Evaluation of Florida's Sub-Acute Inpatient Psychiatric Program (SIPP)

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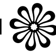

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Executive Summary

In March 1998, the State of Florida received approval of a 1915 (b) waiver from the Health Care Financing Administration (HCFA) to implement an alternative, Sub-acute Inpatient Psychiatric Program (SIPP) for children under the age of 18, who had two or more psychiatric inpatient stays in a year, or a length of stay greater than thirteen days. For these high risk youth, who were typically served in general hospitals, the SIPP model was designed to improve the transition from inpatient care to community based care, in an effort to reduce the high rates of readmission and improve their chances of success in the community. For the Medicaid program, the SIPP model was designed to reduce the cost of psychiatric inpatient care by increasing the days in community and providing an alternative to general inpatient settings. Unique to the SIPP model are several core features, including family therapy, on-site education, an average length of stay up to 60 days, comprehensive assessment and treatment planning, case management and after care follow-up.

The Louis de la Parte Florida Mental Health Institute conducted an evaluation of the SIPP program during the first year of implementation. The evaluation consisted of a three part design, including an analysis of historical administrative data, site visits and interviews with clients, families, program staff, and community agencies, and an examination of current enrollee characteristics and client satisfaction based on provider collected outcome data. Key aspects of the program were examined to understand how the sites interpreted the program model, developed the family involvement component, engaged in comprehensive assessment and treatment planning, delivered after care programming and case management, and established information systems for quality assurance and continuous improvement.

The SIPP was implemented at two sites in Florida, Daniel Memorial in Agency for Health Care Administration (AHCA) Area 4 (Jacksonville) and Charter Glade Behavioral Health System in Area 8 (Fort Myers). Daniel Memorial provides care in a residential setting, in which the SIPP program is a fully staffed, stand-alone unit with a full continuum of services. At Charter Glade, SIPP clients are served in the hospital crisis stabilization unit with minimal access to a broader spectrum of community services. The differences in the two sites, geographically and organizationally, resulted in substantial variance in the implementation of the SIPP model and the potential success of the program.

These two SIPP programs serve children ages 5 to 11, most of whom are 11 years old. Enrollees are predominantly white males, although there were some females and children of minority groups. Clinically the children had severe psychiatric disorders, including bipolar and depressive disorder, Attention Deficit Hyperactive Disorder (ADHD), Oppossitional Defiant Disorder (ODD), intermittent explosive disorder and adjustment reactions. Children at both sites showed improvements in functional level at discharge, with a significant greater gain observed for children at Charter Glade. At Daniel Memorial children stayed for an average of 50 days, as compared to an average of 30 days at Charter Glade.

An historical analysis of inpatient psychiatric claims data showed that among children who met the high risk criteria for the SIPP in Areas 4 and 8, most were white males age 10 to 12. The rate of readmission among this population was between 52 to 78 percent in a given year for up to three years prior to the SIPP program. There was a steady increase in readmission

rates among clients in Area 4, while the trend in Area 8 fluctuated. During these three years, children served in Area 8 had a longer length of stay than those in Area 4: a reverse trend from those enrolled in the SIPP program. The use of targeted case management and community mental health services was considerably higher in Area 4 over the three years.

Findings from the evaluation provide information about the conditions for continued program success statewide, and identify areas that need to be expanded or redesigned to be more effective. The data were gathered from a small population of clients and staff and represent their experiences during the first year of implementation. It became evident during the evaluation that the setting of the SIPP and its accessibility to families of clients and other community agencies impacts the comprehensive quality of care available. The two sites examined in this evaluation represent two locations in Florida, yet it is anticipated that other settings may yield additional findings not apparent in the current locations. Summary observations were made that address the core aspects of the program model and highlight the conditions for success, the value for clients and their families, and the limitations of implementation based on contextual factors.

Summary observations are organized around four domains of interest: Quality of Care, Access to Care, Outcomes, and Policies and Procedures. The observations are drawn from interviews with staff, parents, and community agencies, and analysis of clinical data and satisfaction surveys for those enrolled in the SIPP during the first year of implementation (Spring 1999).

Quality of Care

- Engaging families in the treatment planning process was critical for many parents to understand their child's behavior and to learn new response skills so they can participate in their child's treatment and progress
- Providing a broad array of services, including therapy, education, recreation, gives children important opportunities to learn new behaviors that cross multiple settings
- A multi-disciplinary care team, including a behavior specialist, therapist, teacher, nurse and case manager, provides more comprehensive care for the client and their family
- An integrated educational component helps children catch up in school and transition back into the educational setting more effectively
- The after care component at both sites was limited to case management follow-up and did not represent the intentions of the after care component of the SIPP model
- Questions emerged about whether the SIPP should be a self-contained program or one that is co-mingled with programs for different populations
- The philosophy of the agency and staff contributes significantly to implementation of the model and its success

Access to Care

- Program sites located in an integrated continuum of care provided greater access to appropriate services for enrollees
- Enrollees from mobile families are not able to benefit from the discharge plan and after care component as much as those who remain in a stable location
- Some families who lived far from the SIPP found it difficult to participate in the full treatment program with their children if the visiting hours and treatment sessions were scheduled within a less flexible timeframe
- Questions emerged about the appropriateness of the SIPP model for children in the child welfare system who may not have the family support structure to engage in all aspects of treatment or the discharge process

Outcomes

- Children enrolled in the two SIPP sites showed significant gains in functioning at discharge
- Satisfaction surveys returned indicated high levels of satisfaction with the SIPP at both sites
- Existing 60 day post discharge outcome measures do not produce reliable data for those members of the target population that are highly mobile

Program Policies and Procedures

- Quality assurance at one site included both formal and informal feedback from parents throughout the treatment process, which was used to address client needs as they emerged
- There were inconsistencies in the implementation and accessibility of formal grievance processes between the two sites
- Outcome data reporting mechanisms were inconsistent across sites, making it difficult to measure the impact of the program on all clients and to make comparisons in client outcomes at the two sites

Interviews with parents and family members at one of the sites provide strong evidence that the SIPP model is beneficial for helping many parents address the needs of their children. The focus on individual treatment and array of services, as well as comprehensiveness of assessment, extended length of stay and after care are important departures from traditional inpatient care that hold promise for serving high-risk youth. The initial findings do not demonstrate the impact of the model on long term outcomes for children. Simple measures, such as reduction in rates of readmission and increased time in the community will be examined during the next year. ■

Introduction

Background

In March 1998, the Health Care Financing Administration (HCFA) approved a 1915 (b) waiver for the State of Florida to implement the Sub-Acute Inpatient Psychiatric Program (SIPP) for children under the age of 18. The waiver allowed the state to offer, in two areas of the state, a sub-acute treatment program for clinically eligible, high-risk children of inpatient psychiatric services. High-risk youth are defined in the SIPP waiver application as children who have a history of two or more psychiatric hospitalizations in a year or a number of days in inpatient care per year above the state average (13 days) for children and adolescents under the age of 18.

Previously the Florida Medicaid program provided acute care psychiatric services in general hospitals. The objective of the SIPP is to provide an intermediate level of care for high-risk youth and to reduce the utilization and costs for inpatient psychiatric care in general hospitals for children under the age of 18. Toward this end, First Mental Health, Inc.provides utilization management to insure appropriateness of admission, length of stay and quality of care, and to require aftercare services and/or linkages with appropriate community services upon discharge.

Both the waiver application and the SIPP Request for Proposal require that treatment be active, aggressive, focused and oriented around aftercare planning from the time of admission. The treatment goals are identified as twofold: 1) stabilization of presenting symptoms to allow for a safe return to the community, and 2) design of a treatment plan that can be appropriately implemented in the child's home and community.

HCFA's waiver approval required that the state arrange for an independent evaluation of the waiver program. The Agency for Health Care Administration requested that the Louis de la Parte Florida Mental Health Institute conduct the evaluation.

Implementation of the SIPP Model

The SIPP model was implemented in the spring of 1999, in two regions of the state: AHCA Area 4 covering Jacksonville and Daytona Beach on the east coast, and AHCA Area 8 covering Fort Myers and the surrounding rural area on the west coast. Geographically, the two regions are different. In Area 4 the overall population was documented in 1999 by the Florida Kid's Count project as 1,504,136. By contrast, the overall population in Area 8 was 1,103,798 which represents just over 73 percent of the Area 4 population (Weitzel, Shockley, & Miranda, 1999). The population composition in these two areas differed somewhat with respect to percent of children and representation of various minority groups within the overall population. Children represented 24% of the overall population in Area 4 but only 19 percent of the overall population in Area 8. While the overall minority representation within the Area 4 population was 18 percent, the percent of minority representation within the child population of that area approached 25 percent. In Area 8, the minority representation within the overall population approached only 7 percent, but the percent of minority representation in the child population was almost 12 percent. The higher percentage of minority representation in the child population observed in these two areas is 28 percent higher than in the general population in Area 4 but is 42 percent higher than in the general population in Area 8. The number of hospitals and beds

available in each area along with information about the number of people treated primarily for mental health disorders provides further background detail that will be useful to develop comparison groups for further study. Area 4 has 20 hospitals with 4005 general hospital beds located within its counties to serve its larger population while Area 8 has 12 hospitals with 3685 beds. However, more than twice as many persons (adults and children) were treated and discharged for mental health disorders in Area 4 than were treated and discharged in Area 8 for mental health disorders even though the overall population in Area 4 was only 36 percent larger than the population in Area 8.

Organizationally and philosophically, the two sites are quite different. Daniel Memorial in Area 4 is a facility with a number of stand-alone residential programs and community-based care serving multiple populations. The SIPP program was one such model, housed in its own building, with a staff of administrators and clinicians specific to SIPP. The facility had an educational classroom on site, as well as recreational facilities for clients. The treatment approach at Daniel Memorial is a synthesis of strategies that result in a holistic practice model. This approach to the child and family is used by an interdisciplinary team to extinguish the maladaptive behaviors and teach adaptive behaviors which allow the client to move to a less restrictive setting as quickly as possible. The agency's philosophy regarding this program is summarized in a set of values and treatment assumptions obtained from the agency that include the following:

- Ability to respond to community gaps in service delivery to youth.
- Ability to change in response to client needs and characteristics. Related to this is the ability to provide staff and other resources necessary for accomplishing this flexibility.
- Focus on improving the ability of the support network to respond appropriately to youth. Related to this is the ability to create such a support network if one is absent.
- Development of internalized controls in the youth via the development of understanding of the various factors impinging on and influencing his/her behavior, feelings, etc.
- Treatment in the least restrictive environment possible with an ease of access and continuity from one service level to the next.

Charter Glade in Fort Myers is a psychiatric hospital, serving multiple populations under one roof. There was no separate living area, educational unit or available recreational facility for clients. The SIPP program was combined with other children's inpatient programs in the crisis stabilization unit. The following quote describes their treatment philosophy and approach to care:

- "We believe that mind and body exist in an inseparable unit and that our responsibility is to treat the total person in the knowledge that pathology in one effects the level of functioning in the other. We believe the human being is a delicate balance of emotional, intellectual and spiritual dimensions. Charter Glade Behavioral Health System is committed to the provision of quality behavioral health services to our community. Charter Glade Behavioral Health System provides a total therapeutic environment through an individualized treatment program for each patient. The emphasis is on group, family, educational, and activity therapies, and the focus is on the patient as a unique individual."

These differences in the two sites appear to contribute substantially to how staff implemented the SIPP model and served children and their families. In Part 4 of this report, more detail is given to highlight how these differences impacted implementation of the family involvement component, treatment planning, and provision of a full spectrum of care.

Scope of the Evaluation

This evaluation was designed to address the following questions:

- What were the patterns and cost of psychiatric inpatient utilization among high risk youth in Areas 4 and 8 for the three years prior to implementation of the SIPP?
- What are the characteristics of the children enrolled in the SIPP?
- How did the program sites implement the SIPP model and build systems for family involvement in policy development, quality assurance and improvement, complaint procedures, and treatment teams?
- How satisfied are families with the implementation of the SIPP program?

Organization of this Report

This report is organized into six parts. **Part 1** (Methods) details the different methods used to address the guiding questions. **Part 2** (Historical Analysis) presents the historical analysis of psychiatric inpatient care prior to the SIPP. **Part 3** (Enrollee Characteristics, Clinical Outcomes and Satisfaction) discusses characteristics of current enrollees and service outcomes, including their demographic and clinical characteristics. **Part 4** (Program Implementation, Quality and Access to Care) presents findings from the interviews with families, staff and community agencies. **Part 5** (Quality Assurance, Grievance, Denials, and Data Quality) addresses quality assurance, complaint procedures, and denials, and **Part 6** (Summary and Recommendations) presents a summary and recommendations for program improvement. ■

Part 1: Methods

Three separate analyses were conducted to address the questions guiding the evaluation. Medicaid claims data were analyzed to examine trends in cost and service utilization patterns of high-risk youth served for three years prior to the waiver. Demographic, clinical, functional and satisfaction outcome measures were analyzed for those enrolled in the SIPP during the first year of implementation. Interviews were conducted with SIPP staff, families of enrolled children and community agency personnel to examine implementation and effectiveness of the program components. The methodologies used in the three analyses are detailed below.

Historical Analysis of Administrative Records

An historical analysis was conducted to examine the profiles of high-risk youth utilizing Medicaid inpatient services in AHCA Areas 4 and 8 during the three years prior to implementation of the waiver. The target population is defined as children under the age of 18 who were admitted to an inpatient facility for more than 13 days in a year, or who had more than two inpatient admissions in a year. In later reports this information will be compared with the profiles of actual SIPP enrollees 18 months post waiver implementation. Specifically, this analysis addresses the following questions:

1. What are the characteristics of high-risk youth in Areas 4 and 8 prior to the waiver?
2. What is the rate of recidivism among high-risk youth within a year and across years prior to the waiver? (FY 1995–1998)
3. What is the total volume of service for the categories of inpatient, targeted case management and community mental health among high-risk youth prior to the waiver?
4. What is the average expenditure per client per year in the three service categories: inpatient, community mental health, and targeted case management among high-risk youth prior to the waiver?

Data used in the historical analysis include Medicaid fee-for-service claim records of all inpatient, community mental health, and targeted case management services provided three years prior to implementation of the SIPP: FY 95–96, FY 96–97, and FY 97–98.

Current Enrollee Characteristics, Clinical Outcomes and Satisfaction

Descriptive statistics of youth enrolled in the SIPP programs through February 2000 were prepared to examine their demographic characteristics and treatment needs. The analysis is based on monthly reports from the two SIPP programs (Charter Glade Behavioral Health in Area 8 and Daniel Memorial Hospital in Area 4) on the demographic characteristics of youth, average length of stay, diagnosis, behavioral functioning level and medications.

Program Implementation, Quality and Access to Care

Individual interviews were conducted with SIPP staff, families of children enrolled in the program, and community agency personnel to understand how the SIPP model was implemented at each of the sites. The original evaluation design of this component called for the implementation of focus groups and telephone interviews with the families and individual

interviews with program staff. However, due to the wide geographical area served by the SIPP programs it became logistically impossible to conduct the focus groups in a location convenient for all families. Consequently, it was decided that in order to obtain maximum participation from families face to face interviews conducted at a location of their choice was a better approach.

Family Selection

Family selection followed a two step process: (1) SIPP programs sent letters to the families of all the children discharged informing them that a member of the evaluation team would be contacting them to solicit their participation in the evaluation and (2) a member of the evaluation team from FMHI contacted the families and set up the interviews. Daniel Memorial provided a list of nine families of which six agreed to be interviewed. Charter Glade provided a list of 19 families of which 11 could not be reached because their phones were disconnected or they were no longer at the specified location. The remaining eight families were contacted and interviews were set up with them. Two families dropped out leaving a total of six families.

Staff and Community Agency Selection

The evaluation team requested to interview an administrator, a counselor, a case manager, a nurse and any other front line staff at each of the SIPPs. Community agency personnel were interviewed from among those network providers close to the SIPP who were willing to participate.

Interview Participants for Daniel Memorial

A total of four staff members and six families were interviewed. SIPP staff interviewed represented administrative as well as front line staff. However, at Daniel Memorial all SIPP staff are considered to be front line. The children of all the families interviewed had already been discharged at the time the interviews were conducted in January 2000. In addition to these interviews, a member of the evaluation team solicited the input of a program administrator from a community agency that works closely with the SIPP program. This was done in an effort to gather the perceptions of as many stakeholders as possible regarding the SIPP program.

Interview Participants for Charter Glade

A total of four staff members and six families were interviewed. SIPP staff interviewed represented administrative as well as front line staff. The children of all the families interviewed had already been discharged at the time the interviews were conducted in March 2000. In addition to these interviews, a member of the evaluation team solicited the input from two program administrators from the community who work closely with the SIPP program.

Data Analysis

Data collected from the interviews were organized, coded, reviewed and analyzed according to pre-established categories, consistency of responses, and emerging themes. Following SIPP program guidelines and the questions the evaluation sought to answer through these interviews the evaluation team developed a question guide shown below in **Table 1**. The question guide was organized into categories that addressed the different components of the program. Pre-establishing data categories facilitated the data coding process in that the data collected were pre-sorted and ready for coding. The initial coding corresponded to the research questions. Two independent coders coded the data. Once this process was completed the coding was reviewed for consistency and the coders debriefed in order to reach consensus in areas of disagreement. Then a secondary level of data coding was implemented to identify and cluster emerging themes. In addition, data about extremes or unusual circumstances were identified. Following the secondary coding process, the data were sorted by themes from which the findings and conclusions were derived. ■

Table 1

Question Guide

Primary Caregiver Interview	Provider/Staff Caregiver Interview
Understanding of SIPP • What is the purpose of SIPP? • What makes SIPP different from a residential treatment center? • What are some of the characteristics of SIPP? • Were you offered the opportunity to express your opinions and feelings about the program? How? • Who did you talk to regarding any concerns or questions about SIPP and your child's involvement in it?	**Understanding of SIPP** • What is the purpose of SIPP? • What makes SIPP different from a residential treatment center? • What are some of the characteristics of SIPP? • How are the families offered the opportunity to express their opinons and feelings about the program? • Who do families talk to regarding any concerns or questions about SIPP and their children's involvement in it?
Individualization of Services • What services were offered to your child and family while involved with SIPP? • How were the services your child and family received at SIPP individualized to meet your needs? • How were your child and family's strengths considered during your participation in SIPP? • How often were you allowed to call and visit your child while he/she was at SIPP? • Was this enough for your child and family?	**Individualization of Services** • What services are offered to children and families while involved with SIPP? • How are services individualized to meet children and families' needs? • How are the strengths of children and families considered during their participation in SIPP? • How often are children and families allowed to call and visit with each other while their children are in SIPP?

Table 1 continued on next page ▶

Table 1

Question Guide (Continued)

Primary Caregiver Interview	Provider/Staff Caregiver Interview
Treatment Plan Development • How was your child's treatment plan developed? • Who participated in its development? • How often was the plan reviewed? • Who determined what needed to be reviewed in the plan? • Was the plan implemented? **Educational/Schooling** • What educational services were offered to your child while he/she was at SIPP? • How were these services designed to meet your child's educational needs? • Was there any communication between your child's school and SIPP?	**Treatment Plan Development** • How are treatment plans developed? • Who participates in their development? • How often are plans reviewed? • Who determines what needs to be reviewed in the plans? • Is there someone responsible for plan implementation? **Educational/Schooling** • What educational services are offered to children while they are in SIPP? • How are these services designed to meet the individual educational needs of children? • Is there any communication between SIPP and the children's school? • How is this communication established and maintained?
Discharge Plan and Aftercare • When was the discarge plan developed? • Who participated in its development? • What services were offered to your child and family following your child's discharge? • Are these services conveniently located for your child and family? • Are these services meeting your child and family's needs? • Was there a staff member assigned to help your child transition back to home/community/school? • Are you still in contact with SIPP?	**Discharge Plan and Aftercare** • When are discharge plans developed? • Who participates in their development? • What services are offered to children and families following discharge? • Are these services conveniently located for children and families? • Is there a staff member assigned to help children transition back to home/community/school? • How long after discharge is SIPP in contact with children and families?

Table 1 continued on next page ▶

Table 1

Question Guide (Continued)

Primary Caregiver Interview	Provider/Staff Caregiver Interview
Satisfaction with SIPP • How satisfied were your child and family with SIPP? • Were SIPP staff easily accessible to your child and family? • How is your child doing after his/her participation in SIPP (home, school, and community)? • What was the most helpful aspect of SIPP? • What was the least helpful aspect of SIPP? • What would you do differently?	**Satisfaction with SIPP** • In general, how satisfied have the children and families that have participated in SIPP been with this program? How do you know this? • How accessible are SIPP staff to children and families? • In general, how are the children and families that have participated in SIPP doing at home, school, and community? How do you know this? • What do you consider to be the most helpful aspect of SIPP? • What do you consider to be least helpful aspect of SIPP? • What would you do differently?
Additional comments/information	**Additional comments/information**

Part 2: Historical Analysis

This section of the report provides a baseline analysis of the characteristics of high-risk youth in Areas 4 and 8 who had an inpatient stay greater than 13 days or more than one in a year during a three year period prior to the SIPP waiver. The findings are based on an examination of Medicaid inpatient claims, community mental health and targeted case management service utilization and cost for fiscal years 95–95, 96–97 and 97–98.

Demographic Characteristics of High-Risk Youth

As shown in **Table 2**, the high-risk youth in AHCA Areas 4 and 8 in the three years prior to implementation of the SIPP program were predominantly white males approximately 10 years of age. In Area 4, there was a higher proportion of blacks than in Area 8, whereas Area 8 had slightly more Hispanics. These findings mirror the demographic characteristics of the child population in these areas. The demographic characteristics in each Area are similar across the three fiscal years, except in Area 8 where the number of blacks served increased by approximately seven percent, while the number of whites served decreased by over 10 percent. Additionally, the percent in the “other” category, which is known to include Hispanics, increased in Area 8. This increase mirrors a statewide trend of growth in the “other” category.

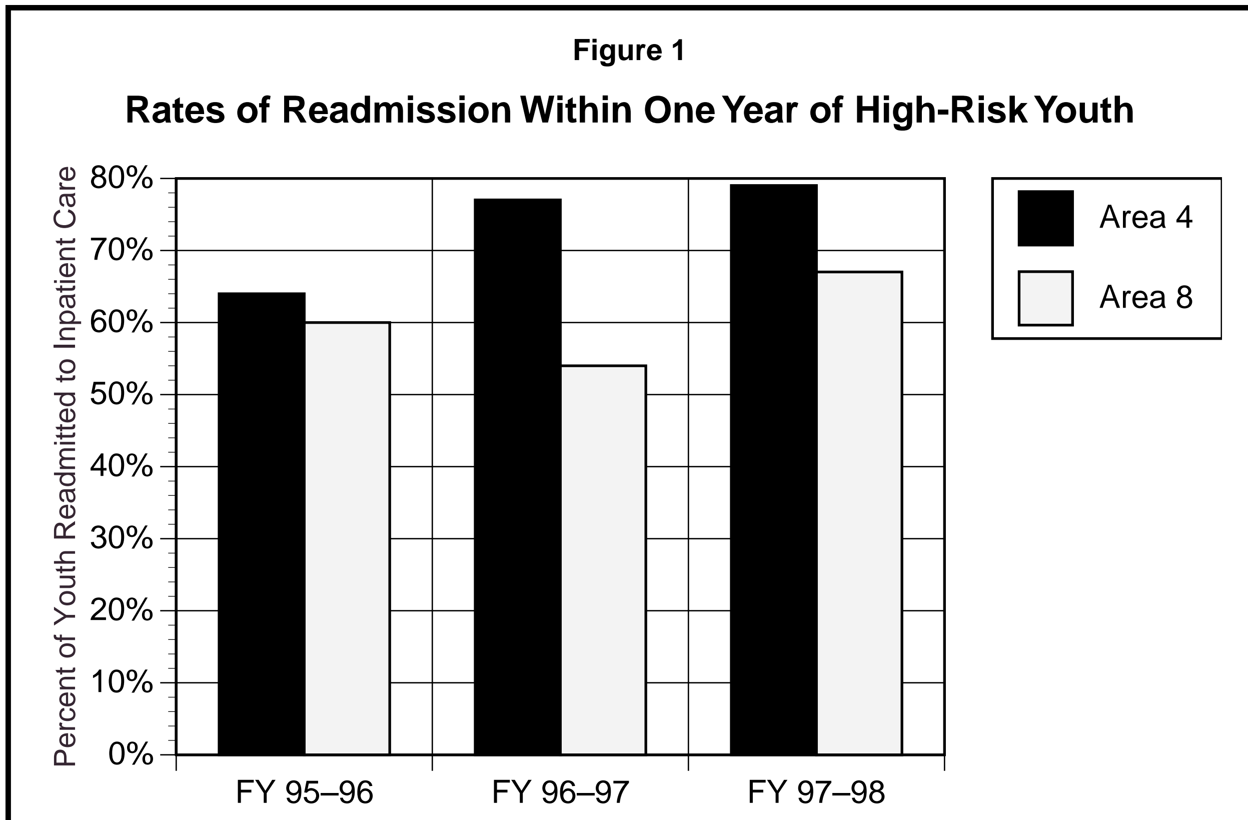
Table 2

Demographic Characteristics of High-Risk Youth in AHCA Areas 4 and 8 Three Years Prior to the SIPP Waiver

	FY 95–96		FY 96–97		FY 97–98	
	Area 4	**Area 8**	**Area 4**	**Area 8**	**Area 4**	**Area 8**
Number of Users	276	126	286	173	291	142
Average Age	10 yrs.	10 yrs.	11 yrs.	10 yrs.	11 yrs.	10 yrs.
Male	69%	68%	69%	70%	63%	72%
Female	31%	32%	31%	30%	37%	27%
Black	28%	10%	25%	17%	26%	16%
White	62%	76%	65%	68%	64%	64%
Asian	0%	0%	0%	0%	0%	0%
Other	9%	12%	9%	12%	8%	17%
Hispanic	1%	2%	1%	3%	1%	3%

Readmission of High-Risk Youth

Two separate issues were explored in the analysis of readmission rates. The first question was “What proportion of high-risk youth have an inpatient readmission within one year?” As **Figure 1** shows, recidivism (i.e., the rate of multiple admissions within one year) increased each fiscal year in Area 4 and fluctuated across the three years in Area 8.



The second question was "what are the patterns of recidivism among high-risk youth over three years?" **Table 3** illustrates the percentage of high-risk youth with one or more subsequent admissions during the second and third years. After the first year following an inpatient admission, rates of recidivism decrease across subsequent years.

Table 3

Rates of Readmission of High-Risk Youth Across Years

	Area 4	Area 8
Readmission rate across two years	21%	20%
Readmission rates across all three years	4%	3%

Historical Service Utilization

Outpatient Service Trends

Service utilization patterns suggest that there are considerable differences in the services that high-risk youth received in the two areas in the 3 years prior to waiver implementation (FY 95-96, FY 96-97, and FY 97-98). **Figure 2** shows that high-risk youth

in Area 4 received substantially greater amounts of targeted case management than did similar youth in Area 8. The use of community mental health services was relatively the same in both areas in FY 95-96. However, rates of community mental health service use decreased substantially in Area 8 during subsequent years.

An analysis of the differences in services is based on the units of service. It is important to note that different services are billed in different time segments. Targeted case management is billed in 15-minute increments (1 unit per 15 minutes). However, the community mental health category is comprised of a number of service types and a unit can represent varying degrees of service intensity. For example, a unit of day treatment represents one day, whereas a unit of individual therapy may represent 45 or 60 minutes. Higher units of service for community mental health could be caused by a variability in the use of day treatment, or more counseling sessions. An aggregate analysis, as presented in this report, limits the amount of information that can be culled from the data. Therefore, we do not know the differences in the types of community mental health services provided between the two areas. We do know that high-risk youth in Area 4 are more likely to receive community mental health services than those in Area 8 in FY 96–97 and FY 97–98.

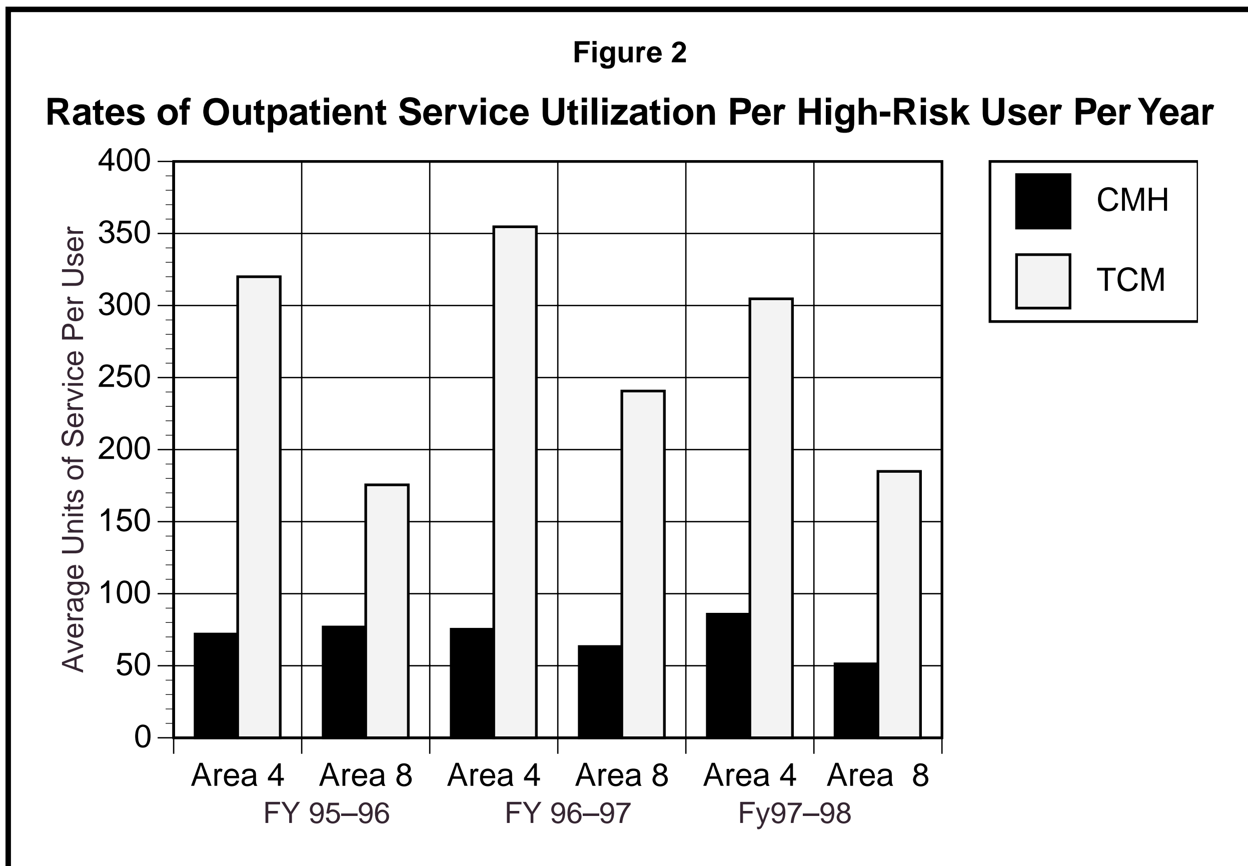
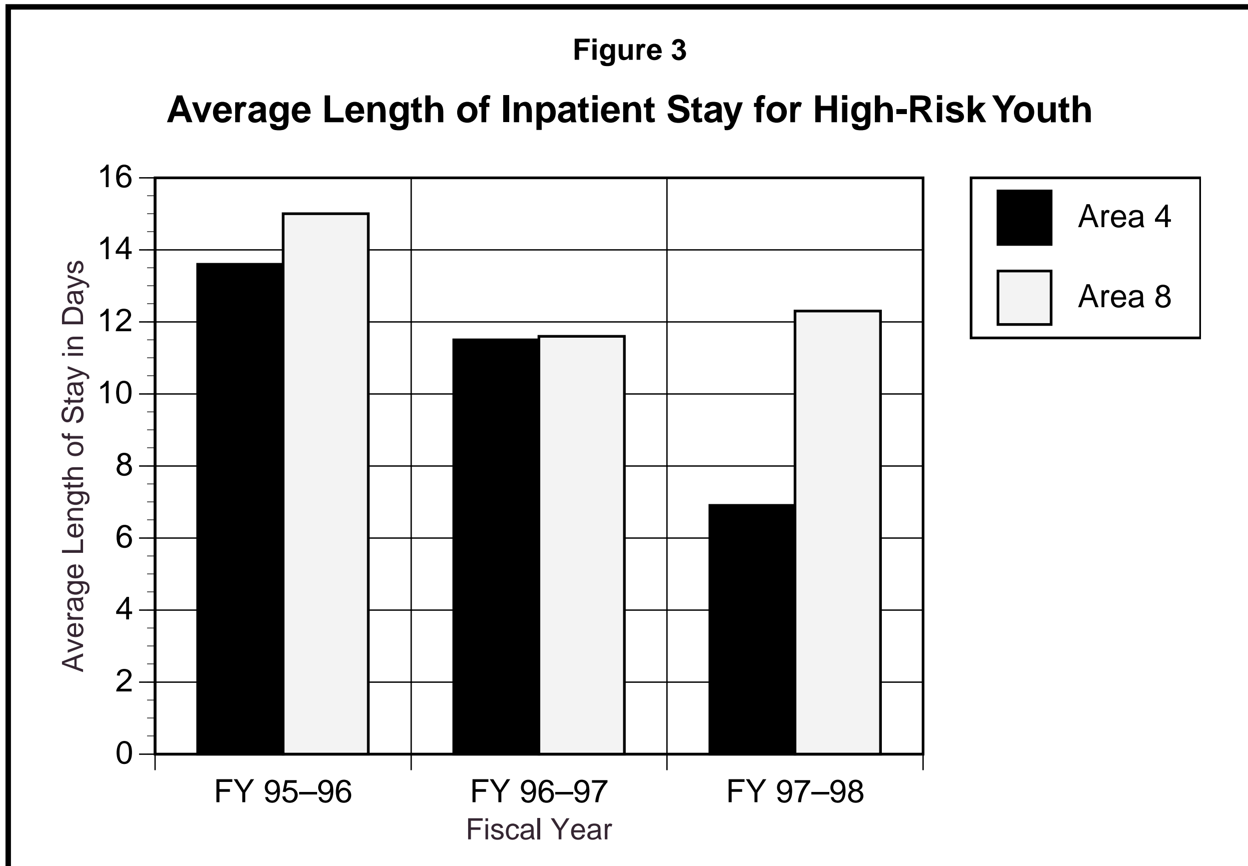


Figure 2

Rates of Outpatient Service Utilization Per High-Risk User Per Year

Inpatient Service Trends

The overall patterns for inpatient care reflected in **Figure 3** indicate a trend of shorter lengths of stay from FY 95-96 to FY 97-98. This is anticipated given the implementation of the First Mental Health Utilization Management program that went into effect January 1997, de-emphasizing the use of inpatient treatment and increasing the use of community mental health in the last half of FY 97–98. However, within the two areas, the trends are different. In Area 4, the average length of stay decreased steadily over time, while it fluctuated in Area 8. The lower rates of outpatient service utilization in Area 8 presented in Figure 2 may contribute to such fluctuations.



Expenditure Patterns

As shown in **Figure 4**, patterns of expenditures per member per year were generally consistent with service utilization trends. In Area 4, community mental health expenditures increased while inpatient expenditures decreased. Conversely, Area 8 inpatient expenditures increased while expenditures for community mental health decreased. In both areas, targeted case management expenditures peaked in FY 96-97. ■

Figure 4

Average Expenditures Per Member Per Year Among High-Risk Youth in AHCA Areas 4 and 8

Average Expenditure PMPY
12000
10000
8000
6000
4000
2000
0
Area 4 Area 8 Area 4 Area 8 Area 4 Area 8
FY 95–96 FY 96–97 FY 97–98
IP (In Patient)
CMH (Community Mental Health)
TCM (Targeted Care Management)

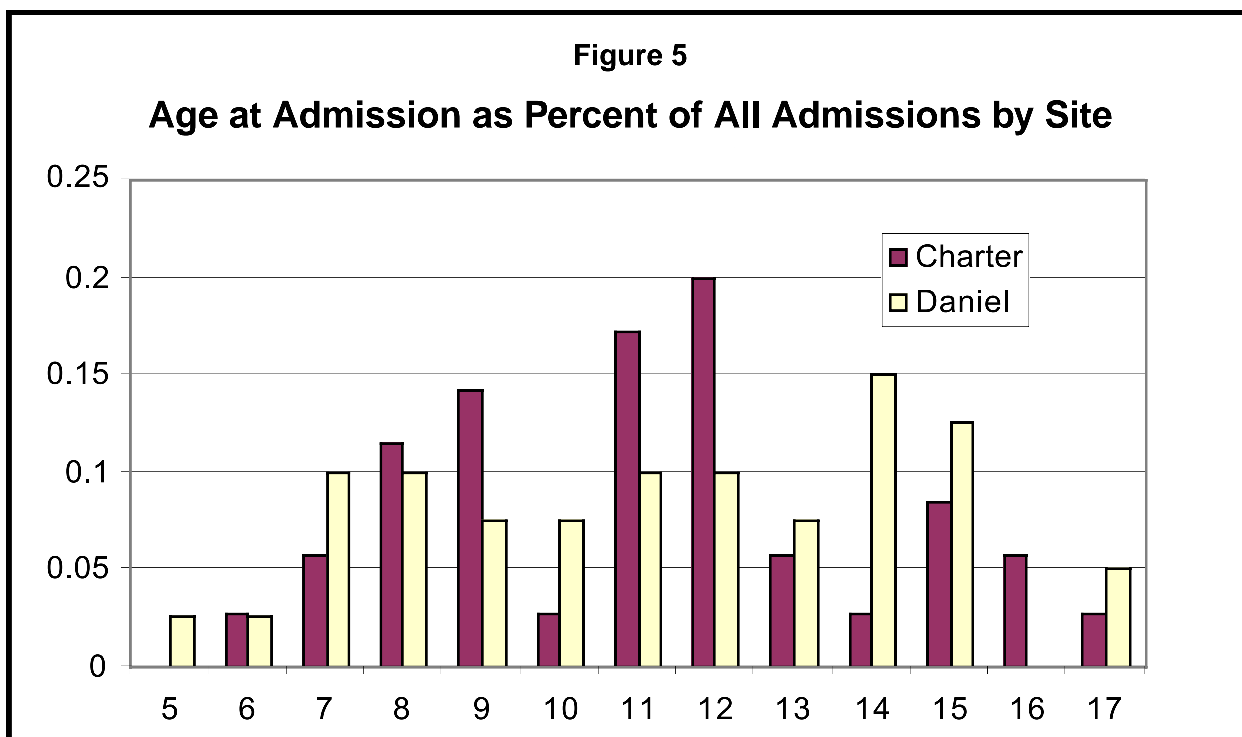
Part 3: Enrollee Characteristics, Clinical Outcomes and Satisfaction

Description of Current SIPP Enrollees

Admission Demographics

Data were available for 75 children who received services at Charter Glade and Daniel Memorial Hospital. The data provide information on 35 children served at Charter Glade between May 1999 and February 2000, and 40 children served at Daniel Memorial between April of 1999 and February of 2000. The two sites were similar in the age and gender distribution of their clients. The average age for children in both programs was just over 11 years. Children ranged in age from 5 to 17, with no difference found between the two programs. Age distributions for both sites are provided in **Figure 5**. Females made up approximately 32 percent of the population with slightly more females served by Charter Glade (37 percent as compared to 27 percent). Charter Glade did not report race. For Daniel Memorial 72.5 percent of the clients were white.

Figure 5



The most common admitting diagnoses included bipolar and depressive disorders, ADHD, ODD, intermittent explosive disorder, and adjustment reactions. The primary diagnoses at admission for the two sites are provided in **Figure 6.** All listed diagnoses by program site are provided in **Figure 7.** No reliable differences for diagnosis by site were found.

Figure 6

Primary Diagnoses at Admission by Site

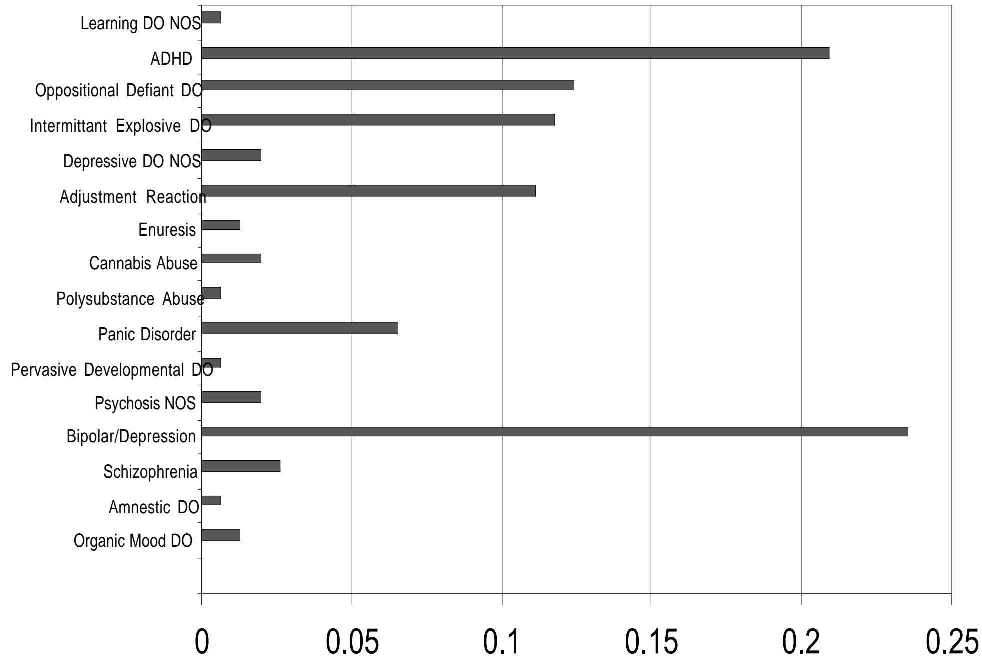
ADHD
Oppositional Defiant DO
Intermittant Explosive DO
Depressive DO NOS
Adjustment Reaction
Panic Disorder
Pervasive Developmental DO
Psychosis NOS
Bipolar/Depression
Schizophrenia
Amnestic DO
Organic Mood DO

Percent of Total
Percent Daniel
Percent Charter

0 0.1 0.2 0.3 0.4 0.5 0.6

Figure 7

All Diagnoses as Proportions of Total Diagnoses



Level of Behavioral Functioning

With regard to behavioral functioning, small but statistically significant differences were found between the two sites in admission Children's Global Assessment Scale (CGAS) scores. Higher scores (indicating better functioning) were found for Charter Glade. While statistically significant, the lack of sensitivity of the instrument precludes a meaningful distinction in the 4 point difference. Scores on the Child and Adolescent Functional Assessment Scale (CAFAS) for the two sites were not significantly different. Average scores at admission and discharge for the two sites for behavioral functioning instruments are provided below in **Table 4** (Lower score on CAFAS indicates better functioning).

Table 4

Average Scores on Measures of Behavioral Functioning

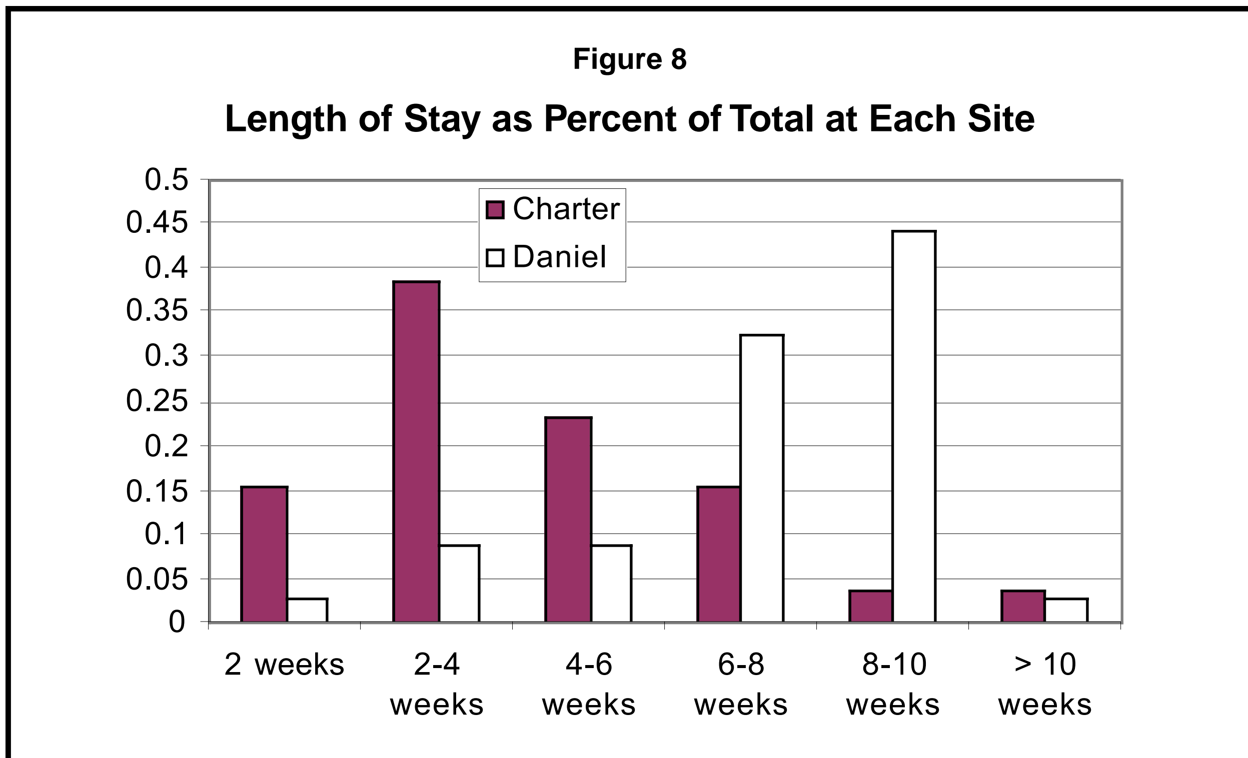
	CGAS			CAFAS		
Site	**Admission**	**Discharge**	**Change**	**Admission**	**Discharge**	**Change**
Charter Glades	34.62 (27)	53.09 (21)	17.38 (21)	96.15 (13)	61.42 (14)	36.67 (9)
Daniel Memorial	30.55 (29)	39.31 (29)	8.75 (29)	86.84 (19)	NA	NA

* (number of cases)

Outcomes

With regard to behavioral functioning, children in both programs significantly improved from admission to discharge as measured by the CGAS. Significantly greater improvements were reported for Charter Glade. Significant improvements were also found on the CAFAS for children in Charter Glade, although post admission data was available for only nine children at the time of the report. Daniel Memorial did not report discharge CAFAS scores. Available discharge and change scores for the two sites are included in **Table 3**.

Children served by Daniel Memorial had a longer length of stay than children served in Charter Glade with average stays of approximately 50 days for children in Daniel Memorial, and approximately 30 days for children in Charter Glade. A majority of children in both sites were discharged to family members. Distributions of length of stay for children served in the two programs are provided in **Figure 8**.



A standard measure has been used to gauge the degree to which families were satisfied with the SIPP. Limited satisfaction measures were obtained from both sites for purposes of the report. Because of the small number of satisfaction measures submitted, no tests of statistical differences were conducted. For consumers for whom information was available, reported satisfaction was high, with both sites reporting positive average scores of approximately 4.1 on a scale of 1 to 5. A subsequent report will provide detailed satisfaction information based on interviews with families. ■

Part 4: Program Implementation, Quality and Access to Care

Staff and Family Perceptions about SIPP Program

This section of the report addresses questions about interpretation of the program philosophy among different stakeholder groups, implementation of the family involvement component, the treatment plan process, discharge planning, and overall satisfaction with the program based on interviews with parents. The findings represent data collected through interviews conducted with primary caregivers, SIPP staff, and representatives from community agencies.

The findings are presented by site (**Daniel Memorial and Charter Glade**) and are organized following the main areas addressed in this assessment. Considering that each site represents a pilot program, is located in different geographical and environmental settings, and differ somewhat in their implementation of SIPP, combining the findings would mean removing the information from its original context and in a sense changing its meaning. In addition, for each site the findings from the interviews with program staff and families are presented side by side in an effort to compare and contrast their perceptions. Findings from the interviews with community agency representatives are presented separately. The findings from the family and staff interviews are followed by a brief discussion of the significant differences found between these respondents. Finally, a discussion of the significant differences found between the two sites is presented.

The interviews utilized for this component of the study were developed to address five areas. These areas are considered to represent the building blocks of this program as established by the initial invitation for proposal. They are:

1. **Understanding of SIPP** aims at obtaining information about the philosophy of the program, family involvement in policy development, staff accessibility, and their ability to make decisions.
2. **Individualization of services** inquires about the different ways in which the SIPP program is customized to meet the individual needs of children and families.
3. **Treatment planning** aims at obtaining an in-depth understanding of the development and implementation of the treatment plan. Special attention is placed on understanding the educational and case management components.
4. **Discharge planning** looks into the development and implementation of the discharge plan.
5. **Satisfaction with SIPP** aims at determining the interviewees' level of satisfaction with the different aspects of the Program; the perceptions of the interviewees regarding those aspects they find most and least helpful about the SIPP; and solicit their input about suggestions to improve the program.

All the information contained in this section of the report with exception of the sections highlighting significant differences between respondents and sites represent the perspectives of the families, SIPP staff, and community agency representatives. Direct quotes are presented to illustrate their views. The subsections of the satisfaction section that address the most and least

helpful aspects of SIPP and the suggestions for improvement represent a list of all the comments gathered rather than a compilation of the most frequent responses following a coding process. Given the wide range of responses provided by respondents in these subsections the evaluation team found this approach to be more appropriate. Finally, considering the newness of the programs, their different implementation approaches, and the contextual differences surrounding them the evaluation team chose not to draw any conclusions.

Daniel Memorial

Understanding of SIPP — Significant Findings

- SIPP is a program where children receive a comprehensive and intensive assessment in order to develop treatment plans that may continue to be implemented in the community.
- Family input and participation is encouraged through family sessions, through an open and continuous communication between families and program staff, and through the program's open door policy.

Staff Perspectives

The staff interviewed described the philosophy of SIPP as one that takes into consideration the child as a whole. That includes family dynamics as well as any other issues that may be at play. What makes SIPP significantly different from a residential program is its focus on completing an intensive assessment of children and developing treatment plans that may be implemented in the community. In this regard SIPP may be viewed as a feeder program to other more intensive programs or as a transition program for children returning to the community. As stated by one of the interviewees, "I think what we have here is a chance to do something different. To not do the usual — fix them [children] up and send them out."

Central to the program's philosophy is the sense of shared responsibility that the staff has toward their clients. Staff members work as a team and as such are able to offer their input about treatment plans and about the program in general. As stated by one staff member, "We are all here for the children. We have a director who has the

Family Perspectives

SIPP is a program intended to help children and families identify their unique needs and to offer them ways to cope with those needs. "Kind of an evaluation place." It is also a program that offers children the opportunity to avoid long term placements. It is an intermediate type of program. One parent's comment summarizes what the Program does for children and families: "It [SIPP] really helped me focus on the main problem this child has. I knew this child had problems but I truly did not know the extent of them. This really gave me a breather. It helped me make a decision."

Families found staff to be accessible and responsive to them. Whenever families called SIPP or had any questions they would receive a prompt response. The Program staff maintained on-going communication with families in person and by phone. Staff members called families on a regular basis to update them about their children's progress and to ask for the families' input. Most families participated in sessions twice per week and used these opportunities to

Understanding of SIPP (Continued)

Staff Perspectives

right philosophy and is a talented clinician and can teach. There is a lot of staff development taking place."

Another important aspect of SIPP is the manner in which children and families are approached. Staff treat children with respect and develop relationships with them so that "children will remember this place as a positive stop in their lives, as a place where they were successful." Parents are treated with equal respect and are not seen as the cause of their children's problems.

Family involvement represents a key aspect of the SIPP program. Family involvement with SIPP mostly takes place at a treatment level. Families participate in the development of their children's treatment plans and in family therapy. The way this process works is that after the initial intake and assessment families meet with their child's therapist and discuss the program, their child's treatment plan, and what is expected of them. Parents are expected to meet with the therapist twice per week and to stay in touch with their children. Staff work with parents on Saturdays, Sundays, and evenings if necessary. As stated by a staff member, "the [SIPP] program meets the needs of child and family. They are in partnership." Those parents who are not able to physically meet with the therapist twice per week due to work schedules or because they live in another town may conduct one of these meetings by phone. For example, at the time this study was conducted the mother of one of the children in the program was calling everyday at midnight to speak with the nurse about her child's condition. This

Family Perspectives

visit with their children. Families were welcomed to visit as regularly as they wished. In addition, children called their homes on a daily basis.

In general families participated in the treatment process and were kept abreast of the progress of their children. This was not the case with a therapeutic foster care family who did not have the opportunity to be involved in the treatment process of the child they were going to take in because they were contacted when the child was ready to be discharged. This was an unusual situation that resulted from a change of mind of the family that originally had intended to take this particular child.

Families were not involved at a programmatic level in a direct manner. They provided input about their needs and concerns to help guide their treatment plan but did not see their input as helping shape the overall program. One family that was more familiar with program implementation and the bureaucracy that usually surrounds these types of programs was aware of the certification process that SIPP had to follow with the overseeing agency. This family reported that at first certification took place every three days and then it was changed to every seven days. For this family, this was disturbing because in their opinion it would take at least two weeks for a child to be acclimated with the Program and for a comprehensive assessment to be completed. Consequently, for them, having to be certified for services every seven days made them feel uneasy about the certainty and continuity of the services. They stated that

Understanding of SIPP (Continued)

Staff Perspectives

mother's work schedule was such that this was the only time she could call. Maintaining an open communication between the staff and the families helps parents feel less anxious when they talk to their children about their program activities.

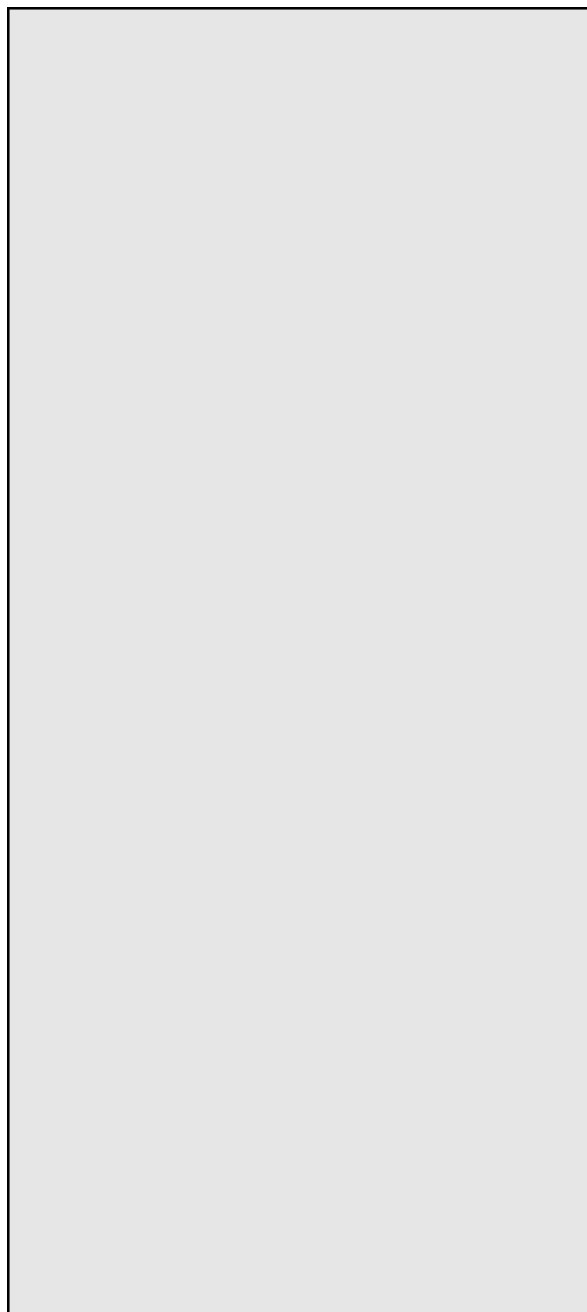
In addition, parents are encouraged to speak with their children on a daily basis. Most children speak with their parents during the evening hours so that their schooling is not interrupted and their daily routines resemble what they would be like if they were home. However, exceptions to this rule are made to accommodate parents' work schedules. The program has a 24 hour 800 number to facilitate access.

Family visitation is also encouraged. Usually when families come in for family sessions their children are allowed to spend time with them. These visits may be restricted based on the behavior of the child. However, it was reported that the Program has never restricted any child from seeing his/her family. They may restrict the possibility of a child going out on a pass, but not from having his/her family visit.

Family participation at a programmatic level is not happening in a direct way. Individually, families offer their input about how the program is working for their children. However, there is not a vehicle (i.e., committee) through which they can obtain more in-depth information about the different programmatic and structural aspects of the program and help shape it. A staff member reported that she had been thinking about creating an organization like a Parent-Teacher Association (PTA) for

Family Perspectives

"We did not know at any special day that we drove up [to SIPP] that we may have to pack [the child] in the car and take him." ☐



Understanding of SIPP (Continued)

Staff Perspectives	Family Perspectives

parents to develop support for each other. She recognized this is not easily accomplished because it is difficult to find meeting times convenient for all parents.

At the time of admission families also receive information explaining their rights and responsibilities. Since the therapist is the person who is in most direct contact with the family, he/she will be the initial person to respond to a grievance. If for some reason the therapist is not able to solve the problem, then the program director will address the issue with input from the team. Grievance forms are displayed in the SIPP's reception area to make them accessible to everyone. □

Individualization of Services — Significant Finding

- The comprehensive assessments implemented for each child and the constant communication between families and Program staff provide the basis for the individualization of services.

Staff Perspectives

By being an intensive diagnostic program, SIPP provides multiple assessments for the children (i.e., educational, substance abuse, independent living skills, etc.). These assessments are completed within two to three weeks from the time of admission depending on the individual circumstances of the children. Using this approach provides SIPP the opportunity to be more individualized beyond the core services of the program. Besides, Daniel as an agency provides a wide range of services that provide a continuum of care to children and families. The core services of the program are individual counseling, family counseling, social skills building, self-esteem workshops, recreational activities, medication monitoring, and educational activities. □

Family Perspectives

All children attending SIPP have access to a core of services; however, these services are individualized according to the specific needs of children. “It was like every kid was a different situation, it was discussed at own individual level, instead of what we [SIPP] do for other kids is what we do for her [child].” Services were also individualized to meet the needs of the families. “[SIPP] work as a whole with the family.”

In addition, service goals were developed based on the children’s strengths. The children’s strengths were integrated into the group and individual therapy sessions. One mother mentioned that her child lacked interests and when he/she came to SIPP began running and playing basketball with a counselor. She added that unfortunately the program was not long enough for her child to integrate these activities into his/her daily routine. □

Treatment Plan — Significant Findings

- Treatment plans are developed as a result of a coordinated team effort led by the therapists and in which families participate as equal partners.
- Treatment plans are inclusive of the families and are constantly evolving.
- SIPP's case management mostly entails making follow-up calls to families upon their children's discharge.

Staff Perspectives

When families first come into SIPP they participate in a psychosocial assessment. During this visit, families state what they want to accomplish during the treatment process, develop an initial plan and sign it. Families are also invited to participate in the weekly rounds where the psychiatrist, nurses, and therapists review the plans. As stated by a staff member, the treatment plan "is a fluid ongoing changing document."

The therapists meet on a weekly basis with the rest of the treatment team to discuss progress, concerns, and strategies. Therapists are also responsible for communicating with families and with the treatment team. In addition, there is a weekly meeting where every single staff member participates with the exception of a few staff members who stay with the children. In this meeting everyone shares information about their experiences working with the children and their families. This helps staff reach consensus about working strategies.

While not every team member may participate in the initial treatment plan meeting with the family, the assessments they complete are integrated into the treatment plan. For example, regarding the educational aspect of the program, the teacher performs an assessment of the children by testing them (if old enough), by

Family Perspectives

The therapist takes the lead in developing the treatment plan with the input of the family and other SIPP staff. One family summarized this process as follows: "They [SIPP staff] were very open about what they were planning to do and asking for our input and thoughts…There was a lot of information from [the child's] past history that was beneficial for the program." The therapist also met with the families twice per week and during these meetings continued to explain their children's treatment process and their progress. These meetings also offered families the opportunity to continue providing their input throughout the entire process.

Education

The children's transition from their own schools to the SIPP's school was well coordinated. When children are admitted at SIPP their families sign the appropriate releases to allow SIPP to obtain their school records. Families were not aware of the communication that takes place between SIPP and their children's schools, but were pleased with the academic improvements made by their children as a result of their participation in SIPP. One mother reported that before her child came to SIPP she was making Cs, Ds, and Fs and after being in SIPP she started making As and Bs and was on the honor roll. The mother stated that her "[child] has come a long way, a real long way."

Treatment Plan (Continued)

Staff Perspectives

observing them, and by reviewing their school reports. Based on this assessment the teacher develops an educational plan that is integrated into the overall treatment plan. The teacher is free to revise this plan based on the children's progress.

The treatment plan is not necessarily focused on the target children only. For example, one mother who did not know how to deal with her son was enrolled in parenting classes and was allowed to spend several days observing and participating in the different activities of the Program. This allowed her to observe the interactions between the staff and the children and learn from them.

Education

Daniel Memorial's group home and residential program are part of School 196. As such, Daniel has a school principal on site. The principal oversees the overall educational program for the entire campus. The educational component at SIPP is linked to this program with the difference that SIPP students do not follow the same school calendar. Since SIPP children are admitted for a relatively short period of time, their schooling must be ongoing. SIPP students do not take school breaks.

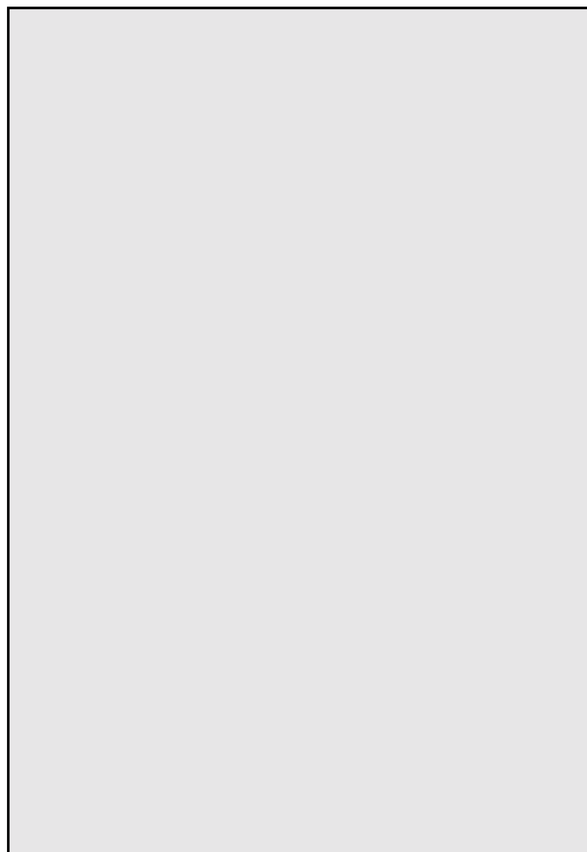
When children are admitted at SIPP they are withdrawn from their school and registered with Daniel Memorial's school. Once children are preparing for discharge, their families make the necessary arrangements to transfer them out to the proper school. The SIPP teacher provides them with a report card and the documentation the families need to complete the transfer.

Family Perspectives

The only educational concern raised by a mother was having children of all ages in the same classroom. This mother said that her child had found this to be distracting.

Case Management

From the families' perception, the role of the case manager was to make follow-up calls to the families following their children's discharge from the program. Most families had targeted case managers who had been working with them prior to their children's admission to SIPP and who continued working with them upon their discharge. □



Treatment Plan (Continued)

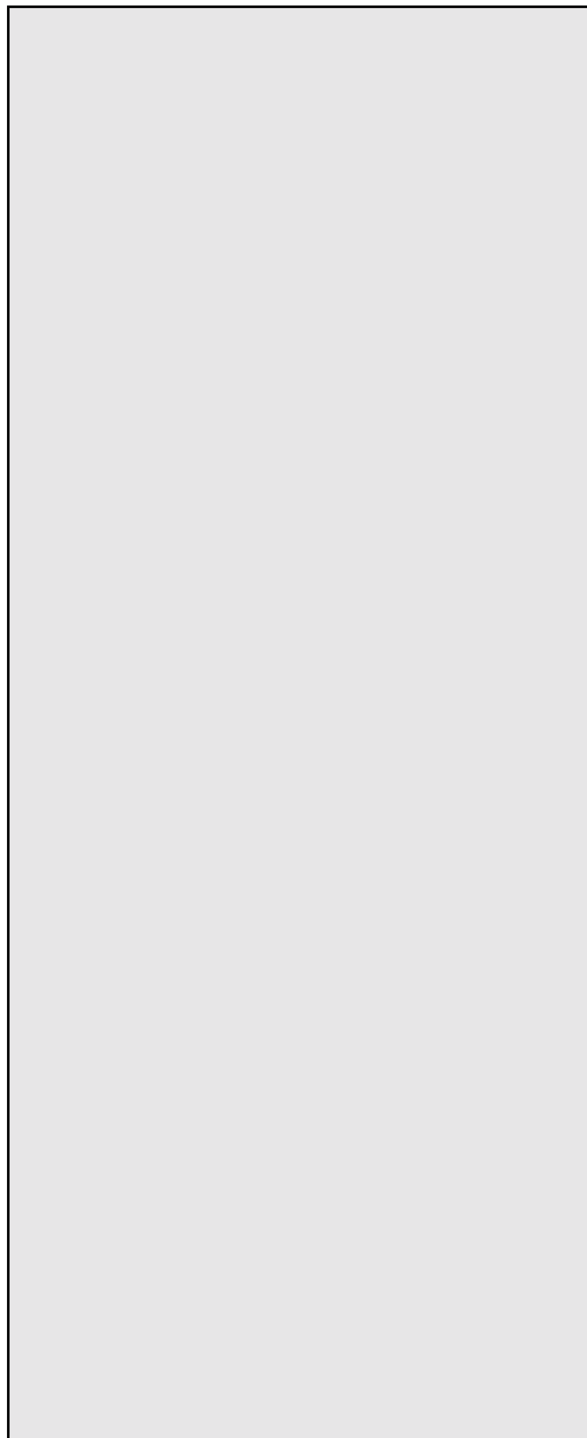
Staff Perspectives	Family Perspectives

Children participating in SIPP have their own classroom and teacher, separate from the other programs offered by Daniel Memorial. Their educational component resembles a regular school in that all children must attend on a daily basis and keep the same hours of instruction.

Case Management

In most cases, children entering the SIPP program were receiving case management services from a community agency. Once they are accepted in SIPP case management becomes the responsibility of the SIPP case manager. At this point, the services provided by the community case manager stop to avoid duplication of services. While children are in SIPP, their community case managers are informed about their progress to keep them abreast of their situation. Once children are ready to be discharged, their community case managers are informed so that they may assist in reintegrating the children to their communities.

The SIPP case manager works with the children while they are in SIPP. The case manager has a dual role: case manager and childcare worker. In the case manager role this person participates in the development of the discharge plan and is responsible for the 60 day follow up. Prior to the children being discharged, the case manager identifies services families need and links them with their community case managers. Once children leave SIPP, the case manager stays in touch with them to ensure they are receiving the services they need and the discharge plan is being followed. In the childcare worker role, this person functions as a teacher aid in the classroom. □



Discharge Planning — Significant Findings

- Discharge plans are developed with input from the treatment team and the families.
- Discharge plans help children transition to community-based services.

Staff Perspectives

Discharge planning starts soon after children are admitted to SIPP. Therapists take the lead in developing discharge plans. The psychiatrist and the case manager support them in this effort. When children first come into SIPP it is not always clear whether they will be going home or to another placement. As the assessment process progresses and the different interventions are in place then the discharge plan is shaped. Input provided by the program staff as well as the families is also considered when developing this plan.

As this process evolves, the community target case managers are invited to participate in discussions about the types of services children will need upon discharge. The case managers will begin identifying needed services and linking families. ☐

Family Perspectives

Planning for discharge starts right after admission into the program. The children's therapists take the lead in shaping this plan. This is how a family described this process, "We had a goal to go by and we went on a week by week basis. She [therapist] didn't say this was going to be a five-week thing and that was it. We took it week by week …SIPP staff would tell [child] that if she was able to behave in a certain manner for a certain number of days then they could start working on her discharge. It [the discharge] was based on [child]. It was up to her. How well she did is how fast she got through it."

The discharge plans were discussed with families and consisted of preparing the child to transition back into the community or another placement and of identifying the services children and families needed in order to succeed in their effort.

One family found that starting the discharge planning process when children are just admitted to the program disturbing. In their view, this is not appropriate because the staff has not had the opportunity to get to know the children and because when families bring their children they are thinking about the assistance they are going to receive while the staff is talking about discharge planning before solving the problem. ☐

Satisfaction with SIPP — Significant Findings

- This is an excellent Program that needs to be lengthened and extended to other areas.

Staff Perspectives

Daniel Memorial sends surveys to all families upon their discharge. Included in the survey is a satisfaction scale ranging from 1 to 5, where 5 is the highest score. Most families assigned the Program a 4 or 5 rating. According to Daniel's quality assurance department, the Program has not received any ratings lower than 4.

Staff is satisfied with the level of communication existing between them and the families. They reported always being accessible and constantly making an effort to nurture the children and their families. In their view, families leave SIPP with the feeling that their children were well taken care of and with a sense of hope.

According to the case manager's follow up about 75% of the children who have participated in SIPP are doing well and have been successful in transitioning back to the community. The remaining 25% may have relapsed or experienced some difficulties after discharge.

Most helpful

- Having a structured supervised environment for the children.
- Being part of a new program offers staff the opportunity to be more creative and to help in the development of the program as a whole.
- The comprehensive nature of their assessments that allows them to stabilize the children and develop more effective discharge plans.

Family Perspectives

Overall families were satisfied with the SIPP Program, although they found the Program not to be long enough. These are some of their comments:

- "I think it was a very excellent program. I couldn't ask for anything else. They [SIPP] turned [child] around."
- "[SIPP] is a fantastic program, diagnosed [child] with [diagnosis]. They saw his behaviors, his needs, but it was not long enough."
- "Everything was great. It was the only relief and most help [child] has had since his diagnosis."
- "Really satisfied, it [SIPP] was excellent. It is a real good program."
- "The timeframe issue is the one negative aspect of the program. There is not a feeling like we [SIPP] are going to do whatever we have to do to solve this child's problem. It is like we are here for 30 days maybe we can extend it a week or two and if that doesn't work then there is nothing we can do. As opposed to the program being part of a sister program where if it doesn't work here [SIPP] we have another place were we can work on the problem."

In general, families reported that children were doing well after SIPP. Families realized that some of the conditions of their children may not be completely cured and know of their need to continue addressing them. One family was having a hard time securing the services needed for her child due to availability and eligibility. The child

Satisfaction with SIPP (Continued)

Staff Perspectives

- Knowing "that things can get better." It is helpful to have Medicaid funding secured for a period of time so that efforts can be placed on treatment rather than on securing funding.
- SIPP is a clinically sound program that can be replicated in other areas and the staff at Daniel Memorial can help others set it up.

Least helpful

- Not having a behavior analyst work more closely with the staff and the children.
- The dual roles played by some of the staff (e.g., case manager) because this prevents them from being more effective in what they do.
- The system barriers (i.e., juvenile justice, education, etc.) that families encounter upon discharge, in addition to the competency level of some mental health providers in the community.

Suggestions for improvement

- Adding more staff to fill the specific roles. For example, the case manager and teacher are the only two online staff during the morning and early afternoon hours, when the children are in school. If a child is not feeling well and would like to go back to his/her room this cannot be done because there is no one available to supervise him/her. Having more employees would provide staff with more planning time to do more creative things.

Family Perspectives

who was placed with the therapeutic foster family that did not have the opportunity to participate in the program experienced difficulties with the child and ended up moving the child to a more suitable family. This family reported that most of these difficulties could have been avoided if there had been better communication between the family and SIPP. This family commented that "eight weeks [length of time child was in SIPP] is too short of a time to learn about a child, find a suitable family, and get them acquainted before they [children] have to go."

Most Helpful

- "Teaching her [child] self control."
- The way in which the program is set up to resemble a home environment rather than a hospital. Children have the opportunity to live as a family and to become aware of how their behaviors impact each other.
- The approach used by the program, which is family oriented and inclusive and at the same time offers children one on one therapy.
- "The light at the end of the tunnel, knowing that she [mother] was not alone. Realizing that both [mother and child] had to work at it. That once they made the commitment it was going to work."

Least helpful

Most families could not find any aspect of the program that was not helpful to them and to their children. One family reported that not receiving complete information about all the issues regarding the child made it difficult for the family to work with the child.

Satisfaction with SIPP (Continued)

Staff Perspectives

- Finding a way to have more family involvement by requiring them to do some type of volunteer work for the program. Also involve the children in community service.
- Continue providing staff training to increase the staff's education and understanding of the objectives of the Program.
- Include a more structured behavioral system in the overall program to provide more consistency to the way staff members work with children and to help families do the same.
- Have a separate program for children and for adolescents.
- Increase the length of the program to 90 days if needed.
- Increase the per day rate to stop SIPP from losing money.
- Make more people aware of the existence of SIPP. The program is not being used to full capacity. ☐

Family Perspectives

Suggestions for Improvement

- Make the program a little longer and have more of them in different areas.
- The program director should consider the different backgrounds and experiences of the children being referred to SIPP so that there is good chemistry among them and as a result are able to benefit from the Program. If there is a lot of conflict among the children going through the program their conflicts get in the way of the treatment.
- "We should have more programs. What is lacking is a comprehensive strategy that involves all levels [of care] needed." ☐

Significant Differences (Daniel Memorial)

The perceptions of the SIPP staff and the families were very similar in most of the areas addressed. There were two areas in which their perceptions vary somewhat: case management and discharge planning.

For the families the role of the SIPP case manager was limited to making follow-up phone calls once their children were discharged. While families appreciated the phone calls they did not perceive that these calls would impact their lives in any way. For the SIPP staff, however, these phone calls were important because they allow them to determine if discharge plans were being followed and to contact the families' targeted case managers if the families were not linked to the appropriate services.

SIPP staff views the development of a discharge plan as a way to ensure family involvement from the start and to create a treatment plan that meets the needs of children and families that may continue to be implemented after the children are discharged. Some families

did not see it this way. For them, being required to have a discharge plan made them feel overwhelmed and uneasy about the process. Rather than helping them focus on the treatment plan, the discharge plan swayed their focus into what was going to happen once their children were discharged.

Community Agency Perspective

A representative from the Community Review Committee (CRC)/Family Services Planning Team (FSPT) provided this input. This committee represents one of the multiple entrance doors for children into SIPP. An intake person from Daniel Memorial sits on this Committee and keeps its members informed about criteria and about the different programs that might meet the needs of children.

This Committee also works closely with SIPP's case manager to ensure a smooth transition for the children coming out of the program. If the children coming out of SIPP are not connected with FSPT they are provided with the appropriate information. However, this FSPT only works with five counties in District 4.

According to this informant some of the children the Committee has referred to SIPP have been denied because they did not meet the program's criteria. These children required long-term treatment and had no discharge plan in place. The informant added that prior to making these referrals the Committee knew that more than likely they would be denied but did it "out of desperation".

Regarding satisfaction with SIPP and what this program is trying to accomplish, this respondent stated the following:

- "SIPP has been able to serve the foster care population well."
- "They [SIPP] have done a really good job in wanting to link with the community."
- "I think it is a very good program. It covers a specific need we have."
- "They [SIPP] have been very responsive to the community."
- "I have appreciated the fact that the children in need are filling those beds and not just any child who meets the criteria."
- "The director has been excellent."

The respondent also added that requiring children to have a discharge plan as well as family involvement are key to this Program. In his/her opinion, SIPP is doing a better job than most programs in this area. Still, this respondent would like to see more creativity in working with resistant families who may be burned out or hopeless and hopes that SIPP may continue to look for ways to engage them.

In closing, the respondent mentioned the need for additional programs such as programs for children without Medicaid and for more severe children. This does not mean changing SIPP, but adding other programs. ☐

Charter Glade

Understanding of SIPP — Significant Findings

- SIPP is an extended program that provides intensive services to children to prevent recidivism.
- Although family involvement represents a key aspect of SIPP the limited flexibility of the program hinders family participation and an on-going communication between families and the program staff.

Staff Perspectives

The goal of the program was described by program staff as providing intensive services to prevent recidivism. SIPP was also described as a program that works well for children who need more than 5-7 days of treatment. Having more time to work with the children and their families results in increased accomplishments in family relationships and placement problems. As stated by an interviewee, “I like doing SIPP work because you see more progress.”

The main difference between the SIPP program and the services received by the children in the crisis unit is on the family and individual counseling offered to the SIPP children. Since SIPP children are in for a longer period of time, their treatment plans allow for a more individualized intervention.

Family involvement represents a key aspect of the SIPP program. Their involvement takes place at a treatment level. Families participate in therapy. They are expected to participate in two family sessions per week, of which at least one has to be in house. During these sessions families are informed about their children’s progress. Family visitation is also encouraged.

There was no family participation at a programmatic level. This is an area in need of development. ☐

Family Perspectives

Mostly parents view SIPP as an extended program that prevents children from going back into the hospital for crisis treatment. Through this program, children receive medication management and the therapy they need in order to return home. As stated by one parent, “SIPP is a short-term residential psychological help center.” One parent viewed SIPP as a drug prevention program. Most of the families interviewed entered SIPP through Charter Glade’s crisis unit where it was established that their children needed more intensive care.

Families found the program’s staff to be less accessible than what they would have liked them to be. Their experiences in this regard varied. Some families mentioned that when they would call SIPP the person answering the phone was not able to answer any questions regarding the status of their children and would say something like “I am not the one working with [child]”, or would not connect them to the appropriate person. A difficulty accessing the doctor was also mentioned. One parent reported leaving many phone messages for the doctor, which were never answered. The same parent also mentioned that during one of her visits to the program the doctor was standing by the nurse’s station and she wanted to ask him a question, but he would not speak to her stating that she needed to speak with the counselor. There were some exceptions to

Understanding of SIPP (Continued)

Staff Perspectives	Family Perspectives

these reports regarding the counselors, which some families found to be more informative and friendly.

Families participated in the weekly sessions in which they learned about their children's progress. For some parents these sessions were scheduled at inconvenient times and they had a difficult time complying with this requirement. For example, one family reported that their meetings were scheduled at 11:00 AM, which meant that the husband would end up losing almost three hours of work twice per week. This family lives almost an hour away from Charter Glade. They tried having their meetings changed to 8:00 AM, but their request was denied. Another family reported that "being there twice per week became a problem although I believe in family involvement." This family also tried to have their meetings changed to the weekend but "SIPP would not accommodate them." In addition, the families had to come back at 6:00 PM to visit their children, since visiting hours were from 6:00 to 7:00 PM daily. This also represented a problem for several families because visitation hours interfered with the family's suppertime and because some of them lived an hour or more away from Charter Glade. One family mentioned that the program was so strict about visiting hours that if parents arrived five minutes earlier, they would have to wait until 6:00 PM before they were allowed to see their children.

Families were not involved with SIPP at a programmatic level. They were not aware of the organizational structure of the program or who was in charge. One family mentioned that as far as they knew the program did not

Understanding of SIPP (Continued)

Staff Perspectives	Family Perspectives
	have a director and that they were told that the doctor was it. According to this family, "[the doctor] was God himself." ☐

Charter Glade

Individualization of Services — Significant Finding

- Individualization of services is guided by the children's goals and family input.

Staff Perspectives

Individualization starts with the plan, which is geared towards the children's goals. As part of this process, the treatment team identifies those areas in need of attention and the behaviors that need to change. In addition, the psychosocial assessment has a section on strengths that are considered when developing the plan.

The core services provided by the program are individual counseling, family counseling, group counseling, medication monitoring, behavioral modification, recreational activities, and schooling. ☐

Family Perspectives

All children attending SIPP have access to a core of services. The services received by the families interviewed included medication management, behavioral modification, counseling, group counseling, family counseling, recreational activities, and schooling. However, not all children received the same services.

Services were individualized based on the information provided by their parents. During the family counseling sessions families were offered the opportunity to set up individual goals for them and for their children. ☐

Treatment Plan — Significant Findings

- The doctor drives the treatment plans with input from the treatment team.
- Families are consulted about their children's treatment plans but are not included as equal partners in plan development.
- The case management component of the program is not defined.

Staff Perspectives

Many admissions to SIPP take place through the crisis unit. Once children are admitted they are assigned a therapist and within two days from admission a plan is developed for each child. The plan is developed as a team effort. The formal team is composed of the psychiatrist, social worker/therapist, utilization review staff, discharge planner, and sometimes the recreational activity person. As stated by one of the interviewees, their approach follows a "doctor driven treatment plan" where the psychiatrist gives "the green or red light."

The nurse, in conjunction with the therapist, is responsible for the implementation of treatment plans. The nurse is also responsible for the administration of the medications following the doctor's orders, for communicating to the doctor any complaints or side effects caused by the medications, and for obtaining informed consent from the children's parents/ guardians regarding medications.

Family participation in the development of the treatment plan is not considered. This is how one of the interviewee's explained this situation: "Family participation at this level is something we would like to do, but we find with SIPP children that the reason they are here is because of a dysfunctional family. When they [children] have guardians through the Department of Children and Families is much easier." However, members of the treatment team talk to families over the phone or during family sessions to seek their feedback about the treatment plan.

Family Perspectives

Except for one family that participated in a staffing meeting where several community agencies were represented, families reported that they never participated in a planning meeting. Furthermore, families were not clear about the existence of a treatment plan. One family stated that "If there was one [treatment plan] it was never discussed with them [parents]." Another family mentioned that when their child was brought to SIPP the family met with a "rude nurse" who gave them a brief overview of what their child's days would be like and informed them that visiting hours were from 6:00 PM to 7:00 PM. One family was aware of the existence of a treatment plan and reported that the plan would change on a daily basis and that they participated as the treatment went along.

Education

The children's experience with the educational component of the Program varied. Overall the children did not receive a lot of education while at SIPP. Some of the reasons mentioned by the families were: (1) the child was in SIPP during the summer when school is out, (2) by the time schooling was arranged it was almost time for the children to be discharged, and (3) the schooling received by the children did not follow what the children had been doing in their schools.

Case Management

Families were not aware of SIPP's in-house case management. When asked if

Treatment Plan (Continued)

Staff Perspectives	Family Perspectives

Education

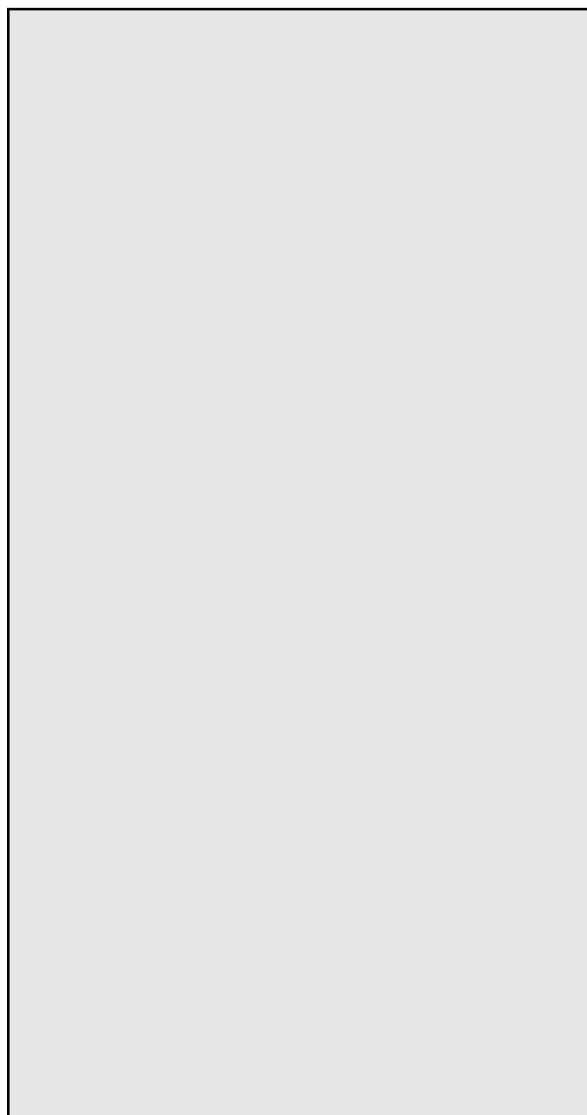
Schooling arrangements are individually made for each child. Charter Glade does not have an assigned teacher for their SIPP Program. The positive aspect of this arrangement is that children are receiving individualized educational services from the school district. The difficulty lays in that it takes time to set up this arrangement. The constant fluctuation of the SIPP population also makes it difficult to have a SIPP-based teacher because at times the number of students is so small that it does not warrant having an in-house teacher. In spite of these difficulties, it was reported that the SIPP Program is still working with the local board of education to improve the educational component of their program.

The educational component is usually coordinated through SIPP's unit coordinator. A room is reserved for teachers to meet with students. Teachers let the unit coordinator or the therapists know if children have to complete homework and also inform them about the children's functioning level. Once children are ready to be discharged, their parents/guardians make the necessary schooling arrangements.

Case Management

At the time this study was conducted the SIPP program did not have a staff member classified as a case manager. Instead, they had a discharge planner who to a certain extent acted as a case manager. The role of the discharge planner is to start discharge planning following the children's admission into the program. As part of this

they received any follow-up calls from the SIPP's case manager after their children's discharge two families reported that this had been the case. In both cases, the families reported that the purpose of the call was to prompt them to complete the Program's satisfaction survey. The remaining families reported not receiving any follow-up calls from SIPP. □



Treatment Plan (Continued)

Staff Perspectives	Family Perspectives

process the discharge planner finds out if families were working with a targeted case manager before coming to SIPP. If this was not the case, then the discharge planner enrolls the families with the local community mental health services to ensure they will receive this service upon discharge. Families are also referred to the Multiple Review Committee (MRC) if they have not gone before the Committee previously.

Once children are discharged, the contact between the SIPP's discharge planner and the families ends. The discharge planner is not responsible for making follow-up calls. However, families are welcomed to call back if they need assistance. ☐

Discharge Planning — Significant Findings

- The discharge planner coordinates discharge plans with input from the treatment team.
- Most families were not prepared for their children's discharge.

Staff Perspectives

The discharge planner coordinates the discharge plan and is responsible for gathering information about the children from the treatment team as well as from their parents. By collecting this information, the discharge planner learns about the children's situation and whether they will be going home or to a different placement. If children are discharged to another facility, then the discharge planner will make the necessary arrangements for transferring the children's records upon discharge.

The therapist also discusses discharge planning with the families to help them establish a home contract and to prepare them for discharge and aftercare. This information is also provided to the treatment team and to the MRC. However, it was reported that at the time of this study the MRC had disbanded due to the length of the waiting list for residential services and efforts to reorganize this committee were underway. This creates a difficult situation for SIPP because their doctors feel the program should keep the children in need of residential treatment until these services are available. It was also reported that the availability of community services in this County is limited. This is having an impact on the aftercare services families are able to obtain. □

Family Perspectives

Families did not perceive their children's discharge as the result of a process in which they were involved and that considered their options for the aftercare of their children. To most families the discharge of their children came up as a surprise. Invariably families felt that their children were not ready for discharge. This is how a family explained the discharge process: "After 30 days [at SIPP], we [the family] were told [child] was ready to go home. They [SIPP] just called [family] to go pick [child] up." Another family reported that their child was discharged after a month because according to SIPP their Medicaid had run out.

The aftercare plan for the children consisted of going back to the services they were receiving prior to their admission to SIPP. Overall, families were not linked with any additional services needed. □

Satisfaction with SIPP — Significant Findings

- A small number of families responded to the satisfaction reports. The feedback from these reports was positive.
- The SIPP concept is good but its implementation failed to meet the families' expectations.

Staff Perspectives

According to SIPP staff families are not responding to the follow-up surveys sent by Charter Glade to help them determine in a more systematic manner the level of family satisfaction with the Program. Reports about family satisfaction were based on the individual experiences of the staff interviewed and as such their views vary somewhat. Overall, staff felt that families were pleased with the services received at SIPP. This is what one of the staff members interviewed reported, "I think children and families are pleased. We get very good feedback from them…I wish we had more feedback from the families. Those who provide feedback are happy."

According to another respondent, "75% of the families are happy. The other 25% I don't know if they feel they should receive more [services]." In this regard, this respondent mentioned the need for families to understand that SIPP is an extended crisis unit program intended to stabilize the children and help them obtain follow up services.

Another respondent stated "I have no clue" when asked to comment on this issue. The respondent had made three family follow-up calls and two were unsatisfied and one did not want to speak about their experiences with SIPP. However, the respondent stated feeling positive about the progress the SIPP Program was making in helping children.

Family Perspectives

In their reports on satisfaction families made a distinction between the SIPP concept and its implementation. Overall, families liked the concept of the Program but had some concerns about its implementation. These are some of their comments:

- "The program in theory was a good idea, but Dr. [psychiatrist] did not allow for services to be provided."
- "[Child] didn't get anything. They [SIPP staff] screwed up his medication management; [child] didn't get any therapy."
- "The program itself is good, the place is the bogus thing."
- "I felt like I was very let down. I expected a lot more help and I don't feel like I got it."
- "SIPP is a good program it just needs some watching to make sure the hospital follows what they are supposed to."
- "There is a need for SIPP, for this concept."

Most families reported that their children were doing well after SIPP. However, they did not attribute their children's condition to their participation in SIPP but to the services they were receiving. Half of the families reported that their children were worse after coming out of SIPP. Some of the reasons they provided were: (1) the lack of structure and supervision of the Program which allowed children to do whatever they wanted, and (2)

Satisfaction with SIPP (Continued)

Staff Perspectives

Most helpful

- Having enough time to bond with the children.
- The Program's structure which is conducive to helping children develop more appropriate behaviors.
- The continuity of care within the Program provided to children. Children are assigned a therapist who has intensive contact with them.
- The opportunity the Program offers to children and families to reach some stability and heal.

Least Helpful

- The Program does not allow children to spend enough time outdoors. It is a great liability for the Program if children run away.
- The length of the Program is too short for some of the children.
- The limited schooling received by children while at SIPP.
- The amount of paperwork related to the Program.

Suggestions for improvement

- Place more emphasis on family participation as one of the expectations of the Program.
- Have more flexibility and individualization when it comes to family participation. Some children do not have families. Some families need more than two family sessions per week.
- Extend the length of the Program to 90 days. ☐

Family Perspectives

the negative behaviors picked up by their children while at SIPP.

Two families reported that the situation of their children was up in the air due to lack of services in the area. Apparently the number of mental health providers that accept Medicaid in this area is quite limited. One family was commuting to St. Petersburg twice per week because that was the closest place where they were able to secure services for their child.

Most Helpful

- "The medication management.'
- "We [family] knew where [child] was for a month."
- "[I] learned from family therapy and learned about medication."
- "[SIPP] gave [child] the time to see what he had done and to calm down."

Least Helpful

- "The confusion with the treatment plan. They [SIPP staff] changed it from day to day. This may be necessary but not convenient."
- "They [SIPP staff] did not keep us informed about things."
- "The nurse, the staff." This family reported that at one time the family had talked to the nurse about their need for better services and his/her response was "beggars can't be choosy, you have Medicaid."
- "The behaviors [child] picked up and the lack of proper staff."
- "The fact that they [SIPP] sent [child] home against our wishes and our fears."

Satisfaction with SIPP (Continued)

Staff Perspectives

Family Perspectives

Suggestions for Improvement

- "I would make the therapy to be 'family' therapy. I would have a different doctor."
- "I would make sure that what they [SIPP staff] do is communicated to the families. They [SIPP staff] are not family oriented. They [SIPP staff] are more family splitting."
- "[A child] wouldn't be released until everyone believed progress was being made."
- "[Would have] more family interaction, more flexibility, have group meetings, have a contact person who can keep you informed, [and] see the reports."
- "SIPP needs group homes, more structure, longer period based on individual needs. A team approach to make decisions, a program that hears a family."
- "I would make SIPP the beginning of an integrated program with several step-ups until children are ready to come home. To drop someone after five and a half weeks is not right."
- "I would make [SIPP] more convenient for the families. They [SIPP staff] expect you to drop everything to comply with their requirements. Most families work and have more children to attend to." ☐

Significant Differences (Charter Glade Site)

The perceptions of the SIPP staff and the families differed mostly in regards to staff accessibility, discharge planning, and satisfaction. Families experienced some difficulties obtaining information about their children and accessing staff at times other than during the family sessions. The SIPP staff did not seem to be aware of any accessibility issues.

For the families, their children's discharge was not a planned event, but something that happened unexpectedly. They did not feel that they had been part of a process to prepare them for this event and for the aftercare. For the SIPP staff, discharge planning was something that began following the children's admission.

The level of satisfaction of the families was not as high as was perceived by the SIPP staff. Granted, the SIPP staff based their comments in their experience with a larger number of families than the number that participated in this study.

Community Agency Perspective

One representative from a community mental health agency and one representative from the local ADM office provided this input. Their involvement with SIPP is part of the transitioning process as children are discharged from the Program. The community mental health agency provides targeted case management and at times refers some of their clients to SIPP. The representative from ADM tracks the admissions and discharges at SIPP and as clients approach the discharge date, the agency starts linking the children who live within the area with services. This person also attends weekly staffing meetings to improve communication within SIPP.

The representative from the community mental health agency reported that some of the children they referred to SIPP were denied because of the absence of a parent willing to participate in the process and in one case because the child required "too much of a one-on-one." The informant felt that these children met the Program's criteria and was disappointed by the denials. Part of his/her disappointment emerged because in conversations with a SIPP supervisor he/she was told these children would be admitted and part because he/she felt that efforts were not made to engage the families.

The coordination between SIPP and these agencies has worked well. The ADM representative mentioned that SIPP was in the process of defining the role of the case manager and had just hired a person to fulfill the dual role of case manager and discharge planning. This is a step that will help SIPP offer more continuity and remain in touch with the families. Both respondents acknowledged that some of the children discharged from SIPP where in need of residential services and that families were looking for these services. One of the respondents mentioned the lack of mental health providers accepting Medicaid in this area as a serious barrier for families.

In terms of their own satisfaction with SIPP the respondents stated:

- "Fifty-fifty." The respondent clarified this statement by adding that some things are working well and some are not. In his/her perceptions this is more a problem of internal communication within SIPP.

- “I think you got a very caring people [at SIPP] who want to serve families in the community. They recognize they are finding their way.”

One of the respondents offered the following suggestions to help improve the Program: (1) turn Charter Glade into a community mental health center that provides a continuum of care, (2) have the school system provide an educator for the Program, (3) lengthen the children’s stay and do more in-depth work, (4) separate SIPP clients from the crisis unit, and (5) separate teenagers from children and the boys from the girls. □

Significant Differences Between Sites

This report summarizes the experiences of Program staff and families in the SIPP Programs iat Daniel Memorial and Charter Glade. While the intention of this assessment was not to identify differences between the two Programs, the perspectives collected throughout this effort showed some clear distinctions between them. These differences can be attributed to factors related to the philosophy of the implementing agencies, their program organization, and the availability of community resources.

The underlying philosophy of the SIPP Program at Daniel Memorial calls for a comprehensive approach to service delivery. Their view is that SIPP requires a comprehensive assessment of children and efforts are made to set them on the most appropriate treatment course. In Charter Glade their approach is geared toward the stabilization of children before their discharge. Their family piece does not seem to address the family situation in a comprehensive manner. Families are not integrated into the program as equal partners.

While both SIPP Programs are embedded in large institutions, the Program at Daniel Memorial is set up as a stand alone program making it easier for families to understand its different components and to know the staff and their responsibilities. At Charter Glade, SIPP is combined with the crisis unit making it more difficult for families to differentiate one program from the other since they share staff and also many of their daily activities. Although both Programs use a team approach for service planning and delivery, the way this was reflected to the families varied. All staff members at Daniel Memorial are considered to be part of the team and as such are expected to know enough about the children’s treatment to be able to communicate with their families. At Charter Glade this was not the case, making it more difficult for families to obtain information/updates about their children’s progress.

The SIPP Program at Daniel Memorial enjoys the availability of a continuum of care provided by this agency. There is also a wider range of community services that may be accessed by SIPP families in the area. This is not the case with Charter Glade. This agency has to rely on the few services available in the community and the limited number of providers willing to accept Medicaid, as such Charter Glade faces an enormous challenge when it comes to suggesting follow up services to families. ■

Part 5: Quality Assurance, Grievance, Denials and Data Quality

The SIPP model contains standard policies for quality assurance, grievance, denials, and data reporting mechanisms. The policies were developed from existing Medicaid procedures and require SIPP sites and First Mental Health to submit regular reports of activity in the above stated areas to the state. The Agency for Health Care Administration is responsible for monitoring a large part of the activities herein through formal audits. As part of the evaluation, our focus was on the perceived utility of quality assurance policies for implementing necessary changes at the care level, the accessibility of grievance procedures for clients and their families, reasons for denials as an indicator of access to care issues, and of the quality of data and management information systems for examining program outcomes. Data provided in this section of the report were derived from interviews with agency staff and families, and reflect their perceptions of the current practices.

Quality Assurance

Quality assurance policies at Daniel Memorial and Charter Glade were examined through interviews with staff and families. Those interviewed were not directly involved with quality assurance decision making, however, they were involved in completing and maintaining data that informed the need for improvements. At both sites, quality assurance was managed by the larger institution serving all programs at each site. Both sites relied on standard measures of quality including medication logs, client events, family feedback forms, denial rates, and access to care. From the interviews the following details differences in quality assurance at the two sites.

Quality improvement at Daniel Memorial is based on formal and informal systems. Formally, information is gathered from customer satisfaction surveys and logs of client events (i.e., emergencies, seclusion, medication management, etc.). These data are analyzed and discussed by staff and administration during weekly meetings and program improvement are made accordingly. Informally, staff sought input and feedback from families on a regular basis. At Charter Glade, little information was available about the quality assurance practices. At the time of the interviews there was a turnover in staff who were familiar with the existing policies rendering it difficult to collect any informative data.

Complaints

The SIPP guidelines clearly outline a grievance process, which both sites appeared to follow, however somewhat differently. The impact on families differed as well. At Daniel Memorial, families were informed of the grievance process and their rights at the time of admission. Grievance forms were displayed in their lobby, and families were encouraged to use them if necessary. Any concerns a family may have are brought to the attention of their therapist. If the therapist is unable to solve the situation, then it is brought to the attention of the Program Director, who consults with the care team. Most families indicated they had a good rapport with the therapist and staff and felt comfortable talking with them about their concerns.

Charter Glade reported that they were trying to develop a grievance process with their follow up by arranging after discharge meetings with the families and by having them complete surveys. In their surveys they ask specific questions about grievances. During interviews with families at Charter Glade, parents indicated they talked to their therapists whenever they had a concern. However, they were not clear about the organizational hierarchy. One family mentioned that they did not think they could go above the psychiatrist. Another reported that the program did not have a director. They also reported not being oriented about this issue.

During the first year of the program, no formal grievances were filed. However, as is indicated above, there were clear differences in the grievance process between the two sites, and at Charter Glade, some families indicated that they were not aware of the grievance procedures.

Access to Care and Denials

Rates of denial are often used as reflectors of access to care. The SIPP model has a utilization management component specifically designed to monitor and approve enrollment in the program for eligible individuals. As part of the evaluation, the rates of denial at each site were analyzed to examine access to care and understand variances in the population that may not be well served by the SIPP program model. According to the data, there were no denials at either site during the first year of implementation. However, their were several cases not admitted to the site or who were not approved care past the 60 days approved by the waiver. Although these were legitimate decisions within the guidelines of the SIPP model, the exclusion of these children from services raise important questions about coordination of records for conducting assessment, the availability of after care placement, and the policy that all clients must have a parent or guardian available to participate in treatment and post discharge placement. The following is an account of the children who did not receive care by the SIPP or who had trouble with follow-up placement.

One of the criteria for admission to SIPP is that children must have a discharge plan, meaning that a family member has been identified for participation during the process and to receive the children upon discharge. One young boy (10 years old) was denied services because SIPP could not access his psychological tests, could not establish his cognitive abilities, and did not have a family member who could be engaged in the process. The child lived with an aunt who has some cognitive limitations that prevented her from participation in the SIPP process. Consequently, this case was not considered a denial, and it was classified as not meeting the program's criteria.

Two children were denied continuation of services. One child was in SIPP for 188 days and was authorized for 60-65 days, and the other child was in SIPP for 100 days and was authorized for 50. The child who stayed for 188 days did not have a discharge placement. This child was back at SIPP at the time of these interviews and a foster family had expressed a desire to work with him/her. The child who remained in the Program for 100 days was not discharged earlier because his/her mother was not psychologically stable to receive him. The records for these two children were submitted to First Mental Health for appeal and Charter Glade was waiting for a response.

Overall, the SIPP staff reported having a good working relationship with First Mental

Health. They indicated that First Mental Health usually responded to their inquiries on a daily basis and that they were pleased with the pre-certification process.

A secondary concern within access to care is that the catchment areas of the current SIPP sites cover a large geographic area. Daniel Memorial is located in Jacksonville, yet Area 4 (which the SIPP covers) includes multiple counties extending down to Daytona Beach. Charter Glade is located on the outskirts of Fort Myers, yet Area 8 serves a large rural region. The long distance to services for some parents (as much as a 1 to 1.5 hour drive one way) created challenges for them to participate in weekly treatment sessions and to regular visits with their children. Parents interviewed were committed to helping their children and met the challenges. However, they requested flexible scheduling for treatment and family visits. For example, Charter Glade had standard visiting hours during the week that did not extend long enough into the evening or into the weekend. The location to the SIPP is critical to insure the greatest access to care for the greatest number of the target population.

Data Quality

Analysis of the quality and completeness of the data submitted to the Florida Mental Health Institute (FMHI) from each site suggests needed improvements. With regard to demographic data, the sites did not share standard data sets or methods of reporting. Race was available for one site, while county of origin of the child was available for another. Presenting problems were available for one site. Medication logs were not consistently formatted and were incomplete. Functional measures were provided at admission for less than half of the children in each site, with discharge data available for even fewer. Satisfaction measures were available for less than half of the clients in each site with several different measures used in one location.

More serious deficits were noted in medical record errors and inconsistent use of client identification numbers over time. Monthly summaries were redundant and sometimes contradictory. The submitted data suggests that neither site maintains an information system that would serve to organize necessary client data for purposes of general management and administrative oversight. Because of the unique status of the programs as demonstration sites, standards for documentation and management information statistics would help establish minimal acceptable record keeping practices for future service providers. ■

Part 6: Summary and Recommendations

During the first year of the waiver, the SIPP sites demonstrated the usefulness of many components unique to the SIPP and also raised questions about the need to enhance or redesign others. The family involvement component, comprehensive assessment, and integrated services in a continuum of care, were perceived by family members as an invaluable departure from the traditional inpatient care previously afforded their children. Less developed were the data systems for monitoring and quality assurance, which require further development for statewide implementation.

At the time of this report, the state has received legislative approval to expand the waiver statewide. Through initial conversations with staff at AHCA, the program will be modified, based in part on findings from this evaluation. The two current sites in this evaluation were used more as a vehicle to examine the model, rather than to compare the degree to which the sites successfully implemented the SIPP program. Key observations and recommendations are offered that address the SIPP model, rather than the need for changes at the actual site. The following are key observations and recommendations as they relate to the core areas of the SIPP: Access to Care, Quality of Care, Management Information Systems, Data Reporting, and Quality Assurance.

Access to Care

The family involvement component enhances the model of care for children, and at the same time denies others access to care. The program guidelines require that a parent or guardian agree to participate in the full treatment program and receive the child upon discharge. Some children, especially those in the child welfare system, did not have a supportive family environment, or were living with foster parents unable to commit their time or their ability to assist in post discharge care. As a result were denied access to the program. And some families did not have flexible schedules that permitted them to participate in treatment. Additionally, some children completed the program but were placed on a waiting list for residential aftercare and consequently were denied continued care in the SIPP at the end of 60 days.

Recommendations

- Access to care will continue to be a problem for some children given the guidelines for family participation. This is a critical issue that the State will have to address given that a number of the high-risk youth are also in the child welfare system and do not live with their families. The commitment to the program may be too much for some foster parents who already care for multiple children. An important question for the State to consider in the expansion of the waiver is to what extent is the SIPP model appropriate for children foster care placement.
- Future sites of the SIPP program should be located centrally to serve the target population. Geo-mapping may be a useful process to estimate the areas for the greatest number of high-risk youth. Similarly, the addition of more than one site within an AHCA area through ADM districts or other configurations may be necessary.

Quality of Care

Quality of care was measured by a number of indicators, including the degree of family involvement and its success for parents, the composition of the care team, the continuum of services, case management and after care, individualized treatment and integrated education. Many of the features enhanced the quality of care:

- The family involvement component was useful to help parents understand their child's behavior and learn how to respond
- Engaging families in the treatment planning process increased their commitment to helping their child
- A full spectrum of services, including individual therapy, recreation, education, behavior modification, discipline, and family time enhanced the opportunities for children to stabilize their affect and behaviors
- A multi-disciplinary care team enhanced the responsiveness of staff to address the needs of children as they emerged daily and to redirect treatment modalities when appropriate
- An integrated education component enhanced children's ability to catch up in school and transition to the educational setting
- The case management function did not seem to enhance the SIPP program
- Some parents found it difficult to participate in the treatment program because they lived far from the SIPP

The evaluation revealed that the after care component of the model was lacking at both sites. The intent of the model was to link case management services with after care follow-up to enhance the transition for youth from an inpatient setting to community outpatient. Data from the interviews with parents and staff indicated that the case management function was limited to follow-up phone calls after discharge. Additionally, the case management function was confused for some families who already received targeted case management. This duplication raises questions about the function of the SIPP case management role for future sites.

Recommendations

- Develop more fully the after care component of the SIPP to serve youth as they transition from a sub-acute setting to the community.
- Expand the practices of the case manager to include coordination to after care
- Examine the duplication of efforts that exist with the current case management function and the presence of targeted case management for many clients
- Secure commitment from local school districts around the SIPP to provide an onsite teacher and coordinate curriculum for the children

Outcomes Monitoring

The management information systems and data reporting mechanisms are traditionally the least developed system in most behavioral health centers, and the SIPP programs were no different. A number of issues were identified that need to be examined for the program to record and maintain appropriate data about the functional status and outcomes of enrollees, as well as provide the state with appropriate program monitoring information. The review of the MIS data available in the SIPP demonstration sites suggests several potential needs which we offer as recommendations for consideration.

Recommendations

- Develop a standardized demographic MIS data set for service providers. The standard minimum data set recommended by the CMHS Mental Health Statistics Improvement Program (MHSIP) may provide a foundation for data set development.
- Develop a clearly identified set of outcome measures that are relevant to the clinical interventions proposed for the program and that would document effective treatment interventions. The identification and/or development of outcome measures should be based on a clear explication of the expected outcomes of treatment and reflect prevailing theory of best clinical practice.
- Document the use of medications, including complete records of the introduction, use and termination of use of drugs administered to consumers. The medication log should document the reasons for the introduction and termination of use and all positive and adverse effects.
- Develop measures of consumer satisfaction associated with access, appropriateness, and outcomes of service from the perspectives of primary children, parents or other caregivers, and referring and community agencies.

Quality Assurance and Data Reporting

Data to measure program outcomes was inconsistent across sites and often lacking. Data systems are often the least developed aspect of agencies. Several recommendations are offered to highlight essential data components for measuring quality improvements and program outcomes.

Recommendations

- Develop a set of measures to examine all aspects of the program, including administrative functioning, care team composition, educational and recreational programming, level of care, and assessment procedures
- Implement quality assurance and outcome monitoring practices consistently at each site

Future Analyses

As part of the intended outcomes, it is anticipated that the SIPP program model will result in a reduction in the cost of inpatient care to the Medicaid system. Youth who experience extended inpatient stays or more than one admission in a year are said to have very complex conditions that require expert attention to their psychiatric and psychosocial needs. The purpose of the SIPP is to provide such care at a less costly level in a specialty setting or residential facility.

The next phase of the evaluation will concentrate on the degree to which the SIPP is able to offset the cost of inpatient general psychiatric care and provide appropriate care in alternative community and residential based settings. A comparison analysis will be conducted of youth enrolled in the SIPP and a matched sample of high-risk youth who have a pattern of service utilization and clinical profile that is similar to SIPP enrollees. The matched sample will be drawn from two additional AHCA Areas, 5 (Pinellas and Pasco County) and 10 (Broward County). The comparison areas were selected based on state aggregate data representing number of hospitals and beds, number of persons treated for mental disorders, and general population statistics including race and age. Of all areas in the state the two chosen are most similar to the profiles of the existing SIPP Areas 4 and 8. Area 5 will be paired to Area 8 and Area 10 will be paired to Area 4. ■

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