Final Report
Youth and Family Centers Program: 2005-2006
EA06-143-2

DEPARTMENT OF EVALUATION AND ACCOUNTABILITY

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Youth and Family Centers Program:
2005-2006

EA06-143-2

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November 2006
# Youth and Family Centers Program

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Final Evaluation Report
Youth and Family Centers Program, 2005-2006

Evaluation Manager: Jeannette A. Oshitoye, Ph.D.

Abstract

The Youth and Family Centers served 30,737 students and their families in 2004-2005 and 2005-2006. Clients made 75,207 visits in both years. Dallas Independent School District (Dallas ISD) students accounted for 70.6% of all clients in 2004-2005 and 66.8% of all clients in 2005-2006. In both years, the typical client served by the centers was Hispanic, male, and enrolled in elementary school.

In 2004-2005, the Youth and Family Centers operated on a budget of $1.9 million, which increased to $2.4 million in 2005-2006. Approximately 69.5% of the budget for the 2004-2005 year was allocated to wages and salaries with an additional 14.5% allocated to consulting and professional services. During the 2005-2006 year these same categories had 58.3% and 15.6%, respectively. Fixed costs for 2004-2005 amounted to $229,748. They increased to $327,121 in 2005-2006, a 42% increase.

As in previous years, the Youth and Family Centers experienced significant problems with data collection. In 2004-2005, 6.7% of all records had missing behavioral health diagnosis codes, and 15.6% had no procedure codes. By 2005-2006, the proportion of records with no diagnosis codes had increased to 20.7%, but the proportion with missing procedure codes had decreased to 5.7%. In both years, the Seagoville Center led all centers with the greatest number of records without a procedure code: 41.1% in 2004-2005 and 14.6% in 2005-2006.

As part of a special request, physical health diagnosis codes were received from Parkland Community Oriented Primary Care (COPC). These data were stripped of all demographic information. Through cursory analysis it was determined that the majority of the codes assigned fell into two main systems—the respiratory system and uro-genital system. Analysis of the V codes used (codes for circumstances other than a disease or injury) indicated that clients were using the centers as their primary care provider. The data also showed that in certain areas of the district a disproportionate amount of services were being provided for venereal disease screenings.

Data from the centers were analyzed on multiple dimensions. Cohort analysis showed that the centers are having the intended effect on promotion, attendance, and TAKS passing rates. Despite having substantially higher morbidity, those students who sought services in both 2004-2005 and 2005-2006 had similar outcomes on promotion, attendance, and TAKS passing rates as those students who did not use the centers.

In 2003-2004, the centers began billing as Medicaid providers. During 2004-2005, the Medicaid billing process was disjointed. Despite these obstacles in billing, the Youth and Family Centers collected $37,755 in Medicaid revenue in 2004-2005 and $106,943 in 2005-2006. The majority of these monies were used to buy supplies for the centers. In 2005-2006, a portion of the monies was used to send several center managers to the Crimes Against Children Conference, which was held in Dallas.

It is recommended that the Medicaid billing processes and procedures be reviewed by the Dallas ISD legal department to ascertain that the program remains in state and federal compliance.
Program Description

Introduction

The Dallas Independent School District’s Youth and Family Centers meet the needs of students and their families by delivering services that are both holistic and culturally competent. From 2001-2003, 25.3% of Dallas residents were without health insurance (“Special Report: The Uninsured: A Hidden Burden on Texas Employers and Communities, April 2005”). Because of the increasing numbers of uninsured individuals in the Dallas area, the services provided by the Youth and Family Centers are especially critical to district students and their families. Currently, the district is largely a minority district with an enrollment of 62.5% Hispanic and 31% non-Hispanic black students. In addition, in 2005-2006, 91% of the students who sought services in the centers did not have private insurance, and 72% qualified for free and reduced lunch. Overall, 89% of district students, in 2005-2006, came from homes below the federal poverty line. Because of the high prevalence of poverty and the increasing numbers of minority students in the district’s population, the Youth and Family Centers provide access to a health care system that might otherwise be denied.

The Youth and Family Centers program is a school-based initiative that is dedicated to providing primary and preventative medical and psychological health care to students and their immediate family members. These services are provided through a partnership between the Dallas Independent School District (Dallas ISD) and Parkland Health and Hospital System. The Youth and Family Centers strive to meet the health needs of students and their families through an interdisciplinary holistic approach that promotes school success, self-sufficiency, and fosters resiliency in both students and their parents.

History

The Dallas ISD has provided school-based health services to its student population for more than three decades. In 1969, the district created the first school-based health care initiative in the nation. The program began with three West Dallas clinics, which provided physical, behavioral, and dental health services to the community. The clinics were eventually taken over by the Dallas County Hospital District. In 1991, the Youth and Family Impact Centers offered an
array of health and social services. In 1993, Dallas ISD, then referred to as Dallas Public Schools, and Dallas Behavioral Health and Behavioral Retardation (now Dallas MetroCare Services) collaborated to open a behavioral health clinic for students at Burnet Elementary and Cary Middle schools. In these early stages of what would become the Youth and Family Centers, services were limited and unavailable in certain areas of the district.

In 1995, to correct for shortcomings in earlier efforts, the district entered into partnership with Parkland’s Community Oriented Primary Care (COPC) division and the Texas Department of Behavioral Health and Behavioral Retardation and opened the Youth and Family Centers. The program began with eight centers located across the district. One center, Nolan Estes, closed due to low usage. The two newest centers, Seagoville and Eddie Bernice Johnson, opened in 1997 and 2004, respectively.

In 2001, Dallas MetroCare, which provided behavioral health services, withdrew from the partnership. The remaining partners, Dallas ISD and Parkland COPC, are guided by the principle that children’s’ physical well-being impacts their academic success. Thus, the Youth and Family Centers provide access to the health care system that some students who are economically disadvantaged might not otherwise have. By improving access to necessary health care, the district is increasing the probability that all students within the district will have the ability to succeed and become productive adults, because health care is important to education.

PURPOSE AND SCOPE OF THE EVALUATION

The purpose of the evaluation is to provide context, process, and outcome data to the project managers and administrators to assess program efficacy, facilitate planning, and assist in the implementation of future activities to improve program operations. Specifically, this report examines four major areas: context of the program, program budget, implementation of the program, and outcomes for students participating in the program. In addition, unlike historical reports, this report will include comparisons of the 2004-2005 and 2005-2006 data. The evaluator did not receive the 2004-2005 data from the Youth and Family consultant in time to be included in the previous year’s report due to contractual issues.
MAJOR EVALUATION QUESTIONS

2.1 *What was the context of the Youth and Family Centers program?*

**Methodology**

Previous evaluation reports, professional journals, program records, and interviews with administrators were used to collect context data.

**Results**

**Goals and Objectives**

The main objectives of the Youth and Family Centers are constructed with the understanding that, by providing services which deliver social, emotional, and physical support, students can make consistent academic progress, and both family and student can achieve optimal health status. The following is the mission statement of the Youth and Family Centers:

- To provide school-based health care, behavioral health care, and support services to Dallas children and their families.
- To reduce barriers to academic success so children can learn and teachers can teach.
- To promote the wholeness of the family and engage families in their children’s health and education.

The guiding principle of the Youth and Family Centers is:

*We believe…*

...that every child is a precious gift.
...that every child needs a nurturing family member and a caring teacher.
...that basic physical health and behavioral health services must be available to all school communities and all children.
...that services must be family-focused and prevention-oriented.
...that schools maintain a central role in the lives of children, and that all facets of a child’s well being impact school performance.
...that YFC staff members are leaders in school-based health care and are zealous in their commitment to children’s well-being."

**Program Organization**

Under the partnership between Dallas ISD and Parkland Hospital and Health systems, Parkland’s Community Oriented Primary Care provides physical health services, while Dallas ISD provides administrative services, clinic space, and comprehensive behavioral health services. Responsibilities for office supplies are shared between the two components.

Management of the program occurs on multiple levels. First, center managers conduct weekly or biweekly meetings with center staff addressing organizational issues and special case
discussions. Second, center managers meet weekly with the program director. Third, the top management team, including the program director, a Dallas ISD associate superintendent, and two vice presidents from Parkland meet quarterly to discuss the program. Fourth, the Dallas ISD general superintendent and the Chief Executive Officer of Parkland Health and Hospital Systems meet annually to review all program activities. Finally, all centers, with the exception of Eddie Bernice Johnson, meet with their respective advisory boards quarterly to coordinate volunteer work that benefits each centers’ clients and the surrounding community. Because the Eddie Bernice Johnson Center is a relatively new center, it did not have an established advisory board. The center manager expected to have an advisory board in place by the middle of 2005-2006 year. Unfortunately, due to challenges arising from meeting the needs of the Katrina and Rita evacuees entering the district, the establishment of a formal advisory board was delayed until 2006-2007. In the meantime, the center received informal advice from prominent members of the surrounding community.

2.2 What were the components of the Youth and Family Centers program?

Methodology

Previous evaluation reports, professional journals, program records, and interviews with administrators were used to collect information about the Youth and Family Centers’ components.

Results

The Youth and Family Centers program is comprised of two components – physical health and behavioral health. The physical health services are provided by Parkland Health and Hospital System staff, while behavioral health services are provided by staff funded by Dallas ISD.

Physical Health

Physical health services provided by the centers include acute health care, chronic health care, laboratory work, nutrition counseling, sports physicals, health maintenance services, medication administration, urgent care, and preventative care, including immunizations. The school nurse is the most frequent referral source of students to the centers for services.
However, parents can also contact the center for services either for the student, other siblings, or themselves. For a student to receive services, a parental consent form must be on file with the center.

When a student is referred to the centers, the first appointment includes the completion of the clients’ family and medical history and a medical evaluation. After a treatment plan is developed, the student receives medical care, medication, and any necessary follow-up care. As part of its services, Parkland COPC maintains weekly immunization clinics each Thursday at each clinic. These clinics are provided for the benefit of school-aged children; however, children younger than school age are also served.

**Behavioral Health**

Behavioral health services include screening, assessment, psychiatric evaluations and consultations, individual, group and family therapy, support groups, and medication. These services are provided by staff funded by Dallas ISD. The Student Support Team (SST) commonly refers students to the centers. However, other school staff, community agencies, or the student’s parents may also make referrals. After a student is referred, he or she is assessed and a treatment plan is developed. As with the delivery of physical health services, students may only receive services from the centers if they have a completed parental consent form on file. Parents are encouraged to accompany their children to the Youth and Family Centers for behavioral health services. To help working parents meet this requirement, all centers maintain evening appointments three to four times a week.

**Other Services**

While the main focus of the Youth and Family Centers is to provide health services, administrators of the program realize that needs of the community may go far beyond health. Other services provided by the centers include school interventions, classroom observations, discussion with teachers, family/home involvement, and youth development services. The philosophy of the Youth and Family Centers advocates working with students and their families to
help solve not only health issues, but other life issues so that students will have the opportunity to realize their full academic potential and their families' potential to succeed.

Center Locations

Currently there are nine centers in the Youth and Family Centers program. The centers are located strategically across the district. The centers are located on middle and high school campuses, as shown in Table 1. A tenth center is expected to open in fall 2006 at Conrad High School. The center will take the name of the surrounding community and will be called the Fair Oaks Youth and Family Center.

<table>
<thead>
<tr>
<th>Center</th>
<th>Campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amelia Flores Center</td>
<td>Bryan Adams High School</td>
</tr>
<tr>
<td>Spruce Center</td>
<td>H. Grady Spruce High School</td>
</tr>
<tr>
<td>Woodrow/Long Center</td>
<td>Woodrow Wilson High School</td>
</tr>
<tr>
<td>Eddie Bernice Johnson Center</td>
<td>Lincoln High School</td>
</tr>
<tr>
<td>Red Bird Center</td>
<td>T.W. Browne Middle School</td>
</tr>
<tr>
<td>Seagoville Center</td>
<td>Seagoville High School</td>
</tr>
<tr>
<td>North Oak Cliff Center</td>
<td>W.E. Greiner Middle School</td>
</tr>
<tr>
<td>West Dallas Center</td>
<td>L.G. Pinkston High School</td>
</tr>
<tr>
<td>Kiosco Center</td>
<td>Edward H. Cary Middle School</td>
</tr>
</tbody>
</table>

Each of the centers serves students and their families residing in the feeder patterns of the campuses in Table 1, thus minimizing transportation problems for both students and parents. Table 2 shows the size of the student population for each center. The Red Bird Center is the largest with a base student population of 34,174. This center is followed by the Kiosco Center (25,059) and the North Oak Cliff Center (24,022). The smallest centers are the Seagoville Center with student population of 4,167 and the Eddie Bernice Johnson Center with a student population of 5,667. Because the centers vary in size, it is important to take this into account when comparing the level of service provided by each one. It is also important to take into consideration the race and ethnicity of the client base that is served by the center.
Table 2
Size of Student Population Served by Each Center

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of Schools</th>
<th>Student Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amelia G. Flores Center (formerly White Rock)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>16</td>
<td>13,425</td>
</tr>
<tr>
<td>Middle</td>
<td>1</td>
<td>881</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>6,695</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>21,001</td>
</tr>
<tr>
<td>Spruce Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>14</td>
<td>10,933</td>
</tr>
<tr>
<td>Middle</td>
<td>7</td>
<td>5,778</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>3,127</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>19,838</td>
</tr>
<tr>
<td>Woodrow/Long Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>17</td>
<td>5,271</td>
</tr>
<tr>
<td>Middle</td>
<td>2</td>
<td>5,158</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>3,056</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>13,485</td>
</tr>
<tr>
<td>Eddie Bernice Johnson Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>10</td>
<td>3,362</td>
</tr>
<tr>
<td>Middle</td>
<td>1</td>
<td>661</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>1,644</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>5,667</td>
</tr>
<tr>
<td>Red Bird Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>41</td>
<td>24,008</td>
</tr>
<tr>
<td>Middle</td>
<td>8</td>
<td>5,156</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>5,010</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>34,174</td>
</tr>
<tr>
<td>Seagoville Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>3</td>
<td>2,064</td>
</tr>
<tr>
<td>Middle</td>
<td>1</td>
<td>928</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>1,121</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>4,113</td>
</tr>
<tr>
<td>North Oak Cliff Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>16</td>
<td>13,021</td>
</tr>
<tr>
<td>Middle</td>
<td>3</td>
<td>3,381</td>
</tr>
<tr>
<td>High</td>
<td>10</td>
<td>7,620</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>24,022</td>
</tr>
<tr>
<td>West Dallas Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>13</td>
<td>5,884</td>
</tr>
<tr>
<td>Middle</td>
<td>2</td>
<td>836</td>
</tr>
<tr>
<td>High</td>
<td>3</td>
<td>1,081</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>7,801</td>
</tr>
<tr>
<td>Kiosco Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>23</td>
<td>15,834</td>
</tr>
<tr>
<td>Middle</td>
<td>5</td>
<td>4,112</td>
</tr>
<tr>
<td>High</td>
<td>3</td>
<td>5,113</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>25,059</td>
</tr>
</tbody>
</table>
Budget

A summary of the Title I budget allocation is presented in Table 3. Approximately 69.5% of the budget for the 2004-2005 year was allocated to wages and salaries with an additional 14.6% allocated to consulting and professional services. During the 2005-2006 year these same categories had 58.3% and 15.6%, respectively. Extra duty pay for teachers and other professional employees experienced the largest increase from 2004-2005 to 2005-2006. This category quadrupled, from $71,720 to $294,184. Fixed costs for 2004-2005 amounted to $229,748. This increased to $327,121 in 2005-2006, a 42% increase.

Table 3
Youth and Family Centers: Title I Budget Allocation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budgeted Amount</td>
<td>%</td>
</tr>
<tr>
<td>Salaries or wages – teachers or other professional employees</td>
<td>$966,652.00</td>
<td>49.0</td>
</tr>
<tr>
<td>Salaries or wages for full-time support personnel</td>
<td>403,379.00</td>
<td>20.5</td>
</tr>
<tr>
<td>Consultant and professional services</td>
<td>287,449.00</td>
<td>14.6</td>
</tr>
<tr>
<td>Extra duty pay for teachers and other professional employees</td>
<td>71,720.00</td>
<td>3.6</td>
</tr>
<tr>
<td>Support Part-time/Temporary</td>
<td>12,000.00</td>
<td>0.6</td>
</tr>
<tr>
<td>Social Security/Medicare</td>
<td>16,363.00</td>
<td>0.8</td>
</tr>
<tr>
<td>Group health and life insurance</td>
<td>54,172.00</td>
<td>2.7</td>
</tr>
<tr>
<td>Worker's compensation</td>
<td>17,245.00</td>
<td>0.9</td>
</tr>
<tr>
<td>Unemployment compensation</td>
<td>1,770.00</td>
<td>0.1</td>
</tr>
<tr>
<td>Teacher Retirement</td>
<td>94,032.00</td>
<td>4.8</td>
</tr>
<tr>
<td>Internal Service Fund Billings</td>
<td>45,000.00</td>
<td>2.3</td>
</tr>
<tr>
<td>Labor Suspense</td>
<td>1,166.00</td>
<td>0.1</td>
</tr>
<tr>
<td>Total</td>
<td>$1,970,948.00</td>
<td>100.0</td>
</tr>
</tbody>
</table>

2.3 How was the Youth and Family Centers program implemented?

Methodology

Implementation data were collected through ongoing meetings and phone conversations with Youth and Family Center staff. However, unlike previous years, center manager interviews were not conducted, as requested by the program manager.
Results

Center Operations

Each of the centers provides physical and behavioral health services to students who attend schools within their feeder pattern. Parkland Health and Hospital System, through its Community Oriented Primary Care Division, provides all physical health services in the centers. All of the centers try to maintain some level of evening appointments to accommodate families with working parents.

Collaboration between Parkland Health and Hospital System and Dallas ISD

All centers, in 2004-2005, with the exception of Eddie Bernice Johnson, had at least one physical health team from Parkland COPC and a behavioral health team from Dallas ISD. Some of the larger centers, such as Kiosco, had two physical and behavioral health teams. In 2004-2005, the Eddie Bernice Johnson Center, because it was the newest and one of the smallest centers, used a floating part-time team to provide physical health services. This center had planned to have a full time team by the 2005-2006 year. Instead, the center received a part-time team in April 2006. The provider for this team was a nurse practitioner who was on site 2-3 days per week.

Behavioral Health Services

In order to receive behavioral health services from the Youth and Family Centers the client is required to have a referral form. The referral form originates from the Student Support Team (SST). The SST meets several times per month to discuss the cases of those students who may be having trouble and need behavioral help. The team decides if the student should be referred to the school counselor or if the student needs more intense counseling and should be referred to the Youth and Family Centers.

Physical Health Services

Physical health services are provided to any student who has a parental consent form on file with the center. These services are provided either by appointment or walk-in. Unlike the
delivery of behavioral health services, students can receive services at the center without any formal referral process.

**Pharmacy Services**

In addition to providing both physical and behavioral health services, each of the centers also maintains a Class D pharmacy. A Class D pharmacy license or clinic pharmacy license authorizes a pharmacy to dispense a limited number of drugs or devices under a prescription drug order. The Youth and Family Centers are authorized to dispense medications such as albuterol, birth control medication, and antibiotics. If clients present with Medicaid or State Children Health Insurance Program (SCHIP) their medications are covered. However, for cash-paying clients, a minimum fee is charged.

2.4 What were the characteristics of the clients served?

**Methodology**

Records were kept and entered into an Access® database. The information collected included student and family demographics, services received, presenting problems, and diagnoses for behavioral health services. The data were then transmitted to the Youth and Family Centers’ consultant, who created and maintained the database and aggregated the data to generate monthly reports for the program manager. The data, specific to the Youth and Family Centers were retrieved from this database for this report. The results for 2004-2005 and 2005-2006 were compared to determine changes in the utilization of program services.

**Results**

A summary of demographic characteristics of those clients who received program services is presented in Table 4. Results show that 16,162 students and family members were served through the Youth and Family Centers in 2004-2005. This number declined slightly to 14,575 in 2005-2006. In 2004-2005, 10,817 physical health clients and 4,211 behavioral health clients presented to the nine centers in the district. Another 1,134 clients were referred and recorded, but not seen. In 2005-2006, the number of physical health clients dropped to 10,343 and the number of behavioral health clients dropped to 3,388. There were also 844 clients who
had documented referrals, but were not seen. The decrease in the number of clients who were referred, but not seen, may be indicative of the Youth and Family Center managers' efforts to contact clients via phone prior to their arrival at their initial intake appointment.

Table 4
Physical and Behavioral Health Clients

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>10,817</td>
<td>66.9</td>
<td>10,343</td>
<td>71.0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>4,211</td>
<td>26.1</td>
<td>3,388</td>
<td>23.2</td>
</tr>
<tr>
<td>No Show</td>
<td>1,134</td>
<td>7.0</td>
<td>844</td>
<td>5.8</td>
</tr>
<tr>
<td>All</td>
<td>16,162</td>
<td>100.0</td>
<td>14,575</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 5 displays demographic information for all Youth and Family Center clients. Of the 16,162 clients who received services at the centers in 2004-2005, 61.2% were Hispanic, 29.9% were African-American, and 7.8% were white. In 2005-2006, the number of Hispanic clients decreased to 60.0%; the number of African-American clients increased to 31.6%, and the number of white clients decreased to 7.5%. The changes mirror student population changes at the district level.

Among the 16,162 clients receiving services in 2004-2005, 54.3% were male, compared to 56.6% in 2005-2006. In 2004-2005, approximately 43.8% of the clients attended elementary school, 22.6% attended middle school, and 33.6% attended high school. In 2005-2006 the number of elementary students seeking services decreased slightly to 43.5% with the number of middle school students increasing to 23.1%. The number of high school students also decreased to 33.4%.

Among the 16,162 clients who visited the centers in 2004-2005 approximately 70.0% qualified for free lunch. In 2005-2006, 72.0% of the clients qualified for free lunch. The increasing number of clients qualifying for free lunch emphasizes the importance of the services provided by the Youth and Family Centers.
Tables 6 and 7 provide data on the family type of clients presenting to the center. In 2004-2005 most of the clients served by the centers came from a nuclear family (21.7%). Another 11.2% came from single-parent homes. Unfortunately, 59.2% of the records maintained by the centers contained no data on family characteristics. This is a continuing problem with the centers (Babu and Mount, 1999; Hall, 2000; Hall, 2001; Williams, 2002; and Oshitoye, 2005). Behavioral health clients accounted for 47.6% of unrecorded family characteristics. Research has shown that family structure and children’s psychological well-being are highly correlated (Kellam, et al, 1997; Dawson, D. A., 1991; Rapoport, R, 1963). Therefore, proper collection of these data can be instrumental when assessing a child’s maladies and developing a treatment plan. Family structure, in 2005-2006, showed that more clients (30.7%) came from a nuclear family. At the same time, the number of clients presenting from single-parent homes increased from 11.2% to 25.3%. On a more positive note, the number of records with missing family relationship decreased by more than 25 percentage points to 34.2%.
Table 6
Youth and Family Center Family Structure, 2004-2005

<table>
<thead>
<tr>
<th>Family Type</th>
<th>Physical Health</th>
<th>Behavioral Health</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Nuclear</td>
<td>2,619</td>
<td>24.2</td>
<td>1,033</td>
</tr>
<tr>
<td>Blended (one biological parent &amp; one stepparent)</td>
<td>488</td>
<td>4.5</td>
<td>269</td>
</tr>
<tr>
<td>Single Parent</td>
<td>1,241</td>
<td>11.5</td>
<td>684</td>
</tr>
<tr>
<td>Foster</td>
<td>57</td>
<td>0.5</td>
<td>22</td>
</tr>
<tr>
<td>Student Lives alone</td>
<td>40</td>
<td>0.4</td>
<td>4</td>
</tr>
<tr>
<td>Adoptive</td>
<td>33</td>
<td>0.3</td>
<td>27</td>
</tr>
<tr>
<td>Blended, but not married</td>
<td>124</td>
<td>1.2</td>
<td>53</td>
</tr>
<tr>
<td>Multi-generational</td>
<td>122</td>
<td>1.1</td>
<td>116</td>
</tr>
<tr>
<td>Missing Data</td>
<td>6,093</td>
<td>56.3</td>
<td>2,003</td>
</tr>
<tr>
<td>Total</td>
<td>10,817</td>
<td>100.0</td>
<td>4,211</td>
</tr>
</tbody>
</table>

Table 7
Youth and Family Center Family Structure, 2005-2006

<table>
<thead>
<tr>
<th>Family Type</th>
<th>Physical Health</th>
<th>Behavioral Health</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Nuclear</td>
<td>3,572</td>
<td>34.5</td>
<td>1,029</td>
</tr>
<tr>
<td>Blended (one biological parent &amp; one stepparent)</td>
<td>526</td>
<td>5.1</td>
<td>285</td>
</tr>
<tr>
<td>Single Parent</td>
<td>2,838</td>
<td>27.4</td>
<td>967</td>
</tr>
<tr>
<td>Foster</td>
<td>54</td>
<td>0.5</td>
<td>5</td>
</tr>
<tr>
<td>Student Lives alone</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Adoptive</td>
<td>137</td>
<td>1.3</td>
<td>13</td>
</tr>
<tr>
<td>Blended, but not married</td>
<td>191</td>
<td>1.8</td>
<td>48</td>
</tr>
<tr>
<td>Multi-generational</td>
<td>180</td>
<td>1.7</td>
<td>47</td>
</tr>
<tr>
<td>Missing Data</td>
<td>2,845</td>
<td>27.5</td>
<td>994</td>
</tr>
<tr>
<td>Total</td>
<td>10,343</td>
<td>100.0</td>
<td>3,388</td>
</tr>
</tbody>
</table>

Table 8 and Table 9 show the employment status of clients’ parents in 2004-2005 and 2005-2006. In 2004-2005, the majority of presenting clients had a father or stepfather working. Fifty-six percent of records did not have employment data recorded, and of these, 44.3% were behavioral health clients. As with family structure, family employment status can have a significant effect on the behavioral health of the parent which can in turn affect the behavioral health of the child.

In 2005-2006, the number of presenting clients with the male father figure working dropped by 4.8 percentage points to 13.0%. It would appear that more clients in 2005-2006 had either the mother working (20.0%) or both parents working (21.3%). There was still a significant
number of records with missing data in 2005-2006 (36.0%). Although the problem is still present, the reduction represents a significant improvement over the prior year by 20.3 percentage points.

Table 8
Youth and Family Center Clients’ Family Employment Status, 2004-2005

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Physical Health</th>
<th>Behavioral Health</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Unemployed</td>
<td>743</td>
<td>6.9</td>
<td>425</td>
</tr>
<tr>
<td>Father/Stepfather only working</td>
<td>2,184</td>
<td>20.2</td>
<td>814</td>
</tr>
<tr>
<td>Both parents working</td>
<td>854</td>
<td>7.9</td>
<td>468</td>
</tr>
<tr>
<td>Mother/Stepmother only working</td>
<td>941</td>
<td>8.7</td>
<td>515</td>
</tr>
<tr>
<td>Guardian working</td>
<td>337</td>
<td>3.1</td>
<td>124</td>
</tr>
<tr>
<td>Missing Data</td>
<td>5,758</td>
<td>53.2</td>
<td>1,865</td>
</tr>
<tr>
<td>Total</td>
<td>10,811</td>
<td>100.0</td>
<td>4,211</td>
</tr>
</tbody>
</table>

Table 9
Youth and Family Center Clients’ Family Employment Status, 2005-2006

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Physical Health</th>
<th>Behavioral Health</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Unemployed</td>
<td>848</td>
<td>36.5</td>
<td>365</td>
</tr>
<tr>
<td>Father/Stepfather only working</td>
<td>1,376</td>
<td>13.2</td>
<td>596</td>
</tr>
<tr>
<td>Both parents working</td>
<td>2,594</td>
<td>25.1</td>
<td>596</td>
</tr>
<tr>
<td>Mother/Stepmother only working</td>
<td>2,334</td>
<td>22.6</td>
<td>683</td>
</tr>
<tr>
<td>Guardian working</td>
<td>144</td>
<td>1.4</td>
<td>95</td>
</tr>
<tr>
<td>Missing Data</td>
<td>3,047</td>
<td>29.5</td>
<td>1,033</td>
</tr>
<tr>
<td>Total</td>
<td>10,343</td>
<td>100.0</td>
<td>3,388</td>
</tr>
</tbody>
</table>

Tables 10 and 11 represent 2004-2005 and 2005-2006 presenting clients’ insurance status. In 2004-2005, 99.5% of presenting clients had no private insurance. Only 78 (0.5%) of the 16,162 clients had private insurance. This figure does not include those clients who had public insurance such as Medicaid or Medicare. In 2005-2006, the number of clients without private health insurance declined to 91.0%, representing a change of 8.5 percentage points. Although changes in insurance status in the number of clients with private health insurance were evident, the number of clients without private health insurance is still high, re-emphasizing the importance of the Youth and Family Centers to those students and their families without health insurance. However, it should also be noted that because there is an inherent problem in the data collection process at the Youth and Family Centers, without an audit of the data collection
process there is no way to determine if this increase is real. The change in data could be the result of better data entry or worse data entry.

Table 10
Youth and Family Center Clients’ Insurance Status, 2004-2005

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>Physical Health</th>
<th>Behavioral Health</th>
<th>All*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>No Private Insurance</td>
<td>10,808</td>
<td>99.9</td>
<td>4,136</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>9</td>
<td>0.1</td>
<td>75</td>
</tr>
<tr>
<td>Total</td>
<td>10,817</td>
<td>100.0</td>
<td>4,211</td>
</tr>
</tbody>
</table>

*The All category consists of clients who received physical health services, behavioral health services, or both.

Table 11
Youth and Family Center Clients’ Insurance Status, 2005-2006

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>Physical Health</th>
<th>Behavioral Health</th>
<th>All*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>No Private Insurance</td>
<td>9,208</td>
<td>89.0</td>
<td>3,171</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>1,135</td>
<td>11.0</td>
<td>217</td>
</tr>
<tr>
<td>Total</td>
<td>10,343</td>
<td>100.0</td>
<td>3,388</td>
</tr>
</tbody>
</table>

*The All category consists of clients who received physical health services, behavioral health services, or both.

Table 12 shows client characteristics by center for 2004-2005. Each center’s client base was reflective of the racial and ethnic diversity in the Dallas ISD’s student population. The centers with the largest number of Hispanic clients were North Oak Cliff (90.4%), Kiosco (82.0%), and Woodrow/Long (76.0%). The Eddie Bernice Johnson Center had the largest number of non-Hispanic black clients (92.6%). The Seagoville Center had the largest number of non-Hispanic white clients (37.8%). All centers, with the exception of Eddie Bernice Johnson and West Dallas, provided services to more males than females. In addition, all centers provided services to all grades. The center that provided the most services to high school students was the Eddie Bernice Johnson Center (48.2%). Kiosco (49.9%), North Oak Cliff (49.0%), and Spruce (52.0%) served more elementary school students. Overall, the centers provided most services to students who were Hispanic (61.2%), male (54.3%), and attending elementary school (43.8%).
Table 12
Client Characteristics by Center, 2004-2005

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Eddie Bernice Johnson</th>
<th>North Oak Cliff</th>
<th>Red Bird</th>
<th>Seagoville</th>
<th>Spruce</th>
<th>West Dallas</th>
<th>Amelia Flores</th>
<th>Woodrow/Long</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>0.7%</td>
<td>4.2%</td>
<td>2.7%</td>
<td>1.3%</td>
<td>37.8%</td>
<td>4.9%</td>
<td>2.0%</td>
<td>11.1%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Black</td>
<td>92.6%</td>
<td>12.1%</td>
<td>6.8%</td>
<td>65.7%</td>
<td>21.5%</td>
<td>37.8%</td>
<td>39.0%</td>
<td>29.4%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6.2%</td>
<td>82.0%</td>
<td>90.4%</td>
<td>32.7%</td>
<td>39.5%</td>
<td>56.6%</td>
<td>58.2%</td>
<td>57.0%</td>
<td>76.0%</td>
</tr>
<tr>
<td>Other</td>
<td>0.5%</td>
<td>1.7%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>1.2%</td>
<td>0.6%</td>
<td>0.9%</td>
<td>2.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Eddie Bernice Johnson</th>
<th>North Oak Cliff</th>
<th>Red Bird</th>
<th>Seagoville</th>
<th>Spruce</th>
<th>West Dallas</th>
<th>Amelia Flores</th>
<th>Woodrow/Long</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>46.3%</td>
<td>58.2%</td>
<td>57.9%</td>
<td>56.2%</td>
<td>51.9%</td>
<td>54.2%</td>
<td>48.5%</td>
<td>53.0%</td>
<td>54.0%</td>
</tr>
<tr>
<td>Female</td>
<td>53.7%</td>
<td>41.8%</td>
<td>42.1%</td>
<td>43.8%</td>
<td>48.1%</td>
<td>45.8%</td>
<td>51.5%</td>
<td>47.0%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>Eddie Bernice Johnson</th>
<th>North Oak Cliff</th>
<th>Red Bird</th>
<th>Seagoville</th>
<th>Spruce</th>
<th>West Dallas</th>
<th>Amelia Flores</th>
<th>Woodrow/Long</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-6</td>
<td>35.6%</td>
<td>49.9%</td>
<td>49.0%</td>
<td>39.4%</td>
<td>36.6%</td>
<td>52.0%</td>
<td>39.0%</td>
<td>41.5%</td>
<td>42.2%</td>
</tr>
<tr>
<td>7-8</td>
<td>16.2%</td>
<td>23.8%</td>
<td>27.0%</td>
<td>26.1%</td>
<td>28.6%</td>
<td>15.1%</td>
<td>22.6%</td>
<td>16.7%</td>
<td>20.2%</td>
</tr>
<tr>
<td>9-12</td>
<td>48.2%</td>
<td>26.3%</td>
<td>24.0%</td>
<td>34.5%</td>
<td>34.8%</td>
<td>32.9%</td>
<td>38.4%</td>
<td>41.8%</td>
<td>37.6%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 13 displays client characteristics by center for 2005-2006. Again, the centers’ client base represents the racial and ethnic diversity of the student population in the district. The centers with the largest number of Hispanic clients’ visits were North Oak Cliff (88.8%), Kiosco (79.2%), and Woodrow/Long (75.9%). The Eddie Bernice Johnson Center had the largest number of non-Hispanic black clients’ visits (94.3%), followed by the Red Bird Center with 68.2%. The Seagoville Center had the largest number of non-Hispanic white clients’ visits (32.6%). All centers provided services to more males than females, and included all grade levels. The center which provided the most services to high school students was the Woodrow/Long Center (41.8%). Kiosco (55.3%) and West Dallas (50.4%) provided the most services to elementary school students. Overall, the majority of clients were Hispanic (60.0%), male (56.6%), and in elementary school (43.5%), similar to the previous year.
Table 13
Client Characteristics by Center, 2005-2006

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Eddie</th>
<th>Bernice</th>
<th>Kiosco</th>
<th>North</th>
<th>Oak</th>
<th>Cliff</th>
<th>Red</th>
<th>Bird</th>
<th>Seagoville</th>
<th>Spruce</th>
<th>West</th>
<th>Dallas</th>
<th>Amelia</th>
<th>Flores</th>
<th>Woodrow/</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>1.2%</td>
<td>5.3%</td>
<td>2.2%</td>
<td>1.3%</td>
<td>32.6%</td>
<td>6.3%</td>
<td>2.1%</td>
<td>10.9%</td>
<td>8.0%</td>
<td>7.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>94.3%</td>
<td>14.8%</td>
<td>8.4%</td>
<td>68.2%</td>
<td>19.7%</td>
<td>38.4%</td>
<td>36.3%</td>
<td>29.9%</td>
<td>14.0%</td>
<td>31.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>4.5%</td>
<td>79.2%</td>
<td>88.8%</td>
<td>30.0%</td>
<td>47.1%</td>
<td>55.2%</td>
<td>60.8%</td>
<td>57.5%</td>
<td>75.9%</td>
<td>60.0%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.1%</td>
<td>0.8%</td>
<td>1.7%</td>
<td>2.1%</td>
<td>0.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Eddie</th>
<th>Bernice</th>
<th>Kiosco</th>
<th>North</th>
<th>Oak</th>
<th>Cliff</th>
<th>Red</th>
<th>Bird</th>
<th>Seagoville</th>
<th>Spruce</th>
<th>West</th>
<th>Dallas</th>
<th>Amelia</th>
<th>Flores</th>
<th>Woodrow/</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>54.8%</td>
<td>60.7%</td>
<td>56.9%</td>
<td>58.5%</td>
<td>52.9%</td>
<td>61.9%</td>
<td>53.4%</td>
<td>55.9%</td>
<td>53.2%</td>
<td>56.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>45.2%</td>
<td>39.3%</td>
<td>43.1%</td>
<td>41.5%</td>
<td>47.1%</td>
<td>38.1%</td>
<td>46.6%</td>
<td>44.1%</td>
<td>46.8%</td>
<td>43.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>Eddie</th>
<th>Bernice</th>
<th>Kiosco</th>
<th>North</th>
<th>Oak</th>
<th>Cliff</th>
<th>Red</th>
<th>Bird</th>
<th>Seagoville</th>
<th>Spruce</th>
<th>West</th>
<th>Dallas</th>
<th>Amelia</th>
<th>Flores</th>
<th>Woodrow/</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-6</td>
<td>45.9%</td>
<td>55.3%</td>
<td>42.8%</td>
<td>37.0%</td>
<td>41.2%</td>
<td>39.5%</td>
<td>50.4%</td>
<td>40.2%</td>
<td>39.8%</td>
<td>43.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-8</td>
<td>19.4%</td>
<td>17.0%</td>
<td>32.2%</td>
<td>25.9%</td>
<td>30.8%</td>
<td>20.4%</td>
<td>19.3%</td>
<td>20.7%</td>
<td>18.5%</td>
<td>23.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-12</td>
<td>34.7%</td>
<td>27.7%</td>
<td>25.1%</td>
<td>37.1%</td>
<td>28.0%</td>
<td>40.1%</td>
<td>30.3%</td>
<td>39.1%</td>
<td>41.8%</td>
<td>33.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary

The Youth and Family Centers served 16,162 students and their families in 2004-2005 and 14,575 students and their families in 2005-2006. The majority of the client base was Hispanic, male, and attended elementary school. While the centers were required to collect both family employment status and family type information in 2004-2005, most records did not contain these data. In 2005-2006, the problem still remained, but the number of records without this information was reduced. It is not clear whether the reduction was the result of increased efforts by the center clerks to complete records or a random chance. Despite this reduction in missing data, efforts still need to be put in place to correct the data entry problem. Because data are collected by the therapist, entered by the center clerk, and transmitted to the Youth and Family Center external consultant, who then manipulates the data, there are many opportunities in the process for errors. An audit of the data entry process needs to be conducted in order to determine where the problem lies.

A significant change in the Youth and Family Center client characteristics was that in 2004-2005, 0.5% of presenting clients had private health insurance. By 2005-2006, this number
had increased to 9.0%. However, because of the data collection issues, further analysis needs to be conducted to determine whether this increase is real.

2.5 What treatments and diagnoses did the Youth and Family Center clients receive?

Methodology

Data from the Youth and Family Center Access® database were retrieved and analyzed. Also, data provided by Parkland Community Oriented Primary Care administrator, though not analyzed, were also included.

Results

Behavioral Health Services and Treatments

Behavioral health treatments and diagnoses were analyzed to determine the level of services for which clients sought treatment at the centers in both years. The behavioral health treatment summaries are presented in Tables 14 and 15 (see Appendix F for definitions). Of the 4,211 behavioral health clients who received services in 2004-2005, 52.5% had no presenting problem recorded on their file. This changed only slightly to 49.1% in 2005-2006. The high amount of missing data illustrates that the Youth and Family Centers have a data collection problem. In 2004-2005, the centers with the most records with missing information were Kiosco (88.7%), Red Bird (76.2%), and North Oak Cliff (74.8%). In 2005-2006, these three centers continued to have the most records with missing data. Kiosco remained the same (88.8%), Red Bird increased (80.4%), and North Oak Cliff decreased (67.8%). In both years, the Woodrow/Long, Eddie Bernice Johnson, and Amelia Flores Centers had the least number of records with missing data.

The total number of records without a presenting problem decreased from 791 in 2004-2005 to 536 in 2005-2006, a 60% percent decrease. The decrease was reflected in records from West Dallas, Seagoville, North Oak Cliff, and Spruce. Unfortunately, the other five centers showed increases in the number of records with missing data. Even though there was a 3.4 percentage decrease in the overall proportion of records with missing data, it is not clear whether
this reduction was a random effect or there have been improvements in the recording of information, but there are still a considerable amount of records with missing data.

In 2004-2005, the largest group of clients with a diagnostic treatment code, sought services at the Youth and Family Centers for behavioral problems (32.5%). This was followed by clients presenting for emotional problems (7.1%). The results for 2005-2006 showed that behavioral (34.4%) and emotional problems (8.9%) were the largest presenting problems with diagnostic codes. In the same year (2004-2005), the Woodrow/Long Center (N=236) saw the most patients for behavioral problems, followed by Seagoville with 232, and West Dallas and Amelia Flores, 186 and 185, respectively. The centers providing the most services for emotional problems were Woodrow/Long (N=79), and Seagoville (N=49), and Amelia Flores (N=50). The Kiosco Center saw the least clients for emotional problems (N=8) in 2004-2005.

In 2005-2006, West Dallas (N=185), Woodrow/Long (N=175), and Seagoville (N=171) provided the most services for behavioral health. Seagoville (N=80), Woodrow/Long (N=49), and Amelia Flores (N=45) provided the most services for emotional issues.
Table 14
Presenting Problem of Behavioral Health Clients by Center, 2004-2005

<table>
<thead>
<tr>
<th>Center</th>
<th>Academic %</th>
<th>Behavioral</th>
<th>Developmental %</th>
<th>Emotional %</th>
<th>Family Issues %</th>
<th>Health Issues %</th>
<th>Truancy %</th>
<th>Missing %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amelia Flores</td>
<td>24</td>
<td>8.9</td>
<td>185</td>
<td>68.8</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
<td>0.4</td>
<td>270</td>
</tr>
<tr>
<td>E. B. Johnson</td>
<td>6</td>
<td>3.9</td>
<td>111</td>
<td>73.0</td>
<td>2</td>
<td>1.4</td>
<td>18</td>
<td>0.7</td>
<td>172</td>
</tr>
<tr>
<td>West Dallas</td>
<td>2</td>
<td>0.9</td>
<td>186</td>
<td>87.3</td>
<td>0</td>
<td>0.0</td>
<td>23</td>
<td>0.5</td>
<td>175.9</td>
</tr>
<tr>
<td>Seagoville</td>
<td>22</td>
<td>4.9</td>
<td>232</td>
<td>51.6</td>
<td>6</td>
<td>1.3</td>
<td>49</td>
<td>0.5</td>
<td>596</td>
</tr>
<tr>
<td>Spruce</td>
<td>18</td>
<td>8.5</td>
<td>140</td>
<td>66.4</td>
<td>12</td>
<td>5.7</td>
<td>29</td>
<td>3.8</td>
<td>448</td>
</tr>
<tr>
<td>North Oak Cliff</td>
<td>6</td>
<td>4.3</td>
<td>101</td>
<td>72.1</td>
<td>1</td>
<td>0.7</td>
<td>27</td>
<td>1.4</td>
<td>116.1</td>
</tr>
<tr>
<td>Woodrow/Long</td>
<td>25</td>
<td>7.1</td>
<td>236</td>
<td>66.7</td>
<td>3</td>
<td>0.8</td>
<td>79</td>
<td>2.3</td>
<td>555</td>
</tr>
<tr>
<td>Red Bird</td>
<td>5</td>
<td>4.1</td>
<td>98</td>
<td>81.0</td>
<td>0</td>
<td>0.0</td>
<td>16</td>
<td>1.7</td>
<td>106</td>
</tr>
<tr>
<td>Kiosco</td>
<td>2</td>
<td>2.2</td>
<td>78</td>
<td>87.6</td>
<td>0</td>
<td>0.0</td>
<td>8</td>
<td>1.1</td>
<td>791</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>2.6</td>
<td>1,367</td>
<td>32.5</td>
<td>25</td>
<td>0.6</td>
<td>299</td>
<td>1.9</td>
<td>4,211</td>
</tr>
</tbody>
</table>

Table 15
Presenting Problem of Behavioral Health Clients by Center, 2005-2006

<table>
<thead>
<tr>
<th>Center</th>
<th>Academic %</th>
<th>Behavioral</th>
<th>Developmental %</th>
<th>Emotional %</th>
<th>Family Issues %</th>
<th>Health Issues %</th>
<th>Truancy %</th>
<th>Missing %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amelia Flores</td>
<td>12</td>
<td>4.9</td>
<td>167</td>
<td>67.6</td>
<td>8</td>
<td>0.4</td>
<td>45</td>
<td>1.2</td>
<td>274</td>
</tr>
<tr>
<td>E. B. Johnson</td>
<td>5</td>
<td>3.4</td>
<td>109</td>
<td>74.1</td>
<td>5</td>
<td>3.4</td>
<td>15</td>
<td>1.4</td>
<td>173</td>
</tr>
<tr>
<td>West Dallas</td>
<td>0</td>
<td>0.0</td>
<td>185</td>
<td>86.0</td>
<td>0</td>
<td>0.0</td>
<td>28</td>
<td>0.5</td>
<td>199</td>
</tr>
<tr>
<td>Seagoville</td>
<td>17</td>
<td>4.3</td>
<td>171</td>
<td>43.4</td>
<td>4</td>
<td>1.0</td>
<td>80</td>
<td>2.1</td>
<td>443</td>
</tr>
<tr>
<td>Spruce</td>
<td>10</td>
<td>6.4</td>
<td>99</td>
<td>63.5</td>
<td>1</td>
<td>0.6</td>
<td>37</td>
<td>1.9</td>
<td>266</td>
</tr>
<tr>
<td>North Oak Cliff</td>
<td>4</td>
<td>2.7</td>
<td>120</td>
<td>80.5</td>
<td>0</td>
<td>0.0</td>
<td>25</td>
<td>0.0</td>
<td>110</td>
</tr>
<tr>
<td>Woodrow/Long</td>
<td>14</td>
<td>2.8</td>
<td>175</td>
<td>70.3</td>
<td>1</td>
<td>0.4</td>
<td>49</td>
<td>1.4</td>
<td>269</td>
</tr>
<tr>
<td>Red Bird</td>
<td>3</td>
<td>2.8</td>
<td>82</td>
<td>75.9</td>
<td>0</td>
<td>0.0</td>
<td>21</td>
<td>0.0</td>
<td>536</td>
</tr>
<tr>
<td>Kiosco</td>
<td>1</td>
<td>1.7</td>
<td>56</td>
<td>93.3</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
<td>0.0</td>
<td>536</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>1.9</td>
<td>1,164</td>
<td>34.4</td>
<td>19</td>
<td>0.6</td>
<td>303</td>
<td>2.2</td>
<td>3,388</td>
</tr>
</tbody>
</table>

21
Table 16 summarizes all recorded behavioral health diagnoses. Of the 4,170 records recorded in 2004-2005, 3,890 (93.3%) had a recorded diagnosis code. The leading diagnosis for these clients was attention-deficit disorder (32.7%). Results were similar in 2005-2006 where attention-deficit disorder diagnoses accounted for 24.0% of all diagnoses. The diagnosis with the largest increase from 2004-2005 to 2005-2006 was conduct disorder, childhood-onset type. This diagnosis showed an increase of 5.5 percentage points. Attention-deficit/hyperactivity disorder combined type had the largest decrease between 2004-2005 and 2005-2006 (10.8 percentage points).

In 2005-2006, 719 (20.7%) of the records did not have a diagnosis code, compared to 280 (6.7%) in 2004-2005, an increase of 14.1 percentage points. Again, this is indicative of a data collection problem. This issue has significant importance now that the Youth and Family Centers are Medicaid providers. All claims submitted to an insurance carrier, regardless of whether it is a private or public entity, require at least one diagnosis code, if not a secondary and tertiary diagnosis code.
Table 16

Behavioral Health Conditions by DSM IV Codes

<table>
<thead>
<tr>
<th>DSM IV Description</th>
<th>DSM IV</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis or Condition Deferred on Axis I or Diagnosis</td>
<td>DSM IV</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Deferred on Axis II</td>
<td>799.90</td>
<td>829</td>
<td>20.0</td>
<td>598</td>
</tr>
<tr>
<td>Anxiety Disorder Due to General Medical Condition</td>
<td>293.84</td>
<td>1</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Schizophrenia, Paranoid Type</td>
<td>295.30</td>
<td>1</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Schizophreniform Disorder</td>
<td>295.40</td>
<td>1</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Bipolar I Disorder Single Manic Episode</td>
<td>296.0x</td>
<td>17</td>
<td>0.4</td>
<td>4</td>
</tr>
<tr>
<td>Major Depressive Disorder Single Episode</td>
<td>296.2x</td>
<td>60</td>
<td>1.4</td>
<td>36</td>
</tr>
<tr>
<td>Major Depressive Disorder Recurrent</td>
<td>296.3x</td>
<td>35</td>
<td>0.8</td>
<td>21</td>
</tr>
<tr>
<td>Bipolar I Disorder Most Recent Episode Hypomaniac</td>
<td>296.40</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Bipolar I Disorder Most Recent Episode Mixed</td>
<td>296.6x</td>
<td>2</td>
<td>0.0</td>
<td>3</td>
</tr>
<tr>
<td>Bipolar I Disorder, Most Recent Episode Unspecified</td>
<td>296.7</td>
<td>3</td>
<td>0.1</td>
<td>1</td>
</tr>
<tr>
<td>Bipolar Disorder NOS</td>
<td>296.8</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>296.90</td>
<td>7</td>
<td>0.2</td>
<td>3</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>299.00</td>
<td>4</td>
<td>0.1</td>
<td>10</td>
</tr>
<tr>
<td>Brief Psychotic Disorder</td>
<td>298.8</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Psychotic Disorder NOS</td>
<td>298.9</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>300.01</td>
<td>3</td>
<td>0.1</td>
<td>7</td>
</tr>
<tr>
<td>Asperger's Disorder</td>
<td>300.02</td>
<td>9</td>
<td>0.2</td>
<td>14</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>300.11</td>
<td>1</td>
<td>0.0</td>
<td>7</td>
</tr>
<tr>
<td>Panic Disorder With Agoraphobia</td>
<td>300.21</td>
<td>2</td>
<td>0.0</td>
<td>4</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>300.3</td>
<td>8</td>
<td>0.2</td>
<td>7</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>300.4</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Panic Disorder With Agoraphobia</td>
<td>300.21</td>
<td>2</td>
<td>0.0</td>
<td>3</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>300.23</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>300.29</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>300.3</td>
<td>8</td>
<td>0.2</td>
<td>6</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>300.4</td>
<td>41</td>
<td>1.0</td>
<td>44</td>
</tr>
<tr>
<td>Unspecified Mental Disorder (nonpsychotic)</td>
<td>300.9</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Cyclothymic Disorder</td>
<td>301.13</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>303.90</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Cannabis Dependence</td>
<td>304.30</td>
<td>1</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Polysubstance Dependence</td>
<td>304.8</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Other (or Unknown) Substance Dependence</td>
<td>304.9</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Nicotine Dependence</td>
<td>305.10</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Opioid Abuse</td>
<td>305.50</td>
<td>2</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Caffeine Intoxication</td>
<td>305.90</td>
<td>4</td>
<td>0.1</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Motor or Vocal Tic Disorder</td>
<td>307.22</td>
<td>1</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>307.51</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Encopresis Without Constipation &amp; Overflow Incont.</td>
<td>307.7</td>
<td>4</td>
<td>0.1</td>
<td>3</td>
</tr>
<tr>
<td>Communication Disorder NOS</td>
<td>307.9</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
<td>308.3</td>
<td>3</td>
<td>0.1</td>
<td>3</td>
</tr>
<tr>
<td>Adjustment Disorder With Depressed Mood</td>
<td>309.0</td>
<td>15</td>
<td>0.3</td>
<td>83</td>
</tr>
<tr>
<td>Separation Anxiety Disorder</td>
<td>309.21</td>
<td>13</td>
<td>0.3</td>
<td>32</td>
</tr>
<tr>
<td>Adjustment Disorder With Anxiety</td>
<td>309.24</td>
<td>59</td>
<td>1.4</td>
<td>0</td>
</tr>
<tr>
<td>Adjustment Disorder With Mixed Anxiety &amp; Dep. Mood</td>
<td>309.28</td>
<td>70</td>
<td>1.8</td>
<td>88</td>
</tr>
<tr>
<td>Adjustment Disorder With Disturbance of Conduct</td>
<td>309.3</td>
<td>39</td>
<td>0.9</td>
<td>24</td>
</tr>
<tr>
<td>Adjustment Disorder With Disturbance of Emotions</td>
<td>309.4</td>
<td>407</td>
<td>9.8</td>
<td>280</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>309.81</td>
<td>8</td>
<td>0.2</td>
<td>15</td>
</tr>
<tr>
<td>Adjustment Disorder Unspecified</td>
<td>309.9</td>
<td>2</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Personality Change Due to General Medical Condition</td>
<td>310.1</td>
<td>2</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Depressive Disorder NOS</td>
<td>311</td>
<td>102</td>
<td>2.5</td>
<td>135</td>
</tr>
<tr>
<td>Impulse-Control Disorder NOS</td>
<td>312.3</td>
<td>5</td>
<td>0.1</td>
<td>2</td>
</tr>
<tr>
<td>Conduct Disorder, Childhood-Onset Type</td>
<td>312.81</td>
<td>3</td>
<td>0.1</td>
<td>3</td>
</tr>
<tr>
<td>Conduct Disorder, Adolescent-Onset Type</td>
<td>312.82</td>
<td>16</td>
<td>0.4</td>
<td>18</td>
</tr>
</tbody>
</table>
### Table 16 continued

<table>
<thead>
<tr>
<th>DSM IV Description</th>
<th>DSM IV</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Conduct Disorder, Unspecified Onset</td>
<td>312.89</td>
<td>1</td>
<td>0.0</td>
<td>6</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>313.81</td>
<td>24</td>
<td>0.6</td>
<td>32</td>
</tr>
<tr>
<td>Disruptive Behavior Disorder NOS</td>
<td>312.9</td>
<td>24</td>
<td>0.6</td>
<td>25</td>
</tr>
<tr>
<td>Selective Mutism</td>
<td>313.23</td>
<td>2</td>
<td>0.0</td>
<td>3</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td>314.00</td>
<td>159</td>
<td>3.8</td>
<td>109</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder Combined Type</td>
<td>314.01</td>
<td>1,170</td>
<td>28.1</td>
<td>511</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder NOS</td>
<td>314.9</td>
<td>35</td>
<td>0.8</td>
<td>23</td>
</tr>
<tr>
<td>Reading Disorder</td>
<td>315.00</td>
<td>2</td>
<td>0.0</td>
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<tr>
<td>Expressive Language Disorder</td>
<td>315.31</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Phonological Disorder</td>
<td>315.39</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Learning Disorder NOS</td>
<td>315.9</td>
<td>2</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Neglect of Child (if focus of attention is on victim)</td>
<td>995.5</td>
<td>3</td>
<td>0.1</td>
<td>1</td>
</tr>
<tr>
<td>Parent-Child Relational Problem</td>
<td>V61.20</td>
<td>8</td>
<td>0.2</td>
<td>3</td>
</tr>
<tr>
<td>Sexual or Physical Abuse or Neglect of Child</td>
<td>V61.21</td>
<td>3</td>
<td>0.1</td>
<td>1</td>
</tr>
<tr>
<td>Sibling Relational Problem</td>
<td>V61.8</td>
<td>1</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Academic Problem</td>
<td>V62.3</td>
<td>2</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Acculturation Problem</td>
<td>V62.4</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Relational Problem NOS</td>
<td>V62.81</td>
<td>2</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Bereavement</td>
<td>V62.82</td>
<td>1</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Phase of Life Problem</td>
<td>V62.89</td>
<td>2</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Antisocial Behavior</td>
<td>V71.01</td>
<td>3</td>
<td>0.1</td>
<td>0</td>
</tr>
<tr>
<td>No Diagnosis or Condition on Axis I or Axis II</td>
<td>V71.09</td>
<td>441</td>
<td>10.6</td>
<td>268</td>
</tr>
<tr>
<td>Missing Diagnosis Code</td>
<td>280</td>
<td>6.7</td>
<td>719</td>
<td>20.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,170</td>
<td>100.0</td>
<td>3,388</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Tables 17 and 18 show the number and types of treatments behavioral health clients received in 2004-2005 and 2005-2006 (see Appendix I for definitions). As shown in Table 17, in 2004-2005 the most frequent services provided were therapy sessions with family and student (20.2%), and group therapy sessions with students (14.9%). Seagoville provided the largest proportion of its services to family and student therapy (35.7%). Red Bird provided the least amount of its services to family and student therapy (12.2%). The Spruce Center provided the largest portion of its services to group therapy for students (56.2%). It had 1,426 documented sessions, which accounted for 34.9% of all student therapy sessions offered by all the centers.

In 2005-2006, (Table 18) the leading therapy services provided were family and student sessions and individual therapy sessions, which were 45-50 minutes in length. Spruce devoted the majority of its services (35.8%) to family with student therapy, and Amelia Flores (3.4%) provided the least. Of the 2,877 individual therapy sessions, which were 45-50 minutes in length, Seagoville provided the greatest proportion (27.6%) and Red Bird (0.6%) provided the least. There appears to be an issue surrounding the recording of services. Although Red Bird was one of the centers providing the largest number of services, it provided the least number of individual
therapy sessions for all centers. Yet this center provided 90% (N=1,621) of all interactive group therapy sessions. This center provided more than 12 times the amount provided by the next largest provider of these therapies. This large difference in the number of interactive services provided in individual therapy sessions compared to the number of similar sessions offered by other centers needs further investigation. It would appear that rather than counting groups, individuals within the groups are being recorded. However, other centers may not be following this same process. Thus, in order to compare services across centers it is important that all centers follow a uniform process for data recording and entry. Because each center is choosing its method for recording visits and services provided, the program cannot obtain an accurate accounting of all services provided. In addition, from a process improvement standpoint, the transference of best practices cannot occur among the centers if each center is employing its own methods.

The Youth and Family Centers serve as a partner to schools across the district and therefore provide school intervention services when necessary. Of all school intervention services provided in 2004-2005, school consultations were the most frequent, followed by classroom observations. Red Bird devoted the greatest proportion (11.6%) of its services to school consultations and North Oak Cliff with 0.1% provided the least. Red Bird again led with the most services in classroom observations. In 2005-2006, West Dallas devoted 14.2% of the services it delivered to school consultations.

Medication management was also an important part of the delivery of services at the Youth and Family Centers. In 2004-2005, 1,578 medication management services were provided. Woodrow/Long devoted the greatest proportion (12.8%) of its services to medication management and Red Bird provided the least (1.2%). In 2005-2006, Kiosco (15.1%) provided the most and Eddie Bernice Johnson provided the least (1.7%).

As in other areas of data collection there was a significant number of records with missing procedural codes. In 2004-2005, 15.6% of all records had no procedure code. The proportion of records with missing codes ranged from 0.3% for West Dallas to 41.1% for Seagoville. In 2005-2006, the number of records with missing procedure codes dropped to 5.7%.
The proportion of records with missing codes ranged from 0.2% for Red Bird and 14.6% for Seagoville. Red Bird experienced the greatest improvement in recording, decreasing the percentage of missing codes from 27.8% in 2004-2005 to 0.2% in 2005-2006. However, Seagoville remained the center with the most incidents of missing data in both years. Because this center is one that provided the largest number of services, and it has the highest number of records lacking a procedure code, this creates a significant problem for the Youth and Family Centers program. This center is pulling the organization down in terms of recording inaccuracies. If the centers aimed for a minimum standard of accuracy of 98%, in 2004-2005 five of the nine centers would have failed (Seagoville, North Oak Cliff, Woodrow/Long, Red Bird, and Kiosco). In 2005-2006, four of the five centers would have failed (Seagoville, Spruce, North Oak Cliff, and Woodrow/Long). The accurate and complete entry of data is essential to determine what services are being provided, how many services are requiring follow-ups, billing and revenue, and for planning and protecting the health of the patient.
| Treatment                        | AF  | %   | EBJ | %   | WD  | %   | SV  | %   | SP  | %   | NO  | %   | WL  | %   | RB  | %   | KI  | %   | Total | %   |
|---------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|
| **Therapy**                     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |     |
| Individual 45-50 min.          | 365 | 20.2| 162 | 14.4| 256 | 8.8| 572 | 25.4| 91  | 3.6| 421 | 13.6| 365 | 13.4| 64  | 2.0| 378  | 11.2| 2,674| 9.8 |
| Individual 20-30 min.          | 43  | 2.4 | 33  | 2.9 | 125 | 4.3| 28  | 1.2 | 39  | 1.5| 21  | 0.7 | 58  | 2.1 | 43  | 1.3| 43   | 1.3 | 433  | 1.6 |
| Family w/ student               | 457 | 25.3| 223 | 19.8| 681 | 23.3| 803 | 35.7| 508 | 20.0| 764 | 24.7| 703 | 25.8| 394 | 12.2| 997  | 29.5| 5,530| 20.2|
| Family w/o student              | 87  | 4.8 | 37  | 3.3 | 50  | 1.7 | 53  | 2.4 | 30  | 1.2| 160 | 5.2 | 31  | 1.1 | 141 | 4.4| 135  | 4.0 | 724  | 2.7 |
| Group - students                | 235 | 13.0| 172 | 15.3| 599 | 20.5| 29  | 1.3 | 1,426| 56.2| 610 | 19.8| 563 | 20.6| 322 | 10.0| 122  | 3.6 | 4,078| 14.9|
| Group - multi-family            | 0   | 0.0 | 2   | 0.2 | 0   | 0.0 | 81  | 3.6 | 1,080| 38.5| 369 | 12.1| 366 | 12.4| 112 | 3.6| 78   | 2.5 | 2,622| 8.4 |
| Group - interactive             | 48  | 2.7 | 192 | 17.1| 0   | 0.0 | 26  | 1.3 | 2   | 0.1 | 0   | 0.0 | 152 | 5.6 | 888 | 27.6| 696  | 20.6| 2,004| 7.3 |
| Support group                   | 0   | 0.0 | 10  | 0.9 | 1   | 0.0 | 0   | 0.0 | 192 | 7.6 | 35  | 1.1 | 6   | 0.2 | 247 | 7.7 | 0    | 0.0 | 491  | 1.8 |
| **School Interventions**        |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |     |
| Behavior mgmt plan              | 1   | 0.1 | 1   | 0.1 | 2   | 0.1 | 3   | 0.1 | 1   | 0.0 | 19  | 0.6 | 29  | 1.1 | 28  | 0.9 | 1    | 0.0 | 85   | 0.3 |
| School consult                  | 21  | 1.2 | 2   | 0.2 | 326 | 11.0| 96  | 3.2 | 146 | 4.8 | 112 | 3.8 | 372 | 11.6| 10  | 0.3 | 849  | 2.9 |
| ARD meeting                     | 1   | 0.1 | 0   | 0.0 | 5   | 0.2 | 1   | 0.0 | 3   | 0.1 | 3   | 0.1 | 0   | 0.0 | 0   | 0.0 | 0    | 0.0 | 3    | 0.1 |
| Classroom observ.               | 6   | 0.3 | 9   | 0.8 | 36  | 1.2 | 0   | 0.0 | 2   | 0.1 | 7   | 0.2 | 2   | 0.1 | 64  | 2.0 | 5    | 0.1 | 131  | 0.5 |
| **Psychiatric Visits**          |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |     |
| Assessment                      | 67  | 3.7 | 51  | 4.5 | 98  | 3.4 | 73  | 3.2 | 34  | 1.3 | 149 | 4.8 | 112 | 4.1 | 28  | 0.9 | 177  | 5.2 | 789  | 2.9 |
| Therapy w/ 50 min*              | 26  | 1.4 | 20  | 1.8 | 0   | 0.0 | 18  | 0.6 | 12  | 0.5 | 0   | 0.0 | 9   | 0.3 | 5   | 0.2 | 8    | 0.2 | 98   | 0.4 |
| Therapy w/ 30 min*              | 140 | 7.7 | 86  | 7.7 | 1   | 0.0 | 121 | 5.4 | 36  | 1.4 | 0   | 0.0 | 172 | 6.3 | 197 | 6.1 | 1    | 0.0 | 754  | 2.8 |
| Psyh. testing                   | 0   | 0.0 | 0   | 0.0 | 0   | 0.0 | 6   | 0.2 | 0   | 0.0 | 0   | 0.0 | 0   | 0.0 | 0   | 0.0 | 0    | 0.0 | 6    | 0.0 |
| Crisis intervention             | 1   | 0.1 | 0   | 0.0 | 2   | 0.0 | 10  | 0.7 | 2   | 0.1 | 2   | 0.1 | 2   | 0.1 | 90  | 2.8 | 4    | 0.1 | 123  | 0.5 |
| Re-evaluation                   | 0   | 0.0 | 0   | 0.0 | 0   | 0.0 | 0   | 0.0 | 9   | 0.3 | 0   | 0.0 | 0   | 0.0 | 30  | 0.9 | 39   | 0.1 |
| **Other Services**              |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |     |
| Intake (licensed)               | 134 | 7.4 | 74  | 6.6 | 52  | 4.5 | 65  | 2.9 | 70  | 2.8 | 141 | 4.6 | 114 | 4.2 | 64  | 2.0 | 216  | 6.4 | 932  | 3.4 |
| Intake (non-licensed)           | 66  | 3.7 | 5   | 0.4 | 152 | 5.2 | 93  | 4.1 | 31  | 1.2 | 219 | 7.1 | 44  | 1.6 | 151 | 4.7 | 162  | 4.8 | 923  | 3.4 |
| Home visit                      | 0   | 0.0 | 24  | 2.1 | 0   | 0.0 | 4   | 0.2 | 3   | 0.1 | 1   | 0.0 | 0   | 0.0 | 7   | 0.2 | 2    | 0.1 | 41   | 0.2 |
| Other                           | 0   | 0.0 | 0   | 0.0 | 211 | 7.2 | 1   | 0.0 | 0   | 0.0 | 123 | 4.0 | 0   | 0.0 | 0   | 0.0 | 3    | 0.1 | 338  | 1.2 |
| **Medication**                  |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |     |
| Med. management                 | 109 | 6.0 | 17  | 1.5 | 309 | 10.6| 182 | 8.1 | 81  | 4.4 | 56  | 2.3 | 349 | 12.8| 37  | 1.2 | 369  | 10.9| 1,578| 5.8 |
| **Total**                       |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |     |

AF = Amelia Flores; EBJ = Eddie Bernice Johnson; WD = West Dallas; SV = Seagoville; SP = Spruce; NO = North Oak Cliff; WL = Woodrow/Long; RB = Red Bird; KI = Kiosco.

*RX = Prescription
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<th>Treatment</th>
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<th>WD</th>
<th>SV</th>
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AF = Amelia Flores; EBJ = Eddie Bernice Johnson; WD = West Dallas; SV = Seagoville; SP = Spruce; NO = North Oak Cliff; WL = Woodrow/Long; RB = Red Bird; KI = Kiosco.

*RX = Prescription
Table 19 shows the number of services provided by each center in 2004-2005 and the types of clients receiving those services. Overall, the centers provided 11,412 services to district students. Kiosco provided the greatest proportion of these services (17.3%). This center also had the most clients (16.6%) who came to the center for the first time during 2004-2005. In addition to providing services to the students, the centers also provided services to the students’ families. In 2004-2005, the West Dallas Center (20.1%) provided the most family-oriented services. The Youth and Family Center program delivered 37,800 visits in 2004-2005. Of these, 12,962 were for physical health, and 24,838 were for behavioral health. Kiosco provided the greatest proportion of physical health services (19.6%). Red Bird provided the greatest number of behavioral health services (16.5%). Of all centers, Seagoville provided the greatest number of services to Medicaid eligible clients (17.5%).
In 2005-2006, the Youth and Family Centers provided 9,746 services to district students (Table 20); 4,829 services to families; and 8,665 services to students seeking assistance for the first time. Red Bird was the center with the largest number of district clients (15.8%). The West Dallas Center had the most families as part of its client base (26.7%). West Dallas also had the largest number of all clients (16.9%). Analysis of visit type showed that Red Bird Center provided the highest number of physical health visits (27.7%) The Kiosco Center provided the highest number of behavioral health visits.
number of behavioral health visits with 17.3%, and Spruce provided the lowest at 6.4%.
However, West Dallas provided the largest total percentage of both physical and behavioral
health services (16.1%).

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<td>Eddie Bernice Johnson</td>
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<tr>
<td>N (%)</td>
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<td>314 (3.2)</td>
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Physical Health Services Diagnoses

Physical health diagnosis codes were not made available to Dallas ISD in 2004-2005 and were only made available in 2005-2006 after discussions with the new COPC administrator. Youth and Family Center administrators determined that the reason diagnosis codes were not made available to Dallas ISD, as they had been in the past, was because of a decision made by the former COPC administrator based on her interpretation of the Health Insurance Portability and Accountability Act of 1996. This privacy act, known as HIPAA, was signed into law on August 21, 1996. The decision to prevent Dallas ISD from accessing the physical health was erroneous but was not challenged by Dallas ISD administration.

The primary purpose of HIPAA is to enable employees and their families to transfer health care benefits from one employer to another, and continue coverage in case of a layoff. While HIPAA is intended to assure portability and accountability of the health care system, many aspects of the law deal specifically with data security and privacy, and establish precise standards for electronic data interchange. The Department of Health and Human Services was required by HIPAA to define rules for the protection of patient information. The rules came into effect April 14, 2001. Full implementation of the rules was required by April 14, 2003. This new regulation was intended to protect medical records and other personal health information, in all forms, maintained by health care providers, hospitals, health plans, health insurers, and health care clearinghouses. The final phase of implementation of the rule brought about significant changes in the data that Parkland shared with Dallas ISD.

In reports prior to the 2004-2005 Youth and Family Centers Final Evaluation Report, data pertaining to physical health services were readily available. During 2003-2004, no evaluation was requested for the Youth and Family Centers. This was the same year that all components of HIPAA were implemented by health care providers, hospitals, health plans, and insurers. As such, data were no longer shared with Dallas ISD. This change took effect without challenge from the Dallas ISD because the data were not central to Dallas ISD’s delivery of services, and these data were not requested for the 2003-2004 evaluation report. Because the district did not request these data, the change became the norm. This is troubling given that the district is a
collaborator with the Parkland Health and Hospital System. Because the district is a collaborator with Parkland, it should be considered a business associate; such designation allows specific data sharing provisions.

As defined by the rule, a “business partner” (referred to as “business associate” in the final rule) is a business entity with whom a covered entity discloses protected health information (PHI) so the person can assist or perform a function for the covered entity. This includes lawyers, auditors, consultants, third-party administrators, health care clearinghouses, data processing firms, billing firms, and other covered entities. A covered entity may not disclose PHI to a business associate without assurance from the business associate that it will appropriately safeguard the confidentiality of protected health information. This argument is called a business associate agreement.

Data from Parkland Health and Hospital System should be shared openly with the Dallas ISD Youth and Family Centers. As such, the evaluator had conversations with the Parkland Community Oriented Primary Care administrators to garner access to, at a minimum, diagnosis codes. The discussions resulted in Dallas ISD receiving counts as associated with diagnosis codes. However, these data were needlessly stripped of all identifiers such as demographic, socioeconomic status, and other variables that could provide worthwhile analysis. Therefore, only a cursory analysis was conducted on these data; the data have been provided in the form in which they were received by the evaluator (Table 21). Unfortunately, delivery of data in this format does not allow the Youth and Family Centers program manager to track and address outbreaks when they occur. In 2004-2005, there was an outbreak of staphylococcus infections across the district, but it was not noticed until one of Parkland’s service providers, who worked in one of the health centers, came forward with the information. This is troubling when the nation is facing the possibility of an Avian Flu epidemic and periodically experiencing West Nile virus outbreaks.

Table 21 shows the most frequent physical health diagnoses assigned by the COPC teams working at the Youth and Family Centers. The diagnoses in both Tables 21 and 22
represent 64% of all the diagnoses and V codes assigned. (Refer to Appendix F for the complete list of diagnosis and V codes). The top seven diagnoses for which clients sought services were:

<table>
<thead>
<tr>
<th>Respiratory Disease</th>
<th>Uro-genital Tract</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Asthma</td>
<td>• Urinary Tract Infection</td>
</tr>
<tr>
<td>• Allergic Rhinitis</td>
<td>• Vaginitis</td>
</tr>
<tr>
<td>• Otitis Media</td>
<td></td>
</tr>
<tr>
<td>• Strep throat</td>
<td></td>
</tr>
<tr>
<td>• Pharyngitis</td>
<td></td>
</tr>
</tbody>
</table>

As shown, the leading diagnoses were confined to two major systems: the respiratory system and the urinary/genital tract systems. Asthma accounted for 11% of the top diagnoses. This disease is the leading cause of school absence and disproportionately affects blacks and Hispanics negatively. This disease cannot be cured, but can be treated effectively through pharmacological management. If not treated appropriately it can lead to death. Allergic rhinitis, which accounted for 12.4% of the leading diagnoses, is a leading contributor to asthma. Urinary tract infections are a possible contributor to kidney infections and can lead to possible cause of future sterility. Another 8.7% of records indicated that the primary diagnosis was vaginitis/vulvovaginitis, which can be caused by bacteria, yeasts, viruses, and other parasites. Some sexually transmitted diseases can also cause vulvovaginitis, as can various chemicals found in bubble baths, soaps, and perfumes. Environmental factors such as poor hygiene and allergens may also cause this condition. All of these illnesses present an opportunity to provide clients with health education about respiratory diseases and how to effectively control them, especially asthma and allergic rhinitis. The same can be said for the uro-genital tract symptoms/diseases. Increasing women’s health education can have a positive impact in reducing the need for future health care visits.
### Table 21
Most Frequently Used Physical Health Diagnosis Codes by Center, 2005-2006

<table>
<thead>
<tr>
<th>DX*</th>
<th>Diagnosis Name</th>
<th>Amelia Flores</th>
<th>Kiosco</th>
<th>Red Bird</th>
<th>Woodrow/Long</th>
<th>Spruce</th>
<th>West Dallas</th>
<th>North Oak Cliff</th>
<th>Eddie Johnson</th>
<th>Seagoville</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>034.0</td>
<td>Strep sore throat</td>
<td>27</td>
<td>13</td>
<td>63</td>
<td>33</td>
<td>19</td>
<td>34</td>
<td>31</td>
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<td>239</td>
<td>2.8</td>
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<tr>
<td>079.99</td>
<td>Viral infection nos</td>
<td>19</td>
<td>20</td>
<td>7</td>
<td>5</td>
<td>15</td>
<td>38</td>
<td>81</td>
<td>1</td>
<td>27</td>
<td>213</td>
<td>2.5</td>
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<td>27</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>85</td>
<td>17</td>
<td>39</td>
<td>16</td>
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<tr>
<td>244.9</td>
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<td>0</td>
<td>2</td>
<td>1</td>
<td>14</td>
<td>10</td>
<td>24</td>
<td>0</td>
<td>28</td>
<td>80</td>
<td>1.0</td>
</tr>
<tr>
<td>250.00</td>
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<td>0</td>
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<td>1</td>
<td>28</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>40</td>
<td>79</td>
<td>0.9</td>
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<tr>
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<td>Hyperlipidemia nec/nos</td>
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<td>0</td>
<td>0</td>
<td>17</td>
<td>28</td>
<td>13</td>
<td>12</td>
<td>0</td>
<td>56</td>
<td>131</td>
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<td>0</td>
<td>5</td>
<td>16</td>
<td>0</td>
<td>1</td>
<td>15</td>
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<tr>
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<td>18</td>
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<td>31</td>
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<td>5</td>
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<td>3</td>
<td>3</td>
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<td>0</td>
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<td>3</td>
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<td>27</td>
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<td>94</td>
<td>63</td>
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<td>55</td>
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<td>187</td>
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<td>16</td>
<td>13</td>
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</table>

Table continues
Table 21 continued

<table>
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<tr>
<th>DX*</th>
<th>Diagnosis Name</th>
<th>Amelia Flores</th>
<th>Kiosco</th>
<th>Red Bird</th>
<th>Woodrow/Long</th>
<th>Spruce</th>
<th>West Dallas</th>
<th>North Oak Cliff</th>
<th>Eddie Bernice Johnson</th>
<th>Seagoville</th>
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<th>%</th>
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<td>3</td>
<td>3</td>
<td>8</td>
<td>17</td>
<td>9</td>
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<td>15</td>
<td>10</td>
<td>34</td>
<td>7</td>
<td>13</td>
<td>2</td>
<td>8</td>
<td>14</td>
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<td>8</td>
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<td>30</td>
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<tr>
<td>729.5</td>
<td>Pain in limb</td>
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<td>0</td>
<td>1</td>
<td>33</td>
<td>102</td>
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<tr>
<td>782.1</td>
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<td>14</td>
<td>9</td>
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<td>28</td>
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<td>5</td>
<td>7</td>
<td>17</td>
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<td>3</td>
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<td>1,358</td>
<td>500</td>
<td>869</td>
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<td>512</td>
<td>357</td>
<td>1,445</td>
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</tbody>
</table>

*DX=diagnosis
Table 22 displays the most frequent supplementary classification of factors influencing health status and contact with health services. These codes are not procedure codes. Rather, they deal with encounter of circumstances other than a disease or injury. There are four primary circumstances for the use of V codes:

1. A person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health-related issues.

2. A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care, encounters the health care system for specific aftercare of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change). A diagnosis/symptom code should be used whenever a current or acute, diagnosis is being treated or a sign or symptom is being studied.

3. Circumstances or problems influence a person’s health status but are not in themselves a current illness or injury.

4. Newborns, to indicate birth status.

Table 22 shows that the majority of V code diagnoses were for immunizations and vaccines (31.8%). The centers provided 3,433 immunizations in 2005-2006. Red Bird (19.17%) and Amelia Flores (16.20%) were the two centers where the most immunizations were provided. The high number of vaccine diagnosis codes is because Parkland Health and Hospital System maintained a weekly immunization clinic at the centers every Thursday. Any school-aged student could attend the clinics; however, children younger than school age also received free immunizations during this time. Other prevalent V codes used included medical examinations for administrative purposes (20.3%) and routine child health examinations (12.2%). This is a positive indication that clients are using the health centers as their location for receiving primary care services. This has the potential of relieving the local emergency rooms of unnecessary visits.

The centers also provided 1,830 contraceptive visits. The centers providing the most services were West Dallas (19.5%), Woodrow/Long (19.1%), Red Bird (18.7%), and Eddie Bernice Johnson (14.2%). The centers also provided 1,497 V codes services that related specifically to well-woman health. These V code services included gynecological exams, pregnancy exams, laboratory examinations, and screenings for venereal diseases and screenings for malignant neoplasm of the cervix (pap screening). The West Dallas Center
(22.7%) and Red Bird Center (17%) provided most of these services. These centers also accounted for a disproportionate number of screenings for venereal diseases. Red Bird accounted for 255 well-woman health V codes and 56.5% of them were for screenings of venereal diseases. Eddie Bernice Johnson had 141 V codes recorded, placing this center at fourth for all centers, but 68.9% of these V codes were for screenings of venereal disease. Again, the high numbers of screenings in these centers indicate the need for specific educational programs directed at women. Based on the center location of these screenings, these educational programs should be directed towards women of color. Untreated venereal disease can lead to future sterility and in late stages can negatively affect behavioral health. Because there is increase incident of HIV/AIDS in the black and Hispanic communities, providing such services can have a significant effect.

The preceding analysis was only cursory because of the lack of demographic information provided with these data. Because the data did not include demographic information, through the analysis, it could not be determined whether the persons presenting for the screenings were students or parents. However, behaviors in parents can be manifested in the behaviors of their children; therefore, regardless of which group is presenting for these screenings, educational programs can still provide a positive benefit. In addition, because V codes are typically recorded as a supplement to an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code, and the data provided were so limited, the analysis did not have the granularity required to determine which specific venereal diseases were being screened.
### Table 22

Supplementary Classification of Factors Influencing Health Status and Contact with Health Services

<table>
<thead>
<tr>
<th>DX Diagnosis Name</th>
<th>Amelia Flores</th>
<th>Kiosco</th>
<th>Red Bird Long Spruce</th>
<th>West Dallas</th>
<th>North Oak Cliff</th>
<th>Eddie Bernice Johnson</th>
<th>Seagoville</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>V03.2 Vaccin for tuberculosis</td>
<td>35</td>
<td>11</td>
<td>8</td>
<td>8</td>
<td>23</td>
<td>30</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>V04.0 Vaccin for poliomyelitis</td>
<td>21</td>
<td>25</td>
<td>55</td>
<td>19</td>
<td>26</td>
<td>14</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>V04.81 Influenza</td>
<td>112</td>
<td>98</td>
<td>25</td>
<td>104</td>
<td>21</td>
<td>65</td>
<td>43</td>
<td>10</td>
</tr>
<tr>
<td>V05.3 Need prphyl vc vrl hepat</td>
<td>139</td>
<td>157</td>
<td>193</td>
<td>139</td>
<td>155</td>
<td>51</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>V05.4 Need prphyl vc varicella</td>
<td>33</td>
<td>6</td>
<td>42</td>
<td>20</td>
<td>16</td>
<td>11</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>V06.4 Vac-measle-mumps-rubella</td>
<td>30</td>
<td>18</td>
<td>55</td>
<td>22</td>
<td>34</td>
<td>17</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>V06.5 Nd vac tetanus-diphthria</td>
<td>113</td>
<td>65</td>
<td>168</td>
<td>82</td>
<td>109</td>
<td>39</td>
<td>42</td>
<td>4</td>
</tr>
<tr>
<td>V06.9 Vac-dis combinations nos</td>
<td>73</td>
<td>22</td>
<td>112</td>
<td>42</td>
<td>80</td>
<td>49</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>V15.89 Hx-health hazards nec*</td>
<td>24</td>
<td>10</td>
<td>62</td>
<td>69</td>
<td>1</td>
<td>86</td>
<td>45</td>
<td>26</td>
</tr>
<tr>
<td>V20.2 Routin child health exam</td>
<td>156</td>
<td>160</td>
<td>167</td>
<td>190</td>
<td>133</td>
<td>201</td>
<td>114</td>
<td>38</td>
</tr>
<tr>
<td>V20.4 Prescrip-oral contracept</td>
<td>40</td>
<td>6</td>
<td>18</td>
<td>41</td>
<td>0</td>
<td>13</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td>V20.5 Initiate contracept nec</td>
<td>8</td>
<td>14</td>
<td>17</td>
<td>19</td>
<td>0</td>
<td>9</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>V20.6 Contraceptive mangmt nec</td>
<td>1</td>
<td>124</td>
<td>48</td>
<td>197</td>
<td>1</td>
<td>73</td>
<td>3</td>
<td>70</td>
</tr>
<tr>
<td>V20.7 Contracept surveil nos</td>
<td>22</td>
<td>26</td>
<td>32</td>
<td>0</td>
<td>5</td>
<td>114</td>
<td>27</td>
<td>17</td>
</tr>
<tr>
<td>V20.8 Contracept pill surveil</td>
<td>33</td>
<td>15</td>
<td>35</td>
<td>43</td>
<td>18</td>
<td>42</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td>V20.9 Contracept surveil nec</td>
<td>23</td>
<td>1</td>
<td>192</td>
<td>50</td>
<td>36</td>
<td>106</td>
<td>0</td>
<td>101</td>
</tr>
<tr>
<td>V64.1 Counseling nos</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>175</td>
<td>5</td>
<td>24</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>V64.2 Follow-up exam nec</td>
<td>0</td>
<td>15</td>
<td>140</td>
<td>55</td>
<td>2</td>
<td>39</td>
<td>70</td>
<td>18</td>
</tr>
<tr>
<td>V64.3 Routine medical exam</td>
<td>13</td>
<td>0</td>
<td>5</td>
<td>9</td>
<td>112</td>
<td>79</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>V64.4 Screen for venerael dis</td>
<td>37</td>
<td>6</td>
<td>144</td>
<td>34</td>
<td>116</td>
<td>131</td>
<td>0</td>
<td>111</td>
</tr>
<tr>
<td>V64.5 Screen mal neop-cervix</td>
<td>18</td>
<td>24</td>
<td>33</td>
<td>8</td>
<td>89</td>
<td>44</td>
<td>28</td>
<td>45</td>
</tr>
<tr>
<td>V64.6 Total</td>
<td>1,300</td>
<td>997</td>
<td>2,169</td>
<td>1,608</td>
<td>1,269</td>
<td>1,675</td>
<td>958</td>
<td>632</td>
</tr>
</tbody>
</table>

*HX-History
Billing

The Youth and Family Centers began billing as a behavioral health Medicaid provider during the 2003-2004 school year. The first full year of billing was 2004-2005.

The administrator for the Youth and Family Center behavioral health claims is ValueOptions. ValueOptions is licensed as a Behavioral Health Organization (BHO) which operates in the same manner that a Health Maintenance Organization (HMO) operates. The physical health plan offered by ValueOptions is called STAR. This is one of several Medicaid programs supported by Parkland Health and Hospital System for physical health services provided at the Youth and Family Centers. NorthStar is the behavioral health and substance abuse program. This program is implemented by ValueOptions in a seven-county area across North Texas.

Over the first year of billing and well into 2005-2006, billing services in the Youth and Family Centers program were disjointed. Each center manager was given the responsibility of billing for the services provided at his/her respective center. Although the managers were responsible for billing, they were not included in the complete process. Traditionally, after a medical service is rendered by a provider, a claim is submitted to the patient's primary insurance company, in this instance, the NorthStar Program. The patient, in this case, the Youth and Family Center, is sent an Explanation of Benefits (EOB) by the insurance company four to six weeks after the claim is filed. The EOB indicates the services that were billed, amount billed, amount paid, any portion the patient still owes, the services denied, and the reason for denial. However, in the case of the Youth and Family Centers, the EOBs from ValueOptions were not delivered to the center manager, who originally filed the claims; instead they were delivered to a consultant who served as a liaison between the Youth and Family Centers and ValueOptions. This consultant was responsible for and attempted to correct and resubmit denied claims. However, because many of the claims had incorrect coding, such as transposed numbers in a procedure or diagnosis code, which would require referencing the medical record to make the appropriate correction, many of the claims were not corrected. Thus, in many instances rejected claims that could have been corrected with a resubmission were not resubmitted. Eventually in
2005-2006, the responsibility of settling rejected claims was transferred to the center managers. In order to support this change, the program established standardized procedures for handling all claims (Refer to Appendices A-E). However, despite these changes, the problem persisted. Now that responsibilities had been transferred to the center manager, the problem was time. The majority of the center managers indicated that they did not have the time to follow up on every claim rejected. Despite the concerns voiced by the center managers, billing and claim corrections remained the responsibility of the center managers throughout the 2005-2006 year.

In order to reduce the likelihood that a claim would be rejected by ValueOptions, certain steps were required to be followed for each client seeking services. Every client who presented to the Youth and Family Centers for behavioral health services was required to provide insurance information to the center at the time of the referral. If the information was not provided at the time of referral, the Youth and Family Center manager or designee was responsible for contacting the family prior to the intake appointment and obtaining third-party (insurance) information. If the family did not have insurance coverage for behavioral health services, a designated center staff member informed the parent about NorthStar and requested that the parent bring proof of address, as well as the last two paycheck stubs in order to complete a NorthStar application. Once all information was gathered the staff member, along with the parent, completed the NorthStar Financial Eligibility Application and faxed it, along with all supporting documentation, to ValueOptions.

During both years observed, the NorthStar Program was available to those clients who did not have health insurance and to clients who had private insurance but either did not have behavioral health coverage or had limited behavioral health coverage. Twenty-four hours after sending the information the client was provided with a NorthStar client identification number.

In addition to the steps required to place a client on the ValueOptions subscriber list, steps were also necessary to keep the client on the list and ascertain that the claims submitted were reimbursed. In order to receive reimbursement for treatment, clients could only receive treatments approved by ValueOptions and these services had to be provided by a licensed clinician. A licensed clinician could include a psychiatrist, psychologist, or a counselor licensed
by the state. In addition to receiving services from a licensed professional, each client had to have a treatment authorization on file with ValueOptions. These treatment authorizations had to be validated every three months. Clients who only received pharmacological management services were not required to have a treatment authorization on file.

In order to bill for services, information related to the services provided had to be entered into the database maintained by the Youth and Family Centers. The information required included the client’s NorthStar number, a diagnosis code, a procedure code, the date service was provided, and the providing clinician’s name and license number. Billable diagnoses did not include ‘deferred’ or V codes. Because these pieces of data are required for each claim submitted for reimbursement, missing data would create a significant problem in regards to billing. As indicated earlier, 20.7% of all behavioral health records did not have a diagnosis code, and 5.7% of all records did not have a procedural code.

Claims that had the required information were submitted electronically via the Worldwide Web. The NorthStar Program did not maintain aged claims systems as some health insurance programs do. Instead, if a claim was entered into the system on Monday, a check, along with its respective EOB, was mailed to the Youth and Family Centers’ administration either on Tuesday or Friday.

As a federal requirement, those individuals who did not qualify for the NorthStar Program were required to pay a fee for services received from the centers. To maintain compliance, the Youth and Family Centers program established a fee schedule based on the federal government’s sliding scale used for Medicaid and Medicare. The fees were to be charged to the family once per month regardless of the number of services received by the family during that month or the number of clients in a family using the Youth and Family Centers. Monthly fees were determined by the family’s gross income and the number of individuals in the home. Those clients who were charged the fee included families who had private insurance, but were not filing on their insurance; those who had no insurance and chose not to apply for the NorthStar Program; and those who did not qualify for the NorthStar Program. The Youth and Family
Centers’ staff members were required to inform the client that even though a monthly fee was assessed, if they could not pay the fee, services would not be denied.

As indicated, the monthly fee assessed remained the same regardless of the number of services provided to the family. Therefore, if a family’s fee was $19.00, that family would pay $19.00 each month regardless of the services they received. As shown in Table 23, after $40,000 of yearly gross income, the monthly fee was increased by $2.00 for every $5,000 above the $40,000 of yearly gross income. Thus, if a family of four earned $50,000 annually they would be charged $25.00 a month for services. This includes the base fee of $21.00 plus $2.00 for each $5,000 above the $40,000 of yearly gross income. As indicated earlier, the monthly fees established by the Youth and Family Centers are based on those used by the Center for Medicaid and Medicare Services (CMS). These fees do not exceed those of patients receiving services from other facilities reimbursed by CMS in the Dallas-Forth Worth metroplex. Thus, although the clients are required to pay out-of-pocket, the way the sliding scale is formulated they would never have to pay fees that were equivalent to those being paid by patients in the private sector.

Those clients who were not eligible for the NorthStar Program were referred to a financial counselor in each center, prior to being placed on the fee schedule, to determine whether they were eligible for the State Children’s Health Insurance Program (SCHIP). SCHIP is a federal- and state-funded program that offers health insurance to children, up to age 19, who do not qualify for Medicaid and are not covered by private health insurance. SCHIP is a state-administered program, and each state sets its own guidelines regarding eligibility and services. Because of the high number of uninsured clients who seek services at the Youth and Family Centers, the program planned to host enrollment clinics during 2006-2007.

Although the sliding scale fee was established in order to meet federal requirements, the program has not been used. According to the billing manager, no fees were collected in 2005-2006, and no bills were submitted to clients. This appears to be a violation of the federal requirements. As stated in *Medicaid and School Health: A Technical Assistance Guide* (August 1997), Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. “Free care,” or services provided without charge, are services for
which there is no beneficiary liability and for which there is no Medicaid liability. Providers of
Medicaid services must have the authority to charge for their services and utilize this authority,
before Medicaid will make payment. If only Medicaid recipients or their third parties are charged
for the service, the care is free and Medicaid will not reimburse for the service. In the case of
schools, the Centers for Medicare and Medicaid Services (formerly the Health Care Financing
Administration) have stated that the “free care” policy would not prevent payment for
Medicaid-covered services to a school-based health center if the school-based health center:

1) establishes a sliding scale fee schedule for services
2) determines whether every student served has any third-party coverage other
   than Medicaid, and
3) bills the student (the student’s insurer, if any) for the cost of services.

Based on these guidelines, although the Youth and Family Centers have established a
sliding fee scale, the fact they are not using it places them in non-compliance.
<table>
<thead>
<tr>
<th>Persons in Family or Household</th>
<th>Yearly Gross Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$9,800 $13,200 $16,600 $20,000 $23,400 $30,200 $31,000 $33,600-40,000</td>
</tr>
<tr>
<td>1</td>
<td>0 $15.00 $17.00 $19.00 $21.00 $22.00 $24.00 $26.00</td>
</tr>
<tr>
<td>2</td>
<td>0 0 $15.00 $17.00 $19.00 $21.00 $22.00 $24.00</td>
</tr>
<tr>
<td>3</td>
<td>0 0 0 $15.00 $17.00 $19.00 $21.00 $22.00</td>
</tr>
<tr>
<td>4</td>
<td>0 0 0 0 0 $15.00 $17.00 $19.00</td>
</tr>
<tr>
<td>5</td>
<td>0 0 0 0 0 0 $15.00 $17.00 $19.00</td>
</tr>
<tr>
<td>6</td>
<td>0 0 0 0 0 0 0 $15.00 $17.00</td>
</tr>
<tr>
<td>7</td>
<td>0 0 0 0 0 0 0 $15.00</td>
</tr>
<tr>
<td>8+</td>
<td>0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>

For every $5,000 increment in salary, the fee is raised by $2.00

$21.00 would be charged to this family

$25.00 would be charged to this family
All licensed clinicians who worked full time for the Youth and Family Centers and received their salaries from general operating funds had the services they provided billed to ValueOptions. Billable clinicians were defined as behavioral health professionals who have earned licenses as professional counselors, clinical social workers, psychologists, marriage and family therapists, and specialists in school psychology. Credentialing data were kept at the central office and each center where the clinician provided services. Center managers collected the documentation of licensure when establishing their provider staffing levels each year. Center managers and supervisors reviewed established provider lists monthly in order to ensure the continuation of appropriate credentialing and renewal requirements. For 2005-2006, the Youth and Family Centers program employed eight licensed professional counselors, two licensed social workers, one licensed family therapist, and two specialists in school psychology. The program also employed three psychologists and six psychiatrists on staff.

Table 24 shows the reimbursable rates for behavioral health services provided by the Youth and Family Centers. As shown, clinicians possessing the designation of doctor of medicine and doctor of osteopathic medicine (psychiatrists) received the largest reimbursement for billable services. Licensed psychologists, holding a doctoral degree, received the second largest amount for reimbursement. Those holding master-level licensure received the least. Master-level licensed staff included licensed professional counselors (LPC), licensed master social worker-advanced clinical providers (LMSW-ACP), licensed specialists in school psychology (LSSP), and licensed marriage family therapists (LMFT). The maximum reimbursable amount for all procedures was $88.55. This was the reimbursable amount for psychiatric examinations and interactive psychiatric diagnostic interview examinations billed by the psychiatrist. Group therapies received the smallest level of reimbursement regardless of the licensure of the clinician.
Table 24
ValueOptions: NorthStar, Billing Rates

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Service Description</th>
<th>MD/DO</th>
<th>Licensed Psychologist Doctoral Level</th>
<th>Licensed Master’s Level: LPC, LMSW-ACP, LSSP, LMFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>Psychiatric diagnostic interview examination</td>
<td>$88.55</td>
<td>$71.00</td>
<td>$54.00</td>
</tr>
<tr>
<td>90802</td>
<td>Interactive psychiatric diagnostic interview examination</td>
<td>$88.55</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>90804</td>
<td>Individual psychotherapy, insight oriented, behavioral modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient</td>
<td>$41.19</td>
<td>$38.24</td>
<td>$33.00</td>
</tr>
<tr>
<td>90805</td>
<td>Individual psychotherapy, insight oriented, behavioral modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient with medical evaluation and management services</td>
<td>$46.00</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>90806</td>
<td>Individual psychotherapy, insight oriented, behavioral modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient</td>
<td>$64.10</td>
<td>$60.00</td>
<td>$54.00</td>
</tr>
<tr>
<td>90807</td>
<td>Individual psychotherapy, insight oriented, behavioral modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient with medical evaluation and management services.</td>
<td>$69.00</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present)</td>
<td>$63.00</td>
<td>$60.00</td>
<td>$54.00</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy with patient)</td>
<td>$63.00</td>
<td>$60.00</td>
<td>$54.00</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
<td>$19.00</td>
<td>$18.05</td>
<td>$18.05</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than a multiple-family group)</td>
<td>$19.64</td>
<td>$19.64</td>
<td>$19.64</td>
</tr>
<tr>
<td>90857</td>
<td>Interactive group psychotherapy</td>
<td>$19.64</td>
<td>$19.64</td>
<td>$19.64</td>
</tr>
<tr>
<td>90862</td>
<td>Pharmacological management, including prescription, use, and review of medication with no more than minimal medical</td>
<td>$40.25</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>96100</td>
<td>Psychological testing (includes psycho diagnostic assessment of personally, psychopathology, emotionality, intellectual abilities, E.g. WAIS-R Rorvach. MMPI) with interpretation and report.</td>
<td>N/A</td>
<td>$53.00</td>
<td>$53.00</td>
</tr>
<tr>
<td>96117</td>
<td>Neuropsychological Testing (60 minutes, includes interpretation or report).</td>
<td>N/A</td>
<td>$53.00</td>
<td>N/A</td>
</tr>
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</table>
As indicated earlier, Medicaid billing for behavioral health services began in 2003-2004. However, the first full year revenue was documented was 2004-2005. Table 25 and Figure 1 show the revenue collected from reimbursement by month. Also as indicated earlier, only those clinicians with salaries which were paid from general operating funds and who had appropriate licensure had claims submitted to ValueOptions for services rendered to NorthStar-eligible clients. Revenue collected from NorthStar for 2004-2005 totaled $37,755.43. Most monies received were in the months of October and April. August and June, which were the beginning and ending points of the Youth and Family Centers program year, had no receipts. The centers did not collect counts of the number of units billed or the number of units denied. Therefore, further analysis is not possible.

Table 25
2004-2005 Youth and Family Centers Revenue

<table>
<thead>
<tr>
<th>Month</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>August</td>
<td>-</td>
</tr>
<tr>
<td>September</td>
<td>347.70</td>
</tr>
<tr>
<td>October</td>
<td>6,209.53</td>
</tr>
<tr>
<td>November</td>
<td>2,682.15</td>
</tr>
<tr>
<td>December</td>
<td>5,390.90</td>
</tr>
<tr>
<td>January</td>
<td>2,500.80</td>
</tr>
<tr>
<td>February</td>
<td>5,058.75</td>
</tr>
<tr>
<td>March</td>
<td>234.05</td>
</tr>
<tr>
<td>April</td>
<td>6,090.85</td>
</tr>
<tr>
<td>May</td>
<td>4,536.05</td>
</tr>
<tr>
<td>June</td>
<td>4,704.65</td>
</tr>
<tr>
<td>Total</td>
<td>$37,755.43</td>
</tr>
</tbody>
</table>
Table 26 and Figure 2 show the revenue collected from reimbursement by month for 2005-2006. This year, the majority of revenue was collected in March ($30,321.85) and May ($37,136.07). September was the slowest month with only $54 in receipts.

<table>
<thead>
<tr>
<th>Month</th>
<th>Revenue ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>August</td>
<td>427.55</td>
</tr>
<tr>
<td>September</td>
<td>54.00</td>
</tr>
<tr>
<td>October</td>
<td>7,658.49</td>
</tr>
<tr>
<td>November</td>
<td>495.10</td>
</tr>
<tr>
<td>December</td>
<td>1,767.95</td>
</tr>
<tr>
<td>January</td>
<td>3,686.00</td>
</tr>
<tr>
<td>February</td>
<td>17,877.60</td>
</tr>
<tr>
<td>March</td>
<td>30,320.85</td>
</tr>
<tr>
<td>April</td>
<td>3,588.45</td>
</tr>
<tr>
<td>May</td>
<td>37,136.07</td>
</tr>
<tr>
<td>June</td>
<td>3,931.65</td>
</tr>
<tr>
<td>Total</td>
<td>106,943.71</td>
</tr>
</tbody>
</table>
Receipts received from the NorthStar Program are placed in a 497 district account. These funds were used to replenish procurement cards, which were used to purchase supplies for the Youth and Family Centers with administrator approval. In 2005-2006, a portion of these monies was used to send several center managers to the 18th Annual Crimes Against Children Conference held in Dallas in August 2006.

Summary

The Youth and Family Centers began billing as a Medicaid provider in 2003-2004. However, the first full year of billing did not occur until 2004-2005. The administration of the Medicaid behavioral health program is ValueOptions, which provides service to seven counties across North Texas. During the first year, the billing process was disjointed. While center managers were responsible for billing for services, they did not receive the EOBs directly. Thus, many claims that could have been reimbursed if resubmitted were not resubmitted. In 2005-2006, the responsibilities of correcting claims were transferred to the center managers but this change also had problems because the center managers found it difficult to correct every claim submitted due to time constraints. Despite these obstacles to billing, the Youth and Family
Centers collected $37,755 in 2004-2005 and $106,943 in 2005-2006. The majority of these monies were used to buy supplies for the centers. However, in 2005-2006, a portion of the monies was used to send several center managers to the Crimes Against Children Conference, which was held in Dallas.

For those clients who did not qualify for the NorthStar Program offered by ValueOptions, the Youth and Family Centers created a sliding scale fee system based on that used by the federal government. This fee was to be paid by each family regardless of the number of services or the number of family members seeking services that month. However, despite this system the fees were not collected from any of the clients.

Diagnoses for services provided to Youth and Family Center clients have not been received or requested from Parkland COPC since 2002-2003. The change came about due to decision made by the former COPC administrator. This year, 2005-2006 data were requested and received by the evaluator. These data were needlessly stripped of demographic identifying data. Analysis showed that the leading diagnoses received by the COPC staff were for two main systems, respiratory and uro-genital tract. Analysis of the V codes used indicated that clients were using the centers as their primary care provider, receiving services such as immunizations, routine medical, and child health examinations. The centers also used a significant number of V codes associated with well-woman visits. Analysis of these codes showed that the West Dallas and Red Bird Centers provided the most of these services. These centers also accounted for a disproportionate number of screenings for venereal diseases. Red Bird (56.5%) and Eddie Bernice Johnson (68.9%) had the greatest proportion of well-woman V codes associated with venereal screenings.
2.6 What were the administrator, parent, teacher, and student perceptions of the services provided by the Youth and Family Centers?

Methodology

Administrator, parent, teacher, and student perceptions of center services were gleaned from respective surveys for each group. All surveys were administered during the spring semester for both 2004-2005 and 2005-2006.

Results

Districtwide Administrator Satisfaction Survey

In 2004-2005, a team of evaluators from Research and Evaluation developed the Districtwide Administrator Satisfaction Survey. Evaluators participated if their evaluation plans called for a survey of campus administrators. Meetings were held throughout the fall. A series of draft copies were produced and edited, and the survey was finalized in December 2004. The surveys were administered via the Office of Institutional Research website. Administrators were notified of the existence of the survey and were requested to complete the sections of the survey that pertained to their particular sites. Deadlines were set for completion. However, if a particular administrator did not complete the survey by the requested date a follow up phone call was made requesting that they complete the survey by another specified date. Questions specific to the Youth and Family Centers were answered by most of the administrators within the district.

For the 2005-2006 year, the electronic version was discontinued; rather, surveys were sent to principals of the schools in the feeder patterns of the Youth and Family Centers. Thus, the sample size for the 2005-2006 administration was much smaller than in 2004-2005. In addition, because the sample used in 2005-2006 was different from that for 2004-2005 (all responders were in the feeder pattern of the Youth and Family Centers) no comparisons were made between the results of the two surveys. For that reason, results appear in two separate tables. Tables 27 and 28 show results from both principal surveys. The 2004-2005 survey contained three questions. The number of questions was increased to five in 2005-2006.

In 2004-2005, the responses to the Youth and Family Center questions included on the Districtwide Administrator Satisfaction Survey were positive, but not overly positive. Most administrators agreed (56.3%) that they had adequate understanding of the services provided
and how to use the referral system to obtain services at the centers. Responders indicated (81.2%) that their teachers, staff, students, and families were aware of services provided through the centers. In addition, in 2004-2005, more than three quarters of the principals (90.7%) agreed or strongly agreed that the centers provided quality services. It should be noted that for two of the three questions, between 14.8% and 37.7% of the administrators answered “don't know.” The sizable percentage of uncertain responses indicate that administrators need additional feedback, communication, and education about what services are provided by the centers and information on how to navigate the referral process.

In 2005-2006, 300 district administrator surveys were delivered to the Youth and Family Centers; however, only 10% of these surveys were completed by the principals. Most of those who completed the surveys were principals at schools that used the Youth and Family Centers’ services frequently. Thus, it was expected that their responses would be overwhelmingly positive. As expected, the responses for the 2005-2006 survey were overly positive. The results indicated that those principals whose students use the centers most frequently overwhelmingly agreed (98.9%) that they have received adequate information to understand the services being provided by the Youth and Family Centers. They also believed that the staff members in their respective schools (98.8%) were fully aware of the services being provided by the Youth and Family Centers and believed that the centers provide quality services (96.5%). Although these results are extremely positive these results should be reviewed with some caution because unlike the survey in the prior year, which was administered to every principal in the district, this survey was only administered to those principals who were in one of the feeder patterns for the Youth and Family Centers. The administration of this survey was not a random sample, but a convenience sample.

Both surveys included sections in which administrators could provide comments and/or recommendations. While the majority of the comments were very positive in 2004-2005, the most frequent recommendations included:

- Would like information surrounding the referral process, roles of Youth and Family Center staff, the school, and the parent.
• Would like to see a system developed that could speed up the referral process.

• Would like information on the category of student behaviors that warrant the attention of the Youth and Family Centers.

• Would like more in depth family background information and like to know the progress being made by the student.

Responses for the 2005-2006 survey differed only slightly from the 2004-2005. As in 2004-2005, the vast majority of comments for 2005-2006 were positive. The most frequent suggestions offered included:

• Youth and Family Centers could improve services by collaborating with principals in regards to services provided to students.

• Let school contact persons know the date and appointment times for students and families so school personnel can follow-up with parents.

• Have a meeting at the beginning of each new school year to address referral procedures.

• Create a brochure listing services offered and contact information or website with links provided. In addition, generate and transmit a reminder email of the link to all counselors at the start of the school year.

Table 27
Districtwide Administrator Satisfaction Survey Results, 2004-2005

<table>
<thead>
<tr>
<th>Questions</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>% Neutral/Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have received adequate information to understand the services provided by and referral procedures for, the Youth and Family Centers.</td>
<td>56.3</td>
<td>6.0</td>
<td>37.7</td>
</tr>
<tr>
<td>Teachers, nurses, counselors, community liaisons and other non-teaching staff are aware of the services provided by the Youth and Family Centers.</td>
<td>81.2</td>
<td>4.0</td>
<td>14.8</td>
</tr>
<tr>
<td>The Youth and Family Center staff provides quality services to students at my school and their families.</td>
<td>90.7</td>
<td>4.7</td>
<td>4.7</td>
</tr>
</tbody>
</table>
Table 28
District Administrator Satisfaction Survey Results, 2005-2006

<table>
<thead>
<tr>
<th>Questions</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>% Neutral/ Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have received adequate information to understand the services provided by and referral procedures for, the Youth and Family Centers.</td>
<td>98.9</td>
<td>0.0</td>
<td>1.1</td>
</tr>
<tr>
<td>The student support team (SST) and Youth Action Officer are aware of the services provided by the Youth and Family Centers.</td>
<td>98.8</td>
<td>0.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Teachers, nurses, counselors, community liaisons and other non-teaching staff are aware of the services provided by the Youth and Family Centers.</td>
<td>100.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>The Youth and Family Center staff provides quality services to students at my school and their families.</td>
<td>96.5</td>
<td>0.0</td>
<td>3.4</td>
</tr>
<tr>
<td>The Youth and Family Centers have a positive reputation in my feeder pattern.</td>
<td>92.9</td>
<td>1.2</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Parent Satisfaction Survey

During the spring of 2004-2005, surveys (in English and Spanish) were delivered to each of the Youth and Family Centers to be administered to parents who presented to the centers with their children. The same method was used for the administration of surveys in 2005-2006. The Parent Satisfaction Survey was completed by parents, guardians, or other family members to assess families’ satisfaction with services received, staff members who worked with them, and the progress of their child and family since coming to the center. In both years, the surveys were administered at the center in order to maximize response rates. Table 29 reflects the results of the Parent Satisfaction Survey for both years.

In 2004-2005, 220 surveys were completed and returned. In 2005-2006, the number of completed surveys nearly tripled to 619 completed surveys. Overall results were very positive for the majority of questions included on the Parent Satisfaction Survey in both years. In 2004-2005, families were very satisfied with the amount of time the staff spent with them (99%), found the staff very helpful (99.6%), and were satisfied with the services provided (99.3%). The results for 2005-2006 were not much different, falling by an insignificant amount to 94.2%, 98.2%, and 95.5%, respectively. Additionally, over two-thirds of the families (97%) in 2004-2005 indicated
that they were always involved in the child’s evaluation and follow-up, compared to 91.3% in 2005-2006, an insignificant decrease of 5.7 percentage points.

In 2004-2005, 85.5% of respondents indicated that they had noticed improvement in their child’s schoolwork since coming to the Youth and Family Center, but 10.5% indicated they did not know if their child had shown any improvement. In 2005-2006, the responses to the same question showed that only 69.9% of guardians believed that they had noticed improvement in their child’s schoolwork, a decline of 16.5 percentage points. Another 30.2% either had not noticed any improvement or did not know whether they had noticed any improvements; this was an increase of 15.7 percentage points. To the question of whether they were satisfied with their child’s or family’s progress, there was no real change from the responses for 2004-2005. Overall in 2004-2005, 92.5% were satisfied with the progress made by their child/or family; however, one percent indicated that they were very unsatisfied. In 2005-2006, 93% of respondents indicated that they were satisfied with the student’s or family’s progress, a change from the prior year of half a percentage point. In 2005-2006, only one person indicated that they were dissatisfied with the progress being made by student or family.

In 2004-2005, parents and guardians indicated that nothing interfered with families getting help at the centers for 87% of the respondents. Others reported transportation (64.7%), center location (5.9%), and language (8.8%) as barriers. In 2005-2006, 81.6% of respondents indicated that nothing interfered with their family getting services. The others reported that transportation (45.0%) center location (24.4%), and language problems (20.6%) were barriers to receiving services. While there was a 20 percentage point decline in the respondents that indicated that transportation was a factor, respondents who cited the center location as a barrier more than tripled from 5.9% to 24.4%. Also, the number indicating that language was a problem almost doubled from 8.8% to 20.6%. In 2004-2005, most families indicated that they would (94.8%) return to the center to receive services. In response to the same question in 2005-2006, 97.1% responded in the affirmative, an increase of 2.3 percentage points.

In regards to the center reflecting the respondents’ culture, 91.1%, in 2004-2005, indicated that it was very important that the center reflect their culture compared to 88.6% in
2005-2006. An overwhelming 90.8% believed that the center reflected their culture, which was very similar to the 2005-2006 response of 89.8%. Most notably, in 2004-2005, 90.3% of respondents believed that the provider, while assessing their health or their child’s health, had taken their culture and their cultural beliefs into consideration when delivering services. By 2005-2006, 94.9% of respondents indicated that this was true as well, an increase of 4.6 percentage points. Also notable is that while 9.7% of respondents in 2004-2005 indicated that they did not think their cultural beliefs and culture had been taken into account, by 2005-2006 only 4.9% indicated that this was true.

In 2005-2006 an additional question was added to the survey. This question asked whether respondents had health insurance. A little less than half of the respondents (48.4%) indicated that they had insurance. This contradicts data taken from the Youth and Family Center database. There are two reasons for this difference. First, responders were not necessarily parents of the client, but could have been any person accompanying the client to the center. And second, the question was not phrased in a way that could differentiate between private insurance (employer based) and public insurance (Medicaid or Medicare).

Table 29

Results of the Parent Satisfaction Survey

<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1. What is your relationship to the child?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>175</td>
<td>65.8</td>
<td>432</td>
</tr>
<tr>
<td>Father</td>
<td>43</td>
<td>16.2</td>
<td>96</td>
</tr>
<tr>
<td>Grandparent</td>
<td>36</td>
<td>13.5</td>
<td>64</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>4.5</td>
<td>37</td>
</tr>
<tr>
<td>2. What is your ethnicity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>6</td>
<td>2.1</td>
<td>6</td>
</tr>
<tr>
<td>Asian</td>
<td>8</td>
<td>2.9</td>
<td>2</td>
</tr>
<tr>
<td>African American</td>
<td>68</td>
<td>24.3</td>
<td>169</td>
</tr>
<tr>
<td>Hispanic</td>
<td>180</td>
<td>64.3</td>
<td>398</td>
</tr>
<tr>
<td>Anglo</td>
<td>16</td>
<td>5.7</td>
<td>51</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.7</td>
<td>6</td>
</tr>
<tr>
<td>3. Why did you visit the YFC today?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shots/immunizations</td>
<td>9</td>
<td>3.7</td>
<td>66</td>
</tr>
<tr>
<td>Other physical health</td>
<td>50</td>
<td>20.8</td>
<td>255</td>
</tr>
<tr>
<td>Counseling</td>
<td>182</td>
<td>75.5</td>
<td>264</td>
</tr>
</tbody>
</table>

Table continues
<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>4. How satisfied were you with the amount of time the YFC staff spent with you and/or your child?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>200</td>
<td>70.2</td>
<td>379</td>
</tr>
<tr>
<td>Satisfied</td>
<td>82</td>
<td>28.8</td>
<td>204</td>
</tr>
<tr>
<td>Mixed</td>
<td>2</td>
<td>0.7</td>
<td>35</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
</tr>
<tr>
<td>5. Overall, how helpful was the YFC staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very helpful</td>
<td>203</td>
<td>75.2</td>
<td>420</td>
</tr>
<tr>
<td>Helpful</td>
<td>66</td>
<td>24.4</td>
<td>172</td>
</tr>
<tr>
<td>Mixed</td>
<td>1</td>
<td>0.4</td>
<td>6</td>
</tr>
<tr>
<td>Very unhelpful</td>
<td>0</td>
<td>0.0</td>
<td>5</td>
</tr>
<tr>
<td>6. Were you treated in a respectful manner?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>278</td>
<td>100.0</td>
<td>587</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0.0</td>
<td>7</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>0</td>
<td>0.0</td>
<td>29</td>
</tr>
<tr>
<td>7. Would you be willing to return to the YFC for services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>271</td>
<td>94.8</td>
<td>610</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>5.2</td>
<td>15</td>
</tr>
<tr>
<td>8. If your child received counseling services, were you involved in your child’s evaluation and follow-up?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>256</td>
<td>97.0</td>
<td>485</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>3.0</td>
<td>46</td>
</tr>
<tr>
<td>9. If the YFC had not been available, where would your family have gone for the services you received here?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No where</td>
<td>113</td>
<td>44.3</td>
<td>203</td>
</tr>
<tr>
<td>Doctor’s office</td>
<td>73</td>
<td>28.6</td>
<td>141</td>
</tr>
<tr>
<td>Emergency room</td>
<td>37</td>
<td>14.5</td>
<td>61</td>
</tr>
<tr>
<td>Other agencies</td>
<td>32</td>
<td>12.6</td>
<td>166</td>
</tr>
<tr>
<td>10. Overall, how satisfied were you with the YFC services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>216</td>
<td>75.8</td>
<td>408</td>
</tr>
<tr>
<td>Satisfied</td>
<td>67</td>
<td>23.5</td>
<td>176</td>
</tr>
<tr>
<td>Mixed</td>
<td>1</td>
<td>0.4</td>
<td>16</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>1</td>
<td>0.4</td>
<td>11</td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>11. Did anything interfere with your family getting services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35</td>
<td>13.0</td>
<td>111</td>
</tr>
<tr>
<td>No</td>
<td>235</td>
<td>87.0</td>
<td>491</td>
</tr>
</tbody>
</table>

Table continues
Table 29 continued

<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th></th>
<th>2005-2006</th>
<th></th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. If you answered “Yes” to question 9, what interfered?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Transportation</td>
<td>22</td>
<td>64.7</td>
<td>59</td>
<td>45.0</td>
<td>-19.7</td>
</tr>
<tr>
<td>Language problems</td>
<td>3</td>
<td>8.8</td>
<td>27</td>
<td>20.6</td>
<td>+11.8</td>
</tr>
<tr>
<td>Center location/schedule</td>
<td>2</td>
<td>5.9</td>
<td>32</td>
<td>24.4</td>
<td>+18.5</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>20.6</td>
<td>8</td>
<td>6.1</td>
<td>-14.5</td>
</tr>
<tr>
<td>13. How many times have you visited the Center this school year?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>First visit</td>
<td>27</td>
<td>10.1</td>
<td>102</td>
<td>16.8</td>
<td>+6.7</td>
</tr>
<tr>
<td>2-3 times</td>
<td>106</td>
<td>39.7</td>
<td>180</td>
<td>29.7</td>
<td>-10.0</td>
</tr>
<tr>
<td>4-5 times</td>
<td>41</td>
<td>15.4</td>
<td>98</td>
<td>16.2</td>
<td>+0.8</td>
</tr>
<tr>
<td>More than 5 times</td>
<td>93</td>
<td>34.8</td>
<td>226</td>
<td>37.3</td>
<td>+2.5</td>
</tr>
<tr>
<td>14. Have you visited the YFC in previous school years?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Yes</td>
<td>122</td>
<td>45.2</td>
<td>299</td>
<td>51.0</td>
<td>+5.8</td>
</tr>
<tr>
<td>No</td>
<td>148</td>
<td>54.8</td>
<td>290</td>
<td>49.0</td>
<td>-5.8</td>
</tr>
<tr>
<td>15. Have you noticed improvement in your child’s schoolwork since coming to the YFC?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Yes</td>
<td>236</td>
<td>85.5</td>
<td>378</td>
<td>69.9</td>
<td>-16.5</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>4.0</td>
<td>45</td>
<td>8.3</td>
<td>+4.3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>29</td>
<td>10.5</td>
<td>118</td>
<td>21.9</td>
<td>+11.4</td>
</tr>
<tr>
<td>16. Overall, how satisfied are you with the progress made by your child/family?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>174</td>
<td>62.6</td>
<td>288</td>
<td>54.3</td>
<td>-8.3</td>
</tr>
<tr>
<td>Satisfied</td>
<td>83</td>
<td>29.9</td>
<td>205</td>
<td>38.7</td>
<td>+8.8</td>
</tr>
<tr>
<td>Mixed</td>
<td>18</td>
<td>6.5</td>
<td>36</td>
<td>6.8</td>
<td>+0.3</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>3</td>
<td>1.1</td>
<td>1</td>
<td>0.2</td>
<td>+0.9</td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>17. How important is it that the center reflects your culture?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Very Important</td>
<td>196</td>
<td>72.3</td>
<td>365</td>
<td>66.0</td>
<td>-6.3</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>51</td>
<td>18.8</td>
<td>125</td>
<td>22.6</td>
<td>+3.8</td>
</tr>
<tr>
<td>Not important</td>
<td>24</td>
<td>8.9</td>
<td>63</td>
<td>11.4</td>
<td>+2.5</td>
</tr>
<tr>
<td>18. Do you think the center reflects your culture?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Yes</td>
<td>237</td>
<td>90.8</td>
<td>475</td>
<td>89.8</td>
<td>+1.0</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>9.2</td>
<td>52</td>
<td>9.8</td>
<td>+0.8</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>0.4</td>
<td>+0.4</td>
</tr>
<tr>
<td>19. When assessing your health or the health of your child do you think the provider took your culture and cultural beliefs into account?</td>
<td></td>
<td>---</td>
<td>-----------</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Yes</td>
<td>196</td>
<td>90.3</td>
<td>461</td>
<td>94.9</td>
<td>+4.6</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>9.7</td>
<td>24</td>
<td>4.9</td>
<td>-4.8</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>0.2</td>
<td>+0.2</td>
</tr>
</tbody>
</table>
### Table 29 continued

<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th></th>
<th>%</th>
<th>2005-2006</th>
<th></th>
<th>%</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Do you have health insurance</td>
<td>N/A</td>
<td>N/A</td>
<td>256</td>
<td>48.4</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>273</td>
<td>51.6</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Student Satisfaction Survey**

In 2004-2005 and 2005-2006, the Student Satisfaction Survey was completed by students who received services. These surveys were similar to the Parent Satisfaction Survey in that they attempted to measure the satisfaction of the students with the services received, their interactions with staff members, and their perceptions of their progress made since receiving services at the centers.

In 2004-2005, approximately 200 completed surveys were returned. In 2005-2006, the number of completed surveys increased to 354. There were very few changes made to the survey in 2005-2006. The most notable change was that one question was removed. This question asked how satisfied the respondent was with service. This question was removed because of its redundancy. Analysis of the overall survey would determine the level of client satisfaction, thus making this question unnecessary. Table 30 shows the results for these surveys.

Overall responses, in 2004-2005, to the Student Satisfaction Survey were positive, but not overly positive. Positive responses were given for questions related to interactions with staff members, and student and parental involvement in the student’s treatment. The same was true in 2005-2006. The majority of respondents, in 2004-2005, classified the staff as either being helpful (37.9%) or very helpful (57.9%). In 2005-2006, the questions garnered responses of 26.5% and 68.7%, respectively. In 2004-2005, clients indicated that since coming to the center their family and/or family situation was either much improved (46.3%) or somewhat improved (32.9%). In 2005-2006, 45.2% indicated their family/family situation had much improved, and 32.1% indicated it had somewhat improved.

The delivery of culturally competent health care has been suggested as being important especially to those patients who are from minority groups. Many researchers have postulated
that cultural competence will lead to a reduction in racial and ethnic disparities in health care (Denoba, et al., 1998; Griffin et al., 1999; Brach and Fraser, 2000). In 2004-2005, responses, though affirmative overall, were mixed on whether it was important that the center reflect the respondents’ culture. Cultural competency includes addressing language barriers and caring for diverse patient populations (Betancourt, et al., 2002). Addressing these areas can lead to higher compliance to treatment plans by patients and improved overall health outcomes (Brach and Fraser, 2000).

In response to questions on the student satisfaction survey, students indicated that it was very important (44.9%), somewhat important (35.6%), and not important (19.6%) that the centers reflected their culture. The fact that 20% indicated that it was not important was puzzling. This may have been due to the age of the respondents. Adults are the keepers of cultural norms; children are more resistant to norms and more likely to challenge them. However, when the same group, in 2004-2005, was asked if the centers reflect their culture, most (68.8%) reported that the centers did reflect their culture while 31.2% indicated that the centers did not reflect their culture. Because one of the main focuses of the Youth and Family Centers is to provide culturally competent health care, further analysis was done to determine why those indicating that the centers did not reflect their culture responded as they did. Through further analysis, it was determined that 34% of the respondents who indicated that the center did not reflect their culture were in high school, 40% were in middle school and 27% were in elementary school. In 2005-2006, this question received a similar response. This year, respondents indicated that it was very important (52.2%), somewhat important (26.9%), and not important (20.6%) that the centers reflect their culture. Being very important experienced an increase of 7.3 percentage points while being somewhat important and not being important experienced a decrease of 8.7 percentage points and an increase of one percentage point, respectively.

In regards to whether the students encountered any problems in accessing services, equal amounts (10.8%) of respondents indicated that either transportation or language problems got in the way of getting help at the center. In 2005-2006, these responses increased to 17.3% and 19.2%, respectively. In 2004-2005, 18.9% of respondents indicated that scheduling of clinic
hours was a problem, in 2005-2006 respondents who indicated that this was a factor increased to 21.2%, an increase of 2.3 percentage points.

Table 30

Results of the Student Satisfaction Survey

<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What school do you attend?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>58</td>
<td>27.9</td>
<td>119</td>
</tr>
<tr>
<td>Middle school</td>
<td>56</td>
<td>26.9</td>
<td>94</td>
</tr>
<tr>
<td>Elementary school</td>
<td>94</td>
<td>45.2</td>
<td>143</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>N/A</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>2. What is your gender?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>115</td>
<td>52.8</td>
<td>168</td>
</tr>
<tr>
<td>Female</td>
<td>103</td>
<td>47.3</td>
<td>208</td>
</tr>
<tr>
<td>3. What is your ethnicity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>3</td>
<td>1.4</td>
<td>4</td>
</tr>
<tr>
<td>African American</td>
<td>77</td>
<td>35.7</td>
<td>134</td>
</tr>
<tr>
<td>Hispanic</td>
<td>117</td>
<td>54.2</td>
<td>197</td>
</tr>
<tr>
<td>Anglo</td>
<td>12</td>
<td>5.6</td>
<td>29</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>3.2</td>
<td>2</td>
</tr>
<tr>
<td>4. How many times have you been to the principal’s office or had to see the Youth Action Officer for misbehavior this school year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>95</td>
<td>44.8</td>
<td>198</td>
</tr>
<tr>
<td>1</td>
<td>32</td>
<td>15.1</td>
<td>67</td>
</tr>
<tr>
<td>2</td>
<td>29</td>
<td>13.7</td>
<td>33</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>7.6</td>
<td>32</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>3.3</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>3.3</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>2.4</td>
<td>2</td>
</tr>
<tr>
<td>7 or more times</td>
<td>21</td>
<td>9.9</td>
<td>18</td>
</tr>
<tr>
<td>5. For what type of services did you come to the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shots/immunizations</td>
<td>17</td>
<td>8.5</td>
<td>26</td>
</tr>
<tr>
<td>Other physical health</td>
<td>30</td>
<td>15.0</td>
<td>78</td>
</tr>
<tr>
<td>Counseling</td>
<td>124</td>
<td>62.0</td>
<td>183</td>
</tr>
<tr>
<td>6. Overall, how helpful was the YFC staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very helpful</td>
<td>124</td>
<td>57.9</td>
<td>246</td>
</tr>
<tr>
<td>Helpful</td>
<td>81</td>
<td>37.9</td>
<td>95</td>
</tr>
<tr>
<td>Sometimes helpful</td>
<td>9</td>
<td>4.2</td>
<td>13</td>
</tr>
<tr>
<td>Not helpful</td>
<td>0</td>
<td>0.0</td>
<td>4</td>
</tr>
<tr>
<td>Made things worse</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table continues
<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Were you treated in a respectful manner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>207</td>
<td>97.2</td>
<td>351</td>
<td>97.8</td>
<td>+0.6</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>2.8</td>
<td>8</td>
<td>2.2</td>
<td>-0.6</td>
</tr>
<tr>
<td>8. Overall, how satisfied were you with the services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>88</td>
<td>42</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Satisfied</td>
<td>97</td>
<td>46</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mixed</td>
<td>26</td>
<td>12</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>0</td>
<td>0.0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>0</td>
<td>0.0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Did anything interfere with you getting services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>10.2</td>
<td>13</td>
<td>3.6</td>
<td>-6.6</td>
</tr>
<tr>
<td>Somewhat</td>
<td>16</td>
<td>7.4</td>
<td>19</td>
<td>5.2</td>
<td>-2.2</td>
</tr>
<tr>
<td>10. If you answered “Yes” to question 9, what interfered?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>4</td>
<td>10.8</td>
<td>9</td>
<td>17.3</td>
<td>+6.5</td>
</tr>
<tr>
<td>Language problems</td>
<td>4</td>
<td>10.8</td>
<td>10</td>
<td>19.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Center location</td>
<td>0</td>
<td>0.0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Scheduling</td>
<td>7</td>
<td>18.9</td>
<td>11</td>
<td>21.2</td>
<td>+2.3</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>59.5</td>
<td>22</td>
<td>42.3</td>
<td>-17.2</td>
</tr>
<tr>
<td>11. How many times have you visited the YFC this school year?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First visit</td>
<td>29</td>
<td>13.6</td>
<td>52</td>
<td>14.8</td>
<td>+1.2</td>
</tr>
<tr>
<td>2-4 times</td>
<td>75</td>
<td>35.2</td>
<td>127</td>
<td>36.1</td>
<td>+0.9</td>
</tr>
<tr>
<td>5-7 times</td>
<td>54</td>
<td>25.4</td>
<td>76</td>
<td>21.6</td>
<td>-3.8</td>
</tr>
<tr>
<td>More than 8 times</td>
<td>55</td>
<td>25.8</td>
<td>97</td>
<td>27.5</td>
<td>+1.7</td>
</tr>
<tr>
<td>12. Have you visited a YFC before this school year?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>105</td>
<td>48.8</td>
<td>186</td>
<td>50.8</td>
<td>-2.0</td>
</tr>
<tr>
<td>No</td>
<td>110</td>
<td>51.2</td>
<td>179</td>
<td>48.9</td>
<td>-2.3</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>0.3</td>
<td>N/A</td>
</tr>
<tr>
<td>13. Since coming to the YFC, how would you rate your personal and/or family situation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much improved</td>
<td>100</td>
<td>46.3</td>
<td>149</td>
<td>45.2</td>
<td>-1.1</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>71</td>
<td>32.9</td>
<td>106</td>
<td>32.1</td>
<td>-0.8</td>
</tr>
<tr>
<td>About the same</td>
<td>44</td>
<td>20.4</td>
<td>73</td>
<td>22.1</td>
<td>+1.7</td>
</tr>
<tr>
<td>Worse</td>
<td>1</td>
<td>0.4</td>
<td>2</td>
<td>0.6</td>
<td>+0.2</td>
</tr>
<tr>
<td>14. Overall, how satisfied are you with the progress you have made?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>88</td>
<td>41.5</td>
<td>163</td>
<td>50.1</td>
<td>+8.5</td>
</tr>
<tr>
<td>Satisfied</td>
<td>97</td>
<td>45.8</td>
<td>125</td>
<td>38.3</td>
<td>-7.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>26</td>
<td>12.3</td>
<td>34</td>
<td>10.4</td>
<td>-1.9</td>
</tr>
</tbody>
</table>
### Table 30 continued

<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>1</td>
<td>0.5</td>
<td>3</td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
</tbody>
</table>

15. How important is it that the center reflects your culture?

<table>
<thead>
<tr>
<th>Importance</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Very important</td>
<td>87</td>
<td>44.9</td>
<td>571</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>69</td>
<td>35.6</td>
<td>81</td>
</tr>
<tr>
<td>Not important</td>
<td>38</td>
<td>19.6</td>
<td>62</td>
</tr>
<tr>
<td>Don't Know</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
</tbody>
</table>

16. Do you think the center reflects your culture?

<table>
<thead>
<tr>
<th>Response</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>128</td>
<td>68.8</td>
<td>221</td>
</tr>
<tr>
<td>No</td>
<td>58</td>
<td>31.2</td>
<td>67</td>
</tr>
</tbody>
</table>

17. When assessing your health do you think the provider took your culture and cultural beliefs into account?

<table>
<thead>
<tr>
<th>Response</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>108</td>
<td>74.0</td>
<td>190</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>26.0</td>
<td>40</td>
</tr>
</tbody>
</table>

### School Personnel Survey

In both the spring of 2005 and the spring of 2006, surveys were delivered to school personnel at select schools in the feeder pattern of each Youth and Family Center. The purpose of the survey was to gather school staff perceptions related to the satisfaction with the services, initiating and maintaining contact with the centers, barriers to collaboration, progress of the child and family, and reputation of the centers.

In 2004-2005 the evaluator received 230 completed surveys. In 2005-2006, the evaluator received 121 completed surveys. In both years, those who completed the School Personnel Survey were mainly counselors, nurses, and teachers. In 2004-2005, 21.5% were teachers compared to 11.6% in 2005-2006. Nurses accounted for 23.4% in 2004-2005 and 6.3% in 2005-2006. Counselors, however, only accounted for 31.2% in 2004-2005, but more than doubled to 67% in 2005-2006. Overall, in both years, results of the School Personnel Survey were positive, but not overly positive. Table 31 shows the results for these surveys.

School personnel survey responses related to service satisfaction and quality were very positive, and responses related to student and family progress were also positive. Most school personnel found making contact with the center either very easy (61.4%) or easy (38.6%) in
2004-2005. By 2005-2006, these numbers had changed to 67.8% and 31.4%, respectively. These results indicate that there was no real change between the two years. In 2004-2005, the range of contact that respondents had with the centers varied. Most collaborated through referral (77.1%) or discussion about cases (10.8%). In 2005-2006, respondents contacted the centers via referrals (86.8%) and case discussions (7.3%).

More importantly, in 2004-2005, school staff perceptions of student progress were encouraging with most believing that the child was much improved (78.7%). There was a substantial improvement on this outcome in 2005-2006 with 90.2% of respondents indicating that the children being treated by the Youth and Family Centers were improved in regards to progress. In 2004-2005, most respondents believed that students had much improved or improved on school work and attendance. In 2005-2006, 81.3% of respondents indicated that they believed students were much improved or improved on schoolwork and 70.6% indicated students had much improved or improved in regards to attendance. Respondents, in 2004-2005, reported that students’ behavior was improved (66.7%) or much improved (18%). In 2005-2006, responders to the same question indicated that students’ behavior was improved (50.5%) or much improved (39.6%). Over three-quarters (98.7%), in 2004-2005, definitely believed that the services were of high quality. In 2005-2006, 99.2% believed that the services provided by the centers were of high quality, an increase of half a percentage point of the prior year. School personnel, in 2004-2005, reported that the Youth and Family center associated with their school had a positive reputation (98.2%). This question experienced an insignificant decline in 2005-2006 to 97.5%. Ninety-nine percent of respondents definitely believed that the Youth and Family Centers were valuable to the students at their school in 2004-2005. This number declined slightly to 98.3% in 2005-2006.
Table 31
Results of the School Personnel Satisfaction Survey

<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1. What is your position?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td>44</td>
<td>21.5</td>
<td>13</td>
</tr>
<tr>
<td>Counselor</td>
<td>64</td>
<td>31.2</td>
<td>75</td>
</tr>
<tr>
<td>Nurse</td>
<td>48</td>
<td>23.4</td>
<td>7</td>
</tr>
<tr>
<td>SST Member</td>
<td>14</td>
<td>6.8</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td>17.1</td>
<td>9</td>
</tr>
<tr>
<td>2. How frequent was your contact with the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very frequent</td>
<td>97</td>
<td>42.9</td>
<td>75</td>
</tr>
<tr>
<td>Somewhat frequent</td>
<td>96</td>
<td>42.5</td>
<td>44</td>
</tr>
<tr>
<td>Little or no contact</td>
<td>33</td>
<td>14.6</td>
<td>2</td>
</tr>
<tr>
<td>3. How easy was it to initiate and maintain contact with the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very easy</td>
<td>140</td>
<td>61.4</td>
<td>82</td>
</tr>
<tr>
<td>Easy</td>
<td>88</td>
<td>38.6</td>
<td>38</td>
</tr>
<tr>
<td>Difficult</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>4. What was the nature of your collaboration with the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td>121</td>
<td>77.1</td>
<td>59</td>
</tr>
<tr>
<td>Case discussion</td>
<td>17</td>
<td>10.8</td>
<td>5</td>
</tr>
<tr>
<td>Sharing of documents</td>
<td>4</td>
<td>2.5</td>
<td>2</td>
</tr>
<tr>
<td>Attendance at meetings</td>
<td>10</td>
<td>6.4</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>3.2</td>
<td>1</td>
</tr>
<tr>
<td>5. Were there any barriers to your collaboration with the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>1.3</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>227</td>
<td>98.7</td>
<td>116</td>
</tr>
<tr>
<td>6. What were the barriers?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School paperwork</td>
<td>1</td>
<td>33.3</td>
<td>N/A</td>
</tr>
<tr>
<td>YFC paperwork</td>
<td>2</td>
<td>66.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Work schedules</td>
<td>0</td>
<td>0.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Dallas ISD procedures</td>
<td>0</td>
<td>0.0</td>
<td>N/A</td>
</tr>
<tr>
<td>YFC not responsive</td>
<td>0</td>
<td>0.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Overall, do you think the YFC staff provides quality services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>227</td>
<td>98.7</td>
<td>119</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>0.9</td>
<td>0</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
</tr>
</tbody>
</table>

Table continues
<table>
<thead>
<tr>
<th>Question/Responses</th>
<th>2004-2005</th>
<th>2005-2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.</strong> Does the Center that serves your school have a positive reputation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>224</td>
<td>98.2</td>
<td>119</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>1.8</td>
<td>3</td>
</tr>
<tr>
<td><strong>9.</strong> Have you had contact with any YFC in previous years?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>164</td>
<td>72.2</td>
<td>107</td>
</tr>
<tr>
<td>No</td>
<td>63</td>
<td>27.8</td>
<td>15</td>
</tr>
<tr>
<td><strong>10.</strong> Overall, how would you assess the school attendance of students served by the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much improved</td>
<td>37</td>
<td>20.2</td>
<td>34</td>
</tr>
<tr>
<td>Improved</td>
<td>95</td>
<td>51.9</td>
<td>45</td>
</tr>
<tr>
<td>About the same</td>
<td>24</td>
<td>13.1</td>
<td>24</td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>27</td>
<td>14.8</td>
<td>9</td>
</tr>
<tr>
<td><strong>11.</strong> Overall, how would you assess the school behavior of students served by the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much improved</td>
<td>33</td>
<td>18.0</td>
<td>44</td>
</tr>
<tr>
<td>Improved</td>
<td>122</td>
<td>66.7</td>
<td>56</td>
</tr>
<tr>
<td>About the same</td>
<td>15</td>
<td>8.2</td>
<td>5</td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>13</td>
<td>7.1</td>
<td>6</td>
</tr>
<tr>
<td><strong>12.</strong> Overall, how would you assess the schoolwork of students served by the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much improved</td>
<td>22</td>
<td>12.0</td>
<td>32</td>
</tr>
<tr>
<td>Improved</td>
<td>105</td>
<td>57.4</td>
<td>59</td>
</tr>
<tr>
<td>About the same</td>
<td>22</td>
<td>12.0</td>
<td>10</td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>34</td>
<td>18.6</td>
<td>11</td>
</tr>
<tr>
<td><strong>13.</strong> How would you assess the overall progress made by students served by the YFC?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much improved</td>
<td>32</td>
<td>15.8</td>
<td>42</td>
</tr>
<tr>
<td>Improved</td>
<td>127</td>
<td>62.9</td>
<td>59</td>
</tr>
<tr>
<td>About the same</td>
<td>9</td>
<td>4.4</td>
<td>4</td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>34</td>
<td>16.8</td>
<td>7</td>
</tr>
<tr>
<td><strong>14.</strong> Overall, is the YFC a valuable resource for students and families?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>220</td>
<td>99.1</td>
<td>117</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>0.9</td>
<td>2</td>
</tr>
</tbody>
</table>
Summary

The surveys indicated that school administrators were very grateful for the existence of the Youth and Family Centers and thought the services provided were valuable. Comments from the administrators indicated that they would like more information regarding the services provided by the center and how to use the referral process.

While responses again were favorable, the parent survey indicated that transportation created a barrier to using the centers. Students, however, indicated that both transportation and language barriers were factors that prevented them from accessing services from the centers. The school personnel survey’s responses were very positive. The majority of respondents believed that students who received services from the centers improved in regards to attendance and academic progress and that the centers were valuable to the students at their respective schools.

2.7 What were the differences in utilization by the Youth and Family Centers’ clients?

Methodology

As Youth and Family Center staff provided services to clients, information related to the services provided were entered into the Youth and Family Center program Access® database by the centers’ clerks. These data included such information as client demographics, utilization rates, and treatments and diagnoses provided. Data were extracted from the database in order to determine differences in utilization by all Youth and Family Center clients. Physical health and mental health visits were used to examine utilization rates. Clients with visits equal to or more than the median number of visits were considered high-frequency users and were examined separately. Those clients who are defined as high-frequency users are presumed to be those clients with higher morbidity levels than their low-frequency counterparts. Thus, utilization rates are examined in three categories – all clients, high-frequency clients, and low-frequency clients.
Results

All Clients

Tables 32 and 33 display descriptive statistics of center visits for all clients – those seeking behavioral health services, physical health services, or both types of service. Clients were divided into two groups: high-frequency users and low-frequency users. The median number of visits for all clients was calculated. Those clients with more than the median number of visits were classified as high-frequency clients. Those clients with fewer than the median number of visits were classified as low-frequency users. As shown in Table 32, of the 14,437 clients who received services in 2004-2005, the mean number of visits was 3.36, with a standard deviation of 5.69. High-frequency users were defined as those clients with at least four visits, equal to the median, while low-frequency users were defined as those clients with three or fewer visits. High-frequency users (N = 6,675) had an average of 6.10 visits, which was almost double the mean number of visits for all users. Low-frequency users (N = 7,762) had an average of one visit each.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clients*</td>
<td>14,437</td>
<td>1</td>
<td>3.36</td>
<td>5.69</td>
</tr>
<tr>
<td>High-Frequency Clients**</td>
<td>6,675</td>
<td>4</td>
<td>6.10</td>
<td>7.48</td>
</tr>
<tr>
<td>Low-Frequency Clients***</td>
<td>7,762</td>
<td>1</td>
<td>1.00</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Table 33 shows the frequency of visits for all clients in 2005-2006. As shown in Table 33, of the 13,307 clients who received services in 2005-2006, the mean number of visits was 3.0 with a standard deviation of 4.4. High-frequency users (N = 5,789) had an average of 5.59 visits with a standard deviation of 5.71; this was slightly lower than the 2004-2005 rate of 6.10. Low-frequency users (N = 7,518) had an average of one visit each.
Table 33

Frequency of Visits for all Clients*, 2005-2006

<table>
<thead>
<tr>
<th>Frequency</th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clients*</td>
<td>13,307</td>
<td>1</td>
<td>3.00</td>
<td>4.4</td>
</tr>
<tr>
<td>High-Frequency Clients**</td>
<td>5,789</td>
<td>3</td>
<td>5.59</td>
<td>5.71</td>
</tr>
<tr>
<td>Low-Frequency Clients***</td>
<td>7,518</td>
<td>1</td>
<td>1.00</td>
<td>NA</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Physical Health Clients

Analyses were conducted to determine the differences in utilization for each type of service provided by the Youth and Family Centers for both years: 2004-2005 and 2005-2006. Table 34 displays descriptive statistics on center visits for all physical health service recipients in 2004-2005. Of the 10,817 clients who received physical health services, the mean number of visits was 1.96, with a standard deviation of 3.13. High-frequency users were defined as those with equal to or more than three visits, the median number of visits for all clients. High-frequency users (N = 3,755) had a mean of 3.76 visits with a standard deviation of 4.83. The 7,062 low-frequency clients had an average of only one visit each.

Table 34

Frequency of Visits for Clients of Physical Health Services, 2004-2005

<table>
<thead>
<tr>
<th>Frequency</th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clients*</td>
<td>10,817</td>
<td>1</td>
<td>1.96</td>
<td>3.13</td>
</tr>
<tr>
<td>High-Frequency Clients**</td>
<td>3,755</td>
<td>3</td>
<td>3.76</td>
<td>4.83</td>
</tr>
<tr>
<td>Low-Frequency Clients***</td>
<td>7,062</td>
<td>1</td>
<td>1.0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Tables 35 displays descriptive statistics on center visits for all physical health service recipients in 2005-2006. Of the 10,343 clients who received physical health services, the mean number of visits was 1.77, with a standard deviation of 1.64. High-frequency users (N = 3,323) had a mean of 3.40 visits with a standard deviation of 2.11. The median number of visits for this group was three visits, the same as the prior year. The 7,020 low-frequency clients had an average of one visit each.
Table 35
Frequency of Visits for Clients of Physical Health Services, 2005-2006

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clients*</td>
<td>10,343</td>
<td>1</td>
<td>1.77</td>
<td>1.64</td>
</tr>
<tr>
<td>High-Frequency Clients**</td>
<td>3,323</td>
<td>3</td>
<td>3.40</td>
<td>2.11</td>
</tr>
<tr>
<td>Low-Frequency Clients***</td>
<td>7,020</td>
<td>1</td>
<td>1.00</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Behavioral Health Clients

As with the physical health services, analyses were also conducted to determine the differences in utilization for behavioral health services provided by the Youth and Family Centers for years, 2004-2005 and 2005-2006. Tables 36 and 37 display descriptive statistics on utilization rates for all behavioral health clients in 2004-2005 and 2005-2006. Table 36 displays behavioral health clients for 2004-2005. The median number of behavioral visits for all behavioral health clients was eight, which set the cut point for high-frequency versus low-frequency users. Of the 4,211 clients who received behavioral health services, the mean number of visits was 6.49, with a standard deviation of 8.22. High-frequency users (N = 2,092) had a mean of 11.43 visits with a standard deviation of 9.33. The 2,119 low-frequency clients had an average of 1.61 visits each with a standard deviation of 0.76. The number of visits per behavioral health clients was almost triple that of the physical health clients.

Table 36
Frequency of Visits for Clients of Behavioral Health Services, 2004-2005

<table>
<thead>
<tr>
<th>Frequency</th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clients*</td>
<td>4,211</td>
<td>3</td>
<td>6.49</td>
<td>8.22</td>
</tr>
<tr>
<td>High-Frequency Clients**</td>
<td>2,092</td>
<td>8</td>
<td>11.43</td>
<td>9.33</td>
</tr>
<tr>
<td>Low-Frequency Clients***</td>
<td>2,119</td>
<td>1</td>
<td>1.61</td>
<td>0.76</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Table 37 displays behavioral health clients for 2005-2006. The median number visits for all behavioral health clients in 2005-2006 was nine visits, this was one visit more than the 2004-2005 school year. Of the 3,388 clients who received behavioral health services, the mean number of visits was 6.37, with a standard deviation of 7.00. Those clients who had more than
nine visits were classified as high-frequency users, and those with eight or less were classified as low-frequency users. High-frequency users (N = 1,528) had a mean of 11.65 visits with a standard deviation of 7.52. The 1,860 low-frequency clients had an average of 2.03 visits with a standard deviation of 1.10.

Table 37
Frequency of Visits for Clients of Behavioral Health Services, 2005-2006

<table>
<thead>
<tr>
<th>Frequency</th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clients*</td>
<td>3,388</td>
<td>4</td>
<td>6.37</td>
<td>7.00</td>
</tr>
<tr>
<td>High-Frequency Clients**</td>
<td>1,528</td>
<td>9</td>
<td>11.65</td>
<td>7.52</td>
</tr>
<tr>
<td>Low-Frequency Clients***</td>
<td>1,860</td>
<td>2</td>
<td>2.03</td>
<td>1.10</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Summary

In summary, the number of clients (both behavioral and physical health) served declined, and the mean number of visits for physical and behavioral health services followed the same trend. The mean number of physical and behavioral health services decreased from 2004-2005 to 2005-2006. In 2004-2005, regardless of the time of services sought, the mean number of visits received by all clients was 3.36, which decreased to 3.00 visits in 2005-2006. The mean number of visits for all high-frequency clients was 6.10 in 2004-2005; this dropped slightly to 5.59 visits in 2005-2006. The mean number of visits for the low-frequency users was one, for both years. The mean number of physical health visits for low-frequency users remained constant at one visit.

Analysis for each component of the program shows that the mean number of visits for all clients seeking physical health services was 1.96 visits in 2004-2005, which decreased to 1.77 visits in 2005-2006. In 2004-2005, high-frequency physical health users had a mean of 3.76 visits. By 2005-2006 this had dropped to 3.40. Analysis of all behavioral health clients showed that the overall mean was 6.49 visits in 2004-2005; this declined to 6.37 in 2005-2006. However, the number of visits for behavioral health, those clients who were high-frequency users had a mean visit of 11.43 visits in 2004-2005 which increased to 11.65 in 2005-2006. Unlike high-frequency physical health users the low-frequency behavioral health users had a mean of 1.61 visits in 2004-2005, which increased to 2.03 visits in 2005-2006.
2.8 What was the impact of the Youth and Family Centers on attendance?

Methodology

Students’ recorded absences, obtained from the district’s database, were reviewed for the second six weeks cycle and fifth six weeks cycle of the 2004-2005 and 2005-2006 school year. Only those clients who received services in the second six weeks cycle and the fifth six weeks cycle were analyzed for improvements in the fifth six weeks cycle.

Results

Physical Health Clients

The analysis of attendance for the second and fifth six weeks cycles for physical health clients in 2004-2005 and 2005-2006 are displayed in Tables 38 and 39. Rather than looking at missed days, an attendance rate was calculated for each client. This rate reflects attendance more accurately than days absent because it controls for days enrolled. Perfect attendance was considered equal to 100%. Paired t-statistics were calculated to note statistically significant changes in attendance rates.

Table 38 displays attendance rates for high-frequency clients who received services during the second and fifth six weeks cycle. For all clients, the mean attendance rate during the second six weeks cycle was 95.0%, this rate dropped to 93.0% during the fifth six weeks cycle, a decline of 2.00 percentage points. This difference was statistically significant.

All grade levels, analyzed separately, showed a lower attendance rate during the fifth six weeks cycle. In all instances, the difference between second and fifth six weeks cycles was significantly different.
Table 38
Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers’ High-Frequency Physical Health Clients, 2004-2005

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Mean</th>
<th>Mean</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2,370</td>
<td>95.0</td>
<td>93.0</td>
<td>-2.00</td>
<td>11.13</td>
<td>0.000</td>
<td>0.18</td>
</tr>
<tr>
<td>Elementary</td>
<td>923</td>
<td>97.7</td>
<td>97.0</td>
<td>-0.70</td>
<td>5.46</td>
<td>0.000</td>
<td>0.13</td>
</tr>
<tr>
<td>Middle</td>
<td>407</td>
<td>95.4</td>
<td>94.0</td>
<td>-1.40</td>
<td>9.20</td>
<td>0.002</td>
<td>0.15</td>
</tr>
<tr>
<td>High</td>
<td>1,040</td>
<td>92.5</td>
<td>89.1</td>
<td>-3.40</td>
<td>14.80</td>
<td>0.000</td>
<td>0.23</td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed

Table 39 displays attendance rates for 2005-2006 high-frequency physical health clients who received services during the second and fifth six weeks cycles. For all clients, the mean attendance rate during the second six weeks cycle was 94.5%, which was slightly lower than the 95.0% of 2004-2005. The 2005-2006 rate dropped to 92.6% during the fifth six weeks cycle, a decline of 1.8 percentage points. This difference was statistically significant.

All grade levels, analyzed separately, showed a lower attendance rate during the fifth six weeks cycle. In all instances, with the exception of high school clients, the difference between second and fifth six weeks cycles was significantly different.

Table 39
Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers’ High-Frequency Physical Health Clients, 2005-2006

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Mean</th>
<th>Mean</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,840</td>
<td>94.5</td>
<td>92.6</td>
<td>-1.8</td>
<td>10.8</td>
<td>0.000</td>
<td>0.18</td>
</tr>
<tr>
<td>Elementary</td>
<td>684</td>
<td>96.6</td>
<td>96.3</td>
<td>-0.2</td>
<td>6.8</td>
<td>0.000</td>
<td>0.04</td>
</tr>
<tr>
<td>Middle</td>
<td>353</td>
<td>95.2</td>
<td>93.1</td>
<td>-2.1</td>
<td>9.9</td>
<td>0.000</td>
<td>0.21</td>
</tr>
<tr>
<td>High</td>
<td>803</td>
<td>92.4</td>
<td>89.3</td>
<td>-3.1</td>
<td>13.5</td>
<td>0.364</td>
<td>0.23</td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed

Table 40 displays attendance rates for low-frequency physical health clients who received services during the second and fifth six weeks cycles. For all clients the mean attendance rate during the second six weeks cycle was 95.3%; this rate dropped to 93.7% during the fifth six weeks cycle, a difference of 1.60 percentage points. The difference between the
second and fifth six weeks cycles was statistically significant. Grade level analysis also showed that attendance rates were higher in the second six weeks cycle than the fifth six weeks cycle for all grade level categories. As with the all client group, the differences for all grade categories remained statistically significant.

Table 40
Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers' Low-Frequency Physical Health Clients, 2004-2005

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>2nd Six Weeks</th>
<th>5th Six Weeks</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4,735</td>
<td>95.3</td>
<td>93.7</td>
<td>-1.60</td>
<td>10.72</td>
<td>0.000</td>
<td>0.15</td>
</tr>
<tr>
<td>Elementary</td>
<td>1,178</td>
<td>97.2</td>
<td>96.3</td>
<td>-0.90</td>
<td>6.49</td>
<td>0.000</td>
<td>0.14</td>
</tr>
<tr>
<td>Middle</td>
<td>1,355</td>
<td>95.7</td>
<td>94.5</td>
<td>-1.20</td>
<td>8.66</td>
<td>0.000</td>
<td>0.16</td>
</tr>
<tr>
<td>High</td>
<td>2,202</td>
<td>94.2</td>
<td>91.9</td>
<td>-2.30</td>
<td>13.33</td>
<td>0.000</td>
<td>0.17</td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed

Table 41 displays attendance rates for the 2005-2006 low-frequency physical health clients who had received services during the second and fifth six weeks cycles. For all clients the mean attendance rate during the second six weeks was 95.7%; this rate dropped to 93.9% during the fifth six weeks cycle. This was a difference of 1.80 percentage points. These rates are almost identical to those for the 2004-2005 school year. As with the 2004-2005 year, the difference between the second and fifth six weeks cycles was statistically significant. Comparisons based on grade level also showed that attendance rates were higher in the second six weeks cycle than the fifth six weeks cycle for all categories. As with the all client group, the differences for all grade categories remained statistically significant.

Table 41
Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers' Low-Frequency Physical Health Clients, 2005-2006

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>2nd Six Weeks</th>
<th>5th Six Weeks</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4,440</td>
<td>95.7</td>
<td>93.9</td>
<td>-1.80</td>
<td>10.0</td>
<td>0.000</td>
<td>0.18</td>
</tr>
<tr>
<td>Elementary</td>
<td>1,135</td>
<td>97.1</td>
<td>96.4</td>
<td>-0.60</td>
<td>6.1</td>
<td>0.000</td>
<td>0.11</td>
</tr>
<tr>
<td>Middle</td>
<td>1,289</td>
<td>95.9</td>
<td>94.2</td>
<td>-1.70</td>
<td>9.4</td>
<td>0.000</td>
<td>0.18</td>
</tr>
<tr>
<td>High</td>
<td>2,016</td>
<td>94.7</td>
<td>92.1</td>
<td>-2.60</td>
<td>11.9</td>
<td>0.001</td>
<td>0.22</td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed
In order to determine if the trend of having the second six weeks cycle attendance rates higher than the fifth six weeks cycle was unique only to those individuals using the Youth and Family Centers, analysis of the entire student population, with the exclusion of those students using the Youth and Family Centers, was also conducted. It was determined that the drop in attendance during the fifth six weeks cycle was not unusual. Rather, the decline in attendance from the second six weeks cycle to the fifth six weeks cycle is a trend that appears at the district level. For those students who did not receive physical health services from the Youth and Family Centers in 2005-2006 (N=147,659), the decline in attendance rates, from the second six weeks cycle to the fifth six weeks cycle, was 1.5 compared to 1.8 for physical health Youth and Family Center clients. This analysis showed that for those presenting students who may be sicker than their counterparts, the services they are receiving from the health centers are beneficial because they allow them to function in the academic arena at rates similar to those experienced by those students not experiencing those ailments.

**Behavioral Health Clients**

Similar to the analysis of attendance rates for physical health services, analysis was also conducted for behavioral health services. Again, high-frequency users and low-frequency users were determined by the median number of visits for all clients. Those clients with the number of visits greater than the median were classified as high-frequency users. Those clients with the number of visits less than or equal to the median were classified as low-frequency users. Table 42 shows results for high-frequency behavioral health clients for 2004-2005. The mean attendance rate for all high-frequency behavioral clients during the second six weeks cycle was 95.1%. This rate dropped to 94.0% during the fifth six weeks cycle, a difference of 1.15 percentage points. The difference between the second and fifth six weeks cycles was statistically significant. Elementary, middle, and high school clients also showed a similar decrease, with the second six weeks maintaining a higher attendance rate than the fifth six weeks cycle. High school clients showed the largest decrease from the second six weeks cycle to the fifth six weeks cycle; a decline of 4.17 percentage points. Elementary grades showed the smallest decrease.
The decrease was 0.39 percentage points. This was the only category that was not statistically significant.

Table 42
Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers’ High-Frequency Behavioral Health Clients, 2004-2005

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>2nd Six Mean</th>
<th>5th Six Mean</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,933</td>
<td>95.1</td>
<td>94.0</td>
<td>-1.1</td>
<td>10.05</td>
<td>0.000</td>
<td>0.11</td>
</tr>
<tr>
<td>Elementary</td>
<td>1,322</td>
<td>96.2</td>
<td>95.8</td>
<td>-0.4</td>
<td>8.02</td>
<td>0.082</td>
<td>0.05</td>
</tr>
<tr>
<td>Middle</td>
<td>409</td>
<td>92.9</td>
<td>90.8</td>
<td>-2.1</td>
<td>11.05</td>
<td>0.002</td>
<td>0.19</td>
</tr>
<tr>
<td>High</td>
<td>202</td>
<td>92.4</td>
<td>88.2</td>
<td>-4.2</td>
<td>16.89</td>
<td>0.000</td>
<td>0.25</td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed

Table 43 shows results for high-frequency behavioral health clients for 2005-2006. The mean attendance rate for all high-frequency behavioral clients during the second six weeks cycle was 94.6%, this rate dropped to 93.4% during the fifth six weeks cycle, a difference of 1.2 percentage points. The difference between the second and fifth six weeks cycles was statistically significant.

Elementary, middle, and high school clients also showed a similar decrease, with the second six weeks cycle maintaining a higher attendance rate than the fifth six weeks cycle. Middle school clients showed the largest decrease from the second six weeks cycle to the fifth six weeks cycle, a decline of 2.8 percentage points. This was the only group that did not show a statistically significant change over the two cycles.
Table 43
Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers’ High-Frequency Behavioral Health Clients, 2005-2006

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>2nd Six Weeks</th>
<th>Mean</th>
<th>5th Six Weeks</th>
<th>Mean</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance* Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,402</td>
<td>94.6</td>
<td>93.4</td>
<td>-1.2</td>
<td>10.5</td>
<td>0.000</td>
<td>0.11</td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>994</td>
<td>95.6</td>
<td>94.8</td>
<td>-0.8</td>
<td>8.9</td>
<td>0.003</td>
<td>0.09</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>259</td>
<td>92.7</td>
<td>89.9</td>
<td>-2.8</td>
<td>14.8</td>
<td>0.089</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>149</td>
<td>90.1</td>
<td>87.9</td>
<td>-2.2</td>
<td>15.7</td>
<td>0.000</td>
<td>0.14</td>
<td></td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed

Table 44 displays low-frequency clients who received behavioral health services from the Youth and Family Centers, and received services during the second six weeks cycle and during the fifth six weeks cycle. For all clients the mean attendance rate during the second six weeks cycle was 94.8%. This rate dropped to 93.4% during the fifth six weeks cycle, a difference of 1.40 percentage points. The difference between the second and fifth six weeks cycles was statistically significant. All levels showed a similar difference, with the second six weeks cycle maintaining a higher attendance rate than the fifth six weeks cycle. In all instances, the difference between second and fifth six weeks cycles was statistically significant.

Table 44
Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers’ Low-Frequency Behavioral Health Clients, 2004-2005

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>2nd Six Weeks</th>
<th>Mean</th>
<th>5th Six Weeks</th>
<th>Mean</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance* Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,745</td>
<td>94.8</td>
<td>93.4</td>
<td>-1.4</td>
<td>10.8</td>
<td>0.000</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>2,434</td>
<td>96.4</td>
<td>95.8</td>
<td>-0.6</td>
<td>7.4</td>
<td>0.000</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>408</td>
<td>92.1</td>
<td>89.9</td>
<td>-2.2</td>
<td>13.6</td>
<td>0.000</td>
<td>0.16</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>225</td>
<td>90.8</td>
<td>87.7</td>
<td>-3.1</td>
<td>18.6</td>
<td>0.000</td>
<td>0.17</td>
<td></td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed

Table 45 displays low-frequency clients who received behavioral health services from the Youth and Family Centers in the second six weeks cycle and the fifth six weeks cycle. For all clients the mean attendance rate during the second six weeks cycle was 94.2%. This rate dropped to 92.3% during the fifth six weeks cycle. The difference between the second and fifth six weeks cycles was statistically significant. All school levels showed a similar difference, with
the second six weeks cycle maintaining a higher attendance rate than the fifth six weeks cycle. In all instances, with the exception of the high school level, the difference between second and fifth six weeks cycles was significant.

### Table 45

Mean Difference in Attendance Rates Between 2nd and 5th Six Weeks Cycles for Youth and Family Centers Low-Frequency Behavioral Health Clients, 2005-2006

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>2nd Six Weeks Mean</th>
<th>5th Six Weeks Mean</th>
<th>Diff.</th>
<th>Std. Dev.</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,547</td>
<td>94.2</td>
<td>92.3</td>
<td>-1.9</td>
<td>12.0</td>
<td>0.000</td>
<td>0.16</td>
</tr>
<tr>
<td>Elementary</td>
<td>1,024</td>
<td>95.5</td>
<td>94.5</td>
<td>-1.0</td>
<td>9.8</td>
<td>0.000</td>
<td>0.10</td>
</tr>
<tr>
<td>Middle</td>
<td>299</td>
<td>91.6</td>
<td>88.3</td>
<td>-3.3</td>
<td>15.4</td>
<td>0.003</td>
<td>0.20</td>
</tr>
<tr>
<td>High</td>
<td>224</td>
<td>91.8</td>
<td>87.8</td>
<td>-4.0</td>
<td>15.3</td>
<td>0.089</td>
<td>0.00</td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed

As with physical health clients, an analysis was also conducted for behavioral health clients to determine if the trend of having the second six weeks cycle attendance rates higher than the fifth six weeks cycle was unique only to those individuals using the Youth and Family Centers. Analysis of the entire student population, with the exclusion of the students using the Youth and Family Centers, was also conducted. It was determined that the drop in attendance during the fifth six weeks cycle was not unusual. Rather, the decline in attendance from the second six weeks cycle to the fifth six weeks cycle is a trend that appears at the district level. Comparisons between those students who did not receive behavioral health services (N=150,928), in 2005-2006, from the Youth and Family Centers and those that did showed that the decline in attendance rates was the same (1.5%). This demonstrated that the services being provided to students who have behavioral health problems are beneficial, allowing those clients to function and to have attendance rates that are the same as those without behavioral health and emotional complaints.

### Summary

Regardless of the year in which services were sought, level of use, or the grade level of the client, all clients showed a decrease in attendance rates from the second six weeks cycle to
the fifth six weeks cycle. This was not unique to those clients using the Youth and Family Centers, but was evident in the entire Dallas ISD student population’s attendance rates.

2.9 What was the impact of use of the Youth and Family Center program on promotion rates?

Methodology

Students’ promotions, obtained from the district’s database, were reviewed for the 2004-2005 and 2005-2006 school years. All clients who received services during the school year observed were included in the analysis. Promoted was defined as those clients who graduated in 2004-2005 or 2005-2006 or were in a higher grade the year after they sought services from the Youth and Family Centers. The promotion rates were adjusted for those individuals who left the district.

Results

Promotion rates for Youth and Family Centers’ clients are provided in Tables 46 and 47. Table 46 shows promotion rates for 2004-2005. Eighty-eight percent of the 6,668 clients who received physical health services in 2004-2005 were promoted. Slightly fewer high-frequency users (87.2%) than low-frequency users (88.5%) were promoted. Table 46 also shows promotion rates for behavioral health clients in 2004-2005. For the 3,646 behavioral health clients who sought services from the Youth and Family Centers, in 2004-2005, 89.6% were promoted. However, 90.3% of high–frequency users were promoted compared to only 88.8% of low-frequency users.

Table 46
Youth and Family Centers’ Clients Promotion Rates by Service Component, 2004-2005

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Promoted</th>
<th>% Promoted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>6,668</td>
<td>5,873</td>
<td>88.1</td>
</tr>
<tr>
<td>High-frequency***</td>
<td>2,186</td>
<td>1,906</td>
<td>87.2</td>
</tr>
<tr>
<td>Low-frequency**</td>
<td>4,482</td>
<td>3,967</td>
<td>88.5</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>3,646</td>
<td>3,266</td>
<td>89.6</td>
</tr>
<tr>
<td>High-frequency***</td>
<td>1,919</td>
<td>1,732</td>
<td>90.3</td>
</tr>
<tr>
<td>Low-frequency**</td>
<td>1,727</td>
<td>1,534</td>
<td>88.8</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group
Table 47 shows promotion rates for 2005-2006. The promotion rates for both physical and behavioral health clients were much lower than those in 2004-2005. Where 88% of all the physical health clients who received physical health services in 2004-2005 were promoted, only 78% of all physical health clients were promoted in 2005-2006, a difference of 10 percentage points. Of all low-frequency users, 78.8% were promoted, while only 76.6% of the high-frequency users were promoted. Table 47 also shows promotion rates for behavioral health clients in 2005-2006. Of the 3,373 behavioral health clients, 78.4% were promoted. This was a significantly lower promotion rate than the same group in 2004-2005, which had a promotion rate of 89.6%. Of low-frequency behavioral health users, 76.3% were promoted, compared to 88.8% in 2004-2005. Of the high-frequency behavioral health users in 2005-2006, 80.8% were promoted, compared to 90.3% in 2004-2005.

Table 47
Youth and Family Centers’ Clients Promotion Rates by Service Component, 2005-2006

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Promoted</th>
<th>% Promoted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>7,471</td>
<td>5,838</td>
<td>78.1</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>2,247</td>
<td>1,721</td>
<td>76.6</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>5,224</td>
<td>4,117</td>
<td>78.8</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>3,373</td>
<td>2,644</td>
<td>78.4</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,551</td>
<td>1,253</td>
<td>80.8</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>1,822</td>
<td>1,391</td>
<td>76.3</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Summary
Promotion rates for all clients, regardless of service component, declined from 2004-2005 to 2005-2006. In both years, high-frequency users of physical health services had lower promotion rates than lower physical health users. This was expected because high-frequency users would be experiencing higher morbidity than their low-frequency counterparts. As noted earlier, asthma was one of the more prevalent diseases for which clients sought services. As those clients who are high-frequency users improve their own disease management skills, they will ultimately migrate out of the high-frequency user group to the low-frequency user group and, as a result, improve their promotion rates.
In regards to behavioral health services, high-frequency users had higher promotion rates than the low-frequency users, indicating that the behavioral services provided may be having a positive effect by allowing individuals to attain the similar rates of promotion as those individuals not requiring behavioral health services. The promotion rate for the general student population was not available due to the expiration of the Youth and Family Center consultant’s contract.

2.10 What was the impact of use of Youth and Family Centers program on TAKS scores?

Methodology

The *Texas Assessment of Knowledge and Skills* (TAKS) is taken by most Texas public school students in grades 3-11 during spring of each year. The district administered the criterion-referenced TAKS in 2004-2005 and 2005-2006. Grades 3 through 9 took the reading component of the test in both years. Grades 3-10 took the mathematics component. The TAKS is used to measure the students’ knowledge of the standards of the Texas Essential Knowledge and Skills, the state-mandated curriculum. Students must pass parts or all the TAKS in order to be promoted. In 2002-2003, third graders were required to pass the reading component in order to be promoted. In 2004-2005, fifth graders were required to pass the reading and math components in order to be promoted. In 2007-2008, eighth graders are expected to pass the reading and math components of the TAKS in order to be promoted.

Data for those students who were clients of the Youth and Family Centers and had taken the exam were extracted from the districtwide database. Using chi-square, $\chi^2$, test of significance, TAKS pass/fail rates were assessed.

Results

Impact of TAKS Reading

The TAKS reading assessments were administered to grades 3 through 9 in 2004-2005 and 2005-2006. Tables 48 and 49 display passing rates for those clients who sought services at the centers and also took the reading component of the TAKS. Of the 4,700 physical health clients who took TAKS reading in 2004-2005, 69.9% passed. There was no noticeable difference between the low-frequency and high-frequency physical health clients, and the all clients
category. Table 48 also shows TAKS passing rates for behavioral health clients. Of the 2,253 behavioral health clients who took the reading component of the TAKS, 63.4% passed. High-frequency users passed at a higher rate (65.2%) than low-frequency users (61.4%). The passing rates for the physical health group were similar to those observed in the general student population (70.3%). The passing rates for the behavioral health group, though lower, were not that different from the general student population, given their circumstances.

Table 48
Youth and Family Centers’ TAKS Rates for Reading by Service Component, 2004-2005

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>4,700</td>
<td>3,284</td>
<td>69.9</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,401</td>
<td>970</td>
<td>69.2</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>3,299</td>
<td>2,314</td>
<td>70.1</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>2,253</td>
<td>1,429</td>
<td>63.4</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,200</td>
<td>782</td>
<td>65.2</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>1,053</td>
<td>647</td>
<td>61.4</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded  
**Clients with number of visits above the median for the group  
***Clients with number of visits at or below the median for the group

Table 49 displays the number of clients who sought services at the centers and took the TAKS reading component in 2005-2006. Of the 4,342 physical health clients who took the exam, 75.9% passed; this is 6 percentage points higher than in 2004-2005. Low-frequency physical health clients passed at the same rate as high-frequency physical health clients (75.9%). Table 49 also shows TAKS passing rates for behavioral health clients. Of the 1,658 behavioral health clients who took the reading component, 65.3% passed. High-frequency users passed the TAKS at a higher rate (66.2%) than low-frequency users (64.5%). The physical health users’ passing rates were not that different from those experienced by the general student population (76.1%). However, behavioral health users experienced a larger difference than the general student population. This may be because their behaviors may be interfering with their test taking skills.
Table 49
Youth and Family Centers' Clients' TAKS Rates for Reading by Service Component, 2005-2006

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>4,342</td>
<td>3,295</td>
<td>75.9</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,197</td>
<td>909</td>
<td>75.9</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>3,145</td>
<td>2,386</td>
<td>75.9</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>1,658</td>
<td>1,083</td>
<td>65.3</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>791</td>
<td>524</td>
<td>66.2</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>867</td>
<td>559</td>
<td>64.5</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Impact on TAKS Mathematics

The TAKS mathematics assessments were administered to all grades, with the exception of first, second, and twelfth grades in 2004-2005 and 2005-2006. Tables 50 and Table 51 display passing rates of those clients who sought services at the centers and took the mathematics component of the TAKS in both years. Of the 4,668 behavioral health clients who took the TAKS mathematics in 2004-2005, 50.1% passed. Low-frequency physical health clients passed at a higher rate (50.7%) than high-frequency physical health clients (48.7%). Table 50 also shows TAKS passing rates for behavioral health clients. Of the 2,293 behavioral health clients who took the mathematics, 49.7% passed. High-frequency users passed at a higher rate (52.1%) than low-frequency users (46.9%). Mathematics passing rates were slightly higher for the general student population (56.8%) than either of the Youth and Family Center client groups. This difference is possibly the result of the clients' disease burden, which may be interfering with their testing skills.

Table 50
Youth and Family Centers' Clients' TAKS Rates for Mathematics by Service Component, 2004-2005

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>4,668</td>
<td>2,338</td>
<td>50.1</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,375</td>
<td>669</td>
<td>48.7</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>3,293</td>
<td>1,669</td>
<td>50.7</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>2,293</td>
<td>1,140</td>
<td>49.7</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,234</td>
<td>643</td>
<td>52.1</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>1,059</td>
<td>497</td>
<td>46.9</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group
Table 51 displays the number of clients who sought services at the centers and took the TAKS mathematics component in 2005-2006. Of the 4,337 public health clients who took the test in 2005-2006, 55.4% passed. Passing rates were similar for the low-frequency and high-frequency physical health users. Only 48.2% of all behavioral health clients who took mathematics portion passed in 2005-2006. Comparison of the passing rates of the mathematics component of the TAKS showed that physical health clients were similar to those of the general student population (58.4%). But the rates were much lower for the behavioral health clients; this may be the result of behaviors displayed by the clients, interfering with their test taking skills.

Table 51
Youth and Family Centers’ Clients’ TAKS Rates for Mathematics by Service Component, 2005-2006

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>4,337</td>
<td>2,402</td>
<td>55.4</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,206</td>
<td>667</td>
<td>55.3</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>3,131</td>
<td>1,735</td>
<td>55.4</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All*</td>
<td>1,673</td>
<td>806</td>
<td>48.2</td>
</tr>
<tr>
<td>High-frequency**</td>
<td>805</td>
<td>392</td>
<td>48.7</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>868</td>
<td>414</td>
<td>47.7</td>
</tr>
</tbody>
</table>

*Does not include clients who may have been referred, but for whom a visit was not recorded
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Summary

Passing rates were higher in 2005-2006 than 2004-2005 for those students who had taken the reading component of the TAKS. In 2004-2005, physical health clients who were low-frequency users passed the reading portion at higher rates than their high-frequency counterparts. In 2005-2006, physical health low-frequency and high-frequency users had similar reading passing rates. Analysis of the mathematics passing rates showed that in 2004-2005, physical health low-frequency users scored at higher rates than the high-frequency users. Also during that year, behavioral health high-frequency users scored higher on the mathematics portion than the low-frequency users. In 2005-2006, there was no distinction in mathematics passing rates between the two groups of physical health users. However, high-frequency behavioral health scored at higher rates on the mathematics portion of the TAKS. While differences were apparent in passing rates between the high and low frequency users, there was
not a significant difference in the rates and the general student population given the increased disease burden.

2.11 What was the difference in outcomes between high- and low-frequency users?

Methodology

Students' recorded absences were obtained from the district's database. They were assessed for the second and fifth sixth weeks of the 2004-2005 and 2005-2006 school years.

Results

The analysis of Youth and Family Centers clients' attendance rates from the second and the fifth six weeks cycles for the 2004-2005 and 2005-2006 school year is displayed in Tables 52 and 53. Comparisons between high- and low-frequency physical health users showed that low-frequency users consistently had better attendance rates than the high-frequency users. This may be related to disease burden or acuity of disease. The differences in means between these groups were much smaller in 2004-2005 than in 2005-2006. In 2004-2005, the difference between the groups for all six weeks cycles was significant. The same was true for the second six weeks cycle, but by the fifth six weeks cycle there was no noticeable difference between the two groups. Similar comparison for the 2005-2006 attendance rates (Table 53) showed that there was a significant difference in attendance for both groups as measured by the all six weeks cycles, the second six weeks cycle, and the fifth six weeks cycle.

Table 52


<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Std. Error</th>
<th>Difference</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Six Weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Frequency**</td>
<td>2,595</td>
<td>93.5</td>
<td>9.20</td>
<td>0.18</td>
<td>0.54</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>5,281</td>
<td>94.0</td>
<td>8.84</td>
<td>0.12</td>
<td>0.60</td>
<td>0.04</td>
<td>0.03</td>
</tr>
<tr>
<td>2nd Six Weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Frequency**</td>
<td>2,446</td>
<td>93.0</td>
<td>12.14</td>
<td>2.5</td>
<td>0.60</td>
<td>0.04</td>
<td>0.03</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>4,884</td>
<td>93.6</td>
<td>11.58</td>
<td>0.17</td>
<td>0.30</td>
<td>0.17</td>
<td>0.02</td>
</tr>
<tr>
<td>5th Six Weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Frequency**</td>
<td>2,478</td>
<td>94.3</td>
<td>10.55</td>
<td>0.21</td>
<td>0.30</td>
<td>0.17</td>
<td>0.02</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>5,025</td>
<td>94.6</td>
<td>10.06</td>
<td>0.14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group
Table 53

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Std. Error</th>
<th>Difference</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Six Weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Frequency**</td>
<td>2,089</td>
<td>93.0</td>
<td>9.8</td>
<td>0.2</td>
<td>1.1</td>
<td>0.00</td>
<td>0.06</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>4,960</td>
<td>94.1</td>
<td>8.7</td>
<td>0.1</td>
<td>1.1</td>
<td>0.00</td>
<td>0.06</td>
</tr>
<tr>
<td>2nd Six Weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Frequency**</td>
<td>1,917</td>
<td>92.3</td>
<td>12.4</td>
<td>0.3</td>
<td>1.4</td>
<td>0.00</td>
<td>0.06</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>4,600</td>
<td>93.7</td>
<td>10.8</td>
<td>0.2</td>
<td>1.4</td>
<td>0.00</td>
<td>0.06</td>
</tr>
<tr>
<td>5th Six Weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Frequency**</td>
<td>1,982</td>
<td>93.8</td>
<td>11.4</td>
<td>0.3</td>
<td>1.2</td>
<td>0.00</td>
<td>0.06</td>
</tr>
<tr>
<td>Low-frequency***</td>
<td>4,711</td>
<td>95.0</td>
<td>10.2</td>
<td>0.1</td>
<td>1.2</td>
<td>0.00</td>
<td>0.06</td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Tables 54 and 55 show the difference in attendance between high- and low-frequency behavioral health users in 2004-2005 and 2005-2006. For all six weeks cycles, in both years, high-frequency users had a higher rate of school attendance than the low-frequency users. As with the physical health clients, the difference in attendance rates for all 2004-2005 six weeks cycles were much smaller than the difference in attendance rates for the 2005-2006 cycles. It is unclear why this difference exists. However, in 2004-2005, the difference was statistically significant when comparing all six weeks, but when comparisons were made between the high-and low-frequency users in the second and fifty six weeks, there was no statistical difference between the two groups.

Table 55 shows attendance rate comparisons for 2005-2006. As indicated, the difference in rates of attendance between the high-and low-frequency users was much higher in 2005-2006 than the prior year, with high-frequency users consistently having a higher rate of attendance than their low-frequency counterparts. While differences between the two groups were statistically significant for all six weeks cycles and for the second six weeks cycle, this difference did not remain significant in the fifth six weeks cycle.
Table 54

Comparison of Mean Difference in Attendance Rates: High-Frequency Behavioral Health Clients versus Low-Frequency Behavioral Health Clients, 2004-2005

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Std. Error</th>
<th>Difference</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Six Weeks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-frequency**</td>
<td>2,046</td>
<td>94.2</td>
<td>7.5</td>
<td>0.1</td>
<td>0.6</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>Low-Frequency***</td>
<td>1,891</td>
<td>93.6</td>
<td>8.7</td>
<td>0.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd Six Weeks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,957</td>
<td>93.9</td>
<td>10.8</td>
<td>0.2</td>
<td>0.6</td>
<td>0.08</td>
<td>0.03</td>
</tr>
<tr>
<td>Low-Frequency***</td>
<td>1,795</td>
<td>93.2</td>
<td>11.4</td>
<td>0.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5th Six Weeks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-frequency**</td>
<td>2,012</td>
<td>94.8</td>
<td>8.5</td>
<td>0.1</td>
<td>0.3</td>
<td>0.25</td>
<td>0.02</td>
</tr>
<tr>
<td>Low-Frequency***</td>
<td>1,824</td>
<td>94.4</td>
<td>9.7</td>
<td>0.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Table 55


<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Std. Error</th>
<th>Difference</th>
<th>Significance*</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Six Weeks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,506</td>
<td>94.0</td>
<td>7.1</td>
<td>0.2</td>
<td>1.0</td>
<td>0.00</td>
<td>0.06</td>
</tr>
<tr>
<td>Low-Frequency***</td>
<td>1,714</td>
<td>93.0</td>
<td>9.3</td>
<td>0.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd Six Weeks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,441</td>
<td>93.3</td>
<td>10.6</td>
<td>0.3</td>
<td>1.0</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>Low-Frequency***</td>
<td>1,593</td>
<td>92.3</td>
<td>12.6</td>
<td>0.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5th Six-Weeks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-frequency**</td>
<td>1,464</td>
<td>94.4</td>
<td>8.9</td>
<td>0.2</td>
<td>0.7</td>
<td>0.06</td>
<td>0.04</td>
</tr>
<tr>
<td>Low-Frequency***</td>
<td>1,636</td>
<td>93.7</td>
<td>10.8</td>
<td>0.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*2-tailed, equal variance assumed
**Clients with number of visits above the median for the group
***Clients with number of visits at or below the median for the group

Summary

As shown previously, low-frequency physical health users had better attendance than their high-frequency counterparts. This difference may be due to disease burden or acuity of disease. However, in 2004-2005, the difference was only significant when comparisons were made for all six weeks cycles. In 2005-2006, the difference was significant for all six weeks cycles and the second six weeks cycle. High-frequency behavioral health clients had better attendance rates than their low-frequency counterparts. Differences were statistically significant between the two groups regardless of the six weeks cycle observed.
2.12 What were the outcomes for Youth and Family Center clients who received services in 2004-2005 and 2005-2006?

Methodology

Students’ recorded absences were obtained from the district’s database. They were assessed for the second and fifth sixth weeks of the 2004-2005 and the 2005-2006 school years. Promotion rates for 2004-2005 and 2005-2006 were compared to each other.

Results

Table 56 shows physical health clients who had attendance recorded for the second six weeks cycle and the fifth six weeks cycle in both 2004-2005 and 2005-2006. As shown, there were 1,722 physical health clients who had attendance in both cycles in both years. These clients were compared to a control group of students who did not receive physical health services from the Youth and Family Centers. The control group included students matched to the Youth and Family Center clients on gender, grade, campus ethnicity, and free lunch status. Table 56 shows that attendance rates for the control group were higher in 2004-2005 than in 2005-2006, and in both years the attendance rates of the control group exceeded those of the cohort group.

Independent t-tests were used to determine if there was a difference in attendance rates between the cohort and the control groups in both years. The 2004-2005 analysis showed that there was a difference in attendance rates \( t(58,250) = 2.8128, p = 0.0049 \), with effect size negligible at \( d = 0.07 \). The results indicated that there was also a difference in 2005-2006 \( t(58,250) = 4.33, p = 0.001 \), but again the effect size was negligible at \( d = 0.11 \).

An assumption can be made that individuals seeking services at the Youth and Family Centers generally had higher morbidity than those in the control group, although it is possible that while they are matched on demographic characteristics the control group members may have sought physical health services elsewhere. Thus, although there was a statistical difference in attendance rates between the cohort and the control groups, the effect sizes indicate that these differences were negligible. Attendance rates of the physical health clients mirror those of the non-physical health clients, indicating that services are having a positive impact on those clients seeking services. Without these services these clients might have missed significantly more school days.
Table 56

<table>
<thead>
<tr>
<th>Client</th>
<th>2nd Six Weeks</th>
<th>5th Six Weeks</th>
<th>Std. Dev.</th>
<th>Gains</th>
<th>Significance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>96.25</td>
<td>95.08</td>
<td>-1.17</td>
<td>12.62</td>
<td>-0.87</td>
</tr>
<tr>
<td>2005-2006</td>
<td>95.14</td>
<td>93.09</td>
<td>-2.04</td>
<td>12.62</td>
<td>-0.87</td>
</tr>
<tr>
<td>Physical Health control group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>96.84</td>
<td>96.08</td>
<td>-0.76</td>
<td>11.52</td>
<td>-0.93</td>
</tr>
<tr>
<td>2005-2006</td>
<td>96.18</td>
<td>94.50</td>
<td>-1.69</td>
<td>11.52</td>
<td>-0.93</td>
</tr>
</tbody>
</table>

Note: The physical health client group includes those clients who received physical health services in both 2004-2005 and 2005-2006 and who had attendance recorded for the second and fifth cycles in both years. The control group is composed of those Dallas ISD students matched to the behavioral health client cohort on gender, grade, campus, ethnicity, and free-lunch status and had attendance recorded for the second and fifth cycles in both years.

*2-tailed, equal variance assumed

Table 57 shows behavioral health clients who had attendance recorded for the second six weeks cycle and the fifth six weeks cycle in both 2004-2005 and 2005-2006. Like their physical health counterparts, these clients were compared to students in the district who did not receive behavioral health services from the Youth and Family Centers in either year. The control group was matched to the behavioral health group on gender, grade, campus, ethnicity, and free-lunch status. They were also required to have had attendance recorded for the second and fifth cycles in both years. As shown, there were 942 behavioral health clients who had attendance in both cycles in both years. As with the physical health cohort, attendance rates for this group were higher in 2004-2005 than in 2005-2006.

Independent t-tests were again employed to determine the magnitude of the difference between the two groups for both years. Results of the test show that in 2004-2005, there was a statistical difference \[ t (37,989) = 3.63, p = 0.0003 \] but again the effect size was negligible \( d = 0.06 \). In 2005-2006, similar results were found with \[ t (37,989) = 4.06, p = 0.0001 \] and \( d = 0.11 \). Again, the fact that the attendance rates of the physical health clients mirrors that of the non physical health clients indicates that services are having a positive impact on those clients seeking services.
Table 57

<table>
<thead>
<tr>
<th>Client</th>
<th>2nd Six Weeks</th>
<th>5th Six Weeks</th>
<th>Std. Dev.</th>
<th>Gains</th>
<th>Significance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>942</td>
<td>95.73</td>
<td>95.04</td>
<td>-0.69</td>
<td>12.40</td>
</tr>
<tr>
<td>2005-2006</td>
<td>942</td>
<td>94.98</td>
<td>93.72</td>
<td>-1.26</td>
<td>12.40</td>
</tr>
<tr>
<td>Behavioral Health control group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>37,049</td>
<td>96.96</td>
<td>96.30</td>
<td>-0.62</td>
<td>10.77</td>
</tr>
<tr>
<td>2005-2006</td>
<td>37,049</td>
<td>96.51</td>
<td>95.21</td>
<td>-1.34</td>
<td>10.77</td>
</tr>
</tbody>
</table>

*Note: The behavioral health client cohort includes those clients who received behavioral services in both 2004-2005 and 2005-2006 and who had attendance recorded for the second and fifth cycles in both years. The non-behavioral health control group is composed of those Dallas ISD students matched to the behavioral health client cohort on gender, grade, campus, ethnicity, and free-lunch status and had attendance recorded for the second and fifth cycles in both years. *2-tailed, equal variance assumed

Table 58 shows promotion rates for physical health clients and their matched control group. As shown, there were 1,678 physical health clients who received services in both years. Ninety-three percent of these clients were promoted. But, in 2005-2006, only 89.8% of these same clients were promoted. This was a difference of 3.9 percentage points. Comparisons of the control group showed that there were 56,530 students who met the matching requirements. In 2004-2005, 93% of these individuals were promoted. However, in 2005-2006, only 89.4% of the same 56,530 students were promoted. This was a 3.6 percentage point change.

Further analysis showed that promotion rates were not significantly different from the control group in 2004-2005 \(\chi^2 = 1.21\) or 2005-2006 \(\chi^2 = 0.22\).

Table 58

<table>
<thead>
<tr>
<th>Client</th>
<th>N</th>
<th>Promoted</th>
<th>% Promoted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health clients*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>1,678</td>
<td>1,573</td>
<td>93.7</td>
</tr>
<tr>
<td>2005-2006</td>
<td>1,678</td>
<td>1,507</td>
<td>89.8</td>
</tr>
<tr>
<td>Physical Health control group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>56,530</td>
<td>52,601</td>
<td>93.0</td>
</tr>
<tr>
<td>2005-2006</td>
<td>56,530</td>
<td>50,567</td>
<td>89.4</td>
</tr>
</tbody>
</table>

*Includes only those individuals who received services in 2004-2005 and 2005-2006
Table 59 shows promotion rates for behavioral health clients. As shown, there were 866 behavioral health clients who received services from the Youth and Family Centers in 2004-2005 and 2005-2006. In 2004-2005, 91.9% of these clients were promoted to the next grade level. In 2005-2006, 87.3% of the original 866 clients were promoted. This was a difference of 4.6 percentage points. Table 59 also shows promotion rates for the matched control group. As shown, there were 37,049 students who met the matching criteria. In 2004-2005, 92.9% of these students were promoted. However, by 2005-2006, the number promoted dropped to 90.5%, a difference of 2.4 percentage points.

Further analysis showed that promotion rates for the behavioral health cohort were significantly different, but lower than the control group in both 2004-2005 \( \chi^2 = 1.45 \) and 2005-2006 \( \chi^2 = 10.03 \).

| Table 59 |
| Mean Difference in Promotion Rates Between 2004-2005 and 2005-2006 for Behavioral Health Clients* |
|-------------|-------------|-------------|
| Behavioral Health clients | N | Promoted | % Promoted |
| 2004-2005 | 866 | 796 | 91.9 |
| 2005-2006 | 756 | 87.3 |
| Behavioral Health control group | N | Promoted | % Promoted |
| 2004-2005 | 37,049 | 34,447 | 92.9 |
| 2005-2006 | 33,530 | 90.5 |

*Includes only those individuals who received services in 2004-2005 and 2005-2006

_TAKS Reading Passing Rates_  
Analysis of the _TAKS_ reading passing rates were conducted in order to determine how clients using the Youth and Family Centers for physical health services fared in terms of passing the reading portion of the exam (Table 60). In both 2004-2005 and 2005-2006, there were 1,025 clients who received physical health services from the Youth and Family Centers and took the reading portion of the _TAKS_ in both years. Of these clients, 74.9% passed the _TAKS_ reading in 2004-2005 and 79.7% of this same group passed in 2005-2006. This was an increase of 4.8 percentage points. During these two years, there were 33,487 students who did not receive services from the Youth and Family Centers but took the reading portion of the _TAKS_ and met the demographic criteria to be included in the matched control group. Of this group, 74.1% passed
the TAKS reading component in 2004-2005 and 76.8% passed the next year. The change between both years’ passing rates was an increase of 2.7 percentage points.

In 2004-2005, there was no statistically significant difference in passing rates between the physical health cohort and control groups [\( \chi^2 = .29 \)]. However, in 2005-2006, statistical tests showed that there was a positive difference in TAKS reading passing rates between the physical health cohort and the control group in 2004-2005 and 2005-2006 [\( \chi^2 = 4.67 \)].

Table 60

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health clients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>1,025</td>
<td>768</td>
<td>74.9</td>
</tr>
<tr>
<td>2005-2006</td>
<td></td>
<td>817</td>
<td>79.7</td>
</tr>
<tr>
<td>Physical Health control group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>33,487</td>
<td>24,840</td>
<td>74.1</td>
</tr>
<tr>
<td>2005-2006</td>
<td></td>
<td>25,724</td>
<td>76.8</td>
</tr>
</tbody>
</table>

*Includes only those individuals who received services in 2004-2005 and 2005-2006

Table 61 also shows comparisons for behavioral health clients and the matched control group. As shown, there were 20,807 students who were eligible to be included in the control group. Of these students, 73.6% passed the reading component in 2004-2005. The following year, 75.3% passed the exam. This was an increase of 1.7 percentage points.

Further analysis showed that the behavioral health clients passing rates were not statistically different in 2004-2005 [\( \chi^2 = 0.43 \)]. However, further analysis of the 2005-2006 results showed that the difference was statistically significant, but lower, for the treatment group than the matched control group [\( \chi^2 = 9.34 \)].

Table 61

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health clients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>363</td>
<td>273</td>
<td>75.2</td>
</tr>
<tr>
<td>2005-2006</td>
<td></td>
<td>248</td>
<td>68.3</td>
</tr>
<tr>
<td>Behavioral Health control group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>20,807</td>
<td>15,330</td>
<td>73.6</td>
</tr>
<tr>
<td>2005-2006</td>
<td></td>
<td>15,670</td>
<td>75.3</td>
</tr>
</tbody>
</table>

*Includes only those individuals who received services in 2004-2005 and 2005-2006
**TAKS Mathematics Passing Rates**

Analyses were also conducted for those clients who took the mathematics portion of the TAKS and received services from the Youth and Family Centers. As shown in Table 62, there were 1,029 clients who took the mathematics component of the TAKS and received physical health services from the Youth and Family Centers in 2004-2005 and 2005-2006. Of these 1,029 clients, 55.8% passed the exam in 2004-2005. In 2005-2006, 59.5% of the 1,029 clients passed the TAKS. This was an increase of 3.7 percentage points.

Similar to previous analyses, a matched control group was also used. As shown in Table 62, there were 33,892 students who met the specified criteria for inclusion in the control group. Of this group, 63.5% passed the mathematics component of the TAKS in 2004-2005. In 2005-2006, 64.9% of these individuals passed the TAKS, which was a 1.4 percentage point increase.

Further analysis of the differences between the physical health cohort and the control group showed the TAKS passing rates for the physical health client cohort were not significantly different from the passing rates for the control group in 2004-2005 \( \chi^2 = 0.177 \) or 2005-2006 \( \chi^2 = 0.412 \).

**Table 62**

<table>
<thead>
<tr>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>1,029</td>
<td>575</td>
</tr>
<tr>
<td>2005-2006</td>
<td></td>
<td>613</td>
</tr>
<tr>
<td>Physical Health control group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>33,892</td>
<td>38,147</td>
</tr>
<tr>
<td>2005-2006</td>
<td></td>
<td>38,991</td>
</tr>
</tbody>
</table>

*Includes only those individuals who received services in 2004-2005 and 2005-2006

Table 63 displays the TAKS mathematics passing rates for those clients who received behavioral health services and took the mathematics component of the TAKS in 2004-2005 and 2005-2006. The table also shows comparison for the matched control group. Results show that the 385 clients who took the mathematics component of the TAKS and received behavioral health services in both years. Of these clients, 59.2% passed the exam in 2004-2005. However, in
2005-2006, the proportion which passed decreased to 54.2%. This was a decrease of five percentage points.

There were 21,219 students who were eligible for inclusion in the control group. Comparison of this groups showed that 59.6% passed the exam in 2004-2005. In 2005-2006, 59.8% of this group passed the examination; an increase of 0.2 percentage points.

Further analysis of the 2005-2006 passing rates between the behavioral health cohort and the control group showed that the TAKS mathematics passing rates were not statistically different in 2004-2005 \( \chi^2 = .031 \). However, analysis of the data from 2005-2006 showed there was a significant difference, but the treatment group was lower than the control group \( \chi^2 = 4.77 \).

Table 63

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Passed</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health clients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-2005</td>
<td>385</td>
<td>228</td>
<td>59.2</td>
</tr>
<tr>
<td>2005-2006</td>
<td>209</td>
<td>209</td>
<td>54.2</td>
</tr>
<tr>
<td>Behavioral Health control group</td>
<td>21,219</td>
<td>12,661</td>
<td>59.6</td>
</tr>
<tr>
<td>2004-2005</td>
<td>12,661</td>
<td>209</td>
<td>59.8</td>
</tr>
<tr>
<td>2005-2006</td>
<td>21,219</td>
<td>209</td>
<td>59.8</td>
</tr>
</tbody>
</table>

*Includes only those individuals who received services in 2004-2005 and 2005-2006

Summary

Comparisons between physical health and behavioral health cohorts and matched control groups were made for attendance. In both years the control group had higher attendance rates than the behavioral health users. This was statistically significant but had a negligible effect size. Physical health clients showed no difference in promotion rates compared to the control group. Physical health clients also showed no difference between themselves and the control group in regards to TAKS reading. However in 2005-2006 the physical health clients taking the TAKS reading showed a significantly positive difference in passing rates.
SUMMARY AND RECOMMENDATIONS

The Youth and Family Centers are the result of collaboration between Dallas ISD and Parkland Health and Hospital System. All behavioral health services are provided by staff funded by Dallas ISD while physical health services are provided and funded by Parkland’s Community Oriented Primary Care Centers (COPC). There are nine centers placed strategically across the district. The Red Bird Center has the largest client base, and the Seagoville Center has the smallest. The Eddie Bernice Johnson Center, located in South Dallas, is the newest center and the second smallest center. It was the only center without a full-time COPC team in both 2004-2005 and 2005-2006.

In 2004-2005, the Youth and Family Centers operated on a budget of $1.9 million. In 2005-2006, the budget increased to 2.4 million. Approximately 69.5% of the budget for the 2004-2005 year was allocated to wages and salaries, with an additional 14.5% allocated to consulting and professional services. During the 2005-2006 year these same categories had 58.3% and 15.6%, respectively. Extra duty pay for teachers and other professional employees experienced the largest increase from 2004-2005 to 2005-2006. This category quadrupled, from $71,720.00 to $294,184.00. Fixed costs for 2004-2005 amounted to $229,748. This increased to $327,121 in 2005-2006, a 42% increase.

The Youth and Family Centers served 16,162 students and their families in 2004-2005 and 14,575 students and their families in 2005-2006. The majority of the clients seen at the centers were Hispanic, male, and enrolled in elementary school.

As in previous years, the Youth and Family Centers experienced significant problems with data collection. While the centers were required to collect both family employment status and family type information, in 2004-2005, most records did not contain these data. In 2005-2006, the problem still remained, but the number of records without this information was reduced. It is not clear whether the reduction was the result of increased efforts by the center clerks or a random chance. In addition, centers failed to collect presenting problem information. The Kiosco Center and the Red Bird Center provided the most services, but also had the highest number of records that did not have presenting problem information. In 2004-2005, 6.7% of all Youth and
Family Center records had missing behavioral health diagnosis codes. By 2005-2006, this proportion had increased to 20.7%. In addition, in 2004-2005, 15.6% of all records had no procedure code; however, the proportion of records with missing diagnosis codes decreased to 5.7% in 2005-2006. In both years, Seagoville led all centers with the greatest number of records without a procedure code: 41.1% in 2004-2005 and 14.6% in 2005-2006.

During 2005-2006, there appeared to be a significant change in the Youth and Family Centers’ client characteristics. In 2004-2005, 0.5% of presenting clients had private health insurance. By 2005-2006, this number had increased to 9.0%. However, because of the issues with data collection, further analysis needs to be conducted to determine whether this increase is real. In 2004-2005 most clients sought services for behavior and emotional problems. Woodrow/Long provided the greatest number of behavioral health services in 2004-2005 and West Dallas did so in 2005-2006. The leading diagnosis for which clients were seen was attention-deficit disorder which accounted for 24.0% of all diagnoses.

In 2004-2005, the most frequent services provided were therapy sessions with family and student and group therapy sessions with students. In 2005-2006, the leading therapy sessions were individual therapy sessions, which were 45-50 minutes in length. The centers’ staff provided 849 school consultations in 2004-2005 and 852 in 2005-2006. The centers’ staff also provided 41 home visits in 2004-2005 and 62 in 2005-2006.

The last time physical health diagnoses were provided to Dallas ISD was in 2002-2003 due to decisions made by the former COPC administrator because of a misinterpretation of HIPAA regulations. Diagnosis codes for 2005-2006 were requested and received by the evaluator. However, these data were unnecessarily stripped of all identifying demographic information. Cursory analysis of these codes showed that the leading diagnoses fell into two main systems, the respiratory, and the uro-genital system. Analysis of the V codes used indicated that clients were using the centers as their primary care provider, receiving services such as immunizations, routine-medical and child-health examinations. This is a positive indicator of the need for the centers. In addition to well-child services, the centers also provided 1,830 contraceptive visits and 1,497 V codes related to well-woman visits. Further analysis of these
codes showed that West Dallas and Red Bird Centers provided the most of these services. However, these centers also accounted for a disproportionate number of screenings for venereal diseases. Red Bird had 255 well-woman health V codes, 56.5% which were for venereal disease screenings. Eddie Bernice Johnson had the fourth largest number of V codes (141), although it was second smallest center and of these codes, 68.9% were for venereal disease screenings.

In 2003-2004, the centers began billing as Medicaid providers. The first full year in which revenue were collected was 2004-2005. Services provided at the center were billed to ValueOptions, the administrator of the NorthStar Program, which was the behavioral health program. During 2004-2005, the Medicaid billing process was disjointed. Although center managers were responsible for billing for services they did not receive the Explanation of Benefits directly. Thus, many claims that could have been reimbursed if resubmitted were not resubmitted. In 2005-2006, responsibilities of correcting claims was transferred to the center managers, but this change also had problems because the center managers found it difficult to correct every claim submitted due to time constraints. Despite these obstacles in billing, the Youth and Family Centers collected $37,755 in 2004-2005 and $106,943 in 2005-2006. The majority of these monies were used to buy supplies for the centers. In 2005-2006, a portion of the monies were used to send several center managers to the Crimes Against Children Conference, which was held in Dallas.

For those clients who did not qualify for the NorthStar Program offered by ValueOptions, the Youth and Family Centers created a sliding scale fee system based on a similar system used by the federal government. The creation of this scale was a federal requirement because Medicaid statute indicates that an entity which bills Medicaid for one patient cannot provide services free of charge to another who may not be covered by Medicaid. Rather, the patient not covered by Medicaid must be billed for services provided. If fees cannot be collected, the billing entity has the option of writing off these fees as uncollectible. Under the sliding fee scale adopted by the Youth and Family Centers, each family not eligible for Medicaid was required to pay a monthly fee. This fee was to be paid by each family regardless of the number of services or the number of family members seeking services that month. The fee was based on the number of
family members and the families’ gross income. Although the system was created it was not used; fees were not collected from any of the Youth and Family Center clients. This practice of not billing non-Medicaid clients for services received may be a violation of the federal regulations.

In the spring of both 2005 and 2006, surveys were administered to school administrators, school personnel, students who received services from the Youth and Family Centers, and parents of the students who received services from the centers. In both years, the responses to the surveys indicated that school administrators were grateful for the existence of the Youth and Family Centers and thought the services provided were a valuable service. Comments from the administrators indicated that they would like more information regarding the services provided by the center and how to use the referral process. Responses to the parent survey were also favorable, but parents indicated that transportation created a barrier to using the centers. Students, however, indicated that both transportation and language barriers were factors that prevented them from accessing services from the centers. The school personnel survey’s responses were very positive. The majority of respondents believed that students who received services from the centers improved in regards to attendance and academic progress and that the centers were valuable to the students at their respective schools.

Analysis of all the services clients received at the Youth and Family Centers, regardless of component, showed that although the number of clients (both behavioral and physical health) served declined in 2005-2006 compared to 2004-2005, only the mean number of visits for physical health services followed the same trend. The mean number of physical health services decreased from 2004-2005 to 2005-2006 but behavioral health services increased from 2004-2005 to 2005-2006.

Analysis of each component of the program showed that the mean number of visits for all clients seeking physical health services was 1.96 visits in 2004-2005, which decreased to 1.77 visits in 2005-2006. Analysis of all behavioral health clients showed that the overall mean was 6.49 visits in 2004-2005 this declined to 6.37 in 2005-2006.

Regardless of the year in which services were sought, level of use, or the grade level of the client, all clients showed a decrease in attendance rates from the second six weeks cycle to
the fifth six weeks cycle. This was not unique to those clients using the Youth and Family Centers, but was evident in the entire Dallas ISD student population’s attendance rates.

Promotion rates for all clients regardless of service component also declined from 2004-2005 to 2005-2006. High-frequency behavioral health users had higher promotion rates than the low-frequency users, indicating that the behavioral services provided may be having a positive effect by allowing individuals to attain the similar rates of promotion as those individuals not requiring behavioral health services. Preventing students from falling behind can have a positive effect on dropout rates.

In both years, high-frequency users of physical health services had lower promotion rates than lower physical health users. This was expected because high-frequency users would be experiencing higher morbidity than their low-frequency counterparts. However, as clients gain control of their condition and improve their disease management skills they will migrate out of the high-frequency user group to the low-frequency user group and, as a result, most likely see their likelihood of promotion improve.

TAKS passing rates were higher in 2005-2006 than 2004-2005 for those students who had taken the reading component of the TAKS. In 2004-2005, physical health clients who were low-frequency users passed the reading portion at higher rates than their high-frequency counterparts. In 2005-2006, physical health low-frequency and high-frequency users had similar reading passing rates. Analysis of the mathematics passing rates showed that in 2004-2005, physical health low-frequency users scored at higher rates than the high-frequency users. Also during that year, behavioral health high-frequency users scored higher on the mathematics portion than the low-frequency users. In 2005-2006, there was no distinction in mathematics passing rates between the two groups of physical health users. However, high-frequency behavioral health scored at higher rates on the mathematics portion of the TAKS. While differences were apparent in passing rates between the high and low frequency users, there was not a significant difference in the rates and the general student population given the increased disease burden. The passing rates on both components were comparable to the passing rates of the general student population.
Analysis of attendance rates showed that low-frequency physical health users had better attendance than their high-frequency counterparts. This difference may be due to disease burden or acuity of disease. However, in 2004-2005, the difference was only significant when comparisons were made for all six weeks cycles. In 2005-2006, the difference was significant for all six weeks cycles and the second six weeks cycle. High-frequency behavioral health clients had better attendance rates than their low-frequency counterpart. Differences were statistically significant between the two groups regardless of the six weeks cycle observed.

Comparisons between physical health and behavioral health cohort and matched control groups were made for attendance. In both years the control group had higher attendance rates than the behavioral health users. This was statistically significant but had a negligible effect size. Physical health clients showed no difference in promotion rates compared to the control group. Physical health clients also showed no difference between themselves and the control group in regards to TAKS reading. However, in 2005-2006 the physical health clients taking the TAKS reading showed a significantly positive difference in passing rates.

Recommendations

Data Collection

- The Youth and Family Centers have a data collection problem that is prevalent in all the centers. The areas for missing data are presenting treatment, procedure and diagnosis codes (pgs. 14, 18, 19, 22). The latter two are essential for claims filing, billing, and revenue generation. Thus, several steps need to be taken to address the data collection problem.

  - First, because there are many steps and persons involved in the process of collection to the extraction of data from the Youth and Family Centers' database, an external audit of the data entry system needs to be conducted to determine the source of the problem.

  - Second, quality improvement processes and strategies need to be put in place to increase accuracy rates. In addition, the database needs to employ more means to ensure all the data elements have been collected and that the data has been entered into the database in a consistent manner across all centers.

  - Third, data entry quality standards need to be established with a systemwide expectation of 98-100% accuracy.

  - Finally, the Youth and Family Center upper management needs to develop a system to generate monthly reports on missing data elements. These reports need to be shared with managers individually to prevent competition, but provide necessary feedback. In addition, aggregate quarterly summary reports need to
The Youth and Family Centers also appear to have a problem counting the services provided and the number of clients served (pg. 25). Therefore, in order to make sure that the centers can be compared with each other steps need to be taken to make sure there is consistency in how service counts are maintained. As a solution:

- Upper management needs to meet with all individuals responsible for data entry, monthly at first and quarterly after processes are established, to make sure that all persons are consistent in how they count and enter services provided.

Physical Health Diagnoses

- The Youth and Family Centers have not had access to data collected by Parkland COPC since 2003-2004 (pg. 32). Without these data Dallas ISD is unaware of the services being provided and the diseases being treated by Parkland COPC. This limits Dallas ISD’s ability to effectively manage disease outbreaks if they should occur and target specific areas within the district when necessary. Thus, as recommendations:

  - Dallas ISD needs to collaborate with Parkland COPC and develop a process through which data from Parkland can be shared monthly with Dallas ISD.
  - All data delivered from Parkland should contain all identifying information for the patient receiving the service.
  - Because Dallas ISD and Parkland do not share the same patient identifiers, steps need to be taken by the assigned data analyst to develop a method of attaching the records collected from Parkland to attendance, promotion, and TAKS records within the district to measure outcomes for physical health services.
  - Because analysis of these data requires a knowledge of the International Classification of Diseases, Ninth Revision Clinical Modification (ICD-9-CM) and Current Procedural Terminology-4 (CPT-4). It is recommended that the program evaluator have some knowledge of medical coding or be willing to work closely with the Parkland staff to accurately analyze the Parkland physical health data.

- Cursory analysis of the limited data provided by Parkland COPC to Dallas ISD showed that the majority of clients seeking physical health services at the Youth and Family Centers are being treated for such ailments as asthma, allergic rhinitis, and otitis media, etc. (pg. 34). Analysis of the V codes used indicates that the centers are providing a significant number of well-woman exams, and the two centers which are providing the majority of these exams are devoted to venereal disease screenings (pgs. 37-38). Thus, as recommendations:

  - The Youth and Family Centers should develop a multi-faceted health promotion program targeting two areas: respiratory disease and women’s health issues.
  - In order to make the delivery of these health education programs as effective and efficient as possible without placing added pressure on the resources of the center managers, the Youth and Family Centers should partner with the district’s Abstinence Department to deliver the educational programs, especially the well-woman program.
The Youth and Family Centers program should also involve educators and take the potential health care issues, such as those affecting the respiratory system, into the classroom. Development of a program similar to the Drugs and Violence Education (DAVE), which partners with physical education teachers to deliver lessons about drug and violence prevention, could be effective.

Billing

- The Youth and Family Centers have been billing the NorthStar Program for services provided to eligible clients since 2003-2004 (pg. 40). Since becoming a Medicaid provider the program has developed a system for collecting receipts, but has not developed an appropriate method for tracking the number of claims submitted, but rejected by center. Also, the program has developed an elaborate sliding scale fee system to be used with non-Medicaid clients, but has yet to put the system into use. Because non-Medicaid clients are not being billed as outlined in the 1997 Medicaid and School Health: A Technical Assistance Guide, the Youth and Family Centers may be out of compliance. Thus, it is recommended that:
  - The billing procedures and practices should be submitted to the legal department so that they may be reviewed for compliance with current Centers for Medicaid and Medicare Services and State of Texas standards.
  - Because the Youth and Family Centers program does not currently collect the number of claims billed and the number rejected, a retrospective and prospective audit needs to be conducted. As part of these audits, an analysis of billed services, by center, needs to be conducted to determine the amount of services billed versus revenue generated, and the amount of revenue lost due to claims not having all the required information submitted.
  - A gap analysis needs to be performed to determine the cost of the program versus the revenues generated by the licensed professionals.
  - In order to maintain compliance with Medicaid, the Youth and Family Center program should consider using a third party billing agency that can verify, through a clearinghouse, whether a client has health insurance.

Information

- Based on results from the Districtwide Administrator Survey, administrators would like and need additional feedback, communication, and education about what services are provided by the centers and information on how to navigate the referral process (pg. 54). Thus, it is recommended the Youth and Family Center program:
  - Develop a marketing plan or strategy to decrease the percentage of district administrators and non-teaching staff that do not understand the services provided and the referral process for using the centers.
  - Require center managers, as part of their role, to market the program in the schools by making presentations at the principals’ training sessions, PTA meetings, parent groups, counselor training sessions, and Student Support Team meetings. The result of these activities will be that teaching and non-teaching staff, as well as school administration, will be aware of the services provided by the centers and the referral process and will in turn be able to refer clients when necessary increasing the utilization of the centers.
Develop quarterly report cards that can be presented to the school board, principal, etc. The information contained on these cards should employ the Lean Six Sigma strategy currently being embraced by the district. Areas of focus should include (1) quality output of data entry improvement (2) billed versus received revenue (3) analysis of cost of program (4) effectiveness of health education directed program.

Transportation

- Parents who responded to the Parent Satisfaction Survey indicated that transportation posed a problem for them seeking services (pg. 56). Thus, it is recommended that:
  - The Youth and Family Centers should determine whether they can provide transportation as an administrative component of the centers. As stated in the Fact Sheet: Medicaid Transportation Services, Title XIX of the Social Security Act and accompanying regulations require that in their state Medicaid programs, states cover medical care and services and fulfill administrative requirements necessary to operate the Medicaid program efficiently. Among these administrative requirements is the mandate that a state plan “specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers and describe methods that the agency will use to meet this requirement.”

Outcomes

- Determine whether those students who are sicker are actually doing better because they access services at the Youth and Family Centers. Currently, both the Achenbach and the Ohio Youth Problems, Functioning, and Satisfaction Scales are being used as assessment tools for all clients that seek services at the Youth and Family Centers. In order to enhance outcome measures it is recommended that:
  - The data gathered from either or both of these instruments be used to determine the impact of the services of the Youth and Family Centers on students being served.
  - An instrument similar to the Achenbach and Ohio Youth Problems, Functioning, and Satisfaction Scales be used to measure the impact of the physical health services on clients’ functioning.

- Researchers have noted that assessing outcomes within children’s behavioral health services is especially challenging. Because the development of an assessment tool for children’s behavioral health services lags behind the efforts for adults (Weber, 1998), there is a paucity of quality measures.
  
  As shown in this report, outcome data used in this report included TAKS reading and mathematics scores, attendance rates, and promotion rates (pgs.73-95). While these are useful measures to determine the impact the health centers have on the educational outcome of these students within the district, they do not provide an accurate assessment of the mental and physical outcome of those students receiving services. To use test scores and attendance rates, while the norm in the district, may not be the best way to measure outcomes for the Youth and Family Centers because there are numerous confounding factors that influence the results that are beyond the control of the centers. While it is important to show how the health centers affect the district's overall goal, it is equally important to determine the impact services have on the individuals seeking services. In the aggregate, are these students improving, regressing, or do they remain the same? Rather than using only test scores and attendance rates to measure
outcomes of the Youth and Family Centers, it also important to use resources that allow those interested to look at the actual progress each client is making during their course of treatment and after the treatment has ended.

The Youth and Family Centers have been using the Achenbach for many years. This instrument contains three independent assessments: teacher, parent, and child self-report. These assessments are completed for each child every three months. In addition to the Achenbach instrument, in 2005-2006, as required by ValueOptions, the Youth and Family Centers began using the Ohio Youth Problems, Functioning, and Satisfaction Scales. These scales are used to measure the problem severity, functioning, hopefulness, and satisfaction with behavioral health services of each client. Thus, as a recommendation:

- In addition to using the traditional outcome measures, it is suggested that scores from either the Achenbach or the Ohio instruments also be used as an additional outcome measure. Over time, it is possible to track any improvement in an objective manner, free from the difficulties of relying on memory (Ogles, Melendez, Davis et al., 1999).

**Data Reporting**

- The maintenance of a database and the analysis of these data are central to the viability of the Youth and Family Centers program. Without these data the program cannot assess where it has been and where it is going. Currently, the database is the responsibility of a contracted external consultant, who experiences lapses in contract, making it difficult for the Youth and Family Centers program administrators and the evaluator to get the data needed to assess the program. In 2004-2005, data were not delivered to the Youth and Family Center evaluator until eight months after the original request (pg. 3, 82). In 2005-2006, data were received five months after the original request. Therefore it is recommended that:

  - Steps need to be taken to hire a data analyst who is an employee of the district rather than a contractual employee.

- In addition to the need for a full-time district employee, a data dictionary also needs to be created and maintained. Currently, if the consultant is without a contract no employee can accurately extract information from the database because a dictionary does not exist. Therefore it is recommended that:

  - Steps need to be taken to make sure a data dictionary is developed so that users of the database know which fields are required for a particular table.

  - The standard query method be used to pull the data to ascertain that data extracted from the system are valid and reliable.

  - An audit of the database be conducted by an external source to determine data integrity and data consistency. The desired result should be development and publication of the database’s inherent logic, data dictionary, and rules to ensure data consistency and integrity.

**Data Analysis**

- In order to maintain the viability of the program within the district, it is important to show the impact that the centers are having on student attendance, promotion, and TAKS scores as specified by the district’s board. Data analysis, in previous years, has used a cross-sectional analysis limiting the ability to establish a cause and effect relationship or the ability to determine the impact that the centers have had on these three variables.
The current report incorporated a cohort analysis across two years of data and showed that students who used the Youth and Family Centers performed as well as those students who did not have to use the Youth and Family Centers (pgs. 89-95). Therefore it is recommended:

- Future analysis of the Youth and Family Centers must incorporate a cohort analysis as the sample size will allow.
References


Appendix A

Tracking a NorthStar Program Claim
Tracking a NorthStar Program Claim

YFC AA enters Visits into YFC Access Database

YFC AA e-mails Access database information to Operations Specialist monthly

Operations Specialist e-mails spreadsheet with billable visits to each center or AA pulls monthly report for each billable provider

YFC AA submits claims to NorthStar

Problem entering Claims? Center Manager correct problem?

ValueOptions sends reimbursement and the EOB to YFC’s central office

Operations Specialist deposits reimbursement at the DISD treasury, peruses EOB and forwards EOB to managers

CM compares results of EOB with claims submitted

Any claims denies in EOB? Can the claim be corrected?

Center Manager documents on Insurance processing form in client’s chart reason claim can not be resubmitted

Operations compiles report of revenue/center. Forward to YFC Executive Director

Terms:
AA: Administrative Assistant
CM: Center Manager
EOB: Explanation of Benefits
YFC: Youth and Family Centers
Appendix B

Fee for Service Flowchart
Fee for Service Flowchart

Staff will write and make a copy of the bill for the monthly fee. Bill is given to parent. Give parent receipt for dollars received.

Staff Fax a copy of the bill or receipt to YFC Operation Staff. File copy of bill or receipt in client's medical chart.

Enter amount received or owed into YFC ledger.

Dallas ISD Treasury Office deposits funds in the YFC line code(s).

Designated staff will receive money from each center and take such funds to DISD Treasury Office.

YFC staff share ledger documentation with YFC Operations Specialist and release collected funds to designated YFC staff.

Staff explain the fee schedule.
Get Parent's signature.
Place form in client's medical record.

On a regular basis designated staff will receive money from each center and take such funds to DISD Treasury Office.

Terms:
YFC: Youth and Family Centers
Appendix C

Determining Eligibility
CM, AA or designee:
Checks NorthStar
Financial Eligibility
Application to ensure it is
correctly completed and
signed.
Checks to ensure
documentation of
income.

**Everything correct?**

YES

CM, AA or designee:
Makes corrections
necessary to fax
NorthStar Financial
Eligibility Application
to ValueOptions.

**Everything Corrected?**

NO

CM, AA or designee:
Checks NorthStar
Financial Eligibility
Application to ensure it is
correctly completed and
signed.
Checks to ensure
documentation of
income.

YES

YFC Administrative
Assistant:
Faxes forms to
ValueOptions.
Documents fax in client's
file and on center
tracking form.

**ValueOptions**

reports more
information
required or
information sent
needs corrections.

**NorthStar number assigned**

NO

Designated YFC staff:
Calls ValueOptions 1-888-800-67XX and obtains the
client's NorthStar member
number.

Designated YFC staff:
Enters NorthStar # in
Access referral tab.
Writes NorthStar
number in client's
chart.

**ValueOptions**

reports no
information
received.

YES

Terms:
AA: Administrative Assistant
CM: Center Manager
YFC: Youth and Family Centers
Appendix D

Billing Intake Flowchart
Billing Intake Flowchart

Referral

Third Party information written on YFC referral form? YES NO

Child has private insurance or CHIPS for behavior health? YES

Third party's information entered into Access third party tab in referral section

NO

Child Medicaid coverage? YES NO

YFC CM or designee explains to the parent how NorthStar works and asks the parent to bring to the intake:
- Proof of residence
- Last two paychecks stubs
- Utility bills
- Drivers license or state issued identification

VFC CM or designee:
- Asks parent to bring proof of Medicaid insurance to intake appointment
- Calls NorthStar and obtains NorthStar member number
- Writes information on YFC referral form
- Enters NorthStar number into referral section in the Access database

Terms:
- CHIPS: Child Health Insurance Program
- CM: Center Manager
- YFC: Youth and Family Centers
Appendix E

Tracking Revenue Generated from NorthStar Program Claims
Tracking Revenue Generated from NorthStar Program Claims

YFC AA enters Visits into YFC Access Database

YFC AA e-mails Access database information to Operations Specialist monthly

Operations Specialist e-mails spreadsheet with billable visits to each center or AA pulls monthly report for each billable provider

YFC AA submits claims to NorthStar

Problem entering Claims?

Center Manager correct problem?

ValueOptions sends reimbursement and the EOB to YFC's central office

Operations Specialist deposits reimbursement at the Dallas ISD treasury, peruses EOB and forwards EOB to managers

CM compares results of EOB with claims submitted

Any claims denials in EOB?

Can the Claim be corrected

Center Manager documents on Insurance processing form in client’s chart reason claim can not be resubmitted

Operations compiles report of revenue/center. Forward to YFC Executive Director

Terms:
AA: Administrative Assistant
CM: Center Manager
EOB: Explanation of Benefits
YFC: Youth and Family Centers
Appendix F

Diagnosis Codes for which Youth and Family Center Clients sought Physical Health Services
from Parkland Health and Hospital System
Table 1a

Parkland COPC diagnosis codes for physical health services provided at the Youth and Family Centers

<table>
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<th>DIAG</th>
<th>Diagnosis Name</th>
<th>Amelia Flores</th>
<th>Kiosco</th>
<th>Red Bird</th>
<th>Woodrow/Long</th>
<th>Spruce</th>
<th>West Dallas</th>
<th>North Oak Cliff</th>
<th>E.B. Johnson</th>
<th>Seagoville</th>
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<td>V20.2</td>
<td>Routin child health exam</td>
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<td>160</td>
<td>167</td>
<td>190</td>
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<td>477.9</td>
<td>Allergic rhinitis nos</td>
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<td>445</td>
<td>55</td>
<td>5</td>
<td>101</td>
<td>187</td>
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<td>Need prphyl vc vrl hepat</td>
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<td>51</td>
<td>49</td>
<td>9</td>
<td>102</td>
<td>994</td>
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<td>Nd vac tetanus-diphtheria</td>
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### Presenting Problem:
- Choose one:
  1. Behavioral
  2. Emotional
  3. Family Issues
  4. Health Issues
  5. Academic
  6. Truancy
  7. Crisis
  8. Developmental

### Diagnosis:
- Choose one:
  1. Developmental Disorder
  2. Disruptive Behavior Disorders (ADHD, etc.)
  3. Substance Related Disorders
  4. Schizophrenia, etc.
  5. Mood Disorders
  6. Anxiety Disorders
  7. Dissociative Disorders
  8. Sexual and Gender Identity Disorders
  9. Eating Disorders
  10. Adjustment Disorders

### Secondary Services:
Enter all that apply:
- 1. Youth Clubs
- 2. Recreational Arts
- 3. Creative Arts
- 4. Character/Life Skills Training
- 5. Parenting Program
- 6. Health Education
- 7. Health Issues Management
- 8. Substance Abuse Education
- 9. Adult Education
- 10. Academic Assistance

### Treatment:

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### Last Name First Name DOB mm/dd/yy Date of Visit DSM IV Code Treatment Code Provider code and name
Appendix H

Descriptions of Treatment Services Offered at the Youth and Family Centers
Descriptions of Treatment Services Offered at the Youth and Family Centers

Treatment:

1—Medication/pharmacological management. This service involves the psychiatrist’s brief consultation with the client and caretaker in order to continue, discontinue, change, or otherwise modify psychotropic medication which has been part of the previously developed treatment plan.

2a—Individual psychotherapy 45-50 minutes. This service involves scheduled sessions between a licensed mental health professional and the student where the one-on-one relationship stimulates the student’s internal resources for growth and development and helps the student become more responsive to his own needs. In short-term therapy, the provider will focus on the student’s most important problems. A variety of therapeutic approaches may be utilized to obtain treatment plan goals.

2b—Individual psychotherapy 20-30 minutes. The previous description also defines this service with the difference being the length of the session.

3a—Family therapy with student. This service brings the licensed mental health professional together with the client and the client’s family in order to utilize the strengths of the family unit to define and ultimately to solve the presenting problem.

3b—Family therapy without student. Family therapy sessions may proceed when the client refuses to attend, or when marital or parenting issues are paramount in the presenting problem. Because the client’s problems exist in a social context, changes made by other family members are believed to have a direct and beneficial effect on the functioning of the identified client.

4a—Group therapy. During this service a licensed behavioral health professional meets with a small group of students in order to therapeutically advance the students’ psychosocial development. Goals will include helping students recognize their strengths and their own to change as well as assuming responsibility for their own choices.

4b—Group therapy—multifamily. In this service several families meet together with a licensed behavioral health professional and perhaps a co-therapist to share experiences in the evolution and solution of problems. Families learn from each other, feel the burden of isolation lifted, and gain hope and expertise as they interact with each other and the behavioral health professional.

4c—Group therapy—interactive. While all group therapy is interactive, this service applies to elementary-age clients with limited ability to verbally interact with a therapist. An example of this service would be young children involved in therapeutic play activities with a mental health professional.

5—Support group (This is a secondary service.). Clients of family members who share a common circumstance, experience, condition, or problem meet together to share their experiences, improve coping skills, and provide and receive support. Examples of support groups are grandparents raising grandchildren, parents of children diagnosed as having ADHD, mothers of multiple, families who have lost a loved one, etc. Because the benefits of support groups come from the affiliation of the members themselves who have been or are in the same life circumstance, facilitators of such groups need not be licensed behavioral health professionals, but merely interested, responsible individuals with good people and organizational skills. Indeed, after a support group becomes established, group members themselves may fulfill the roles of the facilitators or contact persons.
6a—School interventions—behavior management plan. In this service an appropriately qualified member of the behavioral health treatment team develops and writes a structured behavior plan to be used by teachers and/or parents. The behavior plan will be part of the student’s overall treatment to ensure increased school success.

6b—School interventions—school personnel consultation. This service is a collaborative process of interaction between a member or members of the behavioral health treatment team and school personnel who are directly involved with the education of the referred student. The consultant ideally facilitates the coping and creative skill of the educator, and also the school personnel’s point of view. The Youth and Family Center’s treatment plan may call for this student’s primary educator and/or other person who is significantly involved with the student in the school setting. The service of school consultation will involve sharing information learned at the school site with the treatment team members as well as providing hypotheses, suggestions, and encouragement to the educator from the team in order to more clearly identify problems and to engage school personnel in taking on new responsibilities and trying novel approaches with the referred student.

6c—School intervention—ARD meeting. A member of the behavioral health treatment team attends a referred special education student’s school milieu in order to observe the student’s reaction to academic material, what the student does when assignments are made, how the student responds when called upon, and what the student’s interaction with peers is like. A form entitled Observation of Classroom Behavior is available at the centers to use for this purpose. More structured rating scales in which behaviors are precisely categorized, described, and checked off as occurring or not occurring, may also be utilized depending on the information wanted and upon the request and/or approval of the treatment team.

7—Psychiatric assessment. Through review of the school referral information and psychosocial, medial, and developmental history, and an interview with the clients and caregivers, an evaluation of the client’s emotional/behavioral functioning is completed by members of the treatment team.

8a—Psychiatric therapy with mediation 45-50 minutes. More than medication management, this service is provided by a psychiatrist when additional psychiatric attention is needed by a client in order to further assess the psychiatric condition being treated, provide therapy, address a crisis or other stressor which has arisen, or help determine why progress is not being made with a current treatment plan.

9—Intake/assessment licensed clinician. A licensed behavioral health professional obtains detailed developmental and historical information by interviewing the client and the client’s caregiver or caregivers. From this process, the provider formulates hypotheses, determines diagnoses, and makes recommendations which will be shared with other members of the treatment team.

10—Home visit. Treatment team members may call for this service before and/or during treatment in order to provide or obtain information when a family has not been able to accomplish its goals for the treatment process.

11—Intake/assessment non-licensed professional. An appropriate worker in the behavioral health field accurately records, from an interview, the client’s developmental and historical information as well as observes the client and family presented and notes their concerns and wishes regarding the presenting problems and possible alternatives to address them.

12—Diagnostic re-evaluation licensed clinician. Another evaluation conducted through review of current school and home functioning and personal interview of the client and is done in the initial evaluation, diagnoses, determination of current functioning level, and recommendations are made.
13—Psychological testing. This service involves the administration of psychometric and projective measures by an appropriately certified and/or licensed professional for the purpose of improving treatment through a more clearly defined diagnosis and better understanding of the thinking processes and affective state of the client.

14—Crisis intervention. Unscheduled therapy sessions sometimes occur when immediate attention is needed to address critical issues in the student’s life or psychological development.
Appendix I

Descriptions of Secondary Services Offered at the Youth and Family Centers
Descriptions of Secondary Services Offered at the Youth and Family Centers

1—Youth clubs. Some centers may offer a meeting place for clubs. Students who are clients at the center may participate in club meetings and activities thus increasing their social skills and friendships as well as their interest in hobbies and organizations.

2—Recreative arts. Youth and Family Centers may involve clients and their parents in organized activities such as games and sports that stimulate the mind and body and provide enjoyable social relationships with others.

3—Creative arts. Music, arts and crafts, skit production, and other creative activities may be offered at the centers as opportunities for expression, social interaction, and practice in the development of skills and talents.

4—Character/life skills training. This service is small group work which involves the referred student with peers who would also benefit from improved ability to make and keep friends, to cope with disappointment, criticism, and frustration, to identify, express, and manage feelings, to solve problems, to give and receive genuine feedback, and to make decisions in their own and others’ best interests. Character/life skills training will usually be an additional service prescribed by the behavioral health team to augment the goals of the primary treatment. Group should be limited to five to eight members, have defined inclusion and exclusion criteria, addresses specific concerns, have a structured format with prepared curriculum, and involve feedback to the parents and treatment team.

5—Parenting program. This service involves trained staff conducting an approved parenting course which focuses on improved family structure, communication, and enjoyment. Examples of such programs are the Boys Town Parenting Program. Some programs may also be formed to educate parents regarding a particular topic of interest pertaining to their children i.e. ADHD, school phobia, separation anxiety, teenage rebellion, etc.

6—Health education. Classes on nutrition, grooming and hygiene, sufficient rest, accident and disease prevention, first aid, exercise, and other topics which promote overall good health may be featured at the Youth and Family Centers or in actual school classrooms.

7—Health issues management. During this service, an appropriately trained individual presents educational and motivational material about a specific health topic i.e. asthma, diabetes, hygienic practices, sexually transmitted diseases, weight management, etc.

8—Substance abuse education. Classes imparting information about legal and illegal drugs as well as reason and potential for addiction are present at some centers.

9—Adult education. Some centers may offer classes of interest to adult family members who utilized the centers as service providers for their children. Examples of such classes are English or Spanish as a second language, accounting, new math, child care, cardio-pulmonary resuscitation, etc.

10—Academic assistance. In this service, certified teachers coach referred students who, in addition to demonstrating behavioral health difficulties, also have educational deficits which may not be receiving individualized attention in school. Students referred for this supplemental service are considered by the behavioral health treatment team to need better academic skills as part of their progress in obtaining better overall adjustment and behavioral health. Providers of this service will seek information from teachers and parents about crucial academic areas which need attention and will focus the session on these specific skills.