

Evaluation and Sustainability in OSOC

Data	Interpretation, Presentation, Action		Sustainability
Outcomes Measures (Placements, school absences, self-harm, etc.)	<i>Analyzed by</i> QA Team	<i>Presented to</i> Legislators, Agencies <i>Results in</i> Quality Improvement	 \$\$\$s  Better Outcomes
	<i>Reported to</i> Families, Communities	<i>Results in</i> Increased Local Support	 More and Better Advocacy
Process Measures (Referrals, # served, discharge types, wrap events, etc.)	<i>Reviewed by</i> QA Team	<i>Changes Proposed to</i> FSPs, CCs, Project Directors	 Better Wrap, Better Decisions, Better Outcomes – Ultimately, Better Advocacy, More \$\$\$s
	<i>Reported to</i> Local Staff, State Mngmt, Communities	<i>Results in</i> More Informed Management	

Proposed Changes to YIS Related to 3 Levels of Care

- Use the Wrap Event Form to document substantive contacts with the family *prior to* case review by the referral team.
 - ***Question: If the family is referred out or otherwise excluded from direct services by the referral team, how should these events be handled?***
- After review by the referral team, the Wrap Event Form will be the primary tool for tracking the 2 direct service levels:
 - **Service Coordination**
 - Designate ‘Service Coordination’ as the outcome of the referral team.
 - Complete Wrap Event forms for all substantive contacts with the family.
 - **Wraparound**
 - Designate ‘Approved’ as the outcome of the referral team.
 - Complete Wrap Event forms for all ‘Engagement’ and ‘Child/Family Team’ events.
 - Complete Wrap Event forms for the initial occurrence of other wrap activities.
- After discharge, the Wrap Event Form will be used to track ‘**Aftercare**’ events.
 - Complete Wrap Event forms for service contacts with the family after discharge.
 - Until we refine this process and identify activities specific to aftercare, most events may be recorded as ‘Other’.



Oklahoma Systems of Care

Referral Team Review Form

OSOC Site: _____ Youth Name: _____

Date of Referral Team: ____ / ____ / ____

Outcome of Referral Team (Select only one):

- Approved for Wraparound
- Service Coordination
- Referred to Community Services
- Other non-Admission Outcome

If 'Other', specify reason (check as many as apply):

- | | |
|---|--|
| <input type="checkbox"/> Family withdrew / unwilling to cooperate | <input type="checkbox"/> Not SED or no MH diagnosis |
| <input type="checkbox"/> Residence outside county | <input type="checkbox"/> Multiple referrals from the same family |
| <input type="checkbox"/> Inappropriate age | <input type="checkbox"/> No danger of out-of-home placement |
| <input type="checkbox"/> Institutional placement | |
| <input type="checkbox"/> Other (specify) _____ | |

Staff Assignments:

Care Coordinator _____

Family Support Provider _____

Date assigned ____ / ____ / ____

Date family notified of referral team decision: ____ / ____ / ____

Notes: _____

