Comagine Health

Wraparound with Intensive Services (WISe)

July 2023 – June 2024 Findings Summary & Recommendations

WISe Services Delivery Period: July 2022 – June 2023

QIRT Record Review Dates: September 1, 2023 – April 4, 2024

Number of Enrollment Records Reviewed: 199

Number of Transition Records Reviewed: 100

Total Number of Agencies Included: 24

This report was prepared under a subcontract with Comagine Health under contract K3866 with the Washington State Health Care Authority to conduct External Quality Review and Quality Improvement Activities.

Executive Summary

This section of the report summarizes the results of the WISe record review conducted by Comagine Health in partnership with MetaStar, Inc. Key findings from the review activities discussed in this report are summarized below. Additional detailed information is available in the body of the report. Furthermore, a summary of the enrollment and transition trend data is provided in the Appendix.

Conclusions

Strengths

The agencies reviewed exhibited strengths for enrollment practices in the following areas of the WISe service delivery model:

- The initial full Child and Adolescent Needs and Strengths (CANS) assessment was completed within the required timeframe 84% of the time.
- The CANS reassessments were completed in a timely manner 91% of the time.
- A home representative attended Child and Family Team (CFT) sessions 83% of the time for the 0-4 age group and 89% of the time for the 5+ age group.
- Crisis plans were included in 87% of charts included. Of those including crisis plans, 82% were completed in a timely manner.

The agencies reviewed exhibited strengths for transition practices in the following areas of the WISe service delivery model:

- Collaborative transition plans were included in 80% of the transition charts reviewed.
- A home representative attended CFT sessions 100% of the time for the 0-4 age group and 83% of the time for the 5+ age group.

Progress

Progress is defined as an area of practice the agencies made improvements to from the prior review. The following progress was identified for the enrollment and transition reviews:

- The agencies implemented processes to ensure a full CANS assessment was completed no later than 30 days following enrollment.
- The agencies improved processes to include crisis plans in enrollment charts.
- The agencies ensured crisis plans found in enrollment charts were completed in a timely manner.
- The agencies ensured transition plans were developed in a collaborative manner.

Weaknesses/Opportunities for Improvement

The agencies reviewed exhibited the following opportunities for improvement for enrollment practices of the WISe service delivery model:

- The CANS screening was completed in a timely manner 48% of the time.

- The initial full CANS was created collaboratively 15% of the time.
- The "Care Planning" requirement was completed in a timely manner 39% of the time.
- Collaborative crisis plans were included in 42% of the enrollment charts reviewed.

The agencies reviewed exhibited the following opportunities for improvement for transition practices of the WISe service delivery model:

- Crisis plans were included in 45% of transition charts reviewed. Of those including crisis plans, 12% were created collaboratively.
- Formal transition plans were included in 31% of the transition charts reviewed.

Recommendations

Agencies should use the findings in the report and recommendations to drive improvement efforts focusing on the following areas described below.

- Agencies should conduct a root cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention.
- It is recommended that agencies refer to the WISE manual and other WISe training resources, such as the WISe Workforce Collaborative which provides a variety of training and coaching, to identify best practices and ensure compliance with requirements.
- Identified focus areas needing improvement include:
    - Developing processes and tracking systems to ensure the CANS screening and assessments are completed within the required timeframe.
    - Strengthening the connection between the initial full CANS and care planning to improve the timeliness of care planning.
    - Ensuring key members of the youth's team are identified and included to ensure the collaborative development of CANS assessments and crisis plans.
    - Creating procedures to ensure crisis plans are completed as required.
    - Expanding internal tracking systems to identify youths' program transition dates and proactively create formal transition plans.

Due to similar results in prior years, it is also recommended that HCA work with the MCOs to investigate underlying causes of these results such as workforce issues and WISe program processes to drive improvement efforts and reduce barriers to success.

Introduction

Objectives

The State of Washington Health Care Authority (HCA) chose to conduct a state-wide study on quality with focus on the WISe service delivery model in 2023. As the External Quality Review Organization for Washington, Comagine Health is contracted to review agencies throughout the state that have implemented the WISe service delivery model. Comagine Health contracted with MetaStar, Inc. to conduct the WISe record reviews. WISe implementation began in Washington in 2014, with a statewide goal establishing WISe treatment throughout the state by 2018.

The goals of this review summary are to:

- Assess WISe performance at both the individual child and system level
- Gauge fidelity to the WISe program policy and procedure manual program
- Present program data and identify weaknesses/opportunities for improvement
- Develop and refine a review process for future quality assurance use
- Identify practices associated with high-quality, effective care coordination and behavioral health treatment

Overview

WISe is a service delivery model that offers intensive services to Medicaid-eligible youth with complex behavioral health needs within the Washington Apple Health Integrated Foster Care, Washington Apple Health-Integrated Managed Care, Behavioral Health Services Only programs, and the State Children's Health Insurance Program.[1] It is a team-based approach that provides services to youth and their families in home and community settings and is intended as a treatment model to defer from and limit the need for institutional care.

Review Methodology and Scope of Review

Technical Methods of Data Collection

The reviews consisted of clinical record reviews chosen from a statewide sample provided by HCA. Records were chosen for two types of reviews, "Enrollment" spanning the first 90 days of WISe services, and "Transition" reviews spanning the last 90 days of WISe services. These records reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington. The review criteria are identified in the Washington Quality Improvement Review Tool (QIRT)[2].

The key areas evaluated during the Enrollment review include:

- Care Coordination
- Child and Family Team (CFT) Processes

[1] WISe Policy and Procedure Manual. Available at: https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf
[2] WISe QIRT Manual. Available at: https://www.hca.wa.gov/assets/program/qirt-manual-v1.6.pdf

- Crisis Prevention and Response
- Treatment Characteristics
- Parent and Youth Peer Support

The key areas evaluated during the Transition review include:

- Care Coordination
- CFT Processes and Transition Planning
- Crisis Prevention and Response
- Treatment Characteristics
- Parent and Youth Peer Support

In order to determine the significance of year-to-year results, a Pearson's chi-squared test[3] was used to evaluate the statistical significance for both increased and decreased results. The results of the test identified which changes were statistically significant and likely due to actions taken by the WISe agencies as well as the level of significance or whether changes were due to normal variation.

Statistical Significance Level Legend		
Level of Significance	***p*-value**	**Designation of Significance**
Not Statistically Significant	$p > .05$	NS
Statistically Significant	$p \leq .05$	*
Very Statistically Significant	$p \leq .01$	**
Highly Statistically Significant	$p \leq .001$	***

Description of Data Obtained

HCA provided Comagine Health with a list of randomly selected charts from a list of randomly selected agencies. The initial review process included 200 enrollment records and 100 transition records; however, 1 enrollment chart was excluded from the analysis and dashboard due to technical limitations of the data cleaning process. The review included examining pdf records of the clinical charts covering WISe services provided to eligible youth.

Review data was collected using the Research Electronic Data Capture (REDCap) system. REDCap is a secure web-based data collection application supported by the Center for Clinical and Translational Science at the University of Kentucky. Aggregate level results are provided in a dashboard report pulled from REDCap. The dashboard is located at the link below:

https://www.hca.wa.gov/about-hca/behavioral-health-recovery/wraparound-intensive-services-wise-0

[3] Pearson's chi-squared test is a statistical test used to compare categorical variables. This test evaluates how likely it is that any observed difference between data sets occurred by normal variation or chance. A *p*-value, or probability value, that is less than or equal to the .05 significance level indicates that the observed values are different than the expected values.

Data Aggregation and Analysis

This summary review is based on the documentation within the enrollment and transition records for the current review period, which covers September 2023 to April 2024 (FY24). The enrollment record results were compared to those from the two prior years' reviews, conducted during the periods of August 2021 to April 2022 (FY22) and September 2022 to April 2023 (FY23), respectively. Since this is the second year of transition reviews, only data from the period of FY23 was available for comparison.

Each chart review was conducted on documentation from individual WISe provider agencies and may not reflect care provided outside the reviewed agencies unless coordinated and documented by those agencies. After completing the reviews of all charts, HCA provided an aggregate dashboard of the data generated from the QIRT reviews for this report to Comagine Health. WISe agencies should compare the results from this review to the findings from internal QIRT reviews.

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Summary of Findings – Enrollment Reviews

The results reported in this section consisted of clinical record reviews spanning the first 90 days of WISe services. The enrollment record results were compared to those from the two prior years' reviews, conducted during FY22 and FY23, respectively.

Care Coordination Elements

Initial Engagement and Assessment

A CANS screening is required to be offered within 10 business days of a WISe referral and an initial full CANS assessment completed within the first 30 days of enrollment. Documentation should include evidence of youth and family inclusion in the CANS process.

Of the 199 charts reviewed this year, 6 received the 0-4 version compared to the prior review where 5 received the 0-4 version. Of the 199 of records reviewed, 193 received the 5+ version of the CANS, compared to 179 during the prior review. Please note that due to the low number of records in the sample that utilized the 0-4 CANS version, the results of the review are not representative of the population utilizing this assessment.

Chart 1 below identifies the CANS assessment findings.

Chart 1. CANS-related Findings.†

Rate Change Legend	
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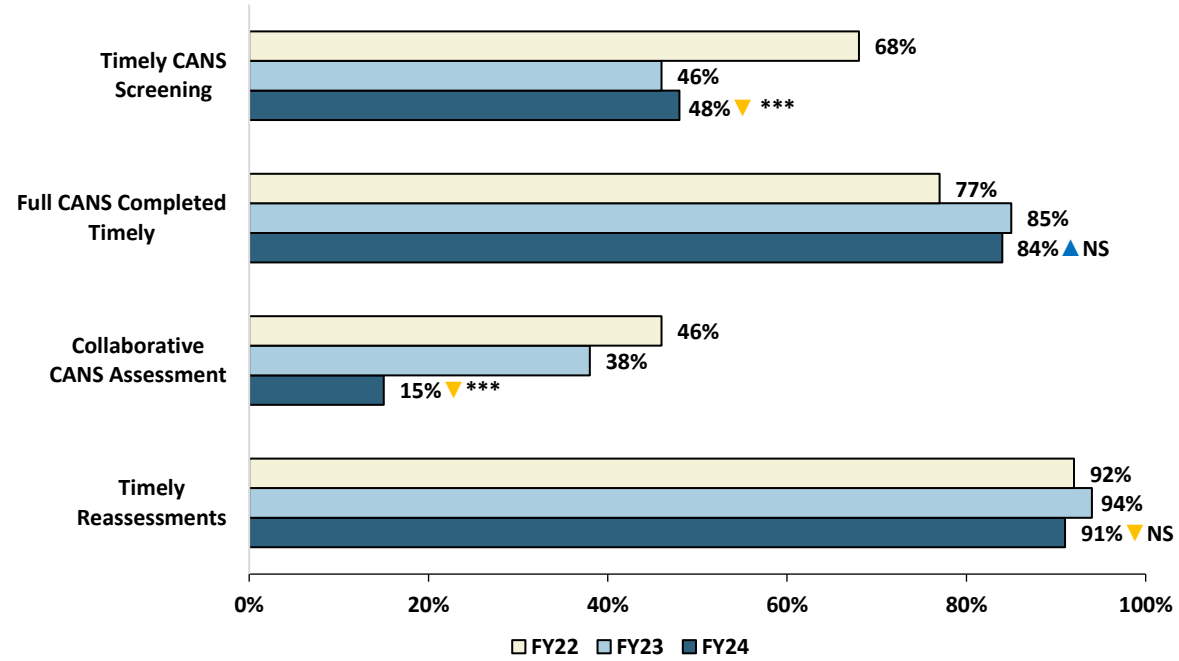
No change	○



NS = Not Statistically Significant

**** Highly Statistically Significant ($p \leq .001$)*

Statistical Analysis of CANS-Related Findings

The requirement of a "Timely CANS Screening" evaluates if the initial CANS screening was conducted within 10 days of a WISe referral.

- Results decreased between FY24 and FY22, from 68% to 48%. Analysis indicated the change in rates is statistically significant and unlikely due to normal variation or chance.

A full CANS assessment must be completed no later than 30 days following enrollment.

- Results increased between FY24 and FY22, 77% to 84%. Analysis indicated the change in rates is likely due to normal variation or chance.

The CANS assessments must be completed collaboratively including members of the child's team in the completion of the assessment.

- Results decreased between FY24 and FY22, from 46% to 15%. Analysis indicated the change in rates is statistically significant and unlikely due to normal variation or chance.

All CANS reassessments must be completed within the required timeframe.

- Results decreased between FY24 and FY23, from 92% to 91%. Analysis indicated the change in rates is likely due to normal variation or chance.

Child and Family Team (CFT) Processes and Transition Planning

Each youth has a CFT that develops and implements the youth and family's plan, addresses unmet needs, works toward the family's vision and monitors progress regularly. CFT meetings should take place every 30 days, with documentation reflecting ongoing discussions for transition planning and discharge criteria.

- During the first 30 days, the average contact between CFT members and youth/family was 6.6 hours in FY24 and 7.1 hours in FY22. The average contact hours measured in FY24 demonstrated a decline from FY22.
- Approximately 5% youth in the sample had fewer than 1 CFTs during the first 90 days of enrollment in FY24, compared to 8% in FY22. The results from FY24 showed a decline from FY22.

During the first 90 days of enrollment:

- Approximately 23% of youth had 0 to 1 CFT meetings in FY24 compared to 23% in FY22. The results remain the same as FY22.
- Approximately 78% of youth had 2 or more CFT meetings in FY24 compared to 77% in FY22. The results from FY24 showed a slight increase compared to FY22.

Participation

Members of the child's team are required to participate in CFTs. Please note due to the small number of children in the 0-4 age group results may not be representative of the entire population.

Chart 2a and 2b identify the percentage of attendees by category who participated in CFT processes.

Chart 2a. CFT Meeting Participants – Year-to-Year Comparison (0-4 Version).

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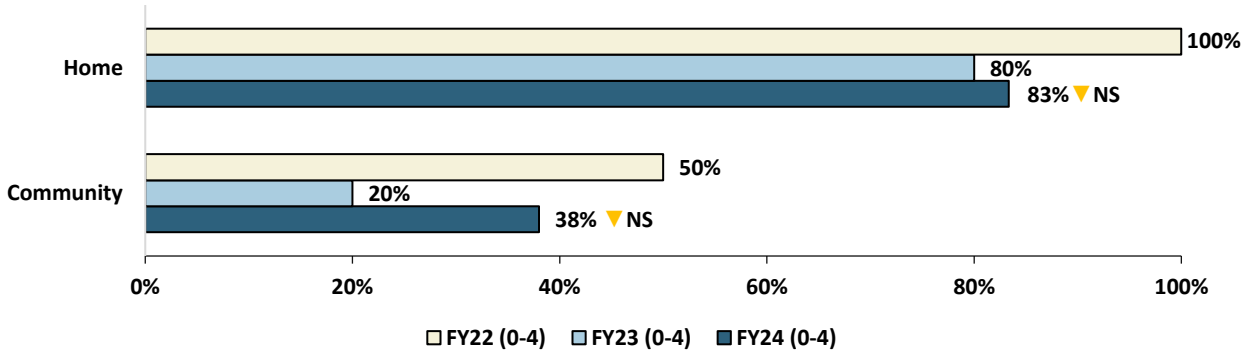

NS = Not Statistically Significant

Chart 2b. CFT Meeting Participants – Year-to-Year Comparison (5+ Version).

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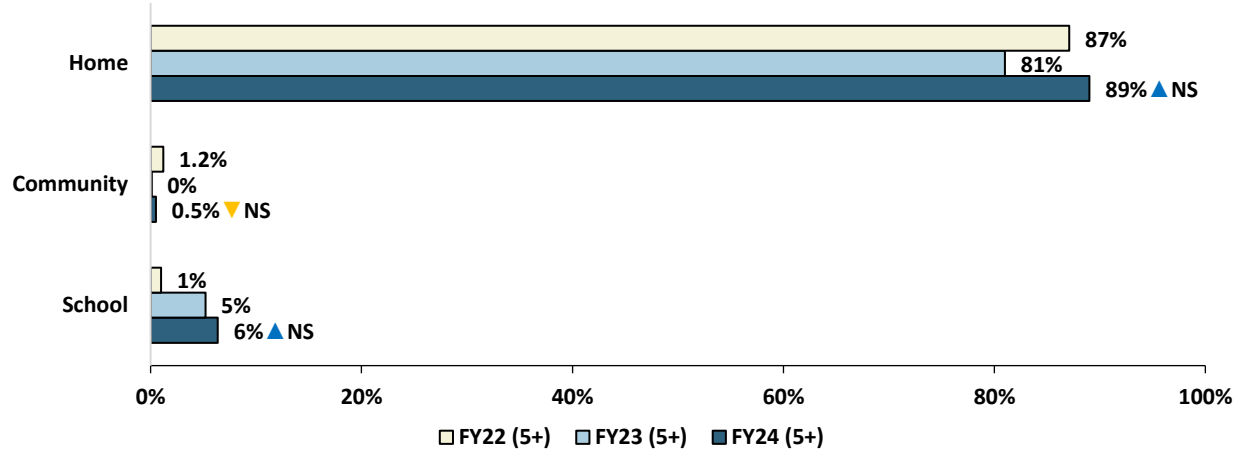

NS = Not Statistically Significant

Statistical Analysis of CFT Processes Findings

During the first 90 days of enrollment, CFT Meeting Participation for youth receiving the 0-4 version showed changes in rates and included:

- Home representatives attended 83% of the sessions during the current year compared to 100% in FY22. Analysis indicated the change in rates is likely due to normal variation or chance.

- Community representatives attended 38% of the sessions during the current year compared to 50% in FY22. Analysis indicated the change in rates is likely due to normal variation or chance.

During the first 90 days of enrollment, CFT Meeting Participation for youth receiving the 5+ version showed changes in rates and included:

- Home representatives attended 89% of sessions during the current year compared to 87% in FY22. Analysis indicated the change in rates is likely due to normal variation or chance.
- Of sessions attended by a community representative, 0.5% attended during the current year compared to 1.2% in FY22. Analysis indicated the change in rates is likely due to normal variation or chance.
- School representatives attended 6% of sessions during the current year compared to 1% in FY22. Analysis indicated the change in rates is likely due to normal variation or chance.

Crisis Prevention and Response (CSCP)

Each CSCP must include a crisis plan that addresses potential crises that could occur for the youth and family to ensure safety. An effective crisis plan includes:

- Crisis identification and prevention steps, with CFT members' roles
- Crisis response actions based on the severity level of a crisis
- Post-crisis evaluation of the youth's behavioral health status and effectiveness of the crisis plan
- A crisis plan must also be completed for each child enrolled in the program no later than 45 days following enrollment and collaboratively involve members of the child's team.

Chart 3 identifies the year-to-year comparison of the "Crisis Plans" requirement.

Chart 3: Crisis Plans (Year-to-Year Comparison) – Crisis Plan Included, Timely, Collaborative.

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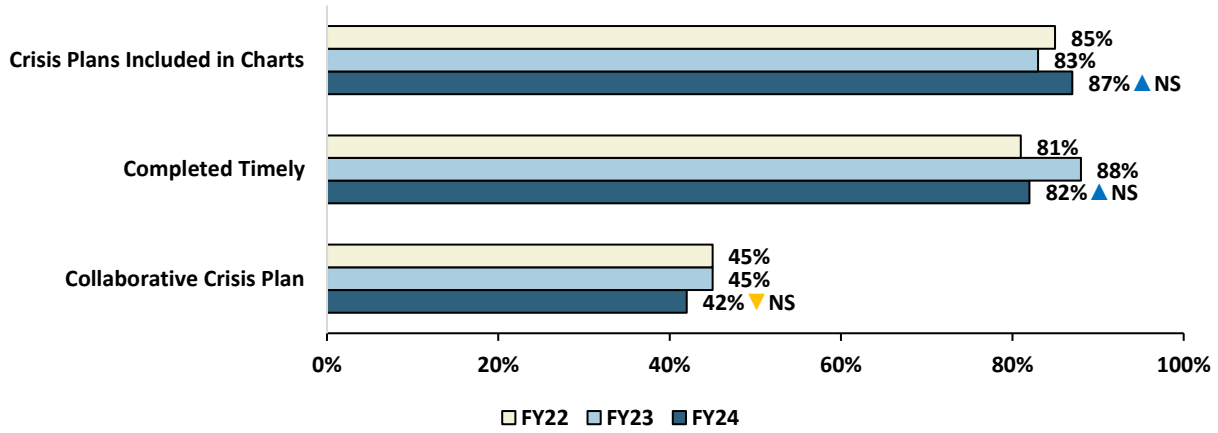

NS = Not Statistically Significant

Statistical Analysis of Crisis Prevention and Response Findings

Of the 199 charts reviewed, 87% contained crisis plans, compared to 85% from FY22. Analysis indicated the increase in rates is likely due to normal variation or chance.

Of the 174 charts containing crisis plans, 82% were completed timely within 45 days of enrollment, compared to 81% from FY22. Analysis indicated the change in rates is likely due to normal variation or chance.

For the 174 charts that contained crisis plans reviewed they were created collaboratively 42% of the time, compared to 45% in FY22. Analysis indicated the change in rates is likely due to normal variation or chance.

Treatment Characteristics

Qualified clinicians provide individual clinical treatment sessions to the youth/family in the amount, duration and scope appropriate to address the identified medically necessary needs. Documentation should reflect needs identified in the CSCP, indicate how the therapeutic intervention benefitted the youth's functioning or symptoms, and the impact of the services for the youth at home, school and/or in the community. Statistical testing on the "Treatment Characteristics" requirement was not conducted as this data is for informational purposes only.

- Therapist involvement in the WISe service model was evidenced by participation in 67% of all CFT meetings and an average of 1.9 treatment sessions monthly, compared to 75% in FY22.
- The review indicated 72% of treatment sessions were attended by the youth alone, compared to 51% in FY22.
- The youth and caregiver participated in 25% of sessions, compared to 33% in FY22.
- The caregiver, without the youth, attended 3% of the treatment sessions, compared to 16% identified during FY22.
- Persistence in problem-solving was evidenced by documentation of the same treatment focus from session to session in 91% of the sessions, compared to 95% sessions identified during FY22.
- Most frequently treatment content documented were "Skill Development" and "Psychoeducation" at 24% and 12%, respectively. Documentation of progress reviewed was identified in 25% of records, while 5% of records included celebrating success.

Parent & Youth Peer Support Elements

Each youth and family must be offered a youth peer or parent peer support partner. These partners are formal members of the CFT who support the parent/youth in the WISe process through active engagement and informed decision making.

Charts 4a (Parent) and 4b (Youth) identify the average hours of peer support by type.

Chart 4a. Parent Peer Support Elements: Average Hours of Peer Support by Type* (Year-to-Year Comparison) **

Rate Change Legend	
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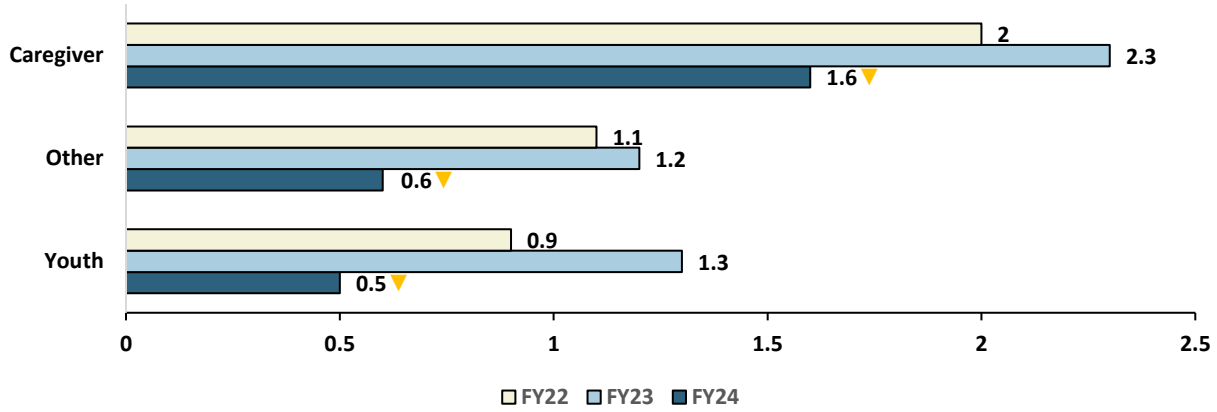
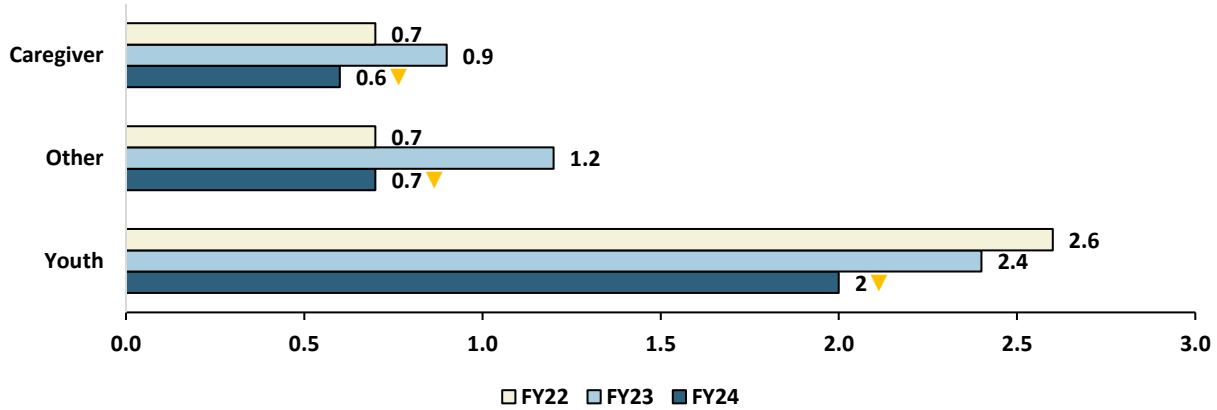
Decreased	▼
No change	○



Since children under age 5 are not eligible for youth peers, these cases are not included in youth peer metrics of any kind.
***Statistical testing was not conducted on parent peer support elements as this data is for informational purposes only.*

Chart 4b. Youth Peer Support Elements: Average Hours of Peer Support by Type* (Year-to-Year Comparison)**

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○



Since children under age 5 are not eligible for youth peers, these cases are not included in youth peer metrics of any kind.

***Statistical testing was not conducted on parent peer support elements as this data is for informational purposes only.*

During the first 90 days of enrollment, the parent peer support partner:

- Spent an average of 1.6 hours with caregiver(s), compared to 2.0 hours during FY22.
- Spent an average of 0.6 hours with other(s), compared to 1.1 hours during FY22.
- Spent an average of 0.5 hours with the youth, compared to and 0.9 hours during FY22.

During the first 90 days of enrollment, the youth peer support partner:

- Spent an average of 0.6 hours with caregiver(s), compared to 0.7 hours during FY22.
- Spent an average of 0.7 hours with other(s), compared to 1.2 hours from FY23 and 0.7 hours during FY22.
- Spent an average of 2.0 hours with the youth, compared to 2.6 hours during FY22.

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Summary of Findings – Transition Reviews

The results reported in this section consisted of clinical record reviews spanning the last 90 days of WISe services. Since this is the second year of transition reviews, only data from FY23 was available for comparison.

Care Coordination Elements

Child and Family Team (CFT) Processes

Each youth has a CFT that develops and implements the youth and family's plan, addresses unmet needs, works toward the family's vision and monitors progress regularly. CFT meetings should take place every 30 days, with documentation reflecting ongoing discussions for transition planning and discharge criteria.

- Approximately 2% of the youth in the sample had fewer than 1 CFT during the last 90 days of care, compared to 8% of the youth from the prior review.

During the last 90 days of care:

- Approximately 22% of youth had 0 to 1 CFT meetings, compared to 29% of the youth from the prior review.
- Approximately 78% of youth had 2 or more CFT meetings, compared to 71% of the youth from the prior review.

Crisis Prevention and Response (CSCP)

Each CSCP must include a crisis plan that addresses potential crises that could occur for the youth and family to ensure safety. An effective crisis plan includes:

- Crisis identification and prevention steps, with CFT members' roles
- Crisis response actions based on the severity level of a crisis
- Post-crisis evaluation of the youth's behavioral health status and the effectiveness of the crisis plan

Chart 5, on the next page, identifies the percentage of compliance with crisis plan requirements for the last 90 days of care.

Chart 5. Crisis Plans (Year-to-Year Comparison) – Crisis Plan and Collaborative.

Rate Change Legend	
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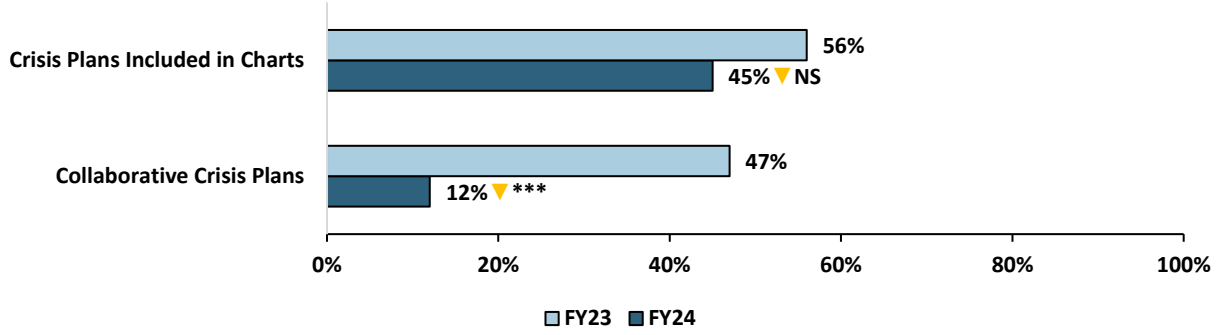

NS = Not Statistically Significant

**** Highly Statistically Significant ($p \leq .001$)*

Statistical Analysis of Crisis Prevention and Response Findings

Of the 100 charts reviewed, 45% contained crisis plans, compared to 56% from the prior review. Results decreased from the prior review. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

For the 45 charts that contained crisis plans reviewed they were created collaboratively 12% of the time, compared to 47% from the prior review. Analysis indicated the year-to-year difference in the rates is statistically significant and unlikely due to normal variation or chance.

Treatment Characteristics

Qualified clinicians provide individual clinical treatment sessions to the youth/family in the amount, duration and scope appropriate to address the identified medically necessary needs. Documentation should reflect needs identified in the CSCP, indicate how the therapeutic intervention benefitted the youth's functioning or symptoms, and the impact of the services for the youth at home, school and/or in the community.

- The average number of treatment sessions attended per month was 2.07 compared to 2.52 from the prior review.
- Therapist involvement in the WISe service model was evidenced by participation in 69% of all CFT meetings, compared to 68% from the prior review.
- The review indicated 79% of treatment sessions were attended by the youth alone, compared to 60% from the prior review.
- The youth and caregiver participated in 18% of sessions, compared to 26% from the prior review.

- Only the caregiver attended 3% of the treatment sessions, compared to 14% from the prior review.

Persistence in problem-solving was evidenced by documentation of the same treatment focus from session to session in 90% of the sessions. Most frequently treatment content documented were Skill Development and Transition Planning at 27% and 13% respectively. Documentation of progress reviewed was identified in 14% of records, while 3% of records included celebrating success, compared to 21% documented progress and 7% documented celebrating success from the prior review.

Parent and Youth Peer Support Elements

Each youth and family must be offered a youth peer or parent support partner. These partners are formal members of the CFT who support the parent/youth in the WISe process through active engagement and informed decision making.

Charts 6a (Parent) and 6b (Youth) identify the average hours of peer support by type.

Chart 6a. Parent Peer Support Elements: Average Hours of Peer Support by Type* (Year-to-Year Comparison) **

Rate Change Legend	
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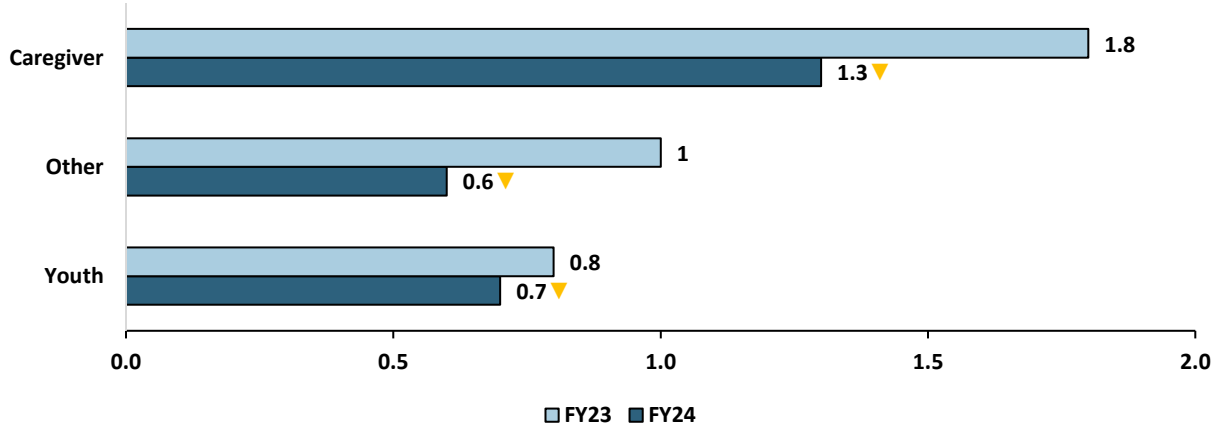
Decreased	▼
No change	○

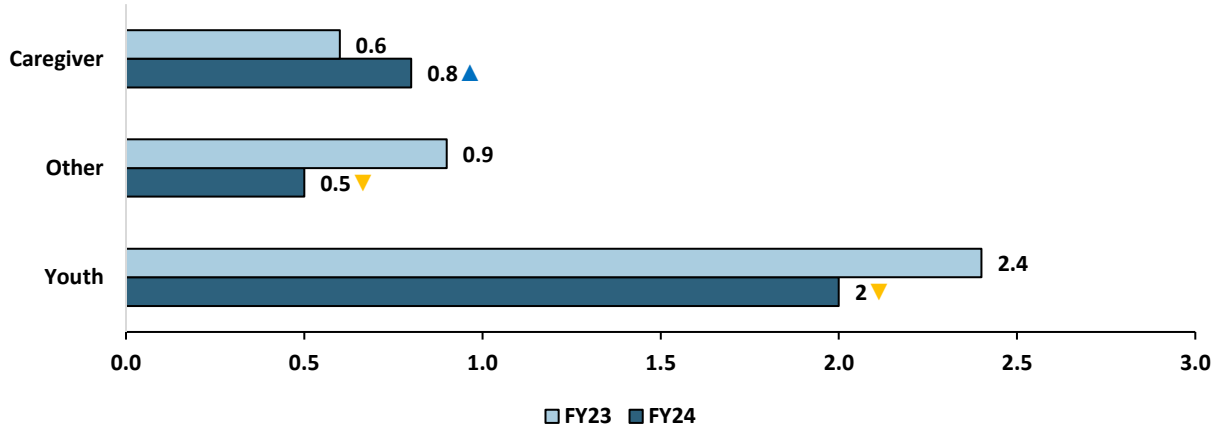


**Since children under age 5 are not eligible for youth peers, these cases are not included in youth peer metrics of any kind.*

***Statistical testing was not conducted on parent peer support elements as this data is for informational purposes only.*

Chart 6b. Youth Peer Support Elements: Average Hours of Peer Support by Type* (Year-to-Year Comparison)**

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○



**Since children under age 5 are not eligible for youth peers, these cases are not included in youth peer metrics of any kind.*

***Statistical testing was not conducted on youth peer support elements as this data is for informational purposes only.*

During the last 90 days of enrollment, the parent peer support partner:

- Spent an average of 1.3 hours with caregiver(s), compared to 1.8 hours from the prior review.
- Spent an average of 0.6 hours with other(s), compared to 1.0 hours from the prior review.
- Spent an average of 0.7 hours with the youth, compared to 0.8 hours from the prior review.

During the last 90 days of enrollment, the youth peer support partner:

- Spent an average of 0.8 hours with caregiver(s), compared to 0.6 hours from the prior review.
- Spent an average of 0.5 hours with other(s), compared to 0.9 hours from the prior review.
- Spent an average of 2.0 hours with the youth, compared to 2.4 hours from the prior review.

Transition Planning

Prior to transitioning from the WISe Program, all youth must have a formal transition plan developed to plan for a successful transition from the program. The plan must contain specific steps to be taken during the transition as well as the supports available to make the transition successful. The plan must be created in collaboration with input from the youth, family, formal service providers and natural supports.

Chart 7 identifies the year-to-year comparison of the transition planning, included and collaborative requirements

Chart 7: Transition Planning (Year-to-Year Comparison) – Included and Collaborative.

Rate Change Legend	
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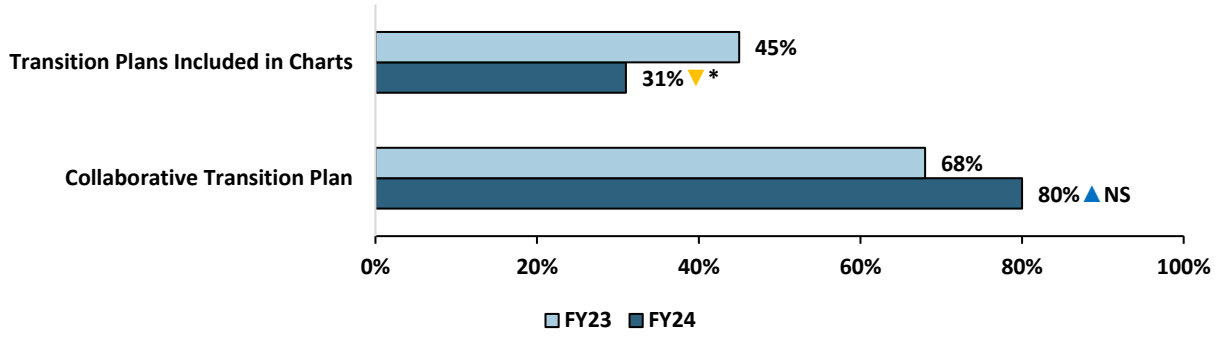
No change	○



NS = Not Statistically Significant

** Statistically Significant (p ≤ .05)*

Statistical Analysis of Transition Planning

A formal transition plan was included in 31 of cases out of 100 of charts reviewed, compared to 50 out of 110 charts reviewed from the prior review. Results decreased from the prior review. Analysis indicated the year-to-year difference in the rates is statistically significant and unlikely due to normal variation or chance.

Of the 31 of transition plans, 80% contained evidence of collaboration and input from the youth, family, formal service providers, and natural supports, compared to 68% from the prior review. Results increased from the prior review. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Appendix

In order to determine the significance of year-to-year results a Pearson's chi-squared test[4] was used to evaluate the statistical significance for both increased and decreased results. The results of the test identified which changes were statistically significant and likely due to actions taken by the WISe agencies as well as the level of significance or whether changes were due to normal variation.

Enrollment Summary Trend Data

The following table provides a summary of the Enrollment Summary Trend Data reported within this report. Changes in rates are compared between FY24 and FY22.

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○

Table A-1. Enrollment Summary Trend Data.

Enrollment Summary Data				
Criteria	**FY2022 Result**	**FY2023 Result**	**FY2024 Result**	**Alpha Level**
CANS-related Findings				
Timely CANS Screening	68%	46%	48% ▼	$p \leq .05$
Full CANS Completed Timely	77%	85%	84% ▲	NS
Collaborative CANS Assessment	46%	38%	15% ▼	*$p \leq .001$*
Timely Reassessments	92%	94%	91% ▼	NS
CFT Meeting Participants (0-4 Version)				
Home	100%	80%	83% ▼	NS
Community	50%	20%	38% ▼	NS
CFT Meeting Participants (5+ Version)				
Home	87%	81%	89% ▲	NS
Community	1.2%	0.1%	0.5% ▼	NS
School	1%	5%	6% ▲	NS
Crisis Plans				
Crisis Plans Included in Charts	85%	83%	87% ▲	NS
Completed Timely	81%	88%	82% ▲	NS
Collaborative Crisis Plan	45%	45%	42% ▼	NS
Parent Peer Support Elements: Average Hours				
Caregiver	2.0	2.3	1.6 ▼	NA*
Other	1.1	1.2	0.6 ▼	NA*
Youth	0.9	1.3	0.5 ▼	NA*
Youth Peer Support Elements: Average Hours				
Caregiver	0.7	0.9	0.6 ▼	NA*
Other	0.7	1.2	0.7 ○	NA*
Youth	2.6	2.4	2.0 ▼	NA*

[4] Pearson's chi-squared test is a statistical test used to compare categorical variables. This test evaluates how likely it is that any observed difference between data sets occurred by normal variation or chance. A *p*-value, or probability value, that is less than or equal to the .05 significance level indicates that the observed values are different than the expected values.

Transition Summary Trend Data

The following table provides a summary of the Transition Summary Trend Data reported within this report.

Rate Change Legend	
Increased	▲
Decreased	▼
No Change	○

Table A-2. Transition Summary Trend Data.

Transition Summary Data *Only data from FY23 was available for comparison*			
Criteria	**FY2023 Result**	**FY2024 Result**	**Alpha Level**
CFT Processes			
Fewer than one (1) CFT	8%	2% ▼	NA*
Zero (0) to one (1) CFT	29%	20% ▼	NA*
Two (2) or more CFT	71%	78% ▲	NA*
Crisis Plans			
Crisis Plans Included in Charts	56%	45% ▼	NS
Collaborative Crisis Plan	47%	12% ▼	$p \leq .001$
Parent Peer Support Elements: Average Hours			
Caregiver	1.8	1.3 ▼	NA*
Other	1.0	0.6 ▼	NA*
Youth	0.8	0.7 ▼	NA*
Youth Peer Support Elements: Average Hours			
Caregiver	0.6	0.8 ▲	NA*
Other	0.9	0.5 ▼	NA*
Youth	2.4	2.0 ▼	NA*
Transition Planning			
Transition Plans Included in Charts	45%	31% ▼	$p \leq .05$
Collaborative Transition Plans	68%	80% ▲	NS