Kids Oneida Challenges

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Executive Director/CEO

What is Kids Oneida?

- Program began in 1998, after years of Oneida County Commissioner's of Mental Health and Social Services advocating for blended funding and regulatory changes.
- KO is a 4.4 Million Dollar Wraparound Program with Blended DSS and Medicaid Funding

What is Kids Oneida?

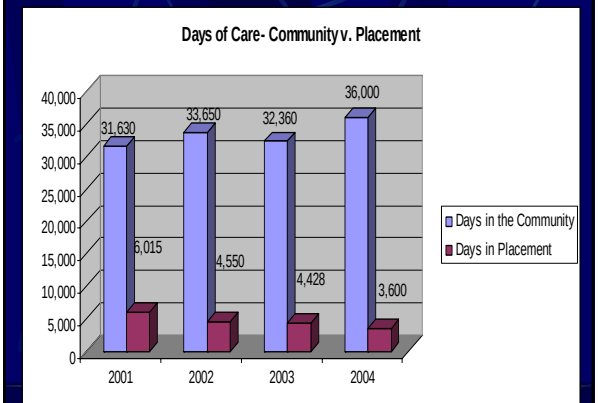
- Last Option before Placement
- Article 31 Mental Health Clinic (Virtual Clinic)
- OCDSS Prevention Program
- Care Management Entity- with financial risk. KO Pays for placement out of our blended funding rate.
- KO- 20 Staff- FTE Equivalent of 50 Providers, more than 50 contracts that provide more than 40 services.

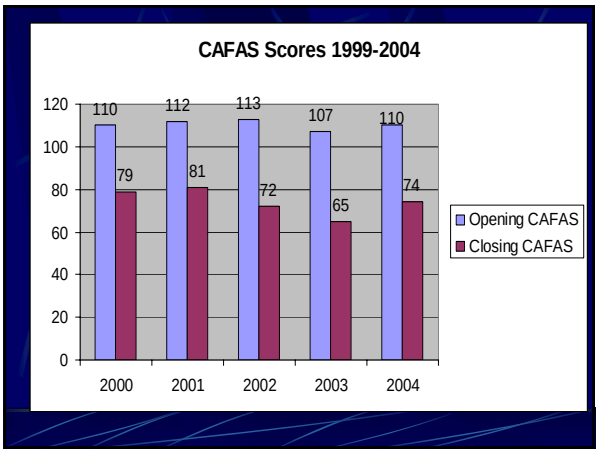
Oneida County Challenges

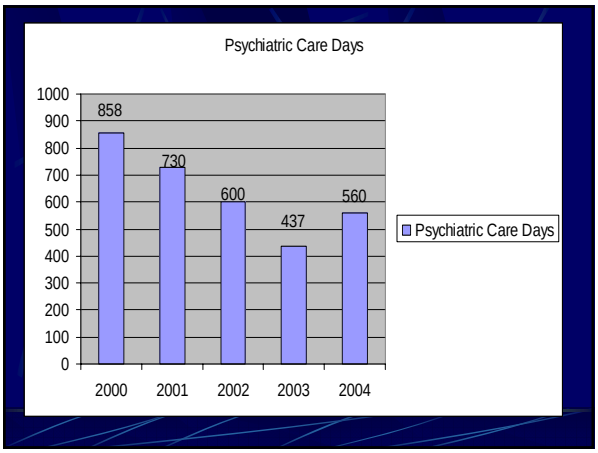
- Getting Community Buy-in
- Formal and informal rules change when an agency is fully empowered with a case rate and decision making.
- Examples of Relationship Changes:
  - Social Services- Probation
  - Other Agencies- Family Court

System Change

- Provider Network Development:
  - Fee for Service-No Contracts
- Cases assigned on a month to month basis, based on performance
- KO utilized mostly larger, long term agencies to start, and has developed smaller, start-up agencies (particularly for non-traditional services)
  - More specialty Providers -Niche Services
- Payments based on timely entry of notes into electronic clinical record.







Outcomes

- Out of 170 Children served in 2004, 19 were placed in Residential care, 1 RTF, 4 in Therapeutic Foster Care.
- Average approximately 35% Clinical Improvement during last 4 years.(CAFAS)
- Approximately 74% of children avoid placement as a result in KO involvement. More than 63% complete their Mental Health objectives.
- 91% of 2004 Days of Care are in the community
- Last four years we have received high marks from our parents (90% Parent Satisfaction)
- On-going Family Support Efforts
- Supportive Work –80% of kids ages 14-up have some part-time employment.

What is Next?

- Conversion to an OMH Waiver Program for our 110 slots
- Finalizing a step-down program for KO-Lower level of Care, continue with same FSC, and other Providers at less intensive level.
- Other payers are interested in purchasing units of services from us. (Insurance companies, Schools, Psychiatric Facilities)

KO Achievements/ Challenges

- 2002 New York State “Excellence in Achievement” award.
- Challenges- meet all of the regulatory requirements.
- Maintain quality services as we provide for a larger population.

The Community Services Program (CSP) of the Trauma Center at Arbour Health Systems

Christina Kloker Young
Co-Chair, National RTC Advisory Board

Program Features

- Provides short-term interventions for those who have essentially normal responses to abnormal situations
  - People whose functioning has been disrupted but who can re-group with short-term support
- Responds to traumatic events 24 hours/day, 7 days/week, 365 days a year
  - Small core staff
  - Network of 100 trained people

History

- Began almost 15 years ago funded by Massachusetts Department of Mental Health
- Reorganized in 1996 to build a training program and incident response infrastructure to meet needs of 90,000 school age children in Metro Boston

Program Philosophy

- The GOLDEN RULE of the program has been that "those most affected by the trauma or threat event must be afforded an ongoing opportunity to play a central role in the resolution of and recovery from the trauma and its aftermath."

Traumatic Incidents

- **Homicide or Fatal Accidents**
- **Suicide or other sudden violent death**
- **Fire and Large Scale Disasters**
- **Non-fatal Beating or Wound**
- **Abduction or Kidnapping**
- **Missing Student or Teacher**
- **Community Violence**
- **Riots, Expulsions, Suspensions**
- **Sexual Harassment or Assault**
- **First Amendment Violations**

Building a Community Provider Network

- Developed an organized infrastructure at the neighborhood level for children and youth exposed to trauma by:
  - Building a trauma response network for neighborhoods and schools in Boston
  - Training about 250 new persons a year in introduction to trauma intervention
  - Advanced training for those who become part of the trauma response network followed by a minimum of four advanced 8-hour trainings per year

Three Major Types of Trauma Interventions

- Information and Education Sessions: "Orientations and Debriefings"
- Individual crises intervention, as needed as well as triage of those individuals likely to need more in-depth, long-term intervention
- Identifying individual and community resources for ongoing coping strategies and development of individual plans for how the person is going to cope with the trauma in the short term

Basic Intervention Strategy

- In the 24-48 hours following an event, the purpose is to stabilize the situation by helping the individual or group feel safe
- The team engages in reconnaissance using identified neighborhood community leaders and local school/agency personnel
- The nature of the actual intervention(s) is determined by those affected by the trauma

Evaluation Design

- Stakeholder interviews
- Analysis of Case Records
- Interviews with licensed professionals, school personnel and community workers who had participated in the CSP trainings over the past four years
- Review of all training evaluations

Conclusions of the Evaluation

- All components of the evaluation showed a consistent picture of a very well respected, highly utilized, effective program
- In a number of instances this training had a broader impact on communities and organizations
- Interviewees commented on how they had transferred the training to reform the operations of their organization

Conclusions

- Several community leaders commented that it had positively changed the way human service organizations interacted with each other in their communities

Conclusions

- They work effectively with all ethnic groups and communities
  - "They know every tragedy is not the same. They have different techniques in different communities. I like developing the local teams to help, to do what they're taught – but also to teach the program about the community. They make an immediate impact – you can see a difference at a wake or funeral when they're there." - Cape Verdean Community leader

Prevailing Implementation Factors

The prevailing factors in this program are

- Transformational leadership
- Provider network
- Collaboration

Transformational Leadership

- State level leadership has recognized the value of continuing and expanding the program to other sites;
- Local mental health leadership has recognized the value of expanding the program to all communities and all schools;
- The program director has clearly articulated program features and requirements.

Program Leadership

- The program director and staff have trained collaborating agencies and community partners to augment their work;
- The program director and staff have provided ongoing supervision and support of those trained;
- Leadership at all three levels have promoted ongoing evaluation.

18th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base
March 6-9, 2005

Presented by: Connie Conklin
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Jim Wotring
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Session B 1:15-2:45 p.m.

Fostering Practices that Contribute to System Transformation

Transforming Systems with Data and Outcome Management

History

- Livingston County CMHSP small pilot
- Statewide began in 1996 at the request of other CMHSP's
- To determine positive outcomes for children served by 22 CMHSPs
- Identify areas for improvement

Purpose

- To promote clinically meaningful outcome assessment at client level
- To promote use of this information to provide better services via continuous agency self-study
- To promote exemplary practices and assist by providing evidence for local programs
- To identify and promote evidence-based practices that match the needs of youth served

Goals

- Professional:
  - is knowledgeable about effective treatments
  - has service array available
  - understands context client lives in
  - informs family of treatment options
- Family chooses goals, intervention and target outcome
- Professional and family:
  - assess "pre" intervention
  - continually monitor progress

Philosophy

- No Shame No Blame
- Hold responsible for data but no punishments
- Produce reports CMHSPs found relevant
- Only compare sites to statewide averages (Not to other sites)

Arrangement

Evaluate youths at intake, 3 months, and at exit

Submit data monthly to the University evaluator, using the CAFAS software

Receive monthly data feedback from University

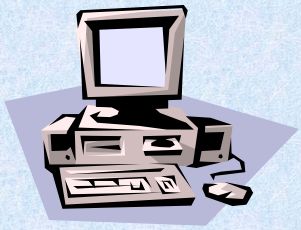
Receive semi-annual fiscal year reports

Data Collected

Collected at intake only

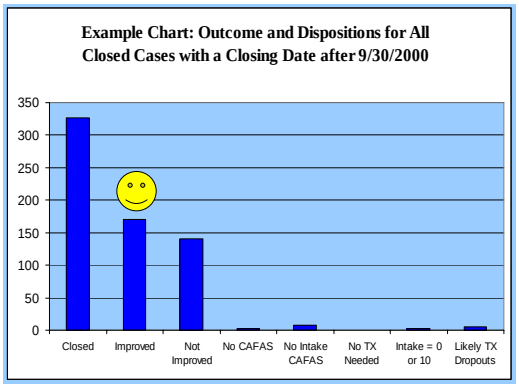
- CAFAS data
- Demographic Data
- Child Risk Factors
  - Previous placement out-of-home
  - Previous juvenile justice involvement
  - Previous psychiatric hospitalization
  - Previous involvement with protective services
- Clinical Diagnoses
- After this data is collected quarterly and at exit

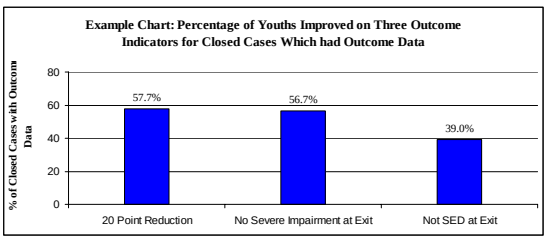
Outcome Management in Michigan: Reports Generated by the CAFAS Software and University



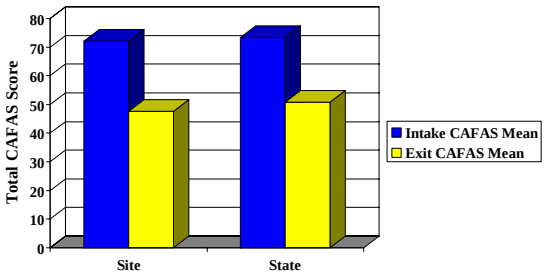
Client Reports

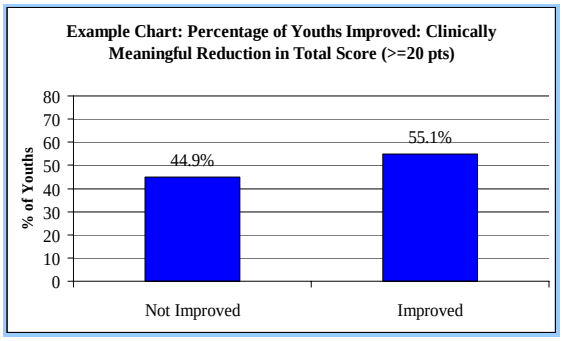
Aggregated Data





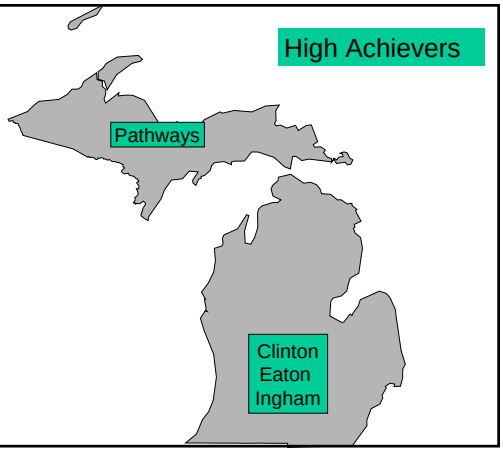
Example: Comparison of Site to State on Intake & Exit CAFAS





Identifying Effective Local Programs Using Data

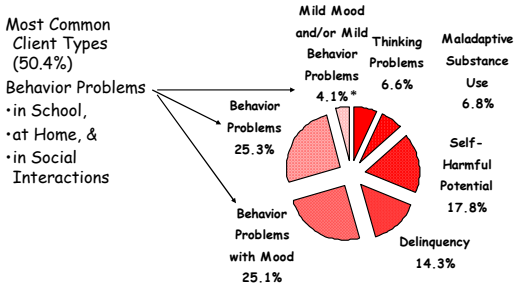
Especially for populations for which EBPs are not readily available



Using the CAFAS To Determine Client Types For Evidence Based Practices

What type of youths do we serve, with what outcomes? 40

Client Types for Youths with SED Served by Michigan Public Health



* Deleted on subsequent bar graphs

Facilitate Providers' Access to Evidence-Based Practices (EBP)

Training in Cognitive Behavioral Treatment for Depression (Asarnow & Rae, UCLA)

- 3-day course
- Manual for youth and therapist
- 6 months of weekly phone consultation (small group format)

Facilitate Providers' Access to Evidence-Based Practices (EBP) (cont'd)

Training in Parent Management Training (PMT) (Forgatch & Bank, Oregon Social Learning Center)

- Wrote a grant to study implementation of PMT

Transforming Systems

- Data, Data, Data
- State, Local, and University Partnership
- Time, Time, Time
- Feedback, Feedback, Feedback
  - State to Local,
  - Local to State
  - Both to University

Lessons Learned

- Using Data to Inform Clinical Practice Takes Time
- Keep it Simple, Use lots of Bar Graphs
- Recognize and Highlight Best Practice with Data
- Recognize and Highlight Need for Evidence Based Practice with Data
- If you Collect Data Give it Back in Useful Formats