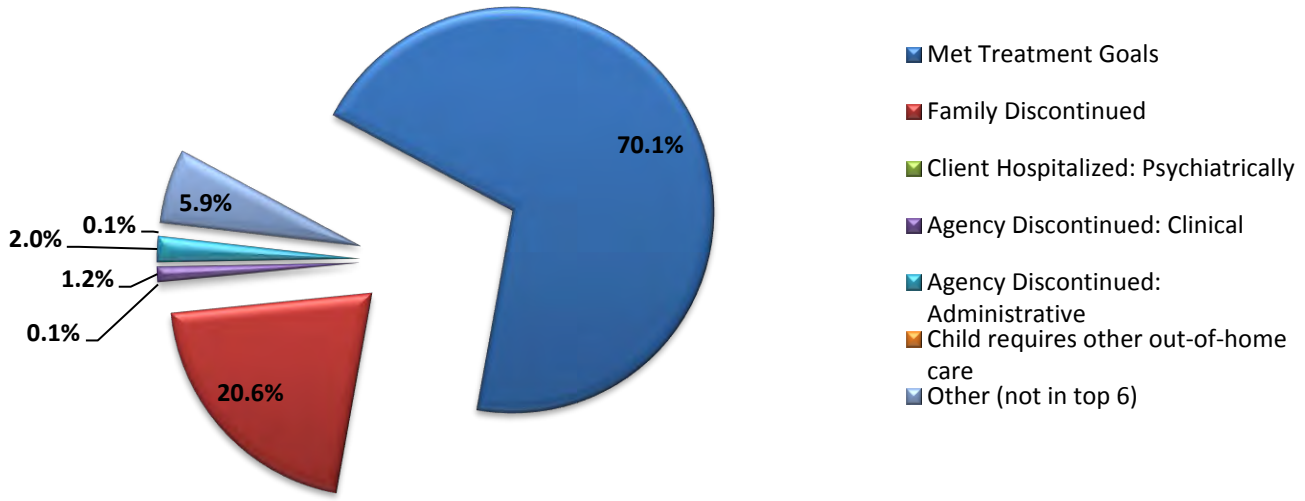


Figure 68. Top Six Places Clients Live at Discharge Statewide

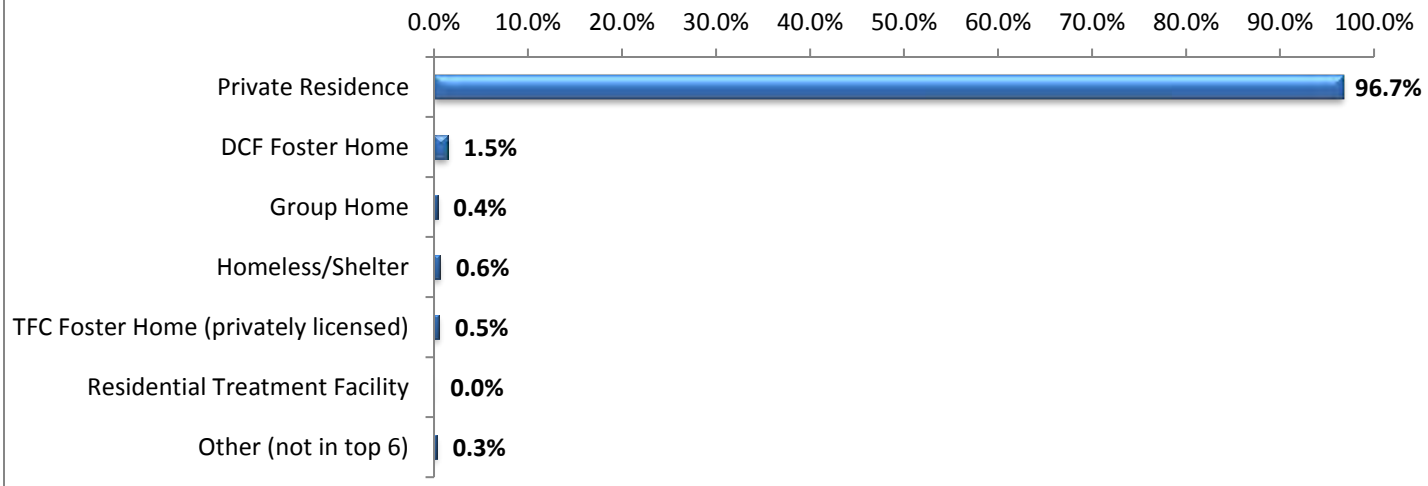
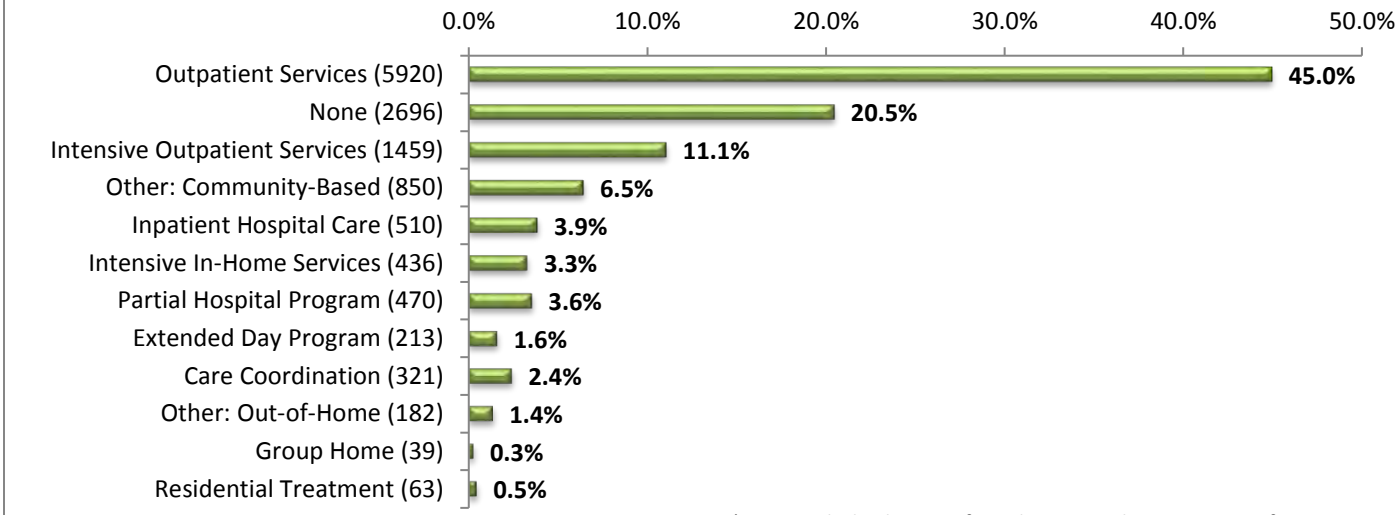


Figure 69. Type of Services Client Referred* to at Discharge Statewide



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

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

** May include referrals back to existing providers

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.	† .05-.10 * P < .05 **P < .01
STATEWIDE							
Parent Functioning Score	236	39.53	40.92	1.39	1.91	0.058	†
Worker Functioning Score	3025	43.84	45.66	1.82	11.46	0.000	**
Parent Problem Score	235	24.58	20.15	-4.43	-7.21	0.000	**
Worker Problem Score	3005	27.90	25.27	-2.63	-16.87	0.000	**
Central							
Parent Functioning Score	23	43.78	43.74	-0.04	-0.04	0.971	
Worker Functioning Score	648	44.50	48.78	4.27	17.33	0.000	**
Parent Problem Score	24	29.50	28.67	-0.83	-1.01	0.324	
Worker Problem Score	649	27.67	23.05	-4.62	-14.74	0.000	**
Eastern							
Parent Functioning Score	82	45.77	47.95	2.18	1.57	0.120	
Worker Functioning Score	257	44.80	47.11	2.31	4.64	0.000	**
Parent Problem Score	85	27.88	20.12	-7.76	-6.21	0.000	**
Worker Problem Score	257	28.87	24.78	-4.09	-7.36	0.000	**
Hartford							
Parent Functioning Score	24	46.42	45.17	-1.25	-0.28	0.782	
Worker Functioning Score	962	43.53	42.95	-0.59	-1.85	0.065	†
Parent Problem Score	24	23.08	17.71	-5.38	-2.04	0.053	†
Worker Problem Score	962	26.46	25.33	-1.12	-4.55	0.000	**
New Haven							
Parent Functioning Score	43	42.49	45.09	2.60	2.40	0.021	*
Worker Functioning Score	243	42.39	43.43	1.05	1.89	0.060	*
Parent Problem Score	44	29.32	25.52	-3.80	-3.16	0.003	**
Worker Problem Score	242	30.52	25.97	-4.56	-7.74	0.000	**
Southwestern							
Parent Functioning Score	13	41.31	45.31	4.00	3.29	0.006	*
Worker Functioning Score	174	44.60	51.11	6.52	7.11	0.000	**
Parent Problem Score	11	36.45	31.91	-4.55	-3.06	0.012	*
Worker Problem Score	169	26.02	23.26	-2.76	-1.94	0.054	†
Western							
Parent Functioning Score	51	21.39	21.71	0.31	0.35	0.731	
Worker Functioning Score	741	43.62	45.40	1.78	6.66	0.000	**
Parent Problem Score	47	9.66	9.32	-0.34	-0.83	0.411	
Worker Problem Score	726	29.22	27.56	-1.66	-9.21	0.000	**

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

NS: Not significant
† .05-.10,
* P < .05,
**P < .01

Section X: Client & Referral Source Satisfaction

Table 5. Client and Referrer Satisfaction for 211 and Mobile Crisis*

211 Items	Q1 FY 2017 Clients (n=78)	Q2 FY2017 Clients (n=60)	Q3 FY2017 Clients (n=60)	Q4 FY2017 Clients (n=64)	Q1 FY2017 Referrers (n=58)	Q2 FY2017 Referrers (n=60)	Q3 FY2017 Referrers (n=59)	Q4 FY2017 Clients (n=64)
The 211 staff answered my call in a timely manner	4.71	4.83	4.30	4.60	4.78	4.80	4.36	4.71
The 211 staff was courteous	4.86	4.87	4.62	4.87	4.79	4.83	4.64	4.81
The 211 staff was knowledgeable	4.84	4.87	4.55	4.84	4.79	4.83	4.63	4.69
My phone call was quickly transferred to the Mobile Crisis provider	4.74	4.77	4.42	4.81	4.74	4.83	4.49	4.61
Sub-Total Mean: 211	**4.79**	**4.83**	**4.47**	**4.78**	**4.78**	**4.83**	**4.53**	**4.71**
Mobile Crisis Items								
Mobile Crisis responded to the crisis in a timely manner	4.71	4.82	4.38	4.84	4.76	4.77	4.41	4.49
The Mobile Crisis staff was respectful	4.82	4.88	4.57	4.82	4.79	4.80	4.58	4.54
The Mobile Crisis staff was knowledgeable	4.79	4.87	4.50	4.85	4.78	4.78	4.58	4.51
The Mobile Crisis staff spoke to me in a way that I understood	4.78	4.87	4.55	4.85	X	X	X	X
Mobile Crisis 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 Mobile Crisis)	4.69	4.75	4.52	4.58	X	X	X	X
The services or resources my child and/or family received were right for us	4.68	4.72	4.50	4.44	X	X	X	X
The child/family I referred to Mobile Crisis was connected with appropriate services or resources upon discharge from Mobile Crisis	X	X	X	X	4.76	4.67	4.56	4.19
Overall, I am very satisfied with the way that Mobile Crisis responded to the crisis	4.73	4.77	4.52	4.69	4.76	4.73	4.54	4.37
Sub-Total Mean: Mobile Crisis	**4.74**	**4.81**	**4.50**	**4.73**	**4.77**	**4.75**	**4.53**	**4.42**
Overall Mean Score	**4.76**	**4.82**	**4.49**	**4.74**	**4.77**	**4.80**	**4.53**	**4.59**

*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:

*I'm very happy with both the 211 and EMPS services.

* She was very helpful. Every time an EMPS person needed to come out, they were always very professional and helpful.

*Both 211 and EMPS were great-thank you.

* I was thrilled with the service - they came out very quickly and were wonderful!

*It was helpful just to be able to talk with someone, even if they could not come right out to our home. Thanks

* Having someone to call when I'm having difficulty with my child/family is comforting.

*Thank you so much for being available in the middle of the night and for talking to me.

* Have always responded quickly. Clinician that family is presently working with is great, very pro-active.

* Clinician was very kind, considerate and companionate.

* It really was not of much help that night.

* Clinician was wonderful. Exceptional follow up and follow through.

Referrer Comments:

* Lifesaver! Thanks for being a service we can use.

* Very satisfied with the services - our school uses often.

* I would have liked a follow up from the EMPS worker about how the student was doing.

*Glad this service exists!

* Nothing but good things to say about EMPS and 211

* The only feedback is that the referral provider and family both had not used EMPS before and the referral provider reported it would have been helpful if while the process was happening EMPS explained the process to the worker and family.

* Great service support while the family awaits their appointments. Thanks.

* We are so grateful for the EMPS services.

*EMPS is a great resource for families to access and for us to use

*So helpful to have a follow up referral resource for families.

*Glad this service exists!

*EMPS has come out a couple of times and all have been great.

Figure 70. Parent/Guardian Satisfaction with the Mental Health Services their Child has Received by Service Area

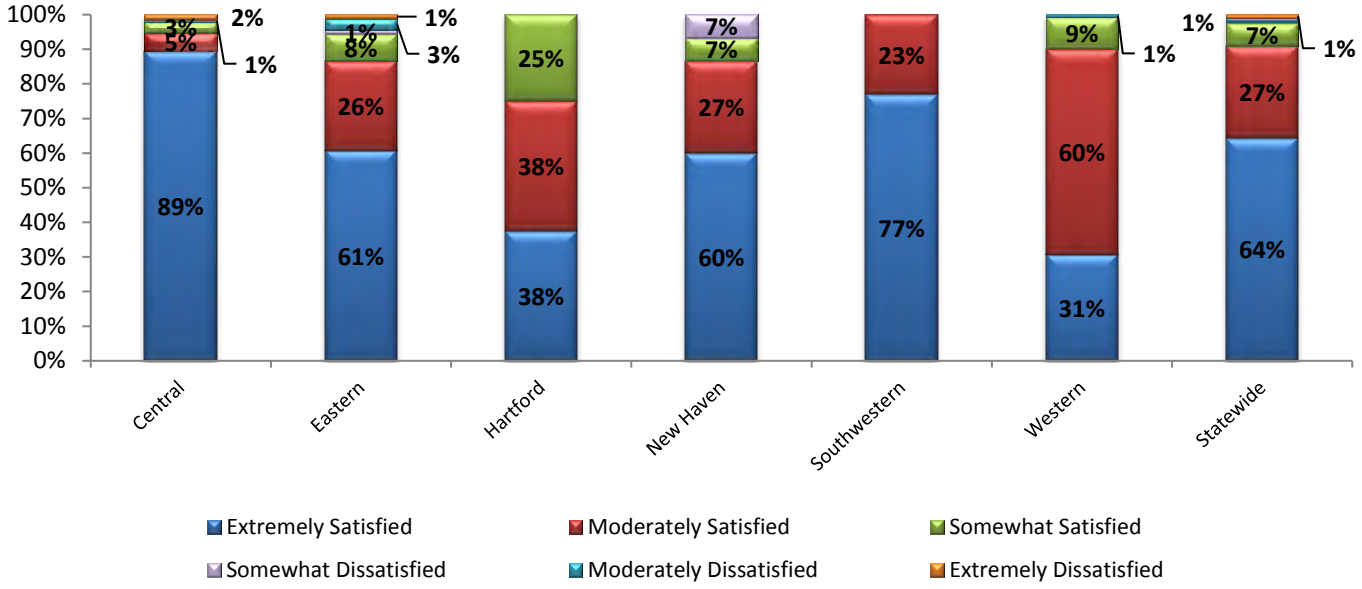
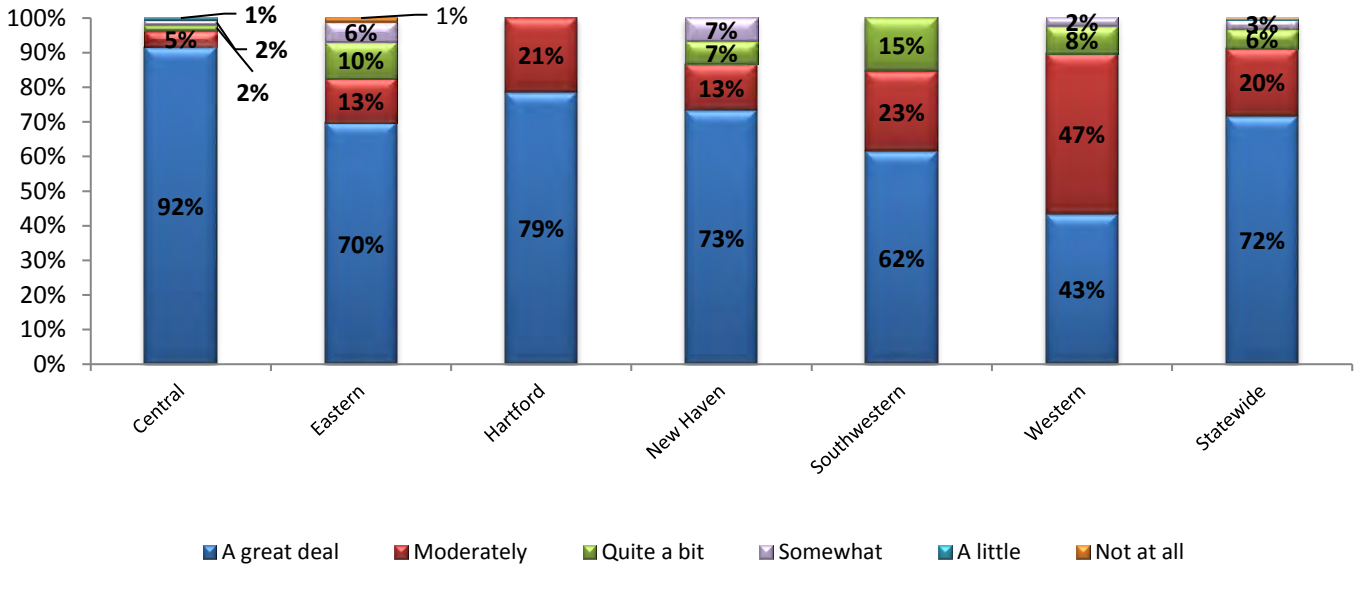


Figure 71. Parent/Guardian Rating of the Extent to Which the Child's Treatment Plan Included their Ideas about their Child's Treatment Needs by Service Area



Section XI: Training Attendance

Table 6. Trainings Completed for All Active* Staff

	DBHRN	Crisis API	DDS	CCSRS	Trauma	Violence	CRC	Str. Based	Emerg. Certificate	QPR	A-SBIRT	All 11 Trainings Completed	All 11 Completed for Full-Time Staff Only
Statewide (158)*	59%	61%	41%	44%	58%	59%	58%	61%	61%	34%	68%	13%	18%
CHR/MiddHosp-EMPS(11)*	55%	73%	36%	64%	55%	73%	64%	73%	73%	82%	82%	9%	25%
CHR-EMPS (13)*	46%	31%	38%	54%	46%	46%	46%	46%	38%	15%	69%	0%	0%
UCFS-EMPS:NE (9)*	33%	22%	33%	78%	0%	11%	22%	11%	22%	22%	100%	0%	0%
UCFS-EMPS:SE (13)*	69%	62%	8%	62%	46%	31%	38%	62%	62%	23%	62%	0%	0%
Wheeler-EMPS:Htfd (12)*	50%	67%	42%	0%	50%	67%	50%	58%	67%	33%	33%	0%	0%
Wheeler-EMPS:Meridn (8)*	50%	50%	50%	50%	63%	63%	38%	63%	50%	50%	38%	13%	0%
Wheeler-EMPS:NBrit (20)*	50%	55%	20%	10%	35%	55%	50%	65%	45%	0%	45%	0%	0%
CliffBeers-EMPS (23)*	78%	78%	74%	87%	78%	70%	74%	74%	70%	83%	91%	52%	57%
CFGC/South-EMPS (6)*	50%	33%	17%	17%	50%	33%	50%	50%	50%	0%	67%	0%	0%
CFGC-EMPS:Nrwlk (5)*	60%	80%	20%	60%	100%	100%	80%	60%	60%	20%	60%	20%	25%
CFGC-EMPS (16)*	88%	81%	56%	63%	88%	88%	81%	88%	94%	44%	63%	31%	40%
Well-EMPS:Dnby (3)*	67%	33%	67%	0%	67%	67%	100%	33%	67%	0%	67%	0%	0%
Well-EMPS:Torr (3)*	33%	67%	33%	0%	33%	67%	33%	67%	33%	0%	100%	0%	0%
Well-EMPS:Wtby (16)*	56%	69%	50%	6%	75%	63%	69%	56%	75%	19%	88%	6%	13%
Full-Time Staff Only (105)	65%	68%	44%	56%	61%	61%	66%	66%	66%	39%	80%	18%	

Note: Count of active staff for each provider or category is in parenthesis;
* Includes all active full-time, part-time and per diem staff

Training Title Abbreviations:

DBHRN=Disaster Behavioral Health Response Network
Crisis API = Crisis Assessment, Planning and Intervention
DDS=An Overview of Intellectual Developmental Disabilities and Positive Behavioral Supports
CSSRS=Columbia Suicide Severity Rating Scale
Trauma = Traumatic Stress and Trauma Informed Care
Violence = Violence Assessment and Prevention
Str Based = Strengths-Based Crisis Planning
CRC = 21st Century Culturally Responsive Mental Health Care
Emerg. Certificate= Emergency Certificate
QPR= Question, Persuade and Refer
A-SBIRT- Adolescent Screening, Brief Intervention and Referral to Treatment

Section XII: Ohio Scales Completion

Figure 72. Ohio Scales Collected at Intake by Provider

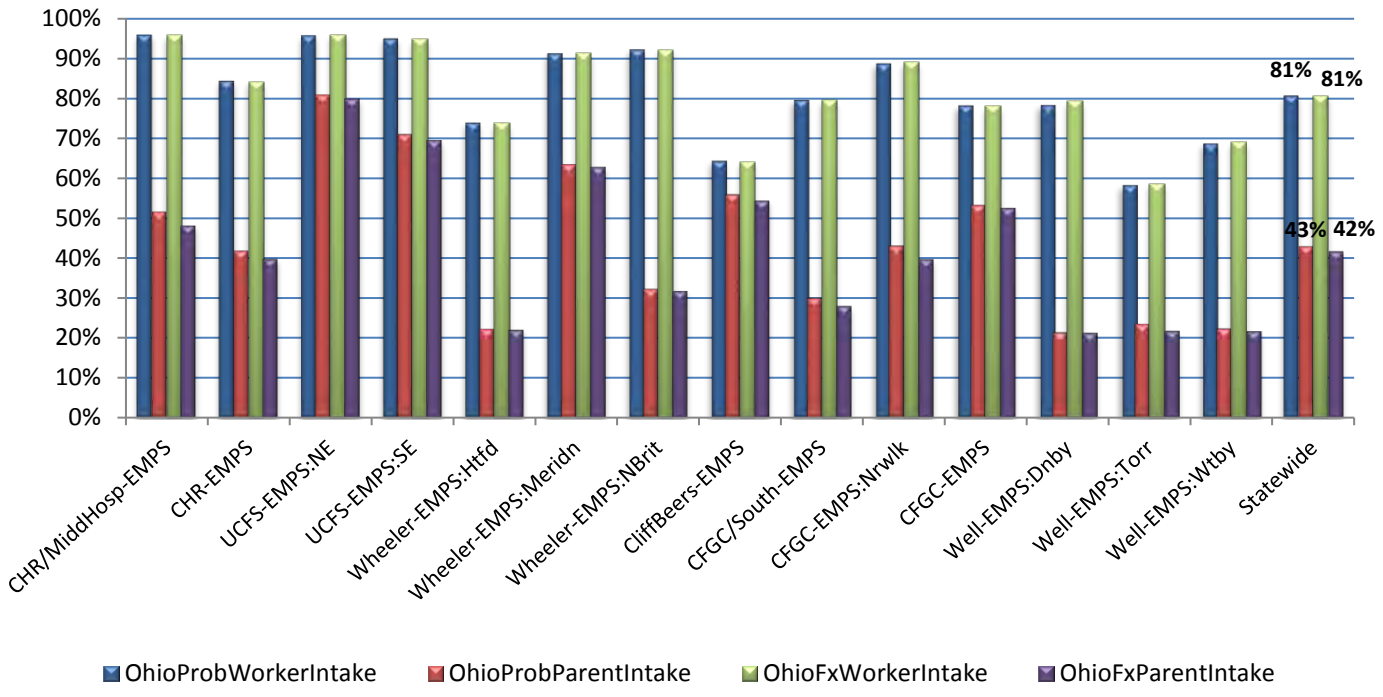
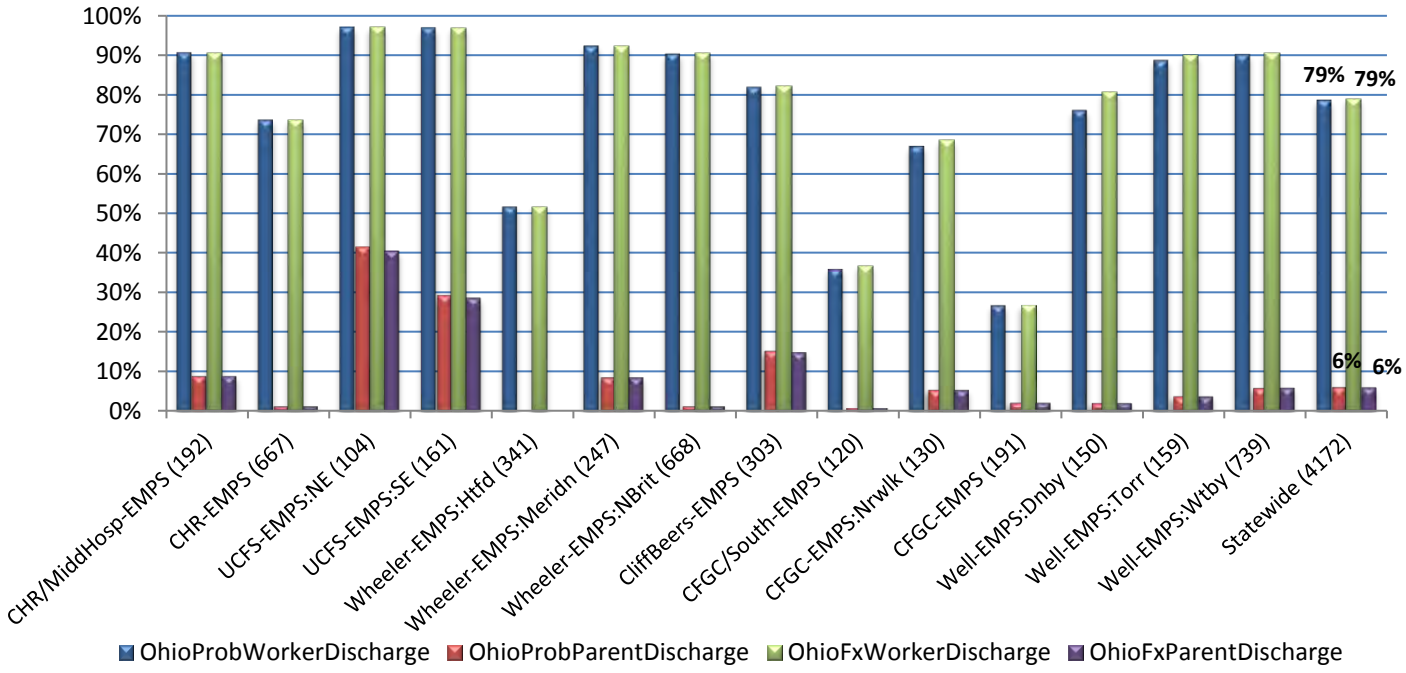


Figure 73. Ohio Scales Collected at Discharge by Provider



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

Section XIII: Provider Community Outreach

Table 7. Number of Times Providers Conducted Formal* Outreach to the Community

Provider	Q1 FY16	Q2 FY16	Q3 FY16	Q4 FY16	Total
CENTRAL	**7**	**13**	**10**	**5**	**35**
CHR/MiddHosp-EMPS	7	3	3	2	15
CHR-EMPS	0	10	7	3	20
EASTERN	**5**	**11**	**4**	**11**	**31**
UCFS-EMPS:NE	1	10	2	9	22
UCFS-EMPS:SE	4	1	2	2	9
HARTFORD	**9**	**5**	**7**	**5**	**26**
Wheeler-EMPS:Htfd	3	0	2	2	7
Wheeler-EMPS:Meridn	0	0	0	0	0
Wheeler-EMPS:NBrit	6	5	5	3	19
NEW HAVEN	**5**	**5**	**2**	**2**	**14**
CliffBeers-EMPS	5	5	2	2	14
SOUTHWESTERN	**27**	**9**	**6**	**16**	**58**
CFGC/South-EMPS	6	1	2	3	12
CFGC-EMPS:Nrwlk	16	5	0	5	26
CFGC-EMPS	5	3	4	8	20
WESTERN	**4**	**2**	**4**	**3**	**13**
Well-EMPS:Dnby	3	0	1	2	6
Well-EMPS:Torr	0	0	1	1	2
Well-EMPS:Wtby	1	2	2	0	5
Statewide	**57**	**45**	**33**	**42**	**177**

*Formal outreach refers to: 1) In person presentations lasting 30 minutes, preferably more, using the Mobile Crisis PowerPoint slides and including distribution to attendees of marketing materials and other Mobile Crisis resources; 2) Outreach presentations that are in person that include workshops, conferences, or similar gatherings in which Mobile Crisis 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 Mobile Crisis 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 Mobile Crisis PIC considers other outreaches for inclusion on a case-by-case basis, as requested by Mobile Crisis providers.

Appendices

Appendix A: Description of Calculations

Section II: Primary Mobile Crisis 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 Mobile Crisis episodes for the specified time frame for the designated service area.
- Figures 5 and 6 show the number of children served by Mobile Crisis per 1,000 children. This is calculated by summing the total number of episodes for the specified service area multiplied 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 Mobile Crisis 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 Mobile Crisis 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 Mobile Crisis response mode mobile that had a response time under 45 minutes divided by the total number of episodes that were coded as Mobile Crisis response mode mobile. Response time is calculated by subtracting the episode First Contact Date Time from the Call Date Time. In this calculation, 10 minutes is subtracted from the original response time for the average 211 call.

Section III: 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 Mobile Crisis response by provider.
- Figure 16 show the number served per 1,000 children in the population by provider and 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 IV: 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.

[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 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 by total count collected and that number is multiplied by 100 to get the percent.

Section V: Diagnosis and Clinical Functioning

- 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 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 secondary 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 primary diagnostic category reported at intake for each site, 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 secondary diagnostic category reported at intake for each site, dividing by total count collected and that number is multiplied by 100 to get the percent.
- Figure 31 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 32 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 33 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 34 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 35 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 36 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 37 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.

Section V: Diagnosis and Clinical Functioning (continued)

- Figure 38 shows the percentages of types of parent/guardian service needs statewide.

- Figure 39 shows the parent reported feeling of capability for dealing with the child's problems at intake and discharge in the state.
- Figure 40 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 Stabilization Follow-up for six months prior and Plus Stabilization for During multiplied by 100.
- Figure 41 shows the parent/guardian rating of client's school attendance during the episode of care compared to pre-admission. The percentages are calculated using the count answered in each category filtered on "Crisis Response" of Plus Stabilization Follow-up divided by the total number answered filtered on "Crisis Response" of Plus Stabilization Follow-up multiplied by 100.
- Figure 42 shows the percentage of school issues that impact the client's functioning at school for intake. This is calculated by taking the count answered in each category filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up and service area divided by the total number answered filtered on "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up and service area multiplied by 100.
- Figure 43 is calculated by taking the count answered in each category filtered on service area and a "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for six months prior and Plus Stabilization Follow-up for During divided by the total number answered filtered on service area and a "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for six months prior and Plus Stabilization Follow-up for During then multiplied by 100.
- Figure 44 is calculated by taking the count answered in each category filtered on service area and a "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for six months prior and Plus Stabilization Follow-up for During divided by the total number answered filtered on service area and a "Crisis Response" of Face-to-Face or Plus Stabilization Follow-up for six months prior and Plus Stabilization Follow-up for During then multiplied by 100.

Section VI: Referral Sources

- Figure 45 and Table 1 are percentage break outs of referral sources across the state.
- Figure 46 counts the number of ED referrals (i.e., routine follow-up or in-patient diversion) by service area.
- Figure 47 calculates the percent of Mobile Crisis 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 Mobile Crisis response episodes for that service area.
- Figures 48 and 49 use the same calculation as 47 and 48 respectively, but are broken down by provider.

Section VII: 211 Recommendations and Mobile Crisis Response

- Figure 50 is a count of the 211 recommended response mode (i.e., mobile, non-mobile, deferred mobile) by provider.
- Figure 51 is contrasted by Figure 51 that shows a count of the actual Mobile Crisis response mode (i.e., mobile, non-mobile, deferred mobile) by provider.
- Figure 52 and 53 show the percent of 211 recommended response of mobile and non-mobile episodes where the actual Mobile Crisis response was different than the recommended.
- Figure 54 is the same graph as Figure 9.

Section VII: 211 Recommendations and Mobile Crisis Response (continued)

- Figure 55 uses the same calculation as Figure 9 but shows the percent mobile response (mobile & deferred mobile) by provider.
- Figure 56 shows the Mobile Crisis site of the first mobile contact.
- Figure 57 shows the mean of mobile contacts and office visits occurring during an episode of care. This is calculated by figuring the average of all mobile contacts and all office visits occurring during an episode of care.
- Figure 58 shows the reason for a non-mobile Mobile Crisis response.
- Figure 59 shows the Mobile Crisis site of the first non-mobile contact.
- Figure 60 is a visual representation of actual Mobile Crisis responses for each of the 211 recommended response categories for the total number of calls to Mobile Crisis.

Section VIII: Response Time

- Figure 61 is the same graph as shown in Figure 11.
- Figure 62 uses the same calculation as Figure 11 but shows the percent of mobile episodes with response time under 45 minutes by provider.
- Figure 63 arranges the response time for those episodes that are coded as Mobile Crisis response mode-mobile and arranges the response time in ascending order by service area and selects the response time in the middle.
- Figure 64 uses the same calculation as Figure 64 and is categorized by provider.
- Figure 65 arranges the response time for those episodes that were coded as Mobile Crisis 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 66 uses the same calculation as Figure 66 and is categorized by provider.

Section IX: 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 is 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 those particular criteria.
- Table 3 shows total number of episodes used to calculate mean, median and percent in Table 2.
- Figure 67 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 68 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.
- Figure 69 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.

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

- Table 4 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 X: Client and Referral Source Satisfaction

- Table 5 shows the mean outcomes of the client and referral source satisfaction survey collected for 211 and Mobile Crisis. All items are measured on a scale of 1 (strongly disagree) to 5 (strongly agree).
- Figure 70 shows the statewide percent of parent/guardian satisfaction with the mental health services their child received, calculated by taking the count for each category divided by the total answered for the survey and multiplied by 100.
- Figure 71 is calculated by taking the count for each category by service area divided by the total answers to the question and multiplied by 100.

Section XI: Training Attendance

- Table 6 calculates the percent of staff that attended trainings by dividing actual number of trainings over expected number of trainings.

Section XII: Data Quality Monitoring

- Figure 72 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 Mobile Crisis 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 Mobile Crisis response mode either mobile OR deferred mobile (what actually happened).
- Figure 73 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 Mobile Crisis 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 Mobile Crisis response mode either mobile OR deferred mobile AND has an episode end date.

Section XIII: Provider Community Outreach

- Table 7 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
314.01 - Attention Deficit/Hyperactivity Disorder NOS

Bipolar Disorders:

296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
296.40 Bipolar I Disorder, Most Recent Episode Hypomanic, Unspecified
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
296.46 Bipolar I Disorder, Most Recent Episode Hypomanic, 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

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

296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
296.6 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.7 Bipolar I Disorder, Most Recent Episode Unspecified
296.8 Bipolar Disorder NOS
296.89 Bipolar II Disorder

Conduct Disorders:

312.34 Intermittent Explosive Disorder
312.81 Conduct Disorder, Childhood-Onset Type
312.82 Conduct Disorder, Adolescent-Onset Type
312.89 Conduct Disorder, Unspecified Onset
312.89 Other Specified Disruptive, Impulse-Control, and Conduct Disorder
312.9 Unspecified Disruptive, Impulse-Control, and Conduct Disorder
313.81 Oppositional Defiant Disorder

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
300.4 Persistent Depressive Disorder, Dysthymia
311 Other Specified Depressive Disorder
311 Unspecified Depressive Disorder
625.4 Premenstrual Dysphoric Disorder

Diagnosis Due to Medical Condition

293 Delirium Due To another Medical Condition
293.83 Bipolar and Related Disorder Due to another Medical Condition, Manic Features
293.83 Bipolar and Related Disorder Due to another Medical Condition, Manic Hypomanic-Like Episodes
293.83 Bipolar and Related Disorder Due to another Medical Condition, Mixed Features
293.83 Depressive Disorder Due to another Medical Condition, Depressive Features
293.83 Depressive Disorder Due to another Medical Condition, Major Depressive Like Episode
293.83 Depressive Disorder Due to another Medical Condition, Mixed Features

293.84 Anxiety Disorder Due To another Medical Condition
293.89 Catatonic Disorder Due to another Medical Condition
294.1 Major Neurocognitive Disorder Due to another Medical Condition, Without Behavioral Disturbance
294.11 Major Neurocognitive Disorder Due to another Medical Condition, Behavioral Disturbance
294.8 Obsessive-Compulsive and Related Disorder Due to another Medical Condition
294.8 Other Specified Mental Disorder Due to another Medical Condition
294.9 Unspecified Mental Disorder Due to another Medical Condition
310.1 Personality Change Due to another Medical Condition
347.1 Narcolepsy Secondary to another Medical Condition

Obsessive Compulsive Disorder

300.3 Hoarding Disorder
300.3 Obsessive-Compulsive Disorder
300.3 Unspecified Obsessive-Compulsive and Related Disorder
300.7 Body Dysmorphic Disorder
312.39 Trichotillomania (Hair Pulling Disorder)

Psychotic Disorder

293.81 Psychotic Disorder Due to another Medical Condition, Delusions
293.82 Psychotic Disorder due to another Medical Condition, Hallucinations
293.89 Catatonia Associated with another Mental Disorder, Catatonia Specifier
295.4 Schizophreniform Disorder
295.7 Schizoaffective Disorder, Bipolar Type
295.7 Schizoaffective Disorder, Depressive Type
295.9 Schizophrenia
297.1 Delusional Disorder
298.8 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Trauma Disorders

308.3 Acute Stress Disorder
309.81 Posttraumatic Stress Disorder
309.89 Other Specified Trauma and Stressor Related Disorder
309.9 Unspecified Trauma and Stressor Related Disorder
313.89 Disinhibited Social Engagement Disorder
313.89 Reactive Attachment 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)	Military Health Care	Medicare
STATEWIDE	63.5%	28.9%	2.0%	3.1%	1.6%	0.2%	0.7%	0.0%
CENTRAL	57.1%	35.5%	1.0%	4.4%	1.7%	0.1%	0.1%	0.0%
CHR/MiddHosp-EMPS	53.5%	39.3%	0.8%	3.6%	2.6%	0.0%	0.3%	0.0%
CHR-EMPS	58.4%	34.2%	1.1%	4.7%	1.4%	0.2%	0.1%	0.0%
EASTERN	63.7%	27.6%	2.1%	1.1%	1.2%	0.2%	4.1%	0.0%
UCFS-EMPS:NE	66.6%	26.8%	2.7%	0.9%	1.8%	0.0%	1.3%	0.0%
UCFS-EMPS:SE	61.9%	28.2%	1.8%	1.2%	0.8%	0.3%	5.9%	0.0%
HARTFORD	66.4%	25.3%	1.8%	4.4%	1.6%	0.1%	0.4%	0.0%
Wheeler-EMPS:Htfd	71.7%	16.1%	2.0%	7.8%	2.0%	0.2%	0.2%	0.0%
Wheeler-EMPS:Meridn	69.2%	22.0%	3.1%	2.8%	2.3%	0.3%	0.3%	0.0%
Wheeler-EMPS:NBrit	61.6%	33.3%	1.2%	2.2%	1.0%	0.1%	0.6%	0.0%
NEW HAVEN	62.3%	32.7%	1.6%	0.8%	1.8%	0.4%	0.2%	0.2%
CliffBeers-EMPS	62.3%	32.7%	1.6%	0.8%	1.8%	0.4%	0.2%	0.2%
SOUTHWESTERN	63.0%	28.5%	4.4%	3.1%	1.0%	0.1%	0.0%	0.0%
CFGC/South-EMPS	59.1%	31.3%	5.7%	2.6%	1.1%	0.2%	0.0%	0.0%
CFGC-EMPS:Nrwlk	44.7%	45.0%	5.9%	3.8%	0.6%	0.0%	0.0%	0.0%
CFGC-EMPS	75.4%	17.7%	2.8%	3.0%	1.1%	0.0%	0.0%	0.0%
WESTERN	66.1%	27.4%	0.9%	2.4%	2.8%	0.2%	0.2%	0.0%
Well-EMPS:Dnby	42.0%	51.7%	1.0%	2.4%	2.4%	0.0%	0.5%	0.0%
Well-EMPS:Torr	58.2%	35.8%	0.5%	4.5%	1.0%	0.0%	0.0%	0.0%
Well-EMPS:Wtby	73.6%	19.7%	1.0%	2.0%	3.2%	0.2%	0.2%	0.0%

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

	Witness Violence	Victim Violence	Sexual Victimization	Disrupted Attachment / Multiple Placements	Recent Arrest of Caregiver (last 30 days)*	Other
STATEWIDE	23%	16%	13%	26%	0.7%	21%
CENTRAL	18%	13%	16%	24%	1.1%	28%
CHR/MiddHosp-EMPS	14%	10%	19%	20%	0.7%	36%
CHR-EMPS	20%	13%	15%	25%	1.2%	26%
EASTERN	23%	18%	11%	26%	0.6%	21%
UCFS-EMPS:NE	22%	17%	9%	35%	0.7%	17%
UCFS-EMPS:SE	23%	20%	14%	18%	0.5%	24%
HARTFORD	25%	20%	14%	15%	0.6%	25%
Wheeler-EMPS:Htfd	24%	16%	15%	19%	0.4%	27%
Wheeler-EMPS:Meridn	22%	22%	9%	16%	0.7%	30%
Wheeler-EMPS:NBrit	27%	23%	14%	12%	0.7%	23%
NEW HAVEN	25%	17%	12%	21%	0.4%	25%
CliffBeers-EMPS	25%	17%	12%	21%	0.4%	25%
SOUTHWESTERN	24%	12%	12%	37%	0.4%	15%
CFGC/South-EMPS	19%	22%	24%	24%	0.9%	11%
CFGC-EMPS:Nrwlk	23%	12%	11%	9%	0.7%	45%
CFGC-EMPS	26%	8%	9%	46%	0.3%	11%
WESTERN	20%	12%	11%	40%	1.2%	15%
Well-EMPS:Dnby	20%	14%	10%	31%	2.4%	24%
Well-EMPS:Torr	19%	10%	10%	47%	1.0%	13%
Well-EMPS:Wtby	21%	13%	12%	40%	1.0%	13%

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)	Child Is Deceased
STATEWIDE	70.1%	20.6%	4.7%	2.0%	1.2%	0.4%	0.5%	0.3%	0.0%	0.1%	0.0%	0.1%	0.0%
CENTRAL	74.0%	15.8%	4.0%	3.9%	0.3%	0.3%	1.0%	0.3%	0.0%	0.2%	0.0%	0.1%	0.0%
CHR/MiddHosp-EMPS	76.0%	5.2%	5.9%	9.9%	0.8%	0.8%	1.0%	0.2%	0.0%	0.2%	0.0%	0.0%	0.0%
CHR-EMPS	73.2%	19.6%	3.4%	1.8%	0.1%	0.1%	1.0%	0.3%	0.0%	0.2%	0.1%	0.1%	0.1%
EASTERN	74.2%	20.7%	4.6%	0.2%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.1%	0.0%
UCFS-EMPS:NE	73.3%	20.1%	5.6%	0.3%	0.2%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%
UCFS-EMPS:SE	74.7%	21.0%	3.9%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%
HARTFORD	54.0%	35.3%	3.9%	0.7%	3.6%	0.9%	0.7%	0.5%	0.0%	0.1%	0.0%	0.1%	0.0%
Wheeler-EMPS:Htfd	45.4%	38.5%	3.4%	1.4%	9.5%	0.2%	0.7%	0.7%	0.0%	0.2%	0.0%	0.1%	0.1%
Wheeler-EMPS:Meridn	46.6%	40.5%	5.1%	1.2%	0.2%	5.1%	0.6%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Wheeler-EMPS:NBrit	62.6%	31.3%	4.0%	0.1%	0.2%	0.2%	0.8%	0.4%	0.0%	0.2%	0.0%	0.1%	0.0%
NEW HAVEN	75.6%	12.8%	5.0%	5.1%	0.7%	0.1%	0.2%	0.3%	0.0%	0.2%	0.0%	0.1%	0.0%
CliffBeers-EMPS	75.6%	12.8%	5.0%	5.1%	0.7%	0.1%	0.2%	0.3%	0.0%	0.2%	0.0%	0.1%	0.0%
SOUTHWESTERN	77.5%	14.4%	6.1%	0.0%	0.3%	0.5%	0.3%	0.5%	0.0%	0.2%	0.0%	0.2%	0.0%
CFGC/South-EMPS	81.6%	12.1%	4.0%	0.0%	0.2%	1.1%	0.0%	0.6%	0.0%	0.3%	0.0%	0.2%	0.0%
CFGC-EMPS:Nrwlk	80.5%	10.6%	7.4%	0.0%	0.0%	0.2%	0.2%	0.5%	0.0%	0.0%	0.0%	0.5%	0.0%
CFGC-EMPS	72.8%	18.2%	7.3%	0.0%	0.5%	0.1%	0.5%	0.4%	0.0%	0.1%	0.0%	0.1%	0.0%
WESTERN	78.1%	13.3%	5.2%	2.8%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.0%	0.1%	0.0%
Well-EMPS:Dnby	72.0%	21.7%	4.2%	1.7%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Well-EMPS:Torr	74.7%	16.5%	4.4%	3.4%	0.0%	0.0%	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%
Well-EMPS:Wtby	80.3%	10.5%	5.6%	2.9%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%

Table 11. Type of Services Client Referred 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	45.5%	20.7%	11.2%	6.5%	3.9%	3.6%	3.3%	1.6%	2.5%	0.3%	1.4%	0.5%
CENTRAL	46.1%	24.8%	12.2%	6.1%	4.6%	7.4%	3.1%	1.3%	1.7%	0.5%	1.4%	0.1%
CHR/MiddHosp-EMPS	34.1%	47.5%	6.2%	2.7%	5.4%	8.7%	1.6%	0.5%	0.4%	0.7%	1.3%	0.0%
CHR-EMPS	50.7%	16.1%	14.5%	7.3%	4.3%	6.9%	3.6%	1.5%	2.2%	0.3%	1.4%	0.1%
EASTERN	48.1%	13.5%	11.6%	3.9%	3.3%	14.4%	2.7%	1.1%	0.6%	0.1%	0.7%	0.8%
UCFS-EMPS:NE	54.0%	18.4%	14.5%	2.7%	3.7%	15.7%	3.7%	1.2%	0.8%	0.0%	0.5%	1.0%
UCFS-EMPS:SE	45.1%	11.0%	10.1%	4.6%	3.1%	13.8%	2.2%	1.0%	0.5%	0.2%	0.8%	0.7%
HARTFORD	48.6%	20.3%	13.0%	7.7%	3.1%	1.5%	3.3%	4.0%	1.4%	0.4%	0.9%	0.3%
Wheeler-EMPS:Htfd	29.0%	30.9%	9.4%	6.9%	1.5%	1.6%	3.6%	2.6%	1.4%	0.4%	0.7%	0.4%
Wheeler-EMPS:Meridn	49.0%	25.9%	11.5%	9.7%	4.3%	0.8%	3.1%	4.5%	1.6%	0.0%	1.9%	0.0%
Wheeler-EMPS:NBrit	66.1%	9.0%	16.8%	7.7%	4.2%	1.6%	3.1%	5.1%	1.4%	0.5%	0.8%	0.2%
NEW HAVEN	36.3%	30.9%	8.3%	6.5%	2.7%	0.7%	4.2%	0.5%	2.2%	0.1%	1.0%	0.3%
CliffBeers-EMPS	36.3%	30.9%	8.3%	6.5%	2.7%	0.7%	4.2%	0.5%	2.2%	0.1%	1.0%	0.3%
SOUTHWESTERN	42.6%	20.9%	4.3%	8.4%	4.9%	0.0%	4.3%	0.2%	7.0%	0.1%	3.5%	0.4%
CFGC/South-EMPS	62.5%	12.3%	2.2%	16.7%	3.7%	0.0%	3.5%	0.1%	12.7%	0.0%	8.4%	0.7%
CFGC-EMPS:Nrwlk	48.0%	20.3%	6.3%	6.3%	6.0%	0.2%	6.3%	0.2%	2.7%	0.4%	0.7%	0.4%
CFGC-EMPS	27.9%	26.6%	4.7%	4.2%	5.2%	0.0%	4.0%	0.2%	5.2%	0.0%	1.6%	0.1%
WESTERN	49.4%	13.0%	17.9%	5.1%	5.2%	0.3%	2.3%	1.1%	1.8%	0.7%	0.9%	1.4%
Well-EMPS:Dnby	61.0%	17.3%	12.1%	3.7%	2.2%	0.0%	3.7%	1.1%	0.7%	0.0%	0.4%	0.4%
Well-EMPS:Torr	35.8%	16.6%	16.2%	7.9%	5.6%	1.7%	1.3%	1.3%	2.0%	2.3%	1.0%	2.0%
Well-EMPS:Wtby	50.2%	11.2%	19.7%	4.7%	5.8%	0.0%	2.2%	1.0%	2.0%	0.4%	1.0%	1.4%

Table 12. Performance Improvement Plan Goals and Results for Fiscal Year 2016

Service Area	Performance Goals and Relevant Quarter(s)	Goal Achieved	Positive Progress Toward Goal	No Positive Progress
Central	Track and monitor utilization and documentation of both A-SBIRT and Columbia Suicide Scale to ensure tools are being used (Q1, Q2, Q3)		Q1, Q2	
	Obtain MOA's between school and EMPS Providers (Q1, Q2, Q3, Q4)		Q1,Q2,Q3,Q4	
	Track and monitor Middlesex Hospital ED utilization data for the quarter (Q2, Q3)		Q2	
	Review Results Based Accountability (RBA) reports and write the story behind the data (Q1, Q2,Q3, Q4)		Q1,Q2, Q3, Q4	
	Establish relationships with ED Staff/Leadership at CCMC/Yale. Facilitate development of Liaison role in working collaboratively with community providers (Q2, Q3,Q4)		Q2, Q3, Q4	
	Obtain additional training in utilization of PIE data monitoring (Q3, Q4)	Q4	Q3	
	Track and Report on the number of episodes that repeat episodes and look at additional indicator of Husky or Commercial Insurance (Q3)	Q3		
	Evaluate if externalizing scores are improving in the Ohio's (Q3)		Q3	
	Help in the planning and facilitation of the EMPS Annual Meeting (Q4)	Q4		
	Achieve Productivity goals and documentation standards (Q4)		Q4	
	Continue recruitment to identify qualified candidates for open positions at Mobile Crisis (Q4)		Q4	
	Effectively utilize the Liaison role by engaging local ED's on using the program more actively (Q4)	Q4		
Eastern	Will have 3 MOA's signed in (Q1, Q2, Q3,Q4)	Q1, Q2, Q3, Q4		
	Review Results Based Accountability (RBA) reports and write the story behind the data (Q1, Q2,Q3, Q4)		Q1,Q2,Q3,Q4	
	To provide follow-up care that provides individualized crisis stabilization by coordinating and collaborating with current providers involved with each client. Will audit 10 charts (Q1)		Q1	
	To have EMPS consistently follow-up with current treatment providers for face to face episodes of care in a timely manner by reaching a 10% increase from Q1 (Q2)	Q2		
	To have EMPS obtain consent to follow up with school for all clients (Q3)	Q3		
	To divert youth in crisis from Emergency Department will audit charts (Q4)	Q4		
Hartford	Meet the 90% mobile response and 45 minute mobile response time of EMPS standards (Q2, Q3,Q4)	Q4	Q2,Q3,	
	Increase uniformity of EMPS services across the state by creating a survey for each agency to complete regarding current information obtained during a crisis assessment (Q1, Q2, Q3, Q4)	Q4	Q1, Q2, Q3	
	Standardize what needs to be included during follow- up sessions and how follow- up services should be documented (Q1,Q2,Q3,Q4)	Q4	Q1, Q2,Q3,	
	Communicate with existing care providers EMPS involvement, recommendations, referral options, and any additional case management (Q1, Q2, Q3, Q4)		Q1,Q2,Q3,Q4	
	Obtain MOA's between schools and EMPS Providers (Q1,Q2,Q3, Q4)	Q4	Q1,Q2,Q3,	

	Finalize EMPS Welcome Binder for new staff to provide uniformity in the training process across all three Wheeler teams to enhance clinical care for all EMPS clients (Q2,Q3)		Q2, Q3	
	Increase focus on obtaining Ohio Scales, specifically Parent and Youth at discharge (Q4)		Q4	
	Review Results Based Accountability (RBA) reports and write the story behind the data (Q1, Q2,Q3, Q4)		Q1,Q2,Q3,Q4	
	Review and analyze data on racial and ethnic disparities to bring awareness and education to staff on disparities (Q4)		Q4	
New Haven	Obtain MOA's between schools and EMPS Providers. Will have two MOA signed each quarter (Q1, Q2, Q3, Q4)		Q1, Q2,Q4	Q3
	Quarterly Collaboration Meeting with Yale ED Staff to continue to develop relationships with staff (Q1, Q2, Q3, Q4)	Q4	Q1, Q2,Q3	
	Outreach to Pediatricians and PTAs in the 17 towns. Contact 4 PTAs per quarter and drop off materials at 4 pediatricians offices each quarter (Q1,)	Q1		
	Quarterly meetings with West Haven Board of Education to improve collaboration with West Haven school staff (Q2, Q3)	Q3	Q2	
	Set up outreaches to both DCF area offices (Milford and New Haven) (Q1)	Q1		
	Review Results Based Accountability (RBA) reports and write the story behind the data (Q1, Q2,Q3, Q4)		Q1,Q2,Q3,Q4	
	Have all staff trained and explore implementing the CSSRS during assessments (Q1, Q2,Q3)	Q3	Q1, Q2	
Southwestern	Obtain MOA's between schools and EMPS Providers. Will have four MOA signed for Stamford and Norwalk catchment area (Q1, Q2 , Q3, Q4)		Q1,Q2,Q3,Q4	
	Obtain MOA's between schools and EMPS Providers for Bridgeport catchment area (Q1)	Q1		
	Track and Monitor the number of Hospital Admissions each month to identify trends and increase awareness for staff (Q1, Q2, Q3, Q4)	Q4	Q1,Q2,Q3	
	Maintain 90% mobility for Region One (Q1)	Q1		
	Will review one record per clinician each month to ensure that they are diagnostically and clinically comprehensive to meet quality assurance and safety standards (Q3)		Q3	
	Review Results Based Accountability (RBA) reports and write the story behind the data (Q1, Q2,Q3, Q4)		Q1,Q2,Q3,Q4	
	Will conduct 2 outreaches a year for DCF regional offices (Q4)		Q4	
Western	Obtain MOA's between schools and EMPS Providers. Will have 4 MOAs signed in Q1 & Q2 and 8 Signed in Q3 and 5 signed in Q4		Q3, Q4	Q1, Q2
	Reduce the number of EMPS episodes for unduplicated clients by reviewing data, looking for themes, patterns, and similar diagnosis, etc. (Q1,Q2,Q3,Q4)		Q3, Q4	Q1, Q2,
	Review Results Based Accountability (RBA) reports and write the story behind the data (Q1, Q2,Q3, Q4)		Q1,Q2,Q3,Q4	
	Maintain staff morale by meeting weekly with full-time staff to discuss concerns , feedback, and support due to experiencing many administrative changes (Q1,Q2,Q3, Q4)	Q4	Q1, Q2,Q3	

Total Goals=112; Number of goals achieved (during at least one quarter): 24 of 112(21%); Number of goals with positive progress (during at least one quarter): 83 of 112 (74%)number of goals with no positive progress 5 of 112(5%).