NEW YORK STATE | NYSTART
Systemic, Therapeutic, Assessment, Resources and Treatment

An initiative of the New York State Office for People With Developmental Disabilities

NYSTART Region 1

September 2016 – March 2018

Annual Report

Prepared for

The New York Office for People With Developmental Disabilities

Prepared by

The Center for START Services

THE CENTER FOR START SERVICES

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START, which stands for Systemic, Therapeutic, Assessment, Resources & Treatment, is a comprehensive model of service supports that optimizes independence, treatment, and community living for individuals with intellectual/developmental disabilities (IDD) and behavioral health needs.

The Center for START Services, a program of the University of New Hampshire Institute on Disability/UCED, is a national initiative that strengthens efficiencies and service outcomes for individuals with and behavioral health needs in the community.

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Introduction

This report offers a comprehensive summary of services provided by the NYSTART Region 1 team for Fiscal Year 2017/2018. The analysis includes assessment of outcomes as well as fidelity measures for the START model. Recommendations reflect the results of the analysis and service provision to date.

This report is separated into five sections:

- FY 2017/2018 Enrollment Trends
- Characteristics of Persons Served (demographics and clinical trends)
- Emergency Service Trends
- START Clinical Team Services
- START Therapeutic Supports

Region 1 will develop an action plan based on recommendations from the analysis in collaboration with the Center for START Services and NYS OPWDD.

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NYSTART Region 1 Program

Program Background

NYSTART Region 1 was the first START program to begin operations in New York State and has been actively serving individuals since August 2014. At this time, 25% of the active START population served in New York are enrolled in the Region 1 program (see figure 1). All NYSTART programs serve individuals aged 6 and older, and about 50% of the current Region 1 caseload consists of children under the age of 18. The percentage of children in this region is higher than in all other NYSTART programs as well as most other START programs nationally (see figure 2).

The following is a list of NYSTART programs by region:
Region 1- Western NY and Finger Lakes
Region 3-Capital District, Taconic and Hudson Valley
Region 4- New York City (Tri-Borough and Richmond Kings)
Region 5-Long Island

Figure 1: Percent of Active NYSTART Population by Region

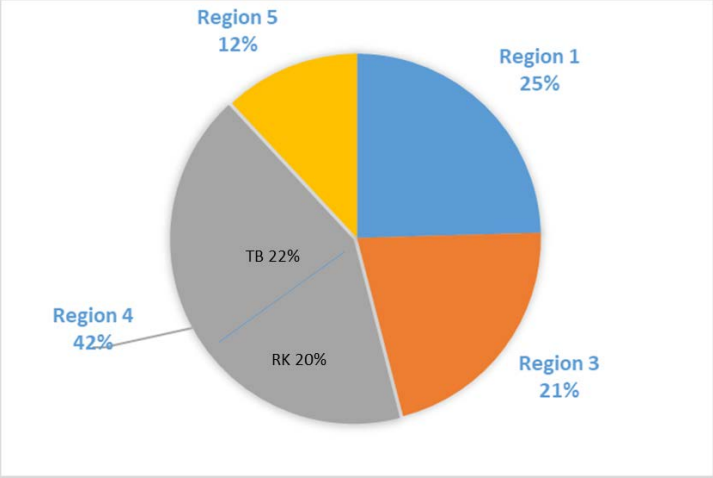
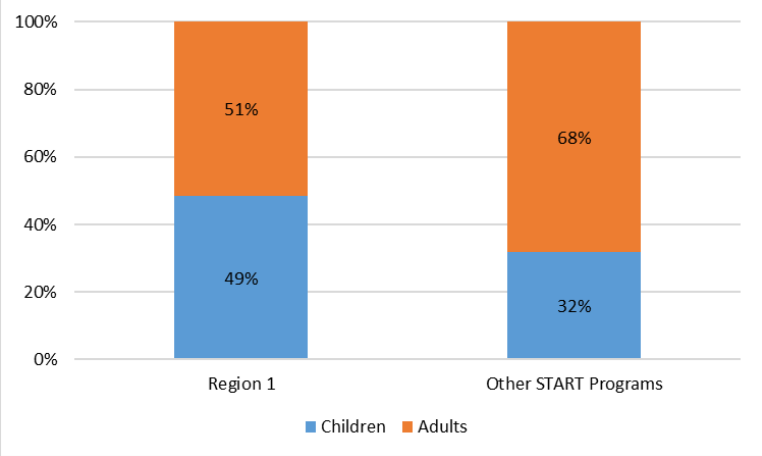
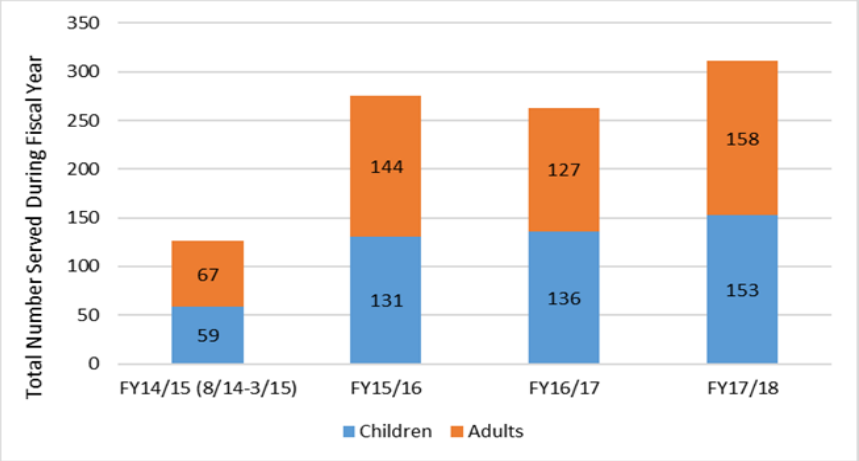


Figure 2: Percent of Active START Population by Age Category for Region 1 and Other START Programs



To date, Region 1 has served a total of 524 individuals since program inception (272 adults and 252 children) with a current active enrollment population of 212. The total yearly census for FY17/18 was the largest to date with a total of 311 individuals receiving services (figure 3). The program has been hiring and training staff and now has 12 coordinators (and 1 coordinator vacancy) and a goal to achieve a total active caseload of at least 300 individuals.

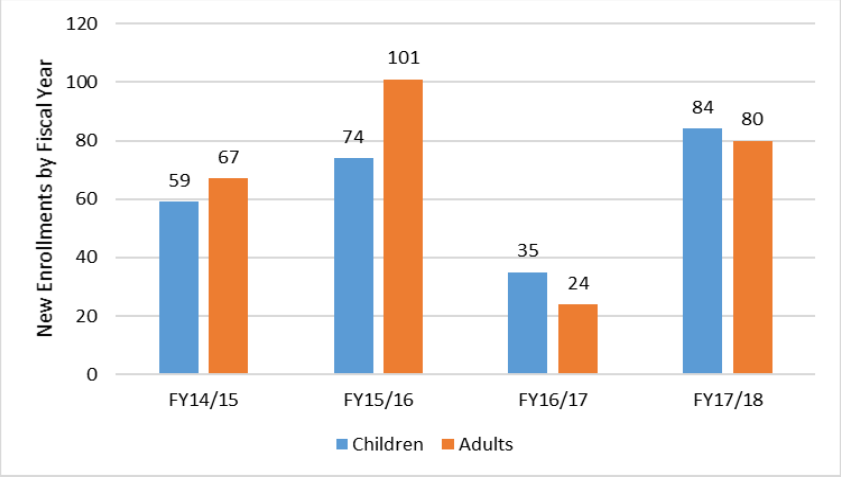
Figure 3: Number of Individuals Served by Region 1 by Fiscal Year*



*Most Individuals have received services in multiple fiscal years.

Figure 4 shows the number of newly enrolled individuals in Region 1 each year since program operations began. There was a decrease in enrollments in FY16/17 due to a referral hold, resulting from the high numbers of referrals in the previous year. The influx of referrals in FY15/16 created strain on the START program and the system as a whole, and the program has worked diligently over the last year to improve stability for enrolled individuals and build community and program capacity. This work has resulted in the enrollment of over 150 individuals in START services during this reporting period. However, Region 1 team needs to reach out to community partners and make them aware that they are accepting referrals in order to maximize caseload capacities.

Figure 4: Number of Individuals Enrolled in Region 1 by Fiscal Year (n=524)



While individuals are not discharged from NYSTART, they are inactive once they reach a period of stability or because their situation has otherwise changed (they leave the Region or they no longer wish to continue services). To date, Region 1 has inactivated a total of 312 individuals. The average length of stay (LOS) in Region 1 START is just over 13 months for all individuals. For individuals who have achieved stable functioning, the average LOS is 17 months. This falls within the national average of 12 – 18 months. The inactivation of so many people is unusual and additional review and focus is needed.

Recommendations from Fiscal Year 2016/2017 Annual Report/Progress

Program Enrollment

- Caseloads dropped significantly throughout FY2016/2017. There was a limited period of not taking new referrals when caseloads were too high, and this seems to have affected the engagement with the system as referrals were slow to return. In early FY2017/2018, enrollments have begun to climb but it is recommended that the Region 1 program develop a plan to assign and sustain caseloads in the long term. This plan should include outreach efforts, linkages and ongoing caseload analyses.
    - In FY2017/2018, the Region1 team was able to increase enrollment, and served over 300 individuals.
    - The rate of enrollment is now steady and appropriate for ongoing growth of the program and within a range allowing for adequate work on secondary and tertiary level interventions.
    - At full capacity, with 13 coordinators, the target census for active cases about 300 cases. Currently, there is 1 coordinator vacancy and 212 open cases. The program should continue to build caseload sizes with a goal of hitting the established benchmark by the end of FY 2018/2019.
- Additional consideration and review of the reasons for inactivity are needed at this time since 20% (n=26 individuals) were made inactive due to no longer requesting services.
    - A similar percentage of the open cases were made inactive this year for these same reasons. See discussion and recommendations in the report for suggested remedies for this ongoing concern.

Characteristics of Persons Served

- Continue to work with the regional stakeholders to assess for needs of the families and develop strategies to address. Focus on primary intervention strategies such as outreach and training to existing family support groups.
    - There continues to be a high percentage of active enrollees who are children and nearly all of children reside with the families. This is ongoing and should continue into FY2018/2019.
- The high percentage of children diagnosed with ADHD has been a consistent trend in the region. Training for the team and to the system on differential diagnosis related to ASD, ADHD, anxiety disorders, and trauma related disorders may be helpful.
    - Region 1 provided a larger number of community based trainings to teams serving with focus on recognition of anxiety and trauma related challenges, and continued education regarding supporting individuals with ASD and ADHD.
    - Data from intake regarding assigned psychiatric diagnoses suggests some improvements are being made in recognizing anxiety disorders and less probable misdiagnosing of Bipolar Disorder. More work clearly needs to be done so that the syndromes that are much more likely and common are routinely diagnosed in this population.
- Continue to engage the system in identifying medical conditions. This has greatly improved during this reporting period and should continue to be an area of focus.
    - Reported rates for various medical concerns are more consistent with expected rates for these comorbidities, though continued work is needed to be certain such concerns are recognized as

potentially being the source of distress that is driving emotional instability and challenging behaviors. It remains a concern that medical issues are addressed when there is evidence of them being present or under-treated.

- Ensure adequate consultation for gastrointestinal and neurologic conditions. Work with START Medical Director to identify system gaps and strategies to address those gaps.
    - This is a goal that was not specifically addressed and the program should work with the medical director during this fiscal year to accomplish this goal.

Emergency Service Trends

- The use of emergency departments prior to START is especially high for the adults who are referred. While there is a substantial reduction in this with START involvement, the over-reliance on the ED continues to be a trend in the system. It would be helpful to identify if the ED use is more frequent among individuals who live with families or those who live in residential settings. This could lead to development of targeted strategies including outreach, training, and refinement of the cross system crisis plan.
    - Post START enrollment ED use by adults served is lower this year, likely due to increased outreach services and both child and adult ED use is between 8-10%.

- The program should review the current linkage agreements and develop a plan to update and/or develop new agreements with stakeholders within the region. With the very high number of enrollments for children in the region, additional linkage development and outreach may be needed to ensure good collaborations with providers who primarily serve children.
    - There has been an increase in formal linkage agreements during this reporting period (10 additional linkages this fiscal year), which demonstrates a positive trend toward collaboration with key community partners though more work in this area is needed. This is an ongoing goal and is recommended to continue in the coming fiscal year.

START Service Trends

- Documented outreach efforts have decreased this year compared to the previous reporting period. In addition to perusing additional linkage agreements within the region and educating stakeholders on the role of START in the community, the opening of the Therapeutic Resource Center in the near future requires outreach efforts to be frequent and consistent. The program should develop a plan to assure that community outreach is being done on a regular basis.
    - Community outreach was provided at a higher rate this year than last, but remains below START standards for adults. See the following report for review of this concern and recommended remedies for FY2018/2019.

- The data presented does not clearly identify the use of START's National Online Training Series as a resource for the program and its stakeholders/partners in the community. It is recommended that the training series be utilized as intended and that the program provide data on attendance and quality of the trainings in their local community through the submission of attendance sheets and surveys. CEUs can also be offered for this series and is a valuable marketing tool for the Region 1 program.
    - Some data were provided suggesting attendance by community partners at these trainings, but the numbers of people was not reported. This will be an important goal moving forward in order to ensure that professionals in the local area receive access to cutting edge, best practices in the field of

IDD and MH. One specific way to increase attendance is to alert all potential participants that Continuing Education Credits can be made available.

- The Region 1 program should analyze how coordinators are entering time spent in crisis planning to understand why the documented time spent on these activities is lower than expected. A plan to improve this area of time tracking should be developed.
    - Additional coordinator training was provided this year on the START Information Reporting System (SIRS) and entering data into SIRS.
    - Data suggest an ongoing problem with low amounts of time spent on CSCPIP. See the report that follows for remedies recommended for this ongoing concern.
- Region 1 should monitor and assure that crisis plans are being updated annually and after a crisis contact.
    - As noted, data suggest an ongoing problem with time spent on CSCPIP. See below for details and remedies recommended for this ongoing concern.
- A plan to improve the completion of the CSE tool should be developed. This is a valuable resource for many teams and is being underutilized in Region 1 with only 5% of enrolled individuals receiving this service during the reporting period.
    - CSE completion in FY 2017/2018 was 4%. See the following report for details and remedies recommended for this ongoing concern.
- The National START Team will work with Region 1 to develop some metrics utilizing FEIS data that can be used to evaluate the work of START in improving family perceptions of the mental health care their family members receive.
    - This was not completed in FY 2016/2017 but should be considered in further planning between the Center for START Services and the Region 1 program.
- During the final quarter of this fiscal year, therapeutic coaching staff began tracking hours differently in order to differentiate between planned and emergency in-home hours. In the upcoming fiscal year, all reports will break out in-home hours into these two categories.
    - Data was reported using this recommended break out for FY 2017/2018.
    - Data show there was very infrequent use of emergency IHTC services (only 2% of all of the IHST hours were for this purpose).
- The high rates of crisis calls for less than half of the individuals enrolled in services may mean that the START program is using their crisis line like a hotline or warmline. More systemic engagement with individuals' teams/supports is needed along with a closer analysis of the data to assure that contacts are coded correctly in the database.
    - There were still individuals with between 30-40 contacts to the crisis line this year. Data suggest work needs to be done to train and support systems with identifying crises earlier, and engaging the needed planned supports to reduce stress over time.
    - It is unclear if all of the possibly helpful START components were fully employed to reduce frequent repeated calls of some of the individuals served (i.e. Was enough outreach provided? Was IHTC used when needed?)
- A plan needs to be developed in order to assure that the team leaders and coordinators have the skills and a clear understanding of START crisis contacts to assure that they are responding in person when necessary. Only 25% of individuals who call the crisis line receive a face-to-face assessment.

- Over the course of FY2017/2018, Region trained coordinators regarding the importance of face-to-face outreach meetings for providers, families and individuals enrolled in services in promoting stability.

- Schedule a SIRS training to ensure that the team is accurately reporting and coding calls to the crisis line.
  - SIRS training was provided and there has been an improvement in recording of crisis contacts.

Findings

Following is an analysis of enrollment, demographic and service outcome data for NYSTART Region 1 for FY2017/2018 (April 1, 2017- March 31, 2018).

Enrollment trends, characteristics of persons served, emergency service trends, and service outcomes of those served by NYSTART Region 1 are based on data entered into the START Information Reporting System (SIRS). When noteworthy, elements are compared to other NYSTART programs or to national START trends.

Section I: FY2017/2018 Program Enrollment

Data below reflect all individuals served by Region 1 during this report period.

Table I.A: FY 2017/2018 Census Summary

Region 1	FY 17/18 (n=311)	
Variable	Children	Adults
Total Served during reporting period N(%)	**153 (49%)**	**158 (51%)**
FY18 New Referrals	84	80
Individuals inactivated	**50**	**49**
Stable functioning	21 (42%)	30 (61%)
Moved out of START region	-	1 (2%)
No longer requesting services	11 (22%)	11 (22%)
Inappropriate for services	2 (4%)	2 (4%)
No contact	16 (32%)	5 (10%)
Long term placement	-	-
Deceased	-	-
Unreported	-	-
Active Caseload at the end of reporting period	**103 (49%)**	**109 (51%)**

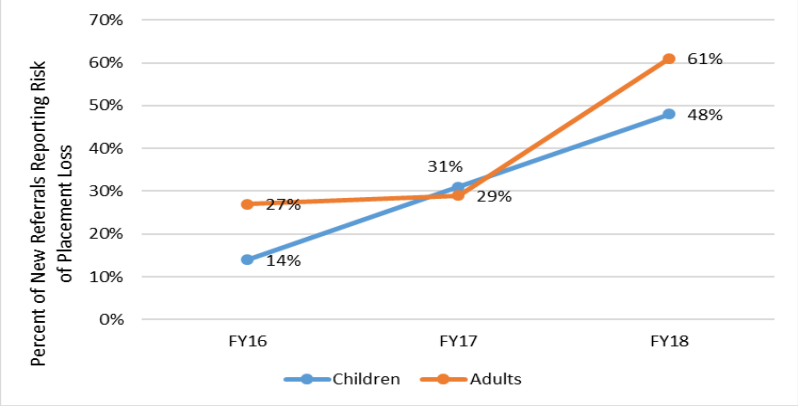
Table I.B: Sources of Referral (FY 17/18 new enrollments only)

Region 1	FY 17/18 (n=164)	
Variable	Children	Adults
N	84	80
Referral Source (%)		
Case Manager	86%	80%
Emergency Department/mobile crisis	2%	1%
Family Member	5%	6%
Residential/Day Provider	-	3%
Hospital/ID Center	2%	-
Mental Health Practitioner	4%	8%
Other (Behavior Analyst, School)	1%	1%
Missing	-	1%

Table I.C: Reasons for enrollment (FY 17/18 new enrollments only)-More than one option can be selected

Region 1	FY18 (n=164)	
Variable	Children	Adults
N	84	80
Most Common Reasons for Enrollment (%)		
Aggression	96%	78%
Family Needs Assistance	89%	49%
Risk of losing placement	48%	61%
Decreased Daily Functioning	49%	68%
Dx and Treatment Planning	64%	66%
Mental Health Symptoms	43%	69%
Leaving Unexpectedly	30%	16%
Suicidality	19%	11%
Self-Injurious Behavior	25%	23%
Sexualized Behavior	7%	10%
Transition from Hospital	6%	6%

Figure I.A: Trends for Reports at Intake that Risk of Loss of Placement was a Reason for Referral for Individuals enrolled in Region 1



Summary

- Census: The Region 1 program served over 300 individuals during the FY 2017/2018.
- Referral Source: Case managers continue to be the primary source of referral to Region 1, as is common in many START programs. The percentage of new enrollments resulting from referrals from case managers has increased in FY 17/18, possibly due to the maturity of the program and work on linkages with systems of care.
- Reasons for referral: As expected, aggression is the primary reported concern at intake for START enrollees, which is consistent across all START programs. However, some positive trends are also evident. There appears to be an increasing recognition by the system of care that individuals with IDD may need added support related to mental health symptoms. Most people with IDD who are referred for mental health treatment present with some form of externalizing behavior such as aggression to self, others or property. In the past when additional education is needed, there has been a tendency to attribute aggression and associated mood challenges to IDD itself, a phenomena called *diagnostic overshadowing*. Referral sources also frequently requested assistance with diagnostic clarification, which is another positive trend.

  An ongoing and very major concern is that children and adults are often referred to Region 1 with a reported risk of losing their placement. Data for FY 2017/2018 demonstrates that most all of the reported crisis events were resolved with placement maintenance (details provided later in this report). These data suggest the need for greater attention to specific characteristics associated with this rising need. In addition, an important role of START is to enhance and bolster existing caretaking systems so that people do not have to move in order to be safe or to attain an improved quality of life.
- While over 150 new enrollments during the reporting period, a subset of cases were made inactive. Individuals enrolled are never discharged from START services and may be inactivated for a number of reasons. Inactivation may occur if a person moves out of the region and every effort is made in these instances to help the individuals be connected to another START program if one is available. The ideal reason for inactivity is stability or the individual is doing well and no longer needs START services, which occurred for 21 children and 30 adults during FY 2017/2018. There are other instances in which people disengaged from START for other reasons (at times unknown). In some situations, a family member or other caregiver might disengage from services early on before having the opportunity to experience START related supports. Often family members have a long history of disappointing encounters with systems of care. As described below, it is an important aim to study factors impacting disengagement and find ways to increase retention of anyone who has been referred and is likely to benefit from START.

Recommendations

- Region 1 should enhance and build linkages and provide outreach and education to increase capacity in the system of care in understanding the many factors that influence the development of distress and behavioral health challenges leading to referrals to the program. Ongoing efforts should also continue to maximize enrollment of new cases within the capacities of the program.
- To better understand the trends noted in regards to rising reports of risk of loss of placement, it would be important to determine if Region 1 interventions reduce actual loss of placement when compared to report at intake at one year of follow-up.
- Region 1 should develop a survey to determine why stakeholders no longer want NYSTART services after a period of enrollment to ensure that capacity has been built and that they are satisfied with services and support provided by the Region.

Section II: Characteristics of Persons Served

Demographics

Section II of this report provides demographic and diagnostic trend data for all individuals served by NYSTART Region 1 (N=311) during FY 17/18 (April 1, 2017-March 31, 2018). There are no significant differences in the demographics of active individuals in FY 17/18 compared to previous fiscal years. When relevant, the Region 1 population is compared to other NYSTART programs the START population from other lifespan programs.

Table II.A: Age, gender, race, level of ID, and living situation

Region 1	FY 17/18 (n=311)	
Variable	Children	Adults
N	153	158
Mean Age (Range)	13 (6-17)	29 (18-61)
Gender (% male)	79%	61%
Race		
White/Caucasian	72%	84%
African American	16%	11%
Asian	3%	2%
Other	4%	2%
Unknown/Missing	5%	1%
Ethnicity (% Hispanic)	3%	4%
Level of Intellectual Disability (%)		
No ID/Borderline	23%	11%
Mild	26%	49%
Moderate	22%	29%
Severe-Profound	7%	7%
None Noted	**20%**	3%
Missing	2%	-
Living Situation (%)		
Family	92%	55%
Group Home and Community ICF/DD	3%	28%
Independent/Supervised	-	11%
Psych. Hospital/IDD Center	1%	3%
Other (Jail, Homeless, "Other")	2%	3%
Missing	3%	1%

Summary

- The average age of adults served by Region 1 is 29, slightly lower than that reported for most START programs (32 years of age). Other demographic data are similar to that reported for other START programs. In the general population of people with IDD, the overwhelming majority are described as having a mild or borderline IDD, while providers of mental health care to the population will often care for a disproportionate number of people with moderate or severe IDD. Research has shown that this sub-population suffers from more health conditions, and has a variety of more complex needs, even when compared to individuals with an IDD who have less cognitive impairment.
- Research has demonstrated that both important social, emotional and economic benefits result from keeping families together. The availability of a natural support system has been identified as one of the most robust protective factors in promoting mental wellness. As shown in Table II.A. almost all of the children and over half of the adults being served in Region 1 reside with family caregivers. This presents unique opportunities to support people with IDD to remain integrated into their communities and with natural supports. It will continue to be a mission of the Region 1 program to provide outreach and support to family caregivers, including the opportunity for access to NYSTART home and center based therapeutic supports.
- There was a somewhat large number of children for whom data regarding level of Intellectual Disability was missing (20%).

Recommendations

- It is recommended that Region 1 identify and enter missing data that are retrievable from caregivers and other referral sources and should reduce missing data for children's level of IDD.
- Expansion of the START Therapeutic Services described later in this report should be aimed at supporting families and individuals who optimally would be able to continue to live in their current setting

Mental Health and Chronic Health Conditions

Table II.B: Mental health conditions

Region 1	FY 17/18 (n=311)	
Variable	Children	Adults
N	153	158
Mental Health Conditions (%)		
At least 1 diagnosis	84%	83%
Mean Diagnoses (range)	1.9 (1-7)	2.4 (1-7)
Most Common MH Conditions (%)		
Anxiety Disorders	21%	25%
ADHD	41%	25%
ASD	76%	38%
Bipolar Disorders	4%	22%
Depressive Disorders	8%	34%
Disruptive Disorders	22%	36%
OCD	5%	11%
Personality Disorders	1%	13%
Schizophrenia Spectrum Disorders	1%	15%
Trauma/Stressor Disorders	6%	9%

Figure II.A: Frequency of most common mental health conditions for enrolled children (trends across START)

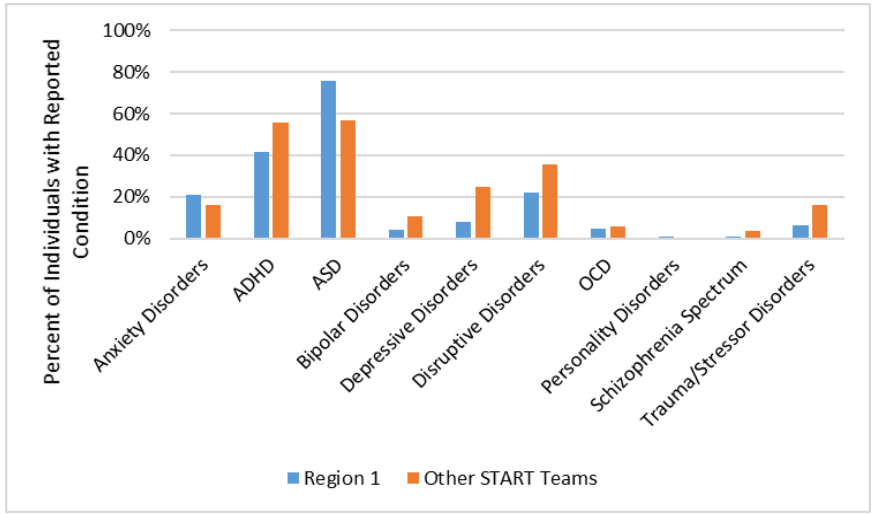


Figure II.B: Frequency of most common mental health conditions for enrolled adults (trends across START)

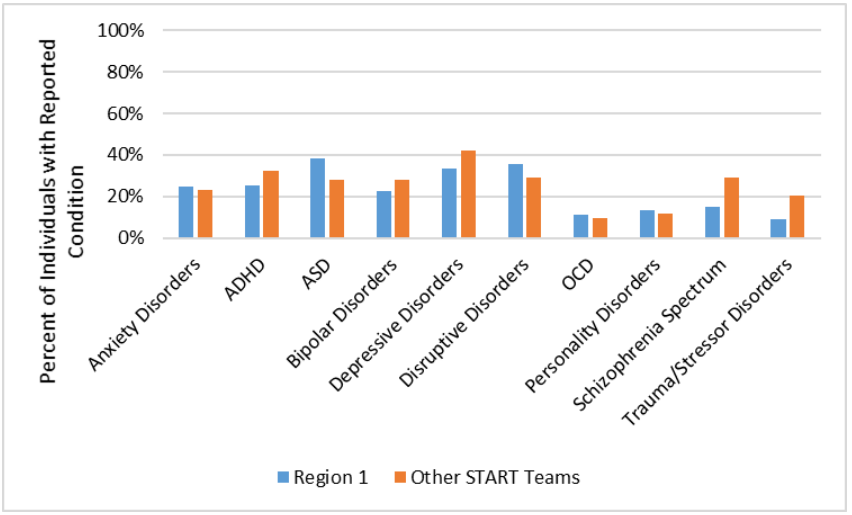


Table II.C: Percent of Region 1 enrollees with chronic medical conditions reported at intake.

Region 1	FY 17/18 (n=311)	
Variable	Children	Adults
N	153	158
Medical Diagnosis (%)		
At least 1 diagnosis	36%	59%
Mean Diagnoses	1.8 (1-6)	1.8 (1-6)
Most Common Medical Conditions (%)		
Cardiovascular	7%	23%
Endocrine	7%	20%
Gastro/Intestinal	35%	28%
Genitourinary	4%	3%
Immunology/Allergy	15%	9%
Musculoskeletal	5%	9%
Neurologic	38%	39%
Obesity	7%	14%
Pulmonary disorders	5%	6%
Sleep Disorder	11%	10%

Figure II.C: Frequency of most common medical conditions for enrolled children (trends across START)

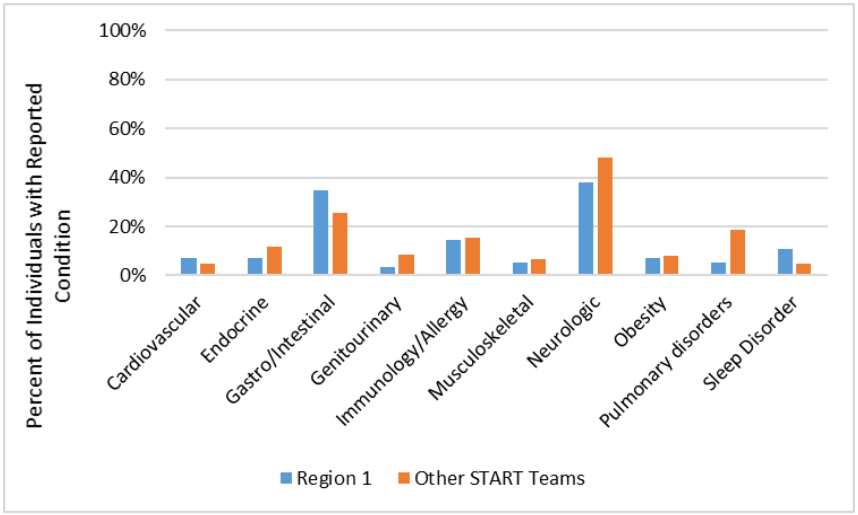
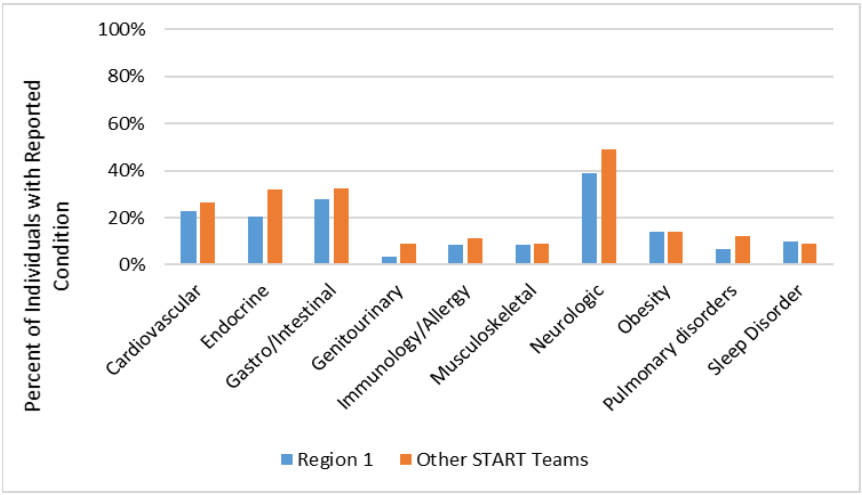


Figure II.D: Frequency of most common medical conditions for enrolled adults (trends across START)



Summary

- Region 1 serves the same percent of children with ASD (over 3/4 of all enrolled children) as do most other START programs serving youth but serves a larger proportion of children than most other START programs.
- Data regarding diagnoses for children served during this reporting period demonstrated an increase in identifying anxiety and trauma, with reduced numbers of youth reported with bipolar disorder. These trends are more in line with the well-controlled studies in which there are direct clinical assessments performed using adapted diagnostic criteria. The lower number of enrollees diagnosed with a "disruptive disorder" is also encouraging, demonstrating a shift towards better recognition of the sources of externalizing behaviors as being more complex. Despite these trends, it is suspected that more individuals than reflected have trauma and anxiety, and that continued work is needed to educate the system of care on the details of a comprehensive differential diagnostic assessment and case formulation when evaluating individuals with IDD. Of both, the children served frequently have multiple psychiatric diagnoses (mean = 1.9).
- Both children and adults served by Region 1 have high rates of medical comorbidities, with neurological and GI issues being most prevalent. For individuals with IDD who also have behavioral health challenges, undetected or undertreated medical problems (including medication side effects) may cause or worsen emotional and behavioral symptoms. This can be secondary to individuals with IDD being poor reporters of their own health concerns, the tendency for informants to attribute behavior changes to "learned behavior" or mental illness, and the fact that many people with IDD have few ways to demonstrate distress. A similar presentation may be seen whether the provoking factors are biological, psychological or social, or some combination of these. The increased work by the Region 1 team appears to have been helpful in raising awareness, but the numbers here are still lower than expected as about 50% of children and 65% of adults will have at least one health condition.

Recommendations

- Primary outreach and educational efforts should continue. Focus in FY 2018/2019 should include more work on accurate diagnostic case formulations, recognition of anxiety, trauma related issues and medical comorbidities as well as other training topics.

Section III: Emergency Service Trends

Table III.A: Emergency Service utilization

Variable	Children	Adults
N	153	158
Psychiatric Hospitalization		
Prior to enrollment, N (%)	**22 (14%)**	**49 (31%)**
Mean Admissions (range)	1.8 (1-8)	2.2 (1-14)
Missing	14 (9%)	13 (8%)
During START, N (%)	**1 (1%)**	**10 (6%)**
Mean (range)	1 (1)	1.3 (1-2)
Average length of stay (days)	45 days	5 days
Emergency Department Visits		
Prior to enrollment, N (%)	**47 (31%)**	**74 (47%)**
Mean Visits (range)	3.0* (1-99)	3.9** (1-100)
Missing	15 (10%)	14 (9%)
During START, N (%)	**12 (8%)**	**33 (21%)**
Mean (range)	2.3 (1-10)	2.8 (1-15)

*There is one child with 99 ED visits documented. The range omitting these outliers is 1-20. The calculated mean excludes this outlier.

**There is one adult with over 100 ED visits and 3 with over 40 documented. The range omitting these outliers is 1-30. The calculated mean excludes outliers.

The figures below show the change in frequency between pre- and post-enrollment emergency service utilization for NYSTART Region 1 enrollees.

Figure III.A: Change in frequency of pre and post START enrollment emergency service utilization (children)

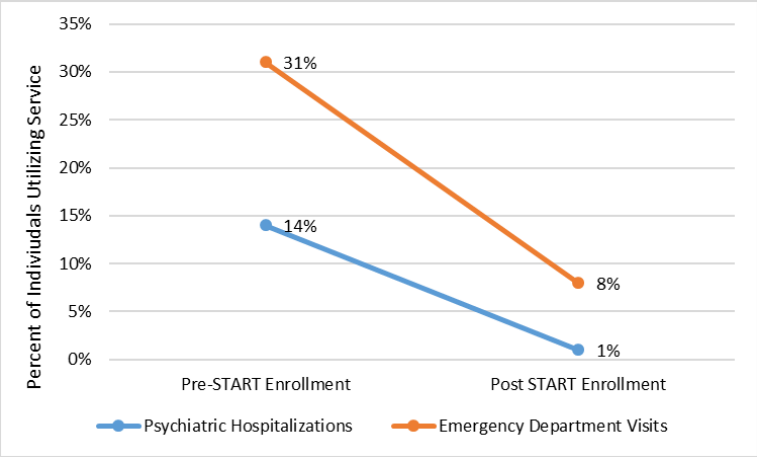
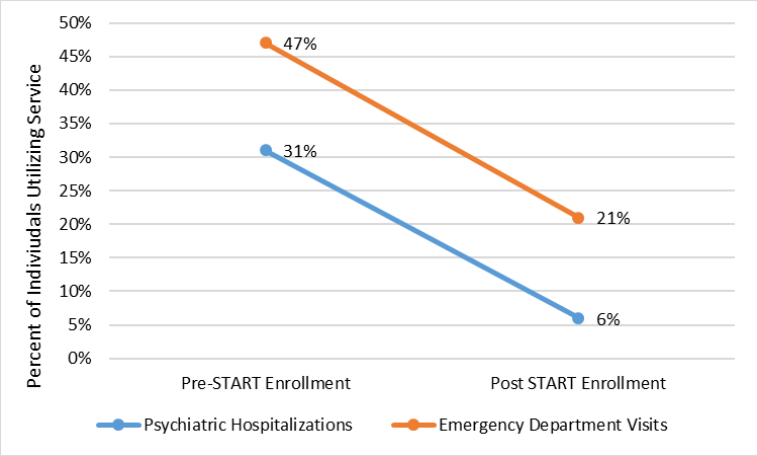


Figure III.B: Change in frequency of pre and post START enrollment emergency service utilization (adults)



Summary

- The change in ED and psychiatric hospitalization rates from pre to post NYSTART Region 1 enrollment was very encouraging for both children and adults.
- Region 1 is the only NYSTART region with some missing data for pre enrollment utilization (10%).

Recommendations

- Region 1 leadership should meet and determine a method to gather data at intake regarding past year ED and psychiatric hospitalizations in those instances when it is not readily available, as well as working to ensure that any and all ED visits and hospitalizations are recorded in SIRS, even if a START person was not called. In the latter instance, data should be recorded when it is uncovered. An important goal should be to increase the use of START crisis responders when there are ED visits or psychiatric hospitalizations.

Section IV: START Clinical Services

Based on a tertiary care approach to crisis intervention, START service measures fall into three crisis intervention modalities:

> **Primary (improved system capacity):** Clinical Education Teams (CETs), community education, training, and system linkage;
>
> **Secondary (specialized direct services to people at risk of needing emergency services):** Intake and assessment activities, Comprehensive Service Evaluations (CSE), outreach, clinical and medical consultation, and Cross Systems Crisis Prevention and Intervention Planning (CSCPIP); planned therapeutic supports (Resource Center and Therapeutic Coaching) and
>
> **Tertiary (emergency intervention services):** emergency assessments and mobile support as well as other emergency services such as hospitalizations and emergency room visits used by START recipients (includes emergency therapeutic supports).

This section looks at utilization patterns in each of these services**.** The goal of START is to support and assist the system in moving from tertiary care (emergency level of crisis intervention services) to primary intervention (able to assist when vulnerable) and secondary services (getting expert assistance without the use of emergency department utilization or psychiatric hospitalization). This is achieved by building capacity across the service system in order to prevent and assist with potential problems rather than manage them as crises later.

Primary Services

Building system capacity to support individuals in their homes and communities.

The following is a summary of the primary service activities reported by Region1 team members since program operations began. Primary START services include system linkages, education and community training. These services are part of the plan to improve the capacity of the system as a whole so that improvements are effective and sustainable over time. Over the last year, the NYSTART team has engaged the community to provide training and education around the unique needs of individuals with IDD and co-occurring behavioral health issues and continues to engage the system to become active participants in the START learning community.

Table IV.A Community training activities

Region 1	**FY17/18**
Number of Activities (N)	
Community-based training	28
Host Advisory Council Meeting	6
Provided Training (N)	
Day provider	-
Emergency services	-
Family	-
Other	5
Physician/medical personnel	3
Residential provider	5
School	-
State facilities (state hospitals, developmental centers)	-
Therapist/mental health providers	4
Transition Support/Planning-Developmental Center	-
Transition Support/Planning-Psychiatric Hospital	1

Total Community Outreach/Training Episodes (N)	52
Total Linkage/Collaboration Agreements Completed Since Program Inception (N)	27
Total Clinical Education Teams in FY17/18 (N)	7

In addition to the above reported specific training and linkage activities, a number of more informal outreach efforts were made. These included providing community partners with information about START and issues pertaining to the population served. More information about these activities can be obtained from the Region 1 Program Director.

The following is a list of some of the training provided to the community as part of the primary services provided by the region during FY17/18.

Table IV. B.: Community Trainings (4/2017-3/2018)

Date	Presenter	Topic/Presentation Type	Location
4/25/17	M. Valder	CET Tourette Syndrome and Other Concerns	Canandaigua, NY
7/11/17	D. Schutt/Dr. D. Messer	CET Electronic Gaming Therapy	West Seneca, NY
10/3/17	E. Drake/D. Braiman	CET Electric Convulsive Therapy	Batavia, NY
10/10/17	J. Mauro/R. Hazlitt	CET Diagnostic Overshadowing in Individuals with IDD	West Seneca, NY
10/24/17	T. Kelly/R. Hazlitt	CET Communication Disorders and Behavioral Concerns	West Seneca, NY
11/14/17	L. Gottorff/R. Hazlitt	CET Positive Behavior Supports	Ashville, NY

Table IV. C: National START Practice Groups

As part of the START model and the national START Professional Learning Community, NYSTART personnel participate regularly in national practice groups with other professionals. These forums are opportunities to gain knowledge and skills needed to improve system capacity. The goal of these groups is to insure that all START teams have the latest knowledge and technical support to provide evidence-based services in all areas of service provision. These study groups include:

- Clinical Directors Study Group, facilitated by Jill Hinton, Ph.D.
- Children's Services Study Group facilitated by Karen Weigle, Ph.D.
- Resource Center Directors Study Group, facilitated by Bob Scholz, M.S., LMHC
- Medical Directors Study Group, facilitated by Karen Weigle, Ph.D. and Laurie Charlot, Ph.D.
- Team Leaders Study Group, facilitated by David O'Neal, MS, and Alyce Benson, MSW
- National Program Director forums held quarterly facilitated by Andrea Caoili, LCSW and Joan B. Beasley, Ph.D.
- National START Online Training Series, offered by the Center for START Services to START programs
- The START National Training Institute chaired by Joan B. Beasley, Ph.D., Director of the Center for START Services

Summary

- Region 1 has continued to provide outreach and training to all sectors in the local system of care, to enhance capacity to understand and support individuals with IDD with behavioral health needs. These primary level services are viewed by START as an essential component of the model, and can reach and influence the care of more individuals in need than do other forms of intervention (secondary and tertiary).

Recommendations

- Continue to provide and expand the frequency and number of trainings offered, with ongoing focus on accurate case formulation and psychiatric diagnostic assessments, health concerns and supporting families with individuals at home who have challenging behaviors and complex service needs.
- Plan to provide specific data on the number and nature of attendees at trainings to better characterize the scope of reach of these efforts and identify any gaps where added work is need to reach out with educational opportunities.
- While there is an improvement in community linkages during this reporting period, it is recommended that relationships and linkages continue to be fostered by the NYSTART Region 1 program throughout the region. Additional efforts should be made this year to gain linkages with schools, emergency service providers, and other community services providers. Feedback from coordinators regarding engagement with partners should guide development and refinement of linkages.
- In order to meet program fidelity, it is expected that Region 1 conduct 10-12 Clinical Education Team meetings annually. Use this forum as one of the ways to provide more education regarding health problems, given the high rate of medical comorbidities identified in the population served.

Secondary Services

Specialized direct services to people at risk of emergency service use

Secondary services help to ensure that individuals are getting the supports they need to intervene effectively in times of stress and avoid costly and restrictive emergency services.

The following planned, secondary services are offered by all START programs and time spent on these activities is tracked in SIRS.

- *Intake/Assessment:* Work done to determine the needs of the individual and their team, and the services to be provided. Includes: Information/record gathering; intake meeting; completion of assessment tools; and START action plan development.
- *Outreach*: Any time the START Coordinator provides informal education or outreach to the system of support related to general issues or those specific to the individual. Entities to which the START Coordinator may provide outreach: families/natural supports, residential programs, day programs, schools, mental health facilities, or any entity that may seek or need additional support and education.
- *Clinical Consultation*: Consultations provided by the Clinical Director with community team members who support individuals. Recommendations are given facilitation of goal and action plan development is done by the START Coordinator.
- *Medical Consultation:* Consultation provided by the START Medical Director regarding medication and other medical issues, includes collaboration with prescribing doctor. Recommendations are given facilitation of goal and action plan development is done by the START Coordinator.
- *Cross System Crisis Planning*: Completion of the Cross Systems Crisis Intervention and Prevention Plan (CSCPIP) includes collecting and reviewing relevant information; brainstorming with the team; developing/writing the plan and distributing; reviewing and revising; and training and implementation the plan with the system of support.
- *Crisis Follow-Up*: Time spent following up after a crisis contact. This includes facilitating emergency service admissions and discharges, meetings with emergency service providers and follow-up on crisis plan recommendations.

- *Facilitation of Planned Therapeutic Supports (Resource Center, Therapeutic Coaching)*: Work/coordination related to preparing for and facilitating planned center based or in-home supports.
- *Clinical Education Team (CET)*: Preparing for and holding a CET regarding the enrolled individual. Includes reviewing and identifying relevant recommendations with Clinical Director and assisting system of support with implementing recommendations.
- *Comprehensive Service Evaluation (CSE)*: Completion of the CSE, including receiving and reviewing records; interviewing the individual and system of support; writing the CSE; and reviewing recommendations through development of an action plan.

Table IV.D shows the percent of individuals enrolled in the region who received planned START services during the year. Since each individual enrolled in START is at a different stage of case activity and has unique strengths and needs, not all individuals received all planned services throughout the reporting period.

Table IV.D: Provision of Planned START Clinical (Coordination) Services

Variable	Children	Adults
N	153	158
Utilization of Planned Services (% of Individuals)		
Outreach	81%	78%
Intake/Assessment	68%	65%
CSCPIP	67%	64%
Clinical Consultation	59%	45%
Medical Consultation	6%	9%
Therapeutic Supports	31%	34%
Crisis Follow-Up	24%	28%

START Intake and Assessment

All individuals who are enrolled in START services participate in the Intake/Assessment process in which the START team gathers important historical and biopsychosocial information about the individual and their system of support. This process informs the next step, which is the development of a START Action Plan, outlining specific services and resources that START should provide. Assessment tools used during at intake include the Aberrant Behavior Checklist (ABC), Recent Stressors Questionnaire (RSQ), and START Action Plan. They are re-administered or updated on a regular basis as long as the individual is enrolled and actively receiving START Services.

Table IV.E: Percentage of active individuals who received assessments/tools

START Tools	Tool was completed (FY18)	Up-to-date
START Action Plan	91%	87%
Aberrant Behavior Checklist (ABC)	92%	77%
Recent Stressors Questionnaire (RSQ)	92%	93%
Cross Systems Crisis Prevention and Intervention Plans (CSCPIPs)	92%	88%
Comprehensive Service Evaluations (CSEs) Completed	4%	N/A

Aberrant Behavior Checklist (ABC)

The Aberrant Behavior Checklist (ABC) is a 58-item informant report psychopathology rating tool designed specifically for use with individuals with IDD. (Aman, Burrow, & Wolford, 1997). The ABC is administered to START service recipients at intake and again at 6-month intervals.

The ABC has been reported in the literature as an *outcome measure*, having demonstrated sensitivity to detecting changes in psychopathology ratings over time. The ABC is used here to determine if use of START services is associated with reduced psychopathology ratings over a 6 month or greater period of time. When using the ABC, the authors suggest use of the subscales, and not a total scale score. Subscales were identified via a factor analytic process, and three of these have been reported in the literature as sensitive to treatment effects, including the *Irritability*, *Hyperactivity* and *Lethargy* scales so these are reported below for active enrolled START cases in Region 1.

For this analysis, only individuals enrolled in START services for least 6 months of START service with at least two ABC scores were included (N=171). The average time between the two administrations used in this analysis was 16 months. Results show that average scores decreased as shown in Table IV.F. However, the rate for ABC completion for open and active cases was low for the reporting period (77%), which does not meet START model standards.

Table IV.F: ABC Analysis

		Mean Score			
Region1 (N=171)	**Percent with Improvement**	**Initial**	**Most Recent**	**t Stat**	**P(T<=t) one-tail**
Hyperactivity/Noncompliance	69%	25.87	19.96	6.81	<0.00
Irritability/Agitation	71%	25.16	18.98	7.20	<0.00
Lethargy/Social Withdrawal	61%	13.65	11.10	3.73	<0.00

Alpha=0.05

Summary

- Enrollees received a wide range of planned NYSTART services in FY17/18. However, reported rates for some of these services, including outreach, completion of CSCPIPs, and intake/assessment are low. All enrolled individuals should receive outreach at regular intervals until deemed stable. It is expected that over 90% of all enrollees receive intake/assessment and outreach services during the course of a year and that CSCPIP rates are at 85% or greater.
- Individuals served by Region 1 demonstrated reduced measures of psychopathology as evidenced by the ABC subscale scores reported above. This is consistent with data from other New York state and all other START programs.
- Though reduced ABC scores can be a very useful outcome measure, other factors may also be important in determining the effectiveness of interventions, including helping people remain with natural supports. Other data suggest that individuals served in NYSTART demonstrate improved functioning based on the large reduction in ED visits and psychiatric inpatient stays noted above. Collectively, these outcome measures suggest the START model is helping significant numbers of enrollees.

Recommendations

- Region 1 should develop an action plan to increase the percent of enrollees receiving intake/assessment and outreach services to be in line with national NYSTART fidelity standards by the second quarter of FY 2018/2019.

- CSCPIP time tracking is lower than the percentage of completed and updated plans documented. This may be a data entry issue or it could present an incorrect understanding of the crisis planning process. START CSCPIPS are organic, evolving documents which are facilitated by the START coordinator with the full commitment and participation of the individual's team. It is important for the Region 1 leadership team to examine the reason for incongruency and assure that clinical team members are engaging the system of support for enrollees.
- Intakes must be completed in a timely manner. Region 1 leadership should examine this concern, develop an action plan and ensure this goal is met by the second quarter of FY 2018/2019.
- Region 1 leadership should work with coordinators to ensure the completion and readministration of ABCs for active cases and that they are entered into SIRS
- Region 1 should continue to take regular data on outcomes associated with improved functioning and service effectiveness. As more components are being used, even greater reductions in psychopathology measured by the ABC would be an important indicator of the significance of these additions.
- The goal for completion of Comprehensive Eervice Evaluations is 15-20% of the current active caseload. The Region 1 program is not meeting standards in this area. Region 1 leadership team should develop an action plan to correct this and to meet standards.

Tertiary Services

Emergency interventions provided during a crisis

NYSTART tertiary services include the time spent responding to crises, facilitating necessary emergency supports, and transitioning individuals to facilities providing lower levels of care.

- Crisis Contact: An emergency call received by the NYSTART team that requires immediate triage and response, likely resulting in an in-person emergency assessment. Assessment can be conducted in a number of settings including: family home, residential setting, day program, hospital emergency department, etc. In some cases, the on call coordinator may provide consultation to family or caregivers over the phone, or may speak with the individual to help restore calm, and avert the need for higher levels of intervention such as Mobile Crisis Management services or an ER visit.

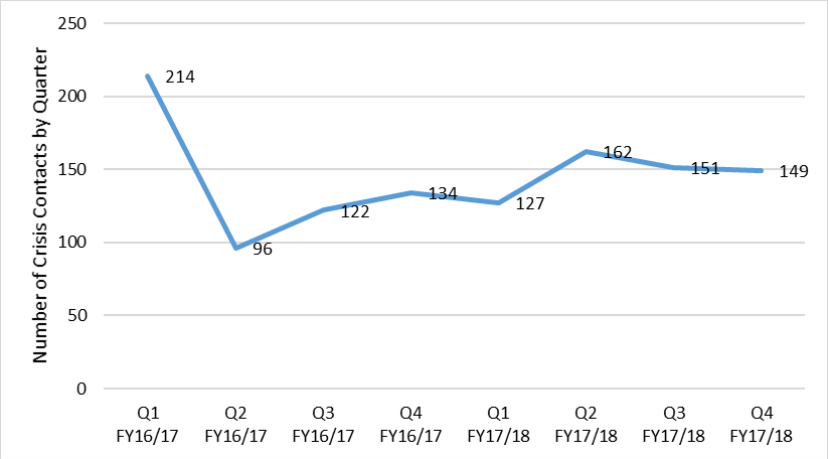
Crisis Contacts

Table IV.G: FY17/18 Crisis Contacts

Region 1	**FY 17/18**	
Variable	Children	Adults
Crisis Contacts Number of Individuals with a contact	54	64
Number with Crisis follow-up	38	44
Number of Crisis Contacts	283	306
Range of Contacts	(1-33)	(1-43)
Frequency of calls with each type of Intervention N (%) In-Person Phone Consultation Missing	 181 (64%) 99 (35%) 3 (<1%)	 168 (55%) 137 (45%) 1 (<1%)
Average Length of In-Person Intervention	3.2 hours	3.3 hours
Crisis Disposition for each crisis contact N (%) Maintain Setting	 257 (91%)	 269 (88%)
Psychiatric Hospital Admission	-	1 (<1%)
Emergency Department	23 (8%)	30 (10%)
Medical Hospital Admission	-	-
START Therapeutic Services	-	1 (<1%)
Crisis Stabilization	-	3 (<1%)
Other (Incarcerated, Referral to services, "Other")	3 (1%)	2 (<1%)

Region 1 START coordinators provide 24-hours crisis response for individuals enrolled in their program. The following chart reflects the number of documented acute crisis calls received by quarter since program inception through the end of FY 17/18. During the period of this report, Region 1 responded to 589 crisis calls from 118 different individuals (38% of population). This is consistent with usage in the previous fiscal year.

Figure IV.A: Acute Crisis Contact Trends per Quarter



Summary

- Data shows that when used, NYSTART crisis services are helpful. In most instances, the individual assisted does not end up going to or staying in an ED or being admitted to a hospital, but rather can "maintain setting."
- In-person assessments should be the predominant intervention in times of crisis. When some telephonic advice resolves the immediate issue quickly (i.e. helping a caregiver employ the CSCPIP strategies by walking through these, reminding people of options to mitigate an escalating situation), this may be the extent of the encounter. However, this requires approval of supervisor and clear knowledge of the person and their system.
- Numbers for FY 2017/2018 show an improvement in the percent of crisis calls for which an in person assessment occurred. However, outreach should be vigorous and all forms of intervention applied when individuals have as many as 30-40 crisis contacts (as illustrated in the reported range of per person contacts identified above). The team continues to educate callers to the START line about proper usage of the line and linking callers to more appropriate resources in the community when able.
- Region 1 may have underutilized Therapeutic Coaching services for individuals experiencing crises, especially individuals with multiple contacts. This is important as START can help improve outcomes for individuals at high risk of needing intrusive and restrictive care.
- Data indicated that all individuals with a crisis contact did not get crisis follow-up. This is a key service and must occur on an ongoing basis.

Recommendations

- Region 1 leadership should explore the causes for low reported rates of outreach and crisis contacts to ensure that coordinators are carefully following up on any crisis events with any and all individuals having a crisis encounter.
- An additional goal for FY2018/2019 should be to closely monitor the use of the full range of available START service options for any individuals having repeated need for use of the 24 crisis line. This includes ensuring that outreach visits are occurring at a high frequency, clinical consultation as well as Therapeutic Supports are being employed for individuals experiencing the most acute and ongoing challenges. Specifically:
    - For any individual with repeated calls to the crisis line, a review should be conducted by the Clinical Director. The clinical director working with the coordinator should then take the following steps:
        - If calling the crisis line when not in crisis, schedule phone calls to meet the person's need for contact in a preventive manner.
        - Update the CSCPIP with close involvement of the person' system of care.
        - Check the START plan and ensure this is in alignment with the high need profile of the cases reviewed.
        - Present the case to the medical director.
        - Complete a CSE.
        - Organize a systems meeting and review.
        - If appropriate, schedule a CET.
        - Develop a detailed action plan to reduce crisis events based on above and in conjunction with the person's system of care.
- Continued efforts should be made to educate, link with and encourage full use of START crisis services by enrollees' caregivers when help is needed., which now may include the full array of Therapeutic Services.

Section V: START Therapeutic Services

In-Home Therapeutic Coaching

NYSTART Therapeutic Coaching services are designed to be a short term, therapeutic services provided to an individual in their current setting. The need for this service is determined by the Start Coordinator in collaboration with the Clinical Director, Therapeutic Coaching Team Leader, individual and their circle of support. Person centered, positive psychology based approaches are used to address identified goals that help enhance an individual's social skills, coping strategies, and other related skills while enhancing the system's ability to support the individual through psycho-education and training. Therapeutic Coaching supports can be provided within a variety of settings including family homes, an individual's own home, group homes, day support programs, CPEPs, and residential treatment facilities. The purpose is to provide the individual and system with enhanced understanding, skills and tools to successfully address stressful situations. Other outcomes include the maintenance of the individual's current residence and/or services and to assist the individual and team in linking to services.

Table V.A: Therapeutic Coaching

Region 1	**FY 17/18**	
Variable	Children	Adults
In-Home Therapeutic Coaching		
Individuals Served	39	28
Average number of hours (range)	34 (1.75-140)	29.5 (3-107.5)
Total hours provided	1311	910

Resource Center

The following table reflects utilization of the START Resource Center. The program has four beds half of which are designated for planned admissions. Planned admissions are intended to serve adults who live with their families or natural supports and have not been able to use respite in more traditional settings due to ongoing behavioral health concerns. Depending on the needs of the person and his/her family, the frequency and length of planned Center admissions may vary but average about 3 days per admission. The other two beds are designated for emergency admissions, which serve adult enrollees experiencing acute crises. Emergency admissions are longer and average about 20 days, during which time, guests received assessment and individualized intervention and discharge planning.

Table V.B: Center-Based Supports

Region 1	**Program to Date**	
Variable	Planned Admissions (opened 1/10/2018)	Emergency Admissions (opened 1/29/2018)
Number of individuals admitted	8	3
Total number of admissions	10	3
Range of days	1 to 14	9 to 29
Avg LOS (days)	5	19
Total time spent in resource center (days)	52	56
Number of individuals with more than 1 admission	2	0
Percent of individuals with more than 1 admission	25%	0%
Occupancy Rate (2 beds)	33%	46%

Summary

- Newly launched Resource Center services are being refined and expanded, and should add important additional options for supporting individuals in need. The program has been in early stages of development, and the center based staff and Region 1 leadership team are all learning from experiences with the initial guests as well as from colleagues in other START programs where Resource Center services have been available for more than one year. In particular, the team is learning how to support individuals in creative and positive ways, insuring that the activities are health promoting and provide a forum for people to learn new helpful skills, and for the team to make use of these admissions to expand the scope of clinical assessments.

Recommendations

- During FY2018/2019, both Resource Center and Therapeutic Coaching service elements should be expanded and used to support families staying together and to reduce the use of emergency services. These services also help individuals and caregivers increase their repertoires of skills for reducing challenges and promoting wellness.
- Review the use of In-Home Therapeutic Coaching for individuals with repeated crisis calls and ensure this option is being accessed when it has potential to resolve or reduce crises.
- Occupancy rate goals for the Resource Center should be for 85% or greater use with ongoing targets for low recidivism rates for crisis stays.

Conclusions and Recommendations for FY 2018/2019

Conclusions

The NYSTART Region 1 team served over 300 individuals during FY 2017/2018. Region 1 START supports a large number of children (more than most lifespan START programs), and almost all of the children and over half of the adults reside with family caregivers. Data reported suggest that more and more individuals are reporting risk of loss of placement as a concern at the time of START intake. This concern is addressed in many ways by START teams but the addition of a Resource Center and the consolidation of the In-Home Therapeutic Coaching service should likely play a critical role in helping families remain together and integrated into their communities.

Over 150 new enrollments occurred in Region 1 in this reporting period. A subset of cases were made inactive. As noted, the ideal reason for inactivation is that the person is doing well (has achieved "stabilization"). This occurred for 50 individuals during FY 2017/2018. However, there were a number of individuals who disengaged from services, and the exact reasons for this must be further explored and addressed to maximize retention in the program and ensure inactivation is occurring only when a person moves or no longer needs START services because they are well.

During FY 2017/2018, linkages were created with local colleges and interns. During FY 2017/2018, there was a significant increase in referrals and are increasing caseloads. There had been issues in terms of staff retention/turnover in 2016/2017 (25% turnover occurred in 2017). By the end of FY 2017/2018, Region 1 had close to a full complement of coordinators, as well as adding two Team Leads (each cover half of the large geographical region).

Over the course of FY 2017/2018, a four bed Resource Center opened. Region 1 now has the full array of START services. This should help the program to increase caseloads and provide more support to enrollees.

During this fiscal year, Region 1 continued to fall short of standards for completion of intakes, CSCPIPs, ABCs and in conducting outreach to adults and stabilization of the team and reduced turn over, and the team is committed to

meeting these standards going forward. It is also important that the large volume of crisis calls is reduced by reducing repeat calls from individuals who would need this service less if all of the potentially helpful START components are provided as appropriate, and enough aggressive outreach work is done.

Having positions filled, and a lot of the necessary work done in regards to training these new additions to the Region 1 team also allows for more time to be devoted to community outreach and education efforts. In FY 2017/2018, though a number of trainings were provided, Region 1 only conducted 7 CETs, and they look forward to expanding this forum as well as other training activities, especially targeting large vendor organizations serving people with IDD.

Recommendations for Fiscal Year 2018/2019

Program Enrollment

- Region 1 should enhance and build linkages and provide outreach and education to increase capacity in the system of care in understanding the many factors that influence the development of distress and behavioral health challenges leading to referrals to the program. Ongoing efforts should also continue to maximize enrollment of new cases within the capacities of the program.
- To better understand the trends noted in regards to rising reports of risk of loss of placement, it would be important to determine if Region 1 interventions reduce actual loss of placement when compared to report at intake at one year of follow-up.
- Region 1 should develop a survey to determine why stakeholders no longer want NYSTART services after a period of enrollment to ensure that capacity has been built and that they are satisfied with services and support provided by the Region.

Characteristics of Persons Served

- Demographics
    - It is recommended that Region 1 identify and enter missing data that are retrievable from caregivers and other referral sources and should reduce missing data for children's level of IDD.
    - Expansion of the START Therapeutic Services described later in this report should be aimed at supporting families and individuals who optimally would be able to continue to live in their current settings.
- Mental Health and Chronic Health Conditions
    - Primary outreach and educational efforts should continue. Focus in FY 2018/2019 should include more work on accurate diagnostic case formulations, recognition of anxiety, trauma related issues and medical comorbidities as well as other training topics.

Emergency Service Trends

- Region 1 leadership should meet and determine a method to gather data at intake regarding past year ED and psychiatric hospitalizations in those instances when it is not readily available, as well as working to ensure that any and all ED visits and hospitalizations are recorded in SIRS, even if a START person was not called. In the latter instance, data should be recorded when it is uncovered. An important goal should be to increase the use of START crisis responders when there are ED visits or psychiatric hospitalizations.

START Clinical Services

Primary Services:

- Continue to provide and expand the frequency and number of trainings offered, with ongoing focus on accurate case formulation and psychiatric diagnostic assessments, health concerns and supporting families with individuals at home who have challenging behaviors and complex service needs.

- Plan to provide specific data on the number and nature of attendees at trainings to better characterize the scope of reach of these efforts and identify any gaps where added work is needed to reach out with educational opportunities.

- While there is an improvement in community linkages during this reporting period, it is recommended that relationships and linkages continue to be fostered by the NYSTART program throughout the region. Additional efforts should be made this year to gain linkages with schools, emergency service providers, and other community services providers. Feedback from Coordinators regarding engagement with partners should guide development and refinement of linkages.

- In order to meet program fidelity, it is expected that Region 1 conduct 10-12 Clinical Education Team meetings annually. Use this forum as one of the ways to provide more education regarding health problems, given the high rate of medical comorbidities identified in the population served.

Secondary Services

- Region 1 should develop an action plan to increase the percent of enrollees receiving intake/assessment and outreach services to be in line with national NYSTART fidelity standards by the second quarter of FY 2018/2019.

- CSCPIP time tracking is lower than the percentage of completed and updated plans documented. This may be a data entry issue or it could present an incorrect understanding of the crisis planning process. START CSCPIPS are organic, evolving documents which are facilitated by the START coordinator with the full commitment and participation of the individual's team. It is important for the Region 1 leadership team to examine the reason for incongruency and assure that clinical team members are engaging the system of support for enrollees.

- Intakes must be completed in a timely manner. Region 1 leadership should examine this concern, develop an action plan and ensure this goal is met by the second quarter of FY 2018/2019.

- Region 1 leadership should work with coordinators to ensure the completion and readministration of ABCs for active cases and that they are entered into SIRS

- Region 1 should continue to take regular data on outcomes associated with improved functioning and service effectiveness. As more components are being used, even greater reductions in psychopathology measured by the ABC would be an important indicator of the significance of these additions.

- The goal for completion of Comprehensive Eervice Evaluations is 15-20% of the current active caseload. The Region 1 program is not meeting standards in this area. Region 1 leadership team should develop an action plan to correct this and to meet standards.

Tertiary Services

- Region 1 leadership should explore the causes for low reported rates of outreach and crisis contacts to ensure that coordinators are carefully following up on any crisis events with any and all individuals having a crisis encounter.

- An additional goal for FY2018/2019 should be to closely monitor the use of the full range of available START service options for any individuals having repeated need for use of the 24 crisis line. This includes ensuring that outreach visits are occurring at a high frequency, clinical consultation as well as Therapeutic Supports are being employed for individuals experiencing the most acute and ongoing challenges. Specifically:
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- Continued efforts should be made to educate, link with and encourage full use of START crisis services by enrollees' caregivers when help is needed., which now may include the full array of Therapeutic Services.

Therapeutic Supports

- During FY2018/2019, both Resource Center and Therapeutic Coaching service elements should be expanded and used to support families staying together and to reduce the use of emergency services. These services also help individuals and caregivers increase their repertoires of skills for reducing challenges and promoting wellness.
- Review the use of In-Home Therapeutic Coaching for individuals with repeated crisis calls and ensure this option is being accessed when it has potential to resolve or reduce crises.
- Occupancy rate goals for the Resource Center should be for 85% or greater use with ongoing targets for low recidivism rates for crisis stays.