Management Summary

FY 24-25

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CONTENTS

ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN (PIP) INDICATORS – SECTION I 4
NETWORK SERVICES – SECTION II 18
CONTINUOUS QUALITY IMPROVEMENT (CQI)-CONCERNS/REQUESTS – SECTION III 32
PROFESSIONAL PARTNER PROGRAM – FAMILY & YOUTH INVESTMENT – SECTION IV 34
HOUSING – SECTION V 39
Appendix A: Complaints and Appeals Category Definitions 42
Appendix B: Critical Incident Category Definitions 43

ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN (PIP) INDICATORS – SECTION I

Region 5 Systems believes in a team-driven process for all programs and departments to be monitored, evaluated, and enhanced on a continual basis. The organization uses the Performance Improvement Plan (PIP) to assist in the team-driven process.

Outcomes Region 5 Systems strives for include:

A. Professional accountability and appropriate resource allocation throughout the organization.
B. Active participation by all employees with opportunities for involvement in decision making and correction of problems that impact them directly.
C. Awareness and understanding among all employees of Region 5 Systems that quality is an essential element in service provision and management.
D. The best possible outcomes for persons served and customers.

During the annual PIP planning process, decisions are made regarding several components of the plan. All employees at Region 5 Systems discuss and give feedback regarding all areas to make a final determination and create the annual PIP.

Following are areas of the PIP and a statement of what they mean:

Component of PIP	Definition
Department, Program, CQI Team	Areas of Region 5 Systems that will be accountable and responsible for carrying out business activities and the PIP indicator.
Scope	Gives range/span to the PIP indicator, with a determination being made to achieve, avoid, eliminate, or preserve.
Organizational Risk Exposure	Illustrates if the PIP indicator is an area that could put Region 5 Systems in jeopardy if the threshold is not met.
Expectation	Helps anticipate what should be occurring regarding Region 5 Systems' business activities.
Quality Indicator	States what is being measured.
Threshold	Identifies a minimum or maximum limit in relationship to the expectation.
Measurement Type	Lists how to interpret the data. Specifically identifies whether quarterly scores are independent, dependent, whether to focus on average, trend, or end of year performance.
Standard	This is an accepted benchmark/measure within the industry or years of past performance. This gives you a value to compare Region 5 Systems' future quarterly performance.
Data Source	Indicates where the information gathered will come from.
Data Collector	The person responsible for gathering the information.
Frequency of Collection	How often information is to be collected and reported.
Frequency of Comparison to Threshold by Program/Department	The identified regularity that programs or departments will review and analyze quarterly information/reports.
Frequency of Corporate Compliance Team and Leadership Team Review	The established occurrence that Corporate Compliance Team and Leadership Team will review and analyze quarterly information/reports.
Baseline	A starting point value to which other future quarterly measurements are compared.

Below are the FY 24-25 indicators that have been reviewed by Region 5 Systems' departments, programs, Leadership Team, Corporate Compliance Team, and made available to all employees. Upon Leadership and Corporate Compliance Team's review, a decision point occurred by accepting the PIP as reported, giving other recommendations, approving, or asking for a quality improvement action plan. The spreadsheet is a breakdown of each indicator, a status of the year's review, and determination if the goal will continue within the FY 25-26 PIP.

Indicator	FY 24-25 Threshold	Review	FY 25-26 PIP Status
CQI-1	Overall stakeholder satisfactory rate will be at 85% or above	Approved	Continue
FYI-1	70% of discharged youth's total CAFAS score will decrease by 20 points when comparing intake vs. discharge scores (All Tracks)	Approved	Continue
FYI-2	40% of youth with an admission score of 80 or more will leave the FYI program with a total CAFAS score below 80 (the required admission score). (All Tracks)	Approved	Continue
FYI-3	60% of youth with a 30-point (severe impairment) admission CAFAS score on any of the 8 domains will decrease to 20-point (moderate impairment), 10-point (mild/minimal impairment) when comparing admission to discharge CAFAS scores. (Must have a 30 in any domain at admission to be included in the sample). (All tracks)	Approved	Continue
FYI-4	75% of youth demonstrate improvement on one or more of the three outcome indicators. (All tracks)	Approved	Continue
FYI-5	85% of all teams will have at least one identified informal support on their team member list (utilize FYI statewide consensus of informal support definition; All Tracks)	Approved	Continue
FYI-6	70% of all teams with an informal support on their team member list will have at least one informal support on their team member list attend child/family monthly team meetings or participate in POC goals (utilizing FYI statewide consensus of informal support definition; All Tracks)	Approved	Continue
FYI-7	100% of FYI youth will be living in their home while served in the FYI program (if youth resides out of their home for less than two [2] consecutive weeks during the month, it will not be considered an out-of-home placement; All Tracks)	Approved	Continue
FYI-8	90% of families will have a team meeting every month (all FYI track participants)	Approved	Continue
FYI-9	30% of clients in the FYI program will reside in rural counties (Traditional track)	Approved	Continue
FYI-10	95% of the FYI Professional Partners' performance will be met on all of their gauges	Approved	Continue

(Cont.)

Indicator	FY 24-25 Threshold	Review	FY 25-26 PIP Status
FYI-11	50% of team meetings each month will have at least one formal support present	Quality Improvement Action Plan	Continue
HOUS-1	70% (SUD/MH track combined) of RAP voucher participants (excluding one-time housing costs/flex fund recipients) will successfully discharge/bridge	Quality Improvement Action Plan	Continue
HOUS-2	The average number of days people are on the waitlist will decrease by 10%. Priority 1 MH: 22 days or less. SUD: 15 days or less. Priority 2 MH: 78 days or less. SUD: 22 days or less.	Approved	Continue
HOUS-3	The RPH, LPH, and RTPH Programs will maintain housing units at no lower than 95% of program unit capacity/utilization (Threshold: RPH 30 Units; LPH 11 Units; RTPH 7 Units) (Capacity: RPH 32; LPH 12; RTPH 8)	Approved	Continue
HOUS-4	95% of the RPH, LPH, and RTPH Housing programs performance will be met on the program gauges: • Clarity Enrollments (program participants are enrolled in Clarity NMIS within the required timeframe) • Annual HQS Inspections Conducted (Annual HQS inspections are conducted within 30 days of initial enrollment date) • Annual HQS Inspection Data (Annual HQS Inspection dates are input into the Clarity HQS no later than 30 days after initial enrollment date)	Approved	Modify
HOUS-5	90% of program participants will remain housed or exit program successfully to other permanent housing (annual measurement)	Approved	Continue
HOUS-6	Less than 10% of program participants will return to unhoused status within 6 months of program enrollment	Approved	Continue
HOUS-7	Less than 15% of program participants will return to unhoused status within 12 months of program enrollment	Approved	Continue
HOUS-8	The average length of time (days) from program enrollment to housing move-in date will be 60-days or less	Approved	Continue
NETW-1	100% of Network Providers will receive a copy of their agency's site visit report as prepared by Region 5 Systems' Network Administration within forty-five (45) business days of completion of the site visit	Approved	Continue
NETW-2	Exit conferences will be completed with 100% of Network Providers at completion of each agency/program site visit	Approved	Continue
OPS.HR-1	100% of all employees shall have a documented, signed semi-annual performance evaluation	Approved	Continue

(Cont.)

Indicator	FY 24-25 Threshold	Review	FY 25-26 PIP Status
OPS.HR-2	100% of all employees shall have a documented, signed annual performance evaluation	Approved	Continue
OPS.HR-3	100% of drills completed per established schedule	Approved	Continue
OPS.HR-4	100% of building occupants will be accurately documented on the pegboard during health and safety drills	Approved	Continue
OPS.HR-5	100% of Region 5 Systems employees will be accurately documented on the pegboard	Approved	Discontinue
PREV-1	100% of organized county community prevention coalitions (16) in southeast Nebraska will participate in substance abuse annual assessments and quarterly BH5 reporting, NPIRS (Nebraska Prevention Information Resource System)	Approved	Continue
PREV-2	Increase the number of visits to the www.talkheart2heart.com website above the baseline (Users: Repeat: 3,471, Unique 1,942) by June 30, 2025	Approved	Modify
PREV-3	100% of all counties will have a local LOSS team serving their area	Approved	Continue
PREV-4	85% of counties (16) in southeast Nebraska will sustain an active community prevention coalition by the end of the fiscal year	Approved	Continue
PREV-5	75% of the counties (16) are represented on YAB membership	Quality Improvement Action Plan	Continue
PREV-6	100% of counties (16) will report on deaths identified and documented as suicide	Quality Improvement Action Plan	Continue
PREV-7	100% of all counties will have a minimum of one school district utilizing an evidence-based Social/Emotional learning curriculum	Approved	Modify
SPEC.PROJ-1	100% of Region 5 Systems' employees complete required trainings according to assigned deadline	Approved	Continue
SPEC.PROJ-2	Community trainings sponsored by Region 5 Systems will result in an overall satisfactory rate of 85% or above	Approved	Continue
SPEC.PROJ-3	Evidence-based implementation training sponsored by Region 5 Systems will result in an overall satisfactory rating of 85% or above.	Approved	Discontinue

(Cont.)

Indicator	FY 24-25 Threshold	Review	FY 25-26 PIP Status
SPEC.PROJ-4	80% of approved evidence-based programs will complete all model fidelity and outcomes reporting requirements to maintain evidence-based practice delivery at the end of the fiscal year. (Example of reporting: In Quarter 3, 80% (8/10) of approved programs, per evidence-based practice, completed requirements)	Approved	Continue
SPEC.PROJ-5	80% of grant awardees will submit outcomes as outlined in their contract each quarter	Approved	Continue
SPEC.PROJ-6	30% of identified abatement strategies will be addressed through grants awarded in FY 24-25	Approved	Modify
SPEC.PROJ-7	100% of funding received from LB1355 in FY 24-25 will be awarded/obligated to address the opioid epidemic within Region 5 Systems' catchment area	Approved	Continue

The second part of this section is a summary of Performance Indicators for Fiscal Year 2024-2025. The indicators are sorted by department/program: Continuous Quality Improvement, Family & Youth Investment, Housing, Network, Operations/Human Resources, Prevention, and Special Projects.

Continuous Quality Improvement:

CQI-1:	Stakeholder surveys						
Threshold:	Overall stakeholder satisfactory rate will be at 85% or above.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
90%	85%	New goal	N/A	N/A	87%	N/A	87%

Family & Youth Investment:

FYI-1:	Aggregated Average Child Adolescent Functioning Assessment Scale (CAFAS).						
Threshold:	70% of discharged youth's total CAFAS score will decrease by 20 points when comparing intake vs. discharge scores (All Tracks).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	70%						
All FYI		72%	69%	74%	70%	68%	68%
Traditional		67%	67%	73%	75%	64%	64%
Transition		72%	100%	75%	83%	86%	86%
Prevention		92%	100%	75%	50%	77%	77%
Juvenile Justice		100%	0%	N/A	N/A	0%	0%
Child & Family Services		N/A	N/A	N/A	0%	0%	0%

FYI-2:	Aggregated average Child Adolescent Functioning Assessment Scale (CAFAS).						
Threshold:	40% of youth with an admission score of 80 or more will leave the FYI program with a total CAFAS score below 80 (the required admission score). (All Tracks).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	40%						
All FYI		65%	69%	42%	43%	54%	54%
Traditional		59%	67%	45%	33%	49%	49%
Transition		72%	100%	50%	83%	79%	79%
Prevention		77%	100%	25%	25%	54%	54%
Juvenile Justice		100%	0%	N/A	N/A	0%	0%
Child & Family Services		N/A	N/A	N/A	0%	0%	0%

FYI-3:	Individual Youth Aggregated Average Child Adolescent Functioning Assessment Scale (CAFAS) scores.						
Threshold:	60% of youth with a 30-point (severe impairment) admission CAFAS score on any of the 8 domains will decrease to 20-point (moderate impairment), 10-point (mild/minimal impairment) when comparing admission to discharge CAFAS scores. (Must have a 30 in any domain at admission to be included in the sample). (All tracks).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	60%						
All FYI		52%	56%	42%	55%	57%	57%
Traditional		50%	50%	45%	45%	52%	52%
Transition		50%	100%	50%	83%	79%	79%
Prevention		62%	100%	25%	50%	62%	62%
Juvenile Justice		75%	0%	N/A	N/A	0%	0%
Child & Family Services		N/A	N/A	N/A	0%	0%	0%

FYI-4:	The three outcome indicators for the FYI program using the Child Adolescent Functioning Assessment Scale (CAFAS). (1) Change 20 points of total score; 2) Decrease severe impairment (30) of any domain; and 3) Decrease total CAFAS score below 80 points).						
Threshold:	75% of youth demonstrate improvement on one or more of the three outcome indicators. (All tracks).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	75%						
All FYI		73%	69%	74%	74%	73%	73%
Traditional		69%	67%	73%	75%	69%	69%
Transition		72%	100%	75%	83%	86%	86%
Prevention		92%	100%	75%	75%	85%	85%
Juvenile Justice		100%	0%	N/A	N/A	0%	0%
Child & Family Services		N/A	N/A	N/A	0%	0%	0%

FYI-5:	Documentation of informal supports on wraparound teams.						
Threshold:	85% of all teams will have at least one identified informal support on their team member list (utilize FYI statewide consensus of informal support definition; All Tracks).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	85%						
All FYI		81%	86%	82%	85%	86%	85%
Traditional		77%	84%	75%	82%	85%	82%
Transition		89%	89%	98%	92%	95%	94%
Prevention		89%	88%	95%	89%	80%	88%
Juvenile Justice		100%	N/A	N/A	N/A	N/A	N/A
Child & Family Services		N/A	N/A	100%	N/A	N/A	100%

FYI-6:	Documentation of informal supports attending child/family monthly team meetings or participating in POC goals.						
Threshold:	70% of all teams with an informal support on their team member list will have at least one informal support on their team member list attend child/family monthly team meetings or participate in POC goals (utilizing FYI statewide consensus of informal support definition; All Tracks).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	70%						
All FYI		68%	77%	75%	78%	73%	76%
Traditional		66%	74%	73%	74%	70%	73%
Transition		82%	88%	82%	89%	83%	86%
Prevention		52%	68%	72%	76%	67%	71%
Juvenile Justice		100%	N/A	N/A	N/A	N/A	N/A
Child & Family Services		N/A	N/A	100%	N/A	N/A	100%

FYI-7:	Place of residence.						
Threshold:	100% of FYI youth will be living in their home while served in the FYI program (if youth resides out of their home for less than two [2] consecutive weeks during the month, it will not be considered an out-of-home placement; All Tracks).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%						
All FYI		99%	99%	99%	100%	100%	100%
Traditional		99%	100%	99%	100%	100%	100%
Transition		100%	100%	100%	100%	100%	100%
Prevention		97%	96%	98%	98%	96%	97%
Juvenile Justice		100%	100%	N/A	N/A	N/A	100%
Child & Family Services		N/A	100%	67%	50%	N/A	72%

FYI-8:	Team meeting summary.						
Threshold:	90% of families will have a team meeting every month (all FYI track participants).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	90%						
All FYI		91%	95%	92%	95%	93%	94%
Traditional		91%	92%	91%	94%	92%	92%
Transition		94%	98%	93%	97%	95%	96%
Prevention		90%	100%	93%	97%	100%	98%
Juvenile Justice		92%	100%	N/A	N/A	N/A	100%
Child & Family Services		N/A	100%	67%	100%	N/A	89%

FYI-9:	County of residence at monthly review.						
Threshold:	30% of clients in the FYI program will reside in rural counties (Traditional track).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
30%	30%	30%	34%	36%	36%	38%	36%

FYI-10:	Professional Partners performance gauges.						
Threshold:	95% of the FYI Professional Partners performance will be met on all of their gauges.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	95%	99%	99%	97%	98%	99%	98%

FYI-11:	Monthly Documentation Review						
Threshold:	50% of team meetings each month will have at least one formal support present.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
75%	50%	New goal	38%	33%	26%	23%	30%

Housing:

HOUS-1:	Persons served within the Rental Assistance Program (RAP) will experience a successful discharge (bridge to Section 8 or other housing, bridge to self-sufficiency or self-terminate assistance).						
Threshold:	70% (SUD/MH track combined) of RAP voucher participants (excluding one-time housing costs/flex fund recipients) will successfully discharge/bridge.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	70%						
Combined		70%	46%	38%	53%	38%	44%
Mental Health		71%	41%	35%	54%	41%	43%
Substance Use Disorder		67%	100%	50%	50%	25%	56%

HOUS-2:	Persons served within the Rental Assistance Program (RAP) Mental Health (MH) and Substance Use (SUD) programs will experience timely access. People receiving one-time housing assistance are excluded from this measure.							
Threshold:	The average number of days people are on the waitlist will decrease by 10%. Priority 1 MH: 22 days or less. SUD: 15 days or less. Priority 2 MH: 78 days or less. SUD: 22 days or less.							
Standard	MH: 14 days SUD: 60 days	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
Priority 1 MH		22 Days	15 Days	3 Days	0 Days	6 Days	3 Days	3 Days
Priority 1 SUD		15 Days	7 Days	15 Days	0 Days	0 Days	0 Days	3.75 Days
Priority 2 MH		78 Days	62 Days	79 Days	94 Days	122 Days	47 Days	85.5 Days
Priority 2 SUD		22 Days	92 Days	82 Days	95 Days	115 Days	33 Days	81.25 Days

HOUS-3:	Rural (RPH), Lincoln (LPH), and Rural Transition-age (RTPH) Permanent Housing Units							
Threshold:	The RPH, LPH, and RTPH Programs will maintain housing units at no lower than 95% of program unit capacity/utilization (Threshold: RPH 30 Units; LPH 11 Units; RTPH 7 Units) (Capacity: RPH 32; LPH 12; RTPH 8)							
Standard	100%	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
Capacity	Overall	95%	93%	83%	83%	81%	83%	83%
	LPH	11	97%	97%	92%	92%	97%	95%
	RPH	30	84%	74%	75%	72%	73%	74%
	RTPH	7	25%	96%	100%	100%	100%	74%
Utilization	Overall			88%	91%	92%	91%	91%
	LPH			100%	97%	100%	100%	99%
	RPH			77%	86%	91%	84%	85%
	RTPH			100%	96%	83%	100%	85%

HOUS-4:	Rural (RPH), Lincoln (LPH), and Rural Transition-age (RTPH) Permanent Housing Performance Gauges							
Threshold:	95% of the RPH, LPH, and RTPH Housing programs performance will be met on the program gauges: •Clarity Enrollments (program participants are enrolled in Clarity NMIS within the required timeframe) •Annual HQS Inspections Conducted (Annual HQS inspections are conducted within 30 days of initial enrollment date) •Annual HQS Inspection Data (Annual HQS Inspection dates are input into the Clarity HQS no later than 30 days after initial enrollment date)							
Standard	Threshold		FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	95%		97%					
Clarity Enrollment Results	Total PH			100%	88%	91%	88%	92%
	LPH			100%	0%	0%	0%	25%
	RPH			100%	100%	100%	100%	100%
	RTPH			100%	100%	100%	100%	100%

		FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
Annual HQS Inspection Conducted Results	Total PH		100%	100%	91%	91%	96%
	LPH		100%	100%	100%	100%	100%
	RPH		100%	100%	85%	82%	92%
	RTPH		100%	100%	100%	100%	100%
Annual HQS Inspection Data Results	Total PH		100%	100%	91%	91%	96%
	LPH		100%	100%	100%	100%	100%
	RPH		100%	100%	85%	82%	92%
	RTPH		100%	100%	100%	100%	100%

HOUS-5:	Persons within Permanent Housing will remain housed (within Region 5 Systems Permanent Housing or by discharging to other permanent housing.						
Threshold:	90% of program participants will remain housed or exit program successfully to other permanent housing (annual measurement).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
90%	90%	91%					
Total PH			90%	90%	92%	89%	90%
LPH			93%	93%	92%	93%	93%
RPH			100%	100%	96%	90%	97%
RTPH			91%	91%	85%	85%	88%

HOUS-6:	Persons served by Permanent Housing will remain housed during the first 6 months of enrollment.						
Threshold:	Less than 10% of program participants will return to unhoused status within 6 months of program enrollment.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
10%	10%	7%					
Total PH			0%	0%	2%	2%	1%
LPH			0%	0%	0%	0%	0%
RPH			0%	0%	0%	0%	0%
RTPH			0%	0%	13%	11%	6%

HOUS-7:	Persons served by Permanent Housing will remain housed during the first 12 months of enrollment.						
Threshold:	Less than 15% of program participants will return to unhoused status within 12 months of program enrollment.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
15%	15%	5%					
Total PH			4%	3%	3%	6%	4%
LPH			0%	0%	0%	0%	0%
RPH			0%	0%	0%	6%	2%
RTPH			20%	20%	20%	17%	19%

HOUS-8:	Number of days between program enrollment and housing move-in date.						
Threshold:	The average length of time (days) from program enrollment to housing move-in date will be 60-days or less.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
Less than 60 days	60	New Goal					
Total PH			28 days	12 days	13 days	18 days	18 days
LPH			0 days	6 days	6 days	2 days	34 days
RPH			7 days	3 days	6 days	7 days	6 days
RTPH			39 days	26 days	22 days	22 days	27 days

Network:

NETW-1:	Time between completion of site visit and distribution of site visit report.						
Threshold:	100% of Network Providers will receive a copy of their agency's site visit report as prepared by Region 5 Systems' Network Administration within forty-five (45) business days of completion of the site visit.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	100%	N/A	100%	100%	100%	100%

NETW-2:	Number of site visit exit conferences.						
Threshold:	Exit conferences will be completed with 100% of Network Providers at completion of each agency/program site visit.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	100%	N/A	100%	100%	100%	100%

Operations / Human Resources:

OPS.HR-1:	Completed semi-annual performance evaluations are submitted to HR by the 5th business day following the performance evaluation deadline (completed evaluation = conducted by the established deadline, documented on the correct form; password-protected and saved on the Y-Drive, hard copy signed by the employee and supervisor, and submitted to HR by the 5th business day following the performance evaluation deadline).						
Threshold:	100% of all employees shall have a documented, signed semi-annual performance evaluation.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	98%	100%	100%	60%	90%	88%

OPS.HR-2:	Completed annual performance evaluations are submitted to HR by the required deadline (completed evaluation = conducted by the established deadline, documented on the correct form; password-protected and saved on the Y Drive, hard copy signed by the employee and supervisor, and submitted to HR by the performance evaluation deadline.						
Threshold:	100% of all employees shall have a documented, signed annual performance evaluation.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	93%	80%	100%	78%	95%	88%

OPS.HR-3:	Completion of drills according to established schedule.						
Threshold:	100% of drills completed per established schedule.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	99%	100%	100%	N/A	100%	100%

OPS.HR-4:	Building occupants are accurately documented during health & safety drills, including pegboard status and visitor sign in, per standard procedures.						
Threshold:	100% of building occupants will be accurately documented on the pegboard during health and safety drills.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	94%	100%	N/A	N/A	96%	98%

OPS.HR-5:	Pegboard status is accurately documented. Supervisors will evaluate the pegboard status of each of the employees they supervise once a month to determine whether it is accurate according to the Pegboard Protocol.						
Threshold:	100% of Region 5 Systems employees will be accurately documented on the pegboard.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	90%	94%	92%	92%	Indicator discontinued effective 4/7/2025	

Prevention:

PREV-1:	Substance abuse annual assessments & quarterly BH5 Reporting, NPIRS Reporting.						
Threshold:	100% of organized county community prevention coalitions (16) in southeast Nebraska will participate in substance abuse annual assessments and quarterly BH5 reporting, NPIRS (Nebraska Prevention Information Resource System).						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	100%	100%	100%	100%	100%	100%

PREV-2:		Number of visits to the website						
Threshold:		Increase the number of visits to the www.talkheart2heart.com website above the baseline (Users: Repeat: 3,471, Unique 1,942) by June 30, 2025.						
Website Users	Standard *(Above baseline numbers)*	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
Repeat	3,471	3,471	10,910	19,896	14,899	13,901	15,594	15,594
Unique User Avg	1,942	1,942	4,791	7,054	6,805	9,379	8,553	8,553

PREV-3:	LOSS Teams in Region 5 service area						
Threshold:	100% of all counties will have a local LOSS team serving their area.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	New Goal	100%	100%	100%	100%	100%

PREV-4:	Sustain active community prevention coalitions throughout southeast Nebraska						
Threshold:	85% of counties (16) in southeast Nebraska will sustain an active community prevention coalition by the end of the fiscal year.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	85%	100%	100%	100%	100%	100%	100%

PREV-5:	YAB youth representation						
Threshold:	75% of the counties (16) are represented on YAB membership						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	75%	83%	69%	69%	69%	69%	69%

PREV-6:	Reporting on deaths by suicide						
Threshold:	100% of counties (16) will report on deaths identified and documented as suicide						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	New Goal	0%	0%	0%	0%	0%

PREV-7:	Evidence Based Practice- Social/Emotional learning curriculum.						
Threshold:	100% of all counties will have a minimum of one school district utilizing an evidence-based Social/Emotional learning curriculum.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	100%	100%	100%	100%	100%	100%

Special Projects:

SPEC.PROJ-1:	Completion of CARF & Region 5 required trainings.						
Threshold:	100% of Region 5 Systems' employees complete required trainings according to assigned deadline.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	100%	97%	16%	46%	62%	100%	100%

SPEC.PROJ-2:	Training evaluations.						
Threshold:	Community trainings sponsored by Region 5 Systems will result in an overall satisfactory rate of 85% or above.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
90%	85%	96%	93%	94%	94%	92%	93%

SPEC.PROJ-3:	Training evaluations from evidence-based implementation programs.						
Threshold:	Evidenced-based implementation training sponsored by Region 5 Systems will result in an overall satisfactory rating of 85% or above.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
90%	85%	91%	N/A	96%	96%	98%	97%

SPEC.PROJ-4:	Adherence to fidelity and outcomes reporting required in maintaining evidence-based program delivery.						
Threshold:	80% of approved evidence-based programs will complete all model fidelity and outcomes reporting requirements to maintain evidence-based practice delivery at the end of the fiscal year. (Example of reporting: In Quarter 3, 80% (8/10) of approved programs, per evidence-based practice, completed requirements)						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	80%	53%	100%	63%	100%	67%	83%

SPEC.PROJ-5:	Adherence to Opioid Settlement Grant contract.						
Threshold:	80% of grant awardees will submit outcomes as outlined in their contract each quarter.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
100%	80%	New Goal	100%	100%	100%	100%	100%

SPEC.PROJ-6:	Region 5 Systems opioid resettlement funds will fund a minimum of two identified abatement strategies each grant cycle.						
Threshold:	30% of identified abatement strategies will be addressed through grants awarded in FY 24-25.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
N/A	30%	New Goal	33%	33%	38%	38%	38%

SPEC.PROJ-7:	Region 5 Systems will have zero funds returned to the Statewide Opioid Fund due to unspent or non-obligated funds.						
Threshold:	100% of funding received from LB1355 in FY 24-25 will be awarded/obligated to address the opioid epidemic within Region 5 Systems' catchment area.						
Standard	Threshold	FY 23-24 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY 24-25 Average
N/A	100%	New Goal	100%	100%	100%	100%	100%

NETWORK SERVICES – SECTION II

Region 5 Systems is accountable for coordinating and overseeing the delivery of publicly funded mental health and substance use services covering 16 counties in southeast Nebraska. Specifically, our purpose is to ensure: 1) the public safety and health of persons served, 2) people's access to services, 3) availability of high-quality behavioral health services, and 4) cost-effective behavioral health services.

Region 5 Systems has created a "Regional Quality Improvement Team" (RQIT) to establish a network of accountability for continuous quality improvement by using data to plan, identify, analyze, implement, and report ongoing improvements, celebrate progress, change, and success. Membership includes a representative from each Network Provider agency and Region 5 Systems' personnel. The following information helps to monitor the system's performance.

Substance Abuse Waitlist and Mental Health/Substance Abuse Capacity:

Region 5 Systems gathers information from Network Providers regarding the number of "Persons Served with Life Experiences" that are waiting to enter various levels of substance abuse and mental health care. Monitoring the waitlist helps determine access into treatment, ensures compliance with state and federal requirements on the placement of priority populations into treatment services, reduces the length of time any person is to wait for treatment services, ensures people are placed into the appropriate recommended treatment services as soon as possible, and provide information necessary in planning, coordinating, and allocating resources.

During FY 17-18 there was a change in the way the waitlist information was gathered, managed, and monitored. Waitlist data was reported via an excel spreadsheet by network providers every Monday and was considered a point-in-time observation of how many people were waiting for treatment.

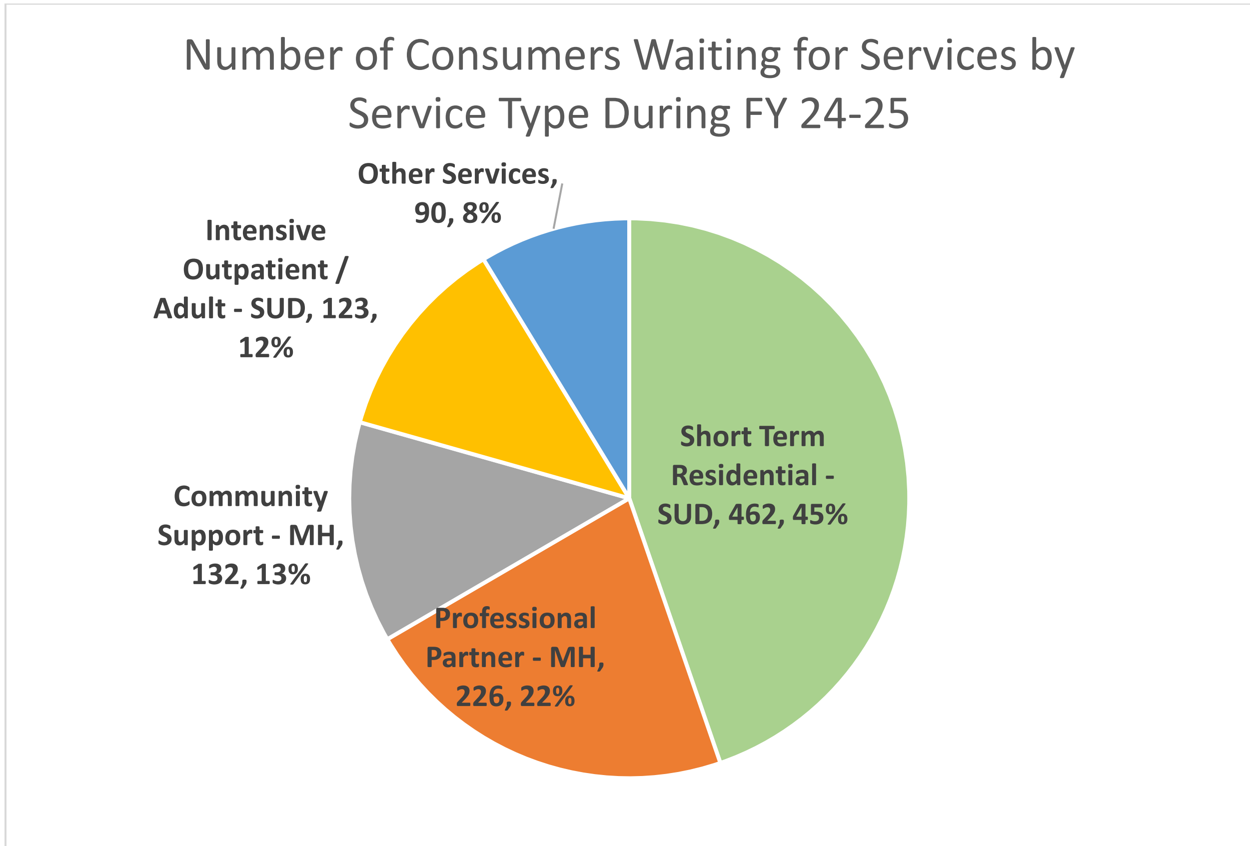
Starting in FY 17-18, information for persons served was entered into the Division of Behavioral Health's Central Data System (CDS). There was a learning curve by the Region and the network providers with utilizing this new system. New ways of entering data, managing the waitlist, and the Region's approach to monitoring continues to be understood and improved.

The Region and network providers continue to implement quality improvement activities to improve the accuracy and validity of the information entered in CDS. For providers who are receiving substance use state or federal dollars, the Substance Abuse Block Grant priority populations for admission include: 1) Pregnant injecting drug users; 2) Other pregnant substance users; 3) Other injecting drug users; and 4) Women with dependent children who have physical custody or are attempting to regain custody of their children.

Current listing of mental health and substance use services that report waitlist:

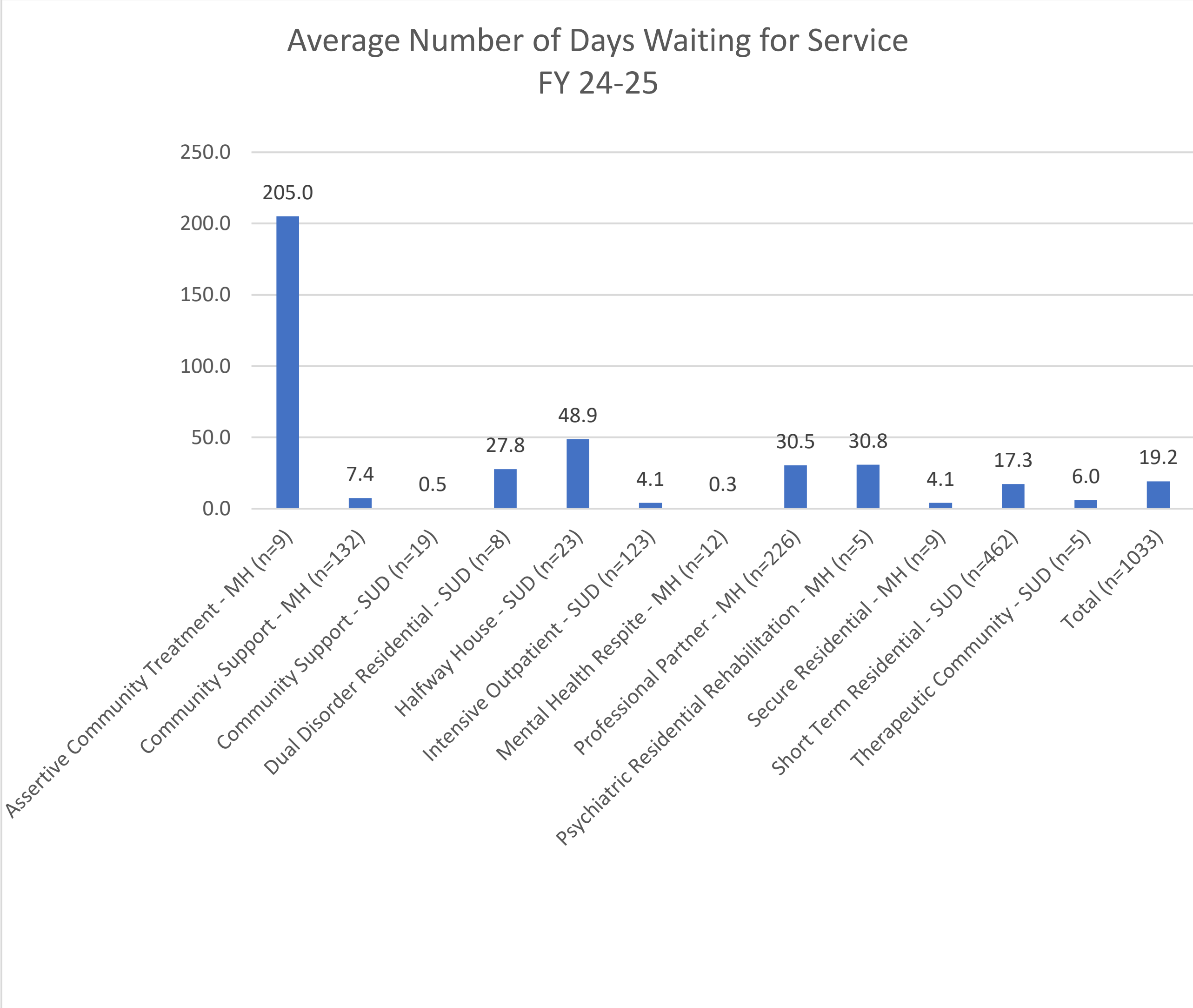
Mental Health Services	Substance Use Disorder Services
ACT (Assertive Community Treatment – MH)	Community Support – SUD
Community Support – MH	Dual Disorder Residential – SUD
Dual Disorder Residential – MH	Halfway House – SUD
Mental Health Respite – MH	IOP (Intensive Outpatient / Adult – SUD)
Professional Partner – MH	Intermediate Residential – SUD
Psychiatric Residential Rehabilitation – MH	Short Term Residential – SUD
Secure Residential – MH	Therapeutic Community – SUD

Below is a chart illustrating the number and percentage of people who waited for services in Fiscal Year 24-25.

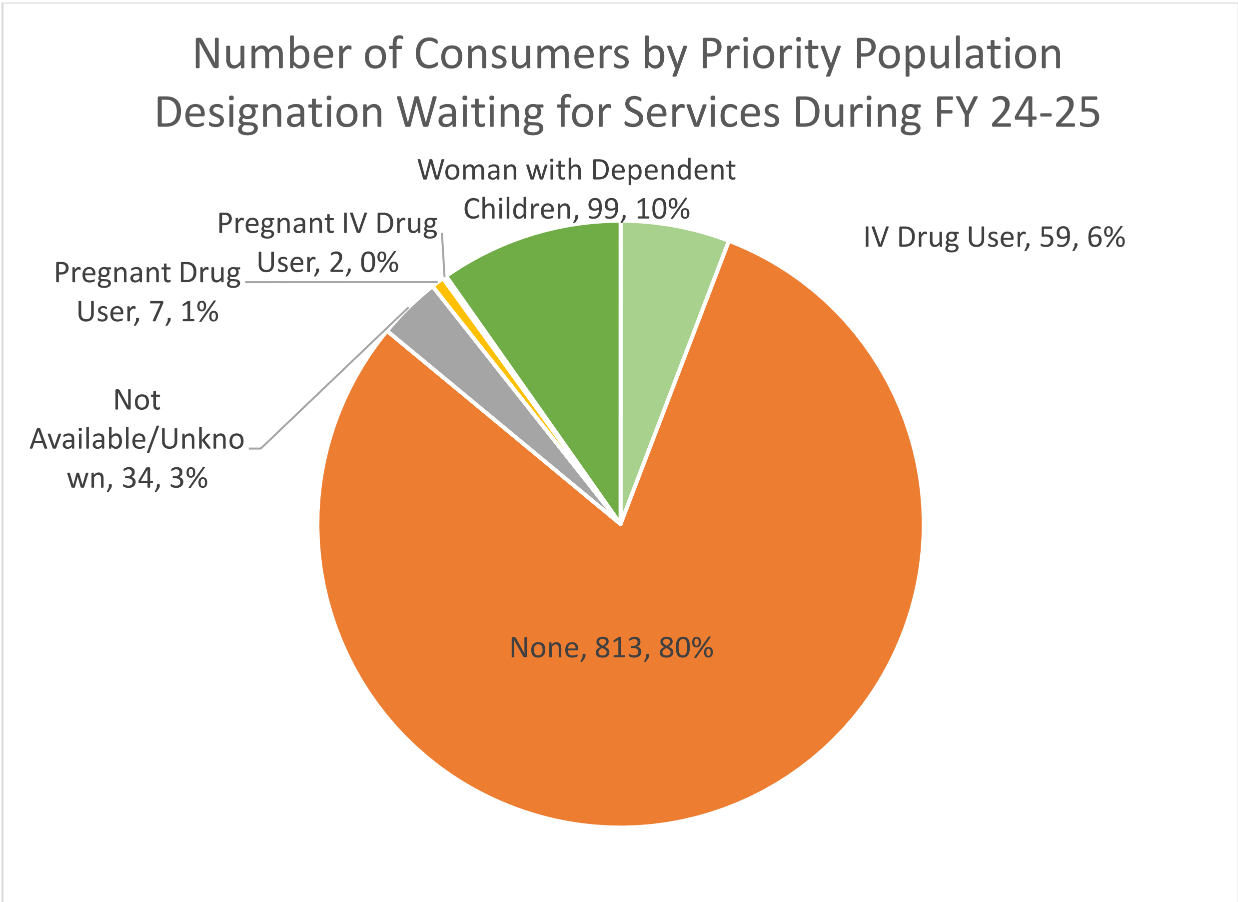


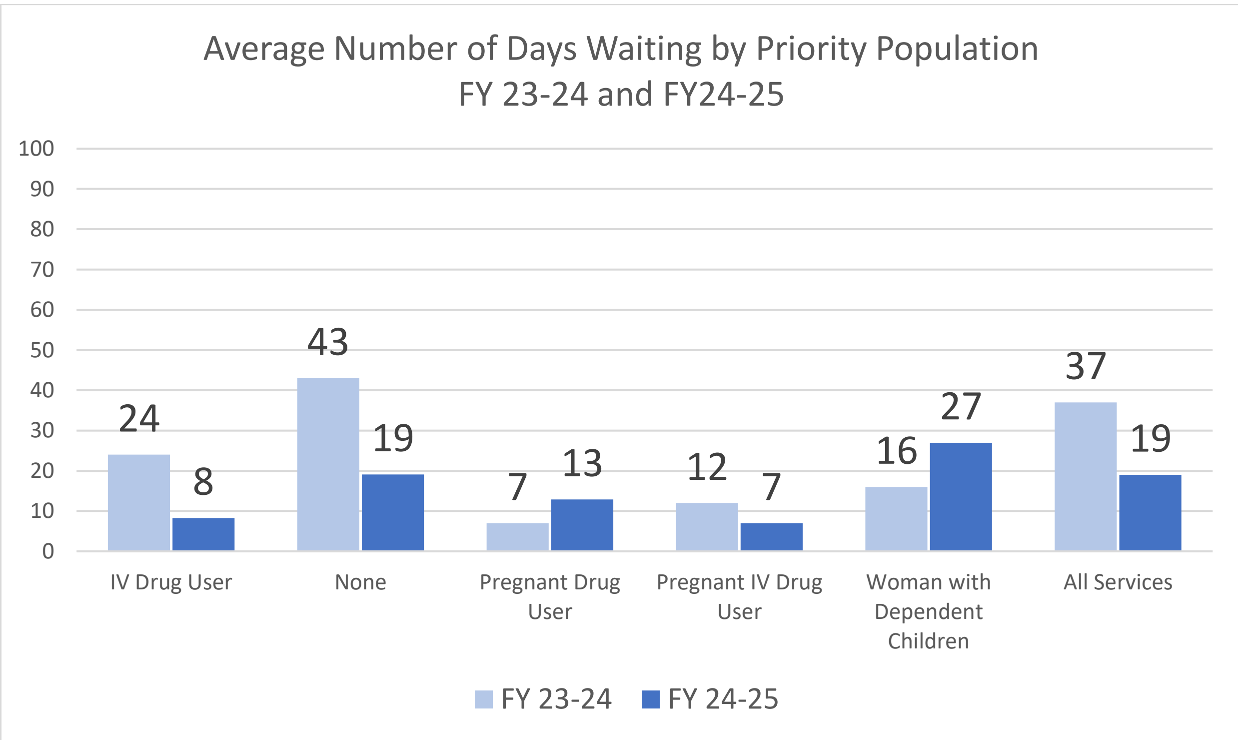
Below is a listing of substance abuse and mental health services available in the Region 5 Systems' network. This is a listing of the average number of days persons served remained on the waitlist until they were removed for various reasons (entering treatment, unable able to be located, refused treatment, went to treatment somewhere else, etc.).

As compared to last fiscal year these average wait times have remained lower due to processes being put in place to monitor data accuracy, ongoing clean-up occurring, electronic health records interfaced with the Central Data System, report accuracy, as well as increasing all users' understanding of the CDS waitlist software. There continues to be quality improvement efforts within the network to increase and maintain the accuracy of this data.

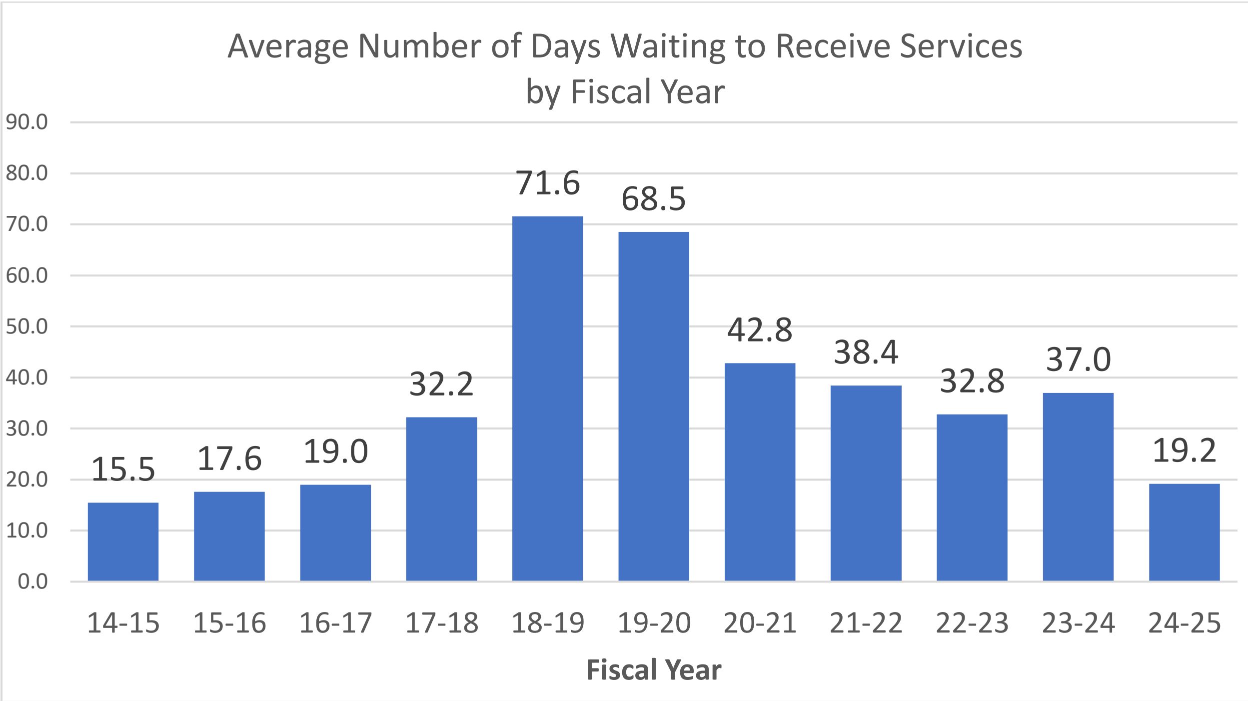


Entrance into substance abuse programs is determined by priority levels identified by the state and federal government. Persons served presenting with these problems take priority in entering treatment over others who do not present with these problems. Women with Dependent Children were the highest priority population identified at 12%.

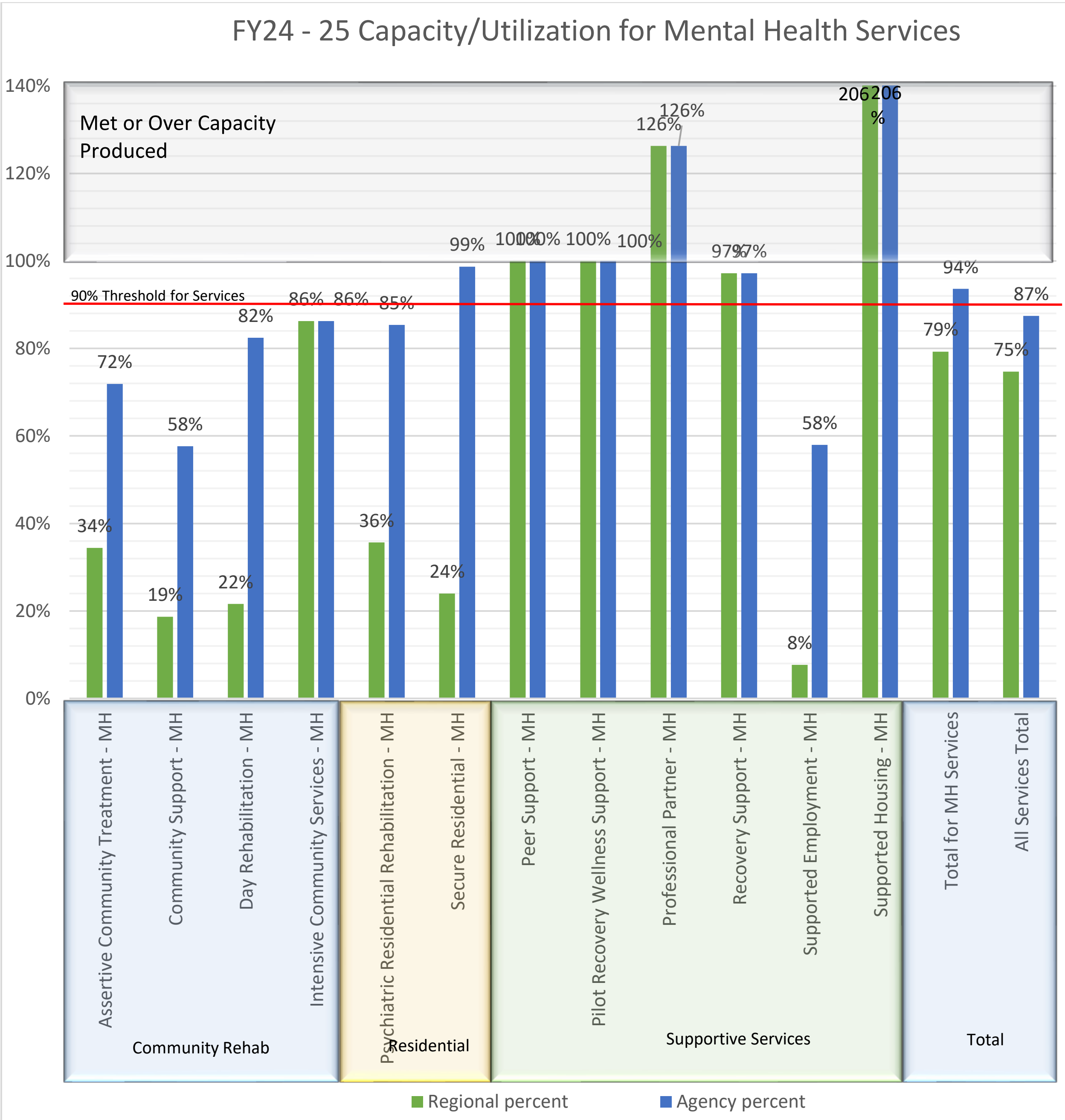

Number of Consumers by Priority Population Designation Waiting for Services During FY 24-25
Woman with Dependent Children, 99, 10%
IV Drug User, 59, 6%
Pregnant IV Drug User, 2, 0%
Pregnant Drug User, 7, 1%
Not Available/Unknown, 34, 3%
None, 813, 80%

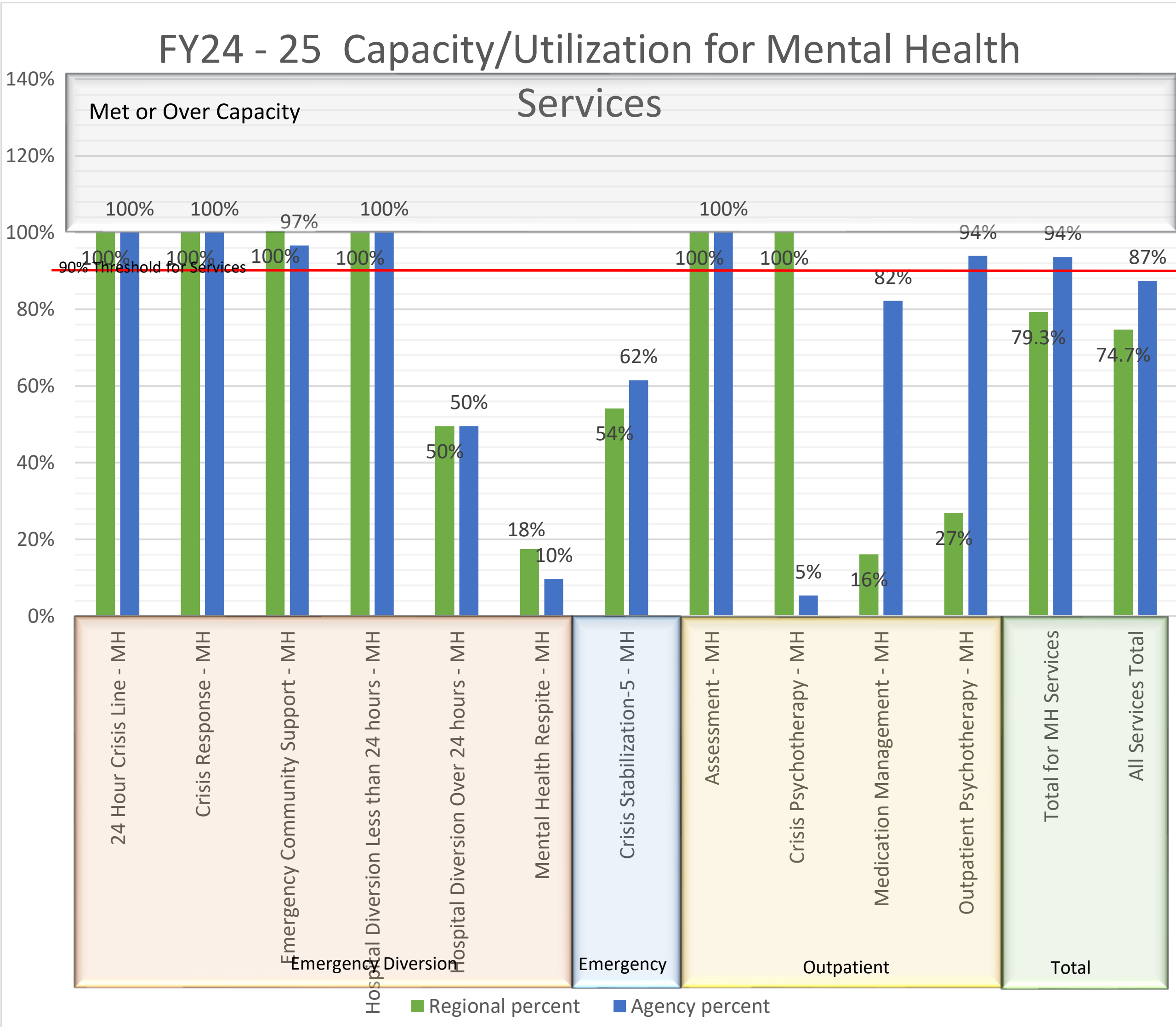

Average Number of Days Waiting by Priority Population FY 23-24 and FY24-25
100
90
80
70
60
50
40
30
20
10
0
24
8
43
19
7
13
12
7
16
27
37
19
IV Drug User
None
Pregnant Drug User
Pregnant IV Drug User
Woman with Dependent Children
All Services
FY 23-24
FY 24-25

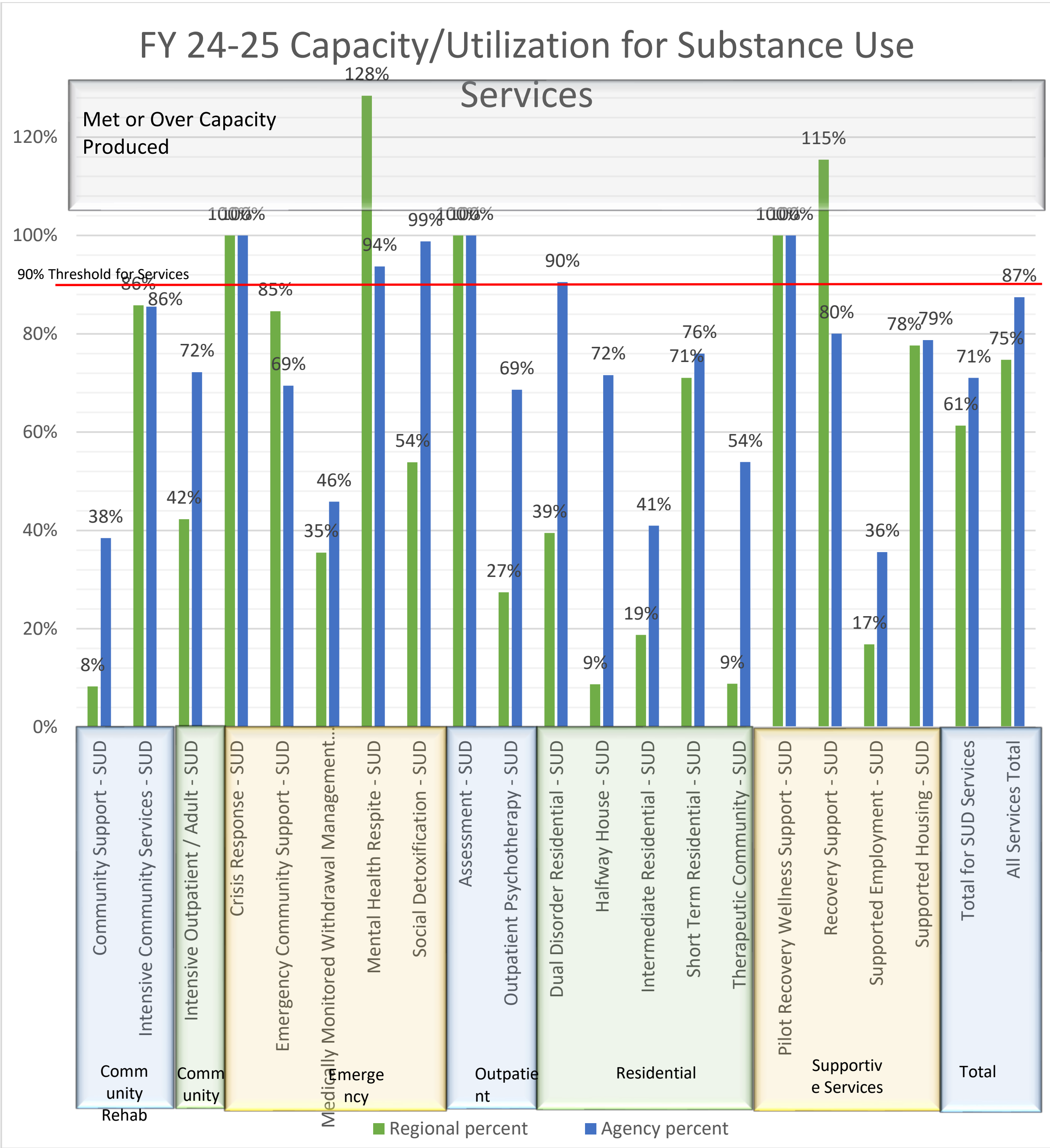
The graph below illustrates the average number of days people wait for all substance abuse services within the Region 5 Systems geographical area.



Region 5 Systems monitors agency capacity, the percentage of capacity used of Region 5 Systems' contract funds, and the overall percentage of capacity used within the network of providers. The agency using over 100% percent of Region 5 Systems' capacity is considered an overproduction on the part of the agency. At the end of the fiscal year, contract adjustments may be made to fund overproduction on services that did not meet capacity. The first two graphs are the Network Mental Health Capacity Report, and the third graph is the Substance Use Capacity Report.


FY24 - 25 Capacity/Utilization for Mental Health Services
140%
120%
100%
80%
60%
40%
20%
0%
Met or Over Capacity Produced
90% Threshold for Services
34%
72%
19%
58%
22%
82%
86%
86%
36%
85%
24%
99%
100%
100%
100%
100%
126%
126%
97%
97%
8%
58%
206
206 %
79%
94%
75%
87%
Assertive Community Treatment - MH
Community Support - MH
Day Rehabilitation - MH
Intensive Community Services - MH
Psychiatric Residential Rehabilitation - MH
Secure Residential - MH
Peer Support - MH
Pilot Recovery Wellness Support - MH
Professional Partner - MH
Recovery Support - MH
Supported Employment - MH
Supported Housing - MH
Total for MH Services
All Services Total
Community Rehab
Residential
Supportive Services
Total
Regional percent
Agency percent


FY24 - 25 Capacity/Utilization for Mental Health Services
Met or Over Capacity
90% Threshold for Services
140%
120%
100%
80%
60%
40%
20%
0%
100%
100%
97%
100%
50%
18%
10%
62%
54%
100%
100%
5%
82%
16%
94%
27%
94%
79.3%
87%
74.7%
24 Hour Crisis Line - MH
Crisis Response - MH
Emergency Community Support - MH
Hospital Diversion Less than 24 hours - MH
Hospital Diversion Over 24 hours - MH
Mental Health Respite - MH
Crisis Stabilization-5 - MH
Assessment - MH
Crisis Psychotherapy - MH
Medication Management - MH
Outpatient Psychotherapy - MH
Total for MH Services
All Services Total
Emergency Diversion
Emergency
Outpatient
Total
Regional percent
Agency percent

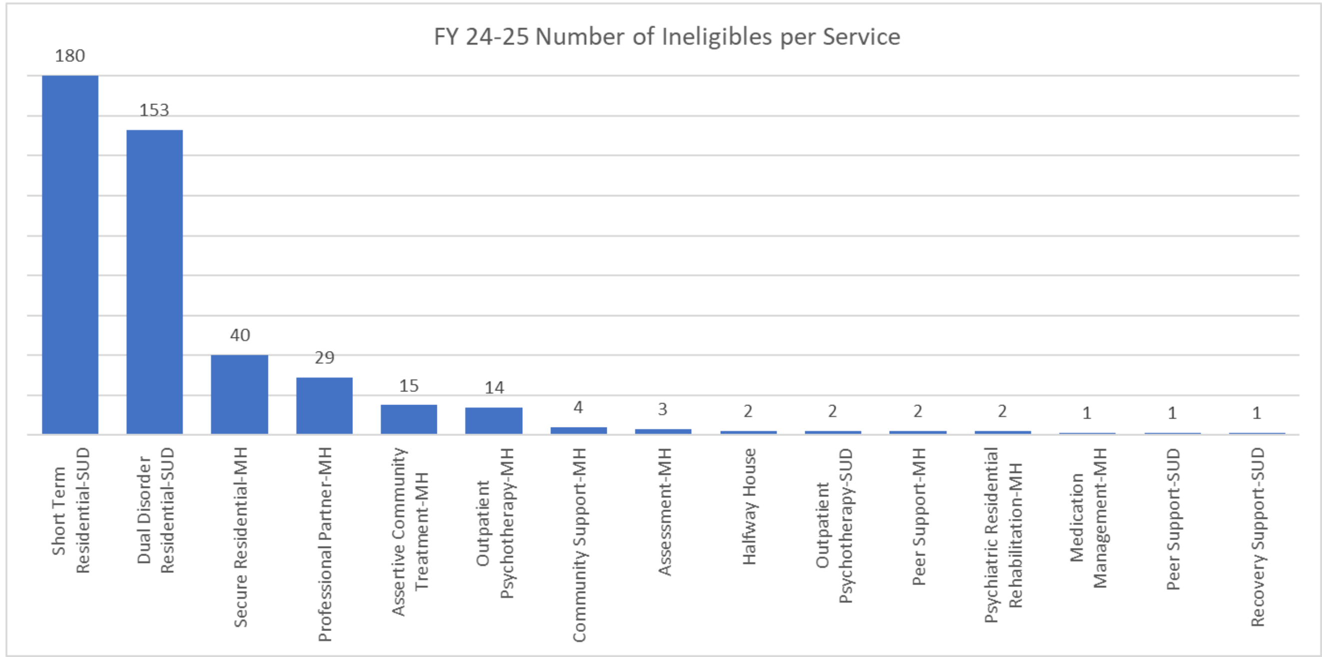


Ineligibles and Denials:

To improve quality standards for people served in the Region 5 Systems provider network, providers document their reasons for either denying or finding a person that is ineligible for services.

A person is deemed **'ineligible'** for service admission by the provider at screening if they do not meet the clinical criteria for the level of service requested or if they do not qualify due to age, gender, or funding reasons.

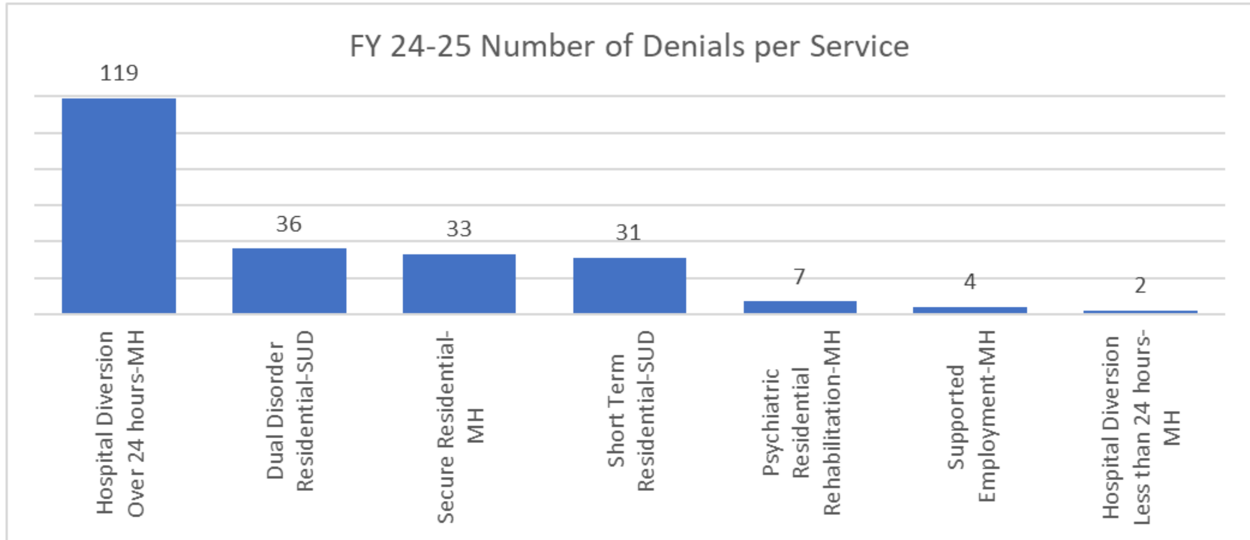
The first chart below identifies the number of people found to be ineligible for services during the FY 24-25 by service.



The following table demonstrates the reasons a person served was found to be ineligible for a service type. “Doesn’t meet other admission criteria” and "Doesn’t have required functional deficits accounted for the highest number of persons found to be ineligible.

Reason for Ineligibility	Short Term Residential	Dual Disorder Residential	Secure Residential	Professional Partner	Outpatient Psychotherapy	Assertive Community Treatment	Community Support	Assessment	Peer Support	Halfway House	Psychiatric Residential Rehabilitation	Medication Management	Recovery Support	Grand Total	Total Percent
Doesn't meet other admission criteria	82	18	4	23	14	10	2	1	3	2	1	1	1	162	36%
Doesn't have required functional deficits		119	9				2							130	29%
Extensive MH, not managed/unstable	46	1	2											49	11%
Medically Unstable	26		5											31	7%
Doesn't meet date of last use criteria	23	6												29	6%
Doesn't meet other clinical criteria		9	2	6	2	4		2						25	6%
Other			11								1			12	3%
Referred by Non-Region 5 Funding			4											4	1%
Recommend Other Level of Care			3											3	1%
Significant Cognitive Impairment	2					1								3	1%
Doesn't meet frequency of use	1													1	0%
Grand Total	180	153	40	29	16	15	4	3	3	2	2	1	1	449	100%

Denials are decisions made by the provider agency at screening to not serve a referral because of agency established exclusionary criteria. Denials may be based on recent aggression against employees or peers, legal history including sexual offenses, or conflicts with peers or employees. The following chart identifies the number of people found to be ineligible for services during FY 24-25 by service.



Most denials were from the category "Person Served is Homeless. This accounted for 32% of denials during FY 24-25.

Denial Reason	Hospital Diversion Over 24 hours	Dual Disorder Residential	Secure Residential	Short Term Residential	Psychiatric Residential Rehabilitation	Supported Employment	Hospital Diversion Less than 24 hours	Grand Total	Total Percent
Person Served is Homeless	73						2	75	32%
Recommend Other Level of Care		18	17	5	5			45	19%
Other	14	16	3	5	1	4		43	19%
At Capacity (Unable to Waitlist)	23		1					24	10%
Recent Aggression	3		11	3				17	7%
Conflict of Interest (With Employee/Person Served)	1			8				9	4%
Legal History				8				8	3%
Out of Region	3	2	1					6	3%
Sexual offender	2			1	1			4	2%
Recent Aggression to Employee				1				1	0%
Grand Total	**119**	**36**	**33**	**31**	**7**	**4**	**2**	**232**	**100%**

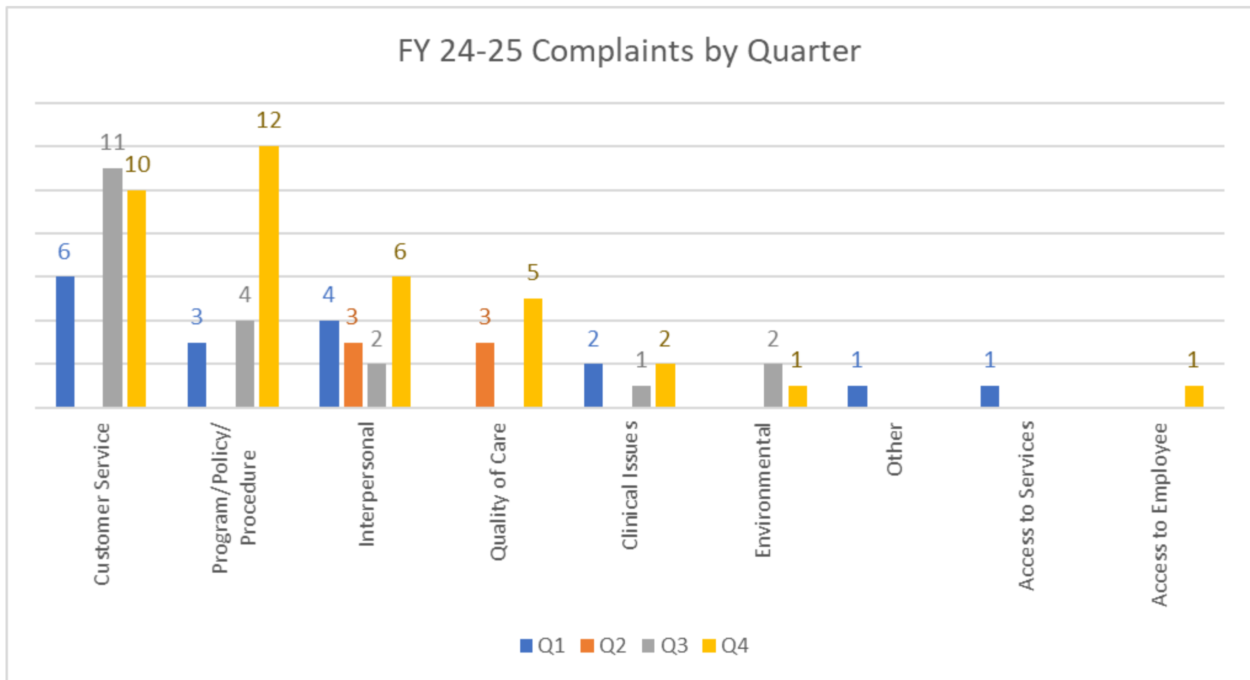
Complaints and Appeals:

To improve quality standards for people served in the Region 5 Systems network, providers report on their complaints and appeals received.

Complaints are defined as a formal written grievance by a person served to express dissatisfaction with any aspect of the operations, activities, or behavior of a Network Provider for which such grievance cannot be resolved at an informal level. Addressing such complaints will follow the Network Provider's established protocol for written complaints.

An **appeal** is a formal request made by a person served for review and reconsideration of the outcome of his/her formal written complaint when the person served is unhappy with the action taken by the Network Provider to remediate the complaint. The person served follows whatever appeal process is set up by the Network Provider.

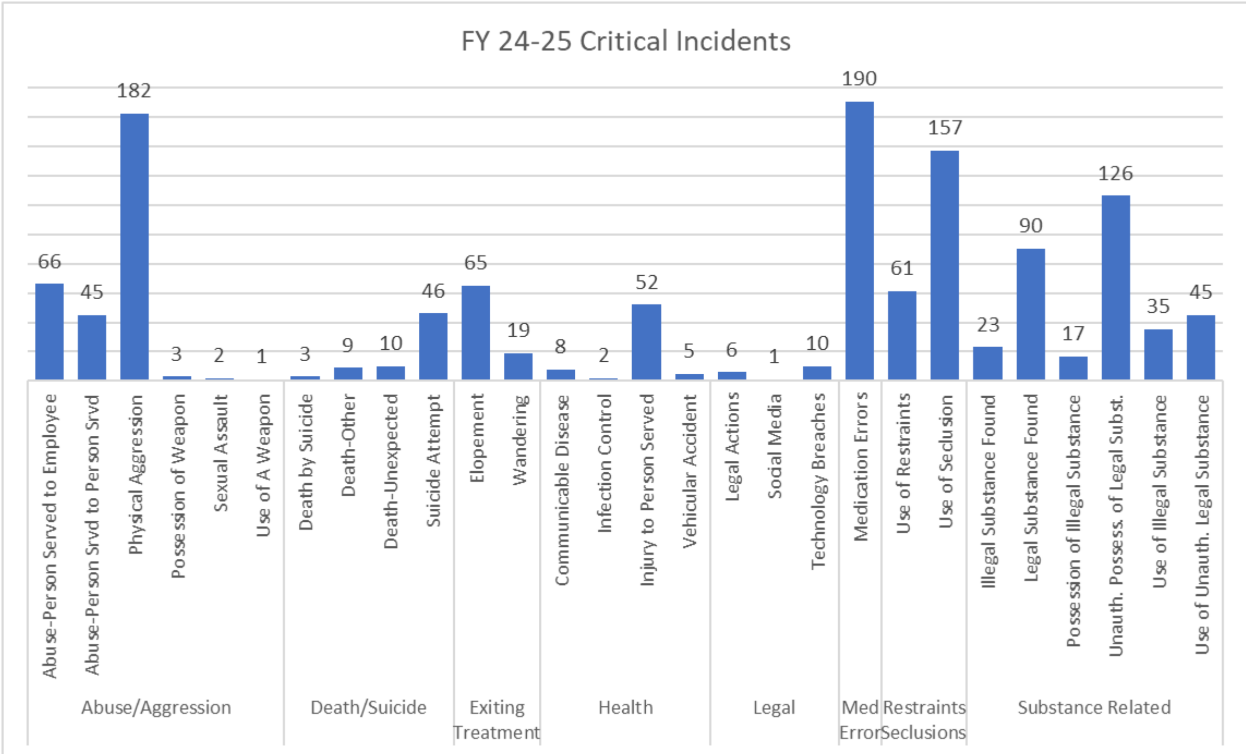
Please see Appendix A for the definition of each category of complaints and appeals being reported on.



There was one appeal in FY 24-25 regarding frequent cancellation of meetings.

Critical Incidents:
Region 5 Systems' providers submit critical incidents to Region 5 Systems on a quarterly basis. **Critical incidents** are actual or alleged events or situations that create a significant risk of substantial or serious harm to the physical, mental health, safety, or well-being of a person served or the Network Provider. Please see Appendix B for the definition of each Critical Incident Category.

The following chart illustrates the type and number of critical incidents received during FY 24-25.



The data reported is by incident and not by person. There may be duplicate people in the data reported above.

Incident Domain	Incident Type	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY 24-25
Abuse/ Aggression	Neglect	7				1	4	
	Physical Aggression	165	154	168	227	172	209	182
	Possession of Weapon	3	2	2	5	9	2	3
	Sexual Assault	5	1	3	5	6	1	2
	Use of A Weapon	1	1		1			1
	Abuse-Person Served to Person Served	49	26	33	58	51	57	45
	Abuse-Person Served to Employee	45	24	42	55	78	87	66
	Abuse-Employee to Person Served					2		
	Total	**275**	**208**	**248**	**351**	**319**	**360**	**299**
Death/ Suicide	Death By Homicide			1		3	1	
	Death by Suicide	2	3	3	2	2	1	3
	Death-Unexpected						2	10
	Suicide Attempt	5	12	15	28	36	24	46
	Death-Other	10	21	23	29	21	7	9
	Total	**17**	**36**	**42**	**59**	**62**	**35**	**68**
Exiting Treatment	Elopement	128	108	45	71	87	87	65
	Wandering	1	3	1		2	5	19
	Total	**129**	**111**	**46**	**71**	**89**	**92**	**84**
Health	Biohazardous Accidents	7	1	3	2	4	2	
	Communicable Disease	3	18	53	88	87	21	8
	Infection Control	2	1	3		16	4	2
	Vehicular Accident	4	5	3	3	7	4	5
	Injury to Person Served	55	58	82	52	49	59	52
	Total	**71**	**83**	**144**	**145**	**163**	**90**	**67**
Legal	Legal Actions	2	2		1			6
	Social Media	2	1	1				1
	Technology Breaches	4	3	1	1	2	4	10
	Total	**8**	**6**	**2**	**2**	**2**	**4**	**17**
Medication Errors	Medication Errors	69	153	134	116	153	87	190
	Total	**69**	**153**	**134**	**116**	**153**	**87**	**190**
Restraints/ Seclusions	Use of Restraints	3	3	2	3	0	1	61
	Use of Seclusion	187	166	164	221	214	229	157
	Total	**190**	**169**	**166**	**224**	**214**	**230**	**218**
Substance Related	Illegal Substance Found	16	17	18	17	14	24	23
	Legal Substance Found	156	143	182	217	89	108	90
	Possession of Illegal Substance	11	7	11	5	6	11	17
	Unauthorized Possession of Legal Substance	46	224	185	57	58	59	126
	Use of Illegal Substance	25	33	33	21	48	24	35
	Use of Unauthorized Legal Substance	69	102	94	113	174	59	45
	Total	**323**	**526**	**523**	**430**	**389**	**285**	**336**
Grand Totals		**1082**	**1292**	**1305**	**1398**	**1391**	**1183**	**1279**

Quality Improvement Actions

Every provider who has a critical incident indicates whether the incidents reported were part of a larger trend in agency or program and what quality improvement actions were undertaken to prevent or reduce further incidents. Some examples of these from FY 24-25 were trainings to reduce medication errors, staff education on programmatic changes, DBT skills for de-escalation of aggression, and tobacco cessation classes and options to decrease tobacco use at residential services.

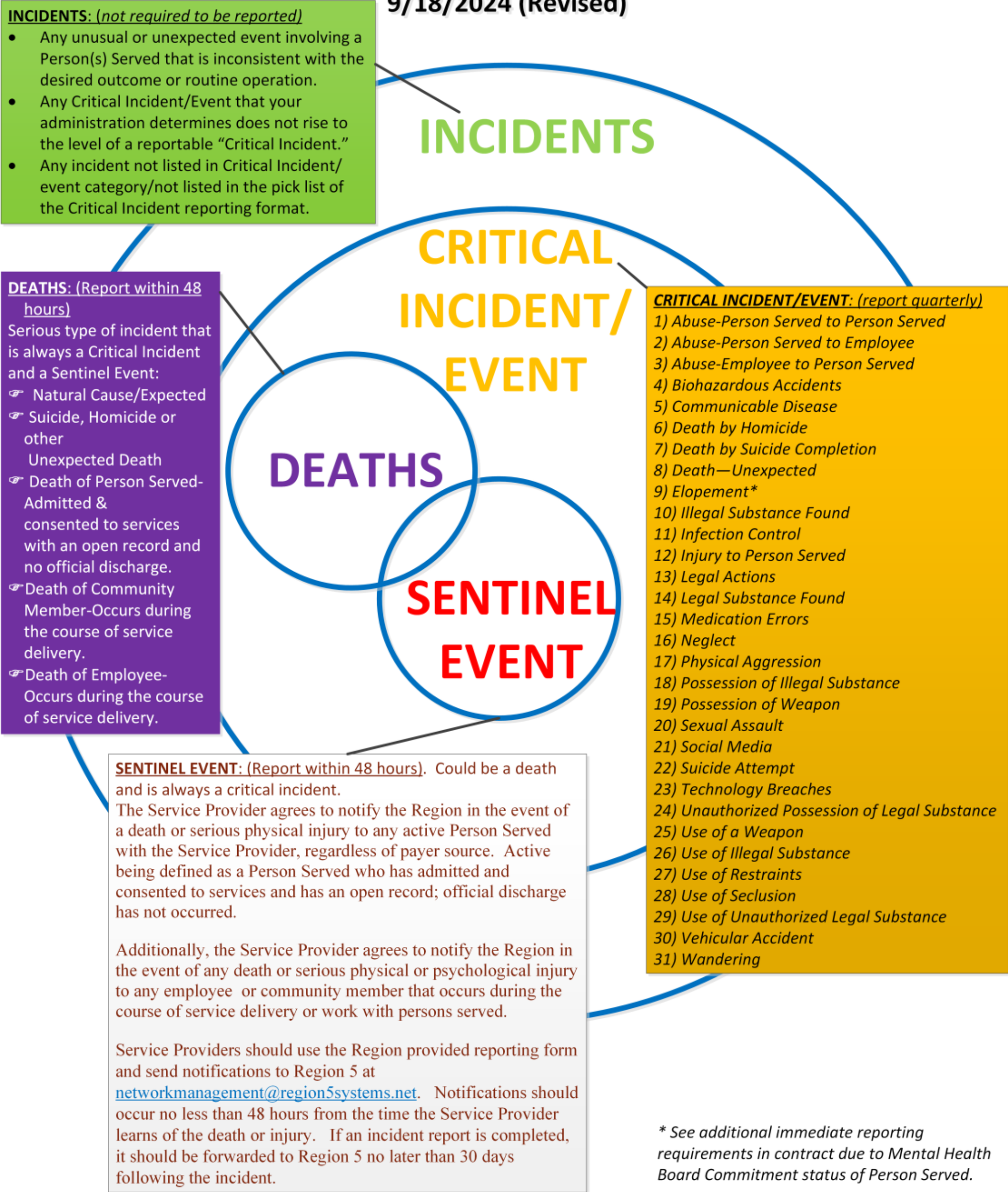
The following is a diagram used to help people served and providers understand the difference between incidents, critical incidents/events, deaths, and sentinel events.

REGION 5 SYSTEMS

(Promoting Comprehensive Partnerships in Behavioral Health)

Understanding Incidents Diagram

9/18/2024 (Revised)



CONTINUOUS QUALITY IMPROVEMENT (CQI)-CONCERNS/REQUESTS – SECTION III

Region 5 Systems' CQI process ensures a mechanism to continuously address employee concerns or requests that arise during the fiscal year. Region 5 Systems seeks to promote an environment that encourages employee feedback and suggestions for improving current services and operating functions within Region 5 Systems' organizational structure. All requests are handled on a case-by-case basis, each given individual attention according to the following procedures:

A. Employee completes a Concerns Request Form, submitting it to the CQI Director for processing. The employee is notified within five days of the concern being received the status of their request, to ensure they are kept apprised of when it will go through the review process.
B. All requests are reviewed by Region 5 Systems' Corporate Compliance Team to determine the feasibility of the request. If the request needs further action, it is delegated to the applicable CQI team or other organizational team, which then makes a recommendation to the Corporate Compliance Team. The Corporate Compliance Team makes the final determination of how a request is handled. In cases that affect policy decisions, the Regional Governing Board (RGB) is consulted for approval.
C. Open communication among employees is of the utmost importance to our CQI process. Documentation is kept on all CQI Concerns Requests, and all final outcomes are communicated to all Region 5 Systems' employees.

The following chart represents the CQI Concerns Requests submitted by employees in FY 24-25. There was a total of seven concerns/requests submitted.

CQI Concerns Requests submitted by employees:

Date Received	CQI Concern/Request	Recommendation/Action Taken
5/28/2025	Add recycling for aluminum and plastic in the breakroom	Not approved. Agency will continue to support recycling of paper (in office) and cardboard (across the street). Due to the low volume of aluminum and plastic refuse in the office, the cost and staff resources needed to carry out additional recycling will not be dedicated at this time. This will continue to be assessed.
11/4/2024	Provide feminine hygiene products for participant use in the office	Approved. Fiscal will purchase products, and they will be stored in the cabinet in the main level women's office.
10/18/2024	Display the date employee last updated pegboard status to pegboard view	Approved
9/6/2024	Explore the use of digital business cards	Approved. Cards were ordered.
9/3/2024	Add note on website indicating Region 5 Systems does not provide immediate rental assistance and listing local organizations that do	Approved

6/25/2024	Consider employees' allergies and food restrictions when ordering food for events	Approved. Protocol developed and shared with all employees in August 2025.

Continuous Quality Improvement Teams:
Region 5 Systems utilizes Continuous Quality Improvement Teams to maximize resources when trying to meet expectations and outcomes associated with the organization's mission. Most team membership is voluntary, and employees have expressed an interest to participate on the team. Teams have charters to guide their purpose and deliverables and report on activities during all employee meetings.

Region 5 Systems
Continuous Quality Improvement Teams

Business Interruption	CARF Training	Diversity Awareness & Acceptance	Grants	Health & Safety	HR Supervisors	Information Technology Response	Internship
Kim Michael, Chair Tami DeShon Theresa Henning Jon Kruse Susan Lybarger Sandy Morrissey Shelly Noerrlinger Amanda Tyerman-Harper	**Kim Michael, Chair** Jade Fowler Deanna Gregg Theresa Henning	**Malcom Miles, Chair** Zina Crowder Munira Husovic Kayla Lathrop Sandy Morrissey Mariah Rivera	**Erin Rourke, Chair** Wendy Baumeister Zina Crowder Sharon Dalrymple John Danforth Theresa Henning Stacy Vogt	**Susan Lybarger, Chair** Zina Crowder Teri Effle Barb Forsman Kim Michael Linda Pope	**Kim Michael, Chair** Danielle Belina Tami DeShon Renee' Dozier Jade Fowler Annie Glenn Deanna Gregg Theresa Henning Patrick Kreifels Malcom Miles Sandy Morrissey Kristin Nelson Erin Rourke Amanda Tyerman-Harper	**Jon Kruse, Chair** Barb Forsman Wade Fruhling Joe Pastuszak	**Kim Michael, Chair** Nicole Giebelhaus Kristin Nelson

Leadership	Move It / Fix It	Quality	Risk Management	Social Media	Training	Wellness
Patrick Kreifels, Chair Sharon Dalrymple John Danforth Teri Effle Annie Glenn Trina Janis Kayla Lathrop Katiana MacNaughton Shelly Noerrlinger	**Jon Kruse, Chair** John Danforth Donna Dekker Wade Fruhling Linda Pope	**Erin Rourke, Chair** Wendy Baumeister Sue Brooks Sharon Dalrymple John Danforth Renee' Dozier Barb Forsman Annie Glenn Munira Husovic Trina Janis Olivia Lemon Katiana MacNaughton Malcom Miles Lisa Moser Joe Pastuszak Maria Rodriguez Jessica Zimmerman	**Kim Michael, Chair** Tami DeShon Jade Fowler Theresa Henning Erin Rourke Liam Stanley Amanda Tyerman-Harper	**Teri Effle, Chair** Kayla Lathrop Olivia Lemon	**Theresa Henning, Chair** Danielle Belina Sue Brooks Teri Effle Trina Janis Kristin Nelson Shelly Noerrlinger	**Annie Glenn, Chair, Katiana MacNaughton, Co-chair** Elise Chaffin Sharon Dalrymple Nicole Giebelhaus Eden Houska Kendra Laushman Anna Thomas Connie Vissering Jessica Zimmerman

Characteristics of CQI Teams: Improvement oriented, maximize resources, opportunities to expand knowledge, contributions to organization may be different from your job duties, interest based, a place where teams can look at system issues versus individual issues, cross-departmental representation, and participation can be voluntary/required and highly encouraged.

PROFESSIONAL PARTNER PROGRAM – FAMILY & YOUTH INVESTMENT – SECTION IV

Wraparound Fidelity Index-EZ:
Region 5 Systems evaluates the Professional Partner Program – Family & Youth Investment (FYI), to determine whether services and supports being received by Region 5 Systems Professional Partner Program's youth and families adhere to the basic characteristics of wraparound. Wraparound is an approach to treatment that helps families with challenging children function more effectively in the community. It provides a planning process that results in individualized community services and supports for a child and family to achieve positive outcomes.

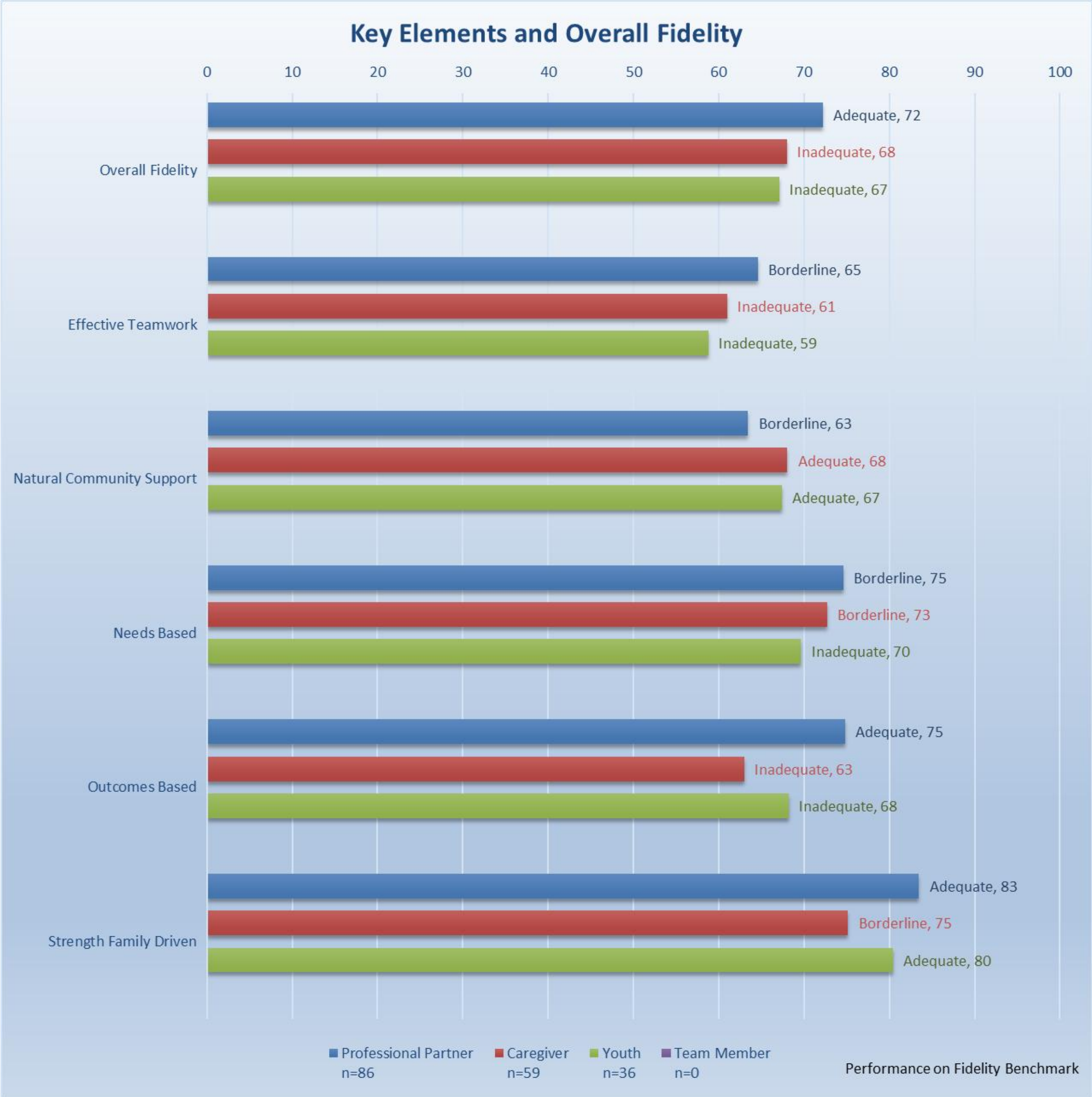
The following ten elements are evaluated:

1. Family voice and choice
2. Youth and family team
3. Natural supports
4. Collaboration
5. Community-based services and supports
6. Cultural competence
7. Individualized services and supports
8. Strength-based services and supports
9. Outcome-based services and supports
10. Persistence

The Wraparound Fidelity Index (WFI-EZ) assesses fidelity by having the respondent (facilitator, caregiver, youth, and team member) rate 25 items on the extent to which they agree each indicator of Wraparound Fidelity has been achieved.

Several studies have found positive associations between WFI scores and ultimate child and family outcomes. Because high-fidelity wraparound implementation is hypothesized to result in better outcomes, these findings provide additional support for the validity of the WFI, as well as for the wraparound process in general. The Wraparound Evaluation and Research Team (WERT) at the University of Washington developed benchmarks to help programs interpret fidelity scores and assess the degree to which implementation meets basic standards. To determine benchmarks, norm-referencing and criterion-referencing was utilized, and mean scores were calculated on predictors of Wraparound fidelity.

The following table of Region 5 Systems' Professional Partner Program Family & Youth Investment (FYI) is a comparison of the Care Coordinator (i.e., Professional Partner), Caregiver, Youth, and Team Member for the FY 24-25 period. Responses were collected from 86 professional partners, 59 caregivers, and 36 youth.


Key Elements and Overall Fidelity
0
10
20
30
40
50
60
70
80
90
100
Overall Fidelity
Adequate, 72
Inadequate, 68
Inadequate, 67
Effective Teamwork
Borderline, 65
Inadequate, 61
Inadequate, 59
Natural Community Support
Borderline, 63
Adequate, 68
Adequate, 67
Needs Based
Borderline, 75
Borderline, 73
Inadequate, 70
Outcomes Based
Adequate, 75
Inadequate, 63
Inadequate, 68
Strength Family Driven
Adequate, 83
Borderline, 75
Adequate, 80
Professional Partner n=86
Caregiver n=59
Youth n=36
Team Member n=0
Performance on Fidelity Benchmark

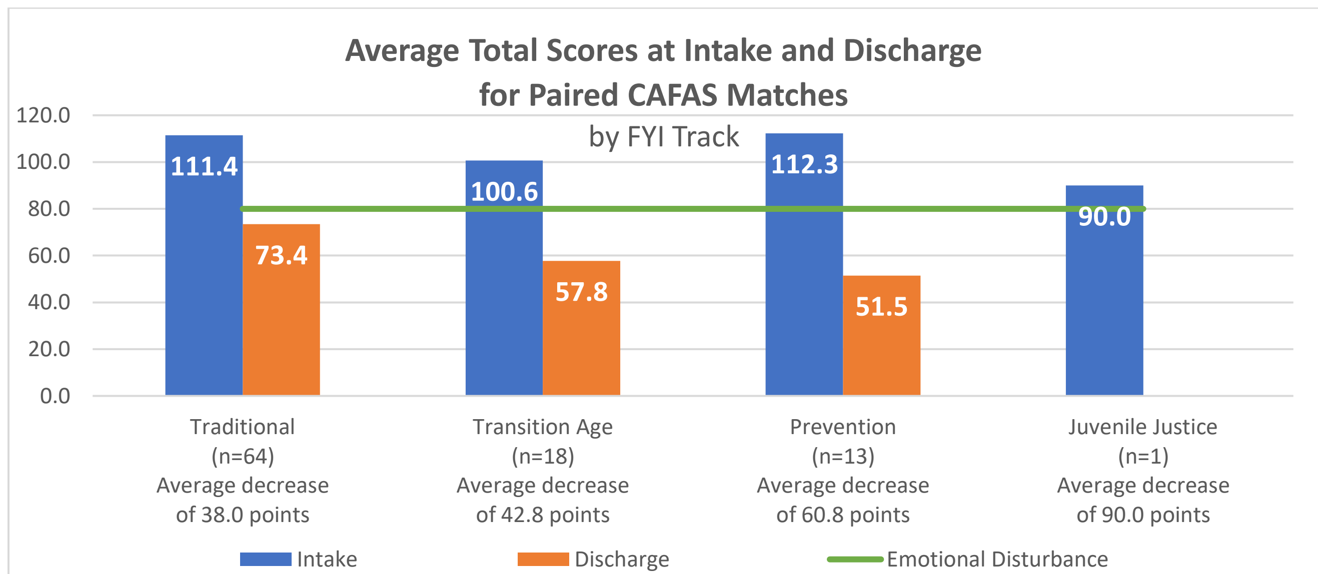
Child Adolescent Functional Assessment Scale (CAFAS):

The Child and Adolescent Functional Assessment Scale (CAFAS) is administered to youth at enrollment, every six months, and at discharge. The purpose of the CAFAS is to measure impairment (i.e., the negative effect of problem behaviors and symptoms on functioning) in day-to-day functioning in children, adolescents, and young adults. The CAFAS assesses youth in eight domains: school/work, home, community, behavior toward others, moods/emotions, self-harmful behavior, substance use, and thinking. This evaluation tool scores youth in the eight domains, using a scale of 0 to 30 (i.e., scores used are 0, 10, 20, or 30). Each score indicates the level of impairment: 0 = No Impairment, 10 = Mild Impairment, 20 = Moderate Impairment and 30 = Severe Impairment. Total scores are classified using a description as shown in Table 10. Total CAFAS scores may range from 0 to 240 points.

Table 10: CAFAS Levels of Overall Dysfunction Based on Youth's Total Score

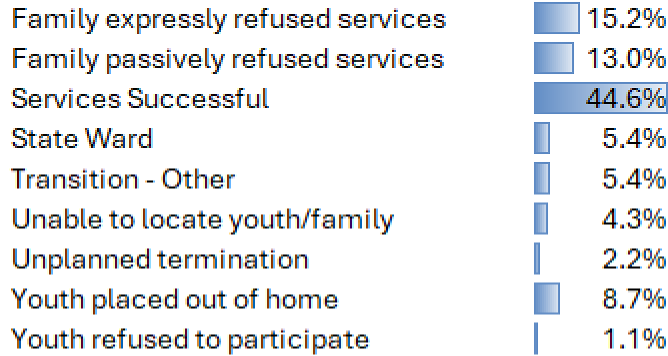
Total Score	Description
0-10	Youth exhibits no noteworthy impairment.
20-40	Youth likely can be treated on an outpatient basis, providing risk behaviors are not present.
50-90	Youth may need additional services beyond outpatient care.
100-130	Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care.
140 and higher	Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community.

The following graphs illustrate youth who have discharged from the respective Professional Partner Program tracks (i.e., Traditional, Transition Age, Prevention, Juvenile Justice) comparing an average total CAFAS score taken at enrollment/intake and comparing it to the discharge average total CAFAS score. The Juvenile Justice, Traditional, and Transition Age tracks demonstrate an average reduction of the total CAFAS scores by 20 points or more. This means youth have, on average, reduced their functional impairments and accomplished clinically significant/meaningful change when comparing intake and discharge CAFAS scores.



Discharge Status:

There were 103 youth/young adults who were discharged from FYI in FY 24-25. The average length of stay was 14.7 months, and successful completion of the program accounted for 45% of discharges.



When looking at individual track completions, there were 106, with 13 of those being internal transfers to other tracks. The average track duration was 12.4 months, with 42% of participants/families discharging, or transferring to another track, after more than 365 days.

Length of Stay in FYI Track

Number of Youth

	Between 0 and 30 days	Between 31 and 90 days	Between 91 and 180 days	Between 181 and 365 days	More than 365+
Child & Family			1		
Juvenile Justice					1
Prevention		1	2	10	2
Traditional	4	12	7	16	35
Transition Age		1	2	5	7
Grand Total	**4**	**14**	**12**	**31**	**45**

Average Length of Track Stay (Months)	
Child & Family	5.0
Juvenile Justice	13.0
Prevention	7.5
Traditional	12.7
Transition Age	16.8
Overall Average Length of Stay	**12.4**

Internal Records File Review for the Family & Youth Investment Program:

Region 5 Systems conducts a file review for its internal quarterly file review. The review is a **records review** designed to assess the necessary forms/documents/evaluations are present, overall completeness of the file, assesses if the initial plan of care links to the interpretive summary, and determines if progress is being documented monthly/quarterly. The areas are identified below as well as the quarterly performance. Areas that are below 80% require the program to complete a quality improvement action plan.

Comparison by Quarter
FY 24-25

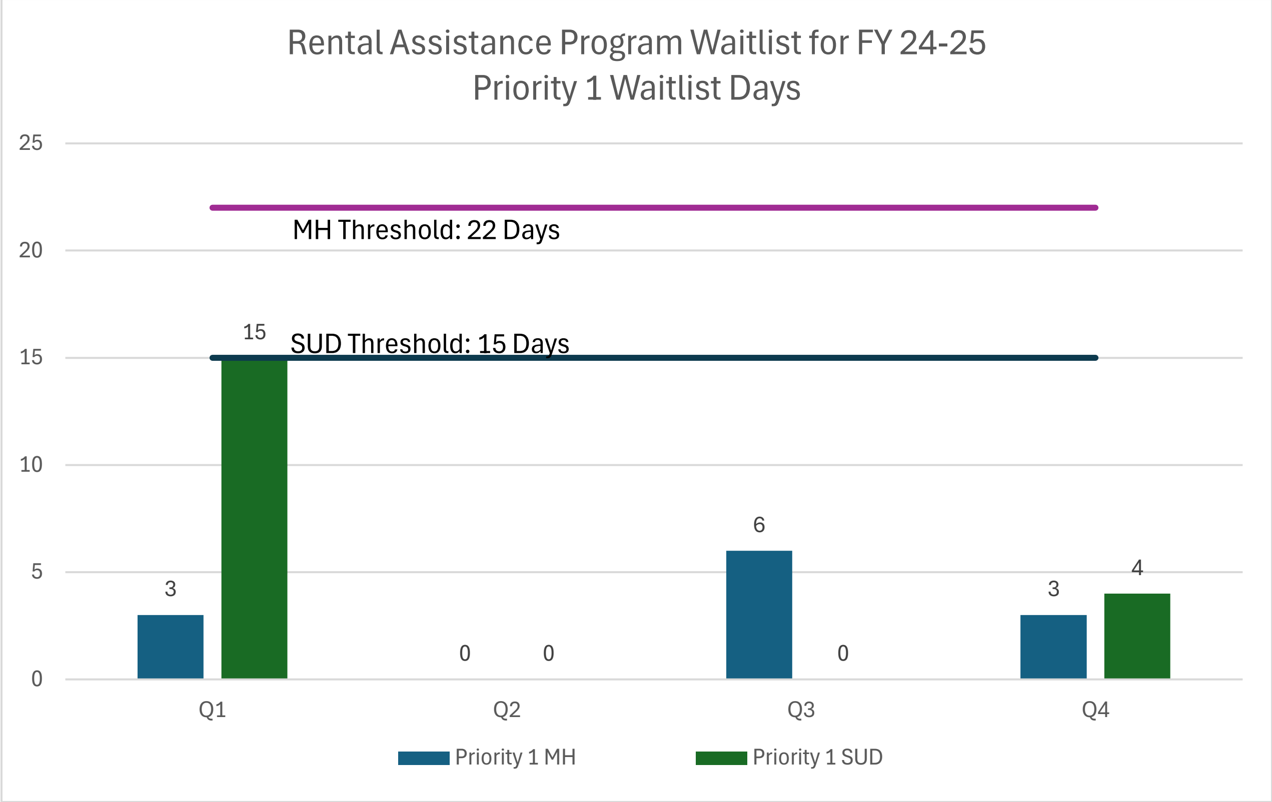
RECORDS REVIEW		Q1	Q2	Q3	Q4
Open Records	**Average completeness of All Items**	**88%**	**89%**	**94%**	**93%**
	General Information	85%	92%	96%	93%
	Team Planning	92%	91%	98%	96%
	FYI Clinical Supervision Notes	79%	94%	91%	82%
	Formal Services	94%	88%	100%	88%
	Evaluation Info	93%	93%	97%	95%
	Legal	77%	58%	73%	93%
	School	92%	67%	82%	93%
Closed Records	**Average completeness of All Items**	**96%**	**93%**	**90%**	**94%**
	General Information	95%	89%	90%	92%
	Team Planning	98%	98%	94%	97%
	FYI Clinical Supervision Notes	97%	83%	75%	89%
	Formal Services	93%	96%	85%	92%
	Evaluation Info	99%	97%	96%	97%
	Legal	86%	89%	78%	86%
	School	90%	89%	91%	97%
	Section Closed	98%	98%	93%	94%
EHR REPORTS REVIEW					
Initial POC		100%	100%	91%	87%
Interpretive Summary		100%	94%	98%	89%
Monthly POC Update		88%	85%	90%	94%
BILLING AND CODING PRACTICES		**Q1**	**Q2***	**Q3***	**Q4***
Team Meeting Documentation		100%	100%	100%	100%
Family or Participant Contact Note		100%	100%	100%	100%
Was Not Discharged Prior to Billing Period		100%	100%	100%	100%

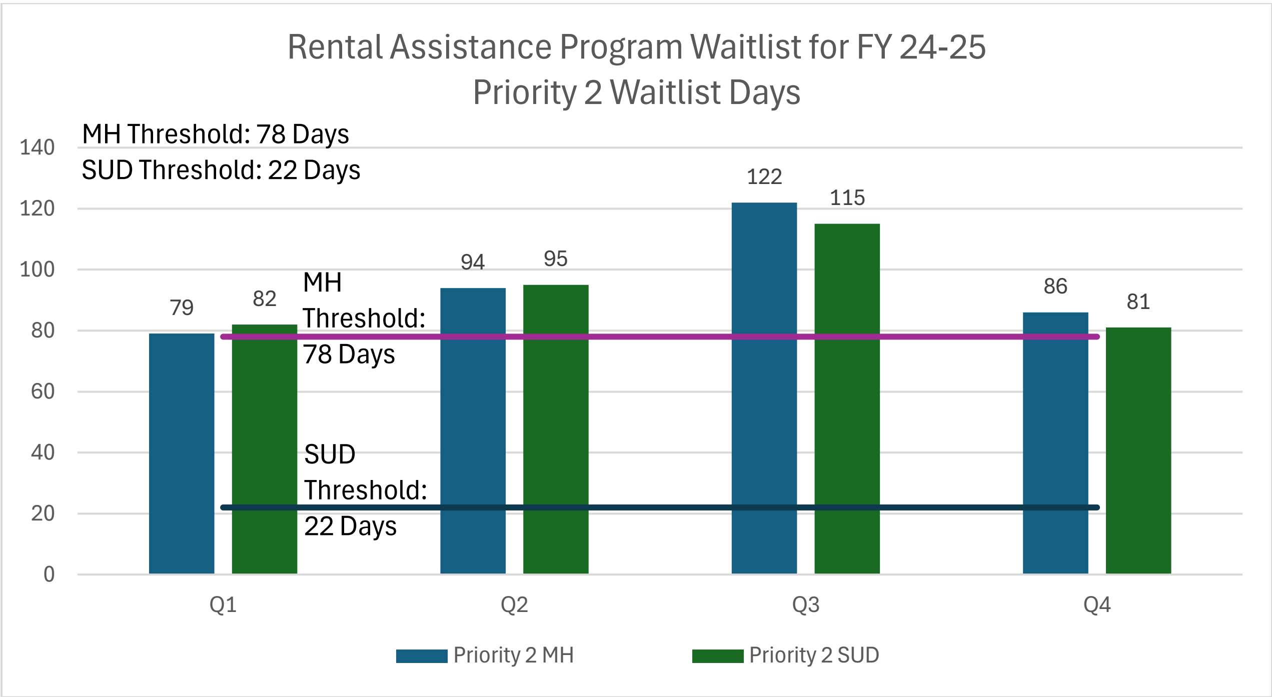
* No JJ invoices issued in the respective quarter.

HOUSING – SECTION V

Rental Assistance Program Waitlist

For those individuals with a Priority 1 status, the average length of time on the waitlist this fiscal year was below the program's established threshold. However, the average length of time on the waitlist was above the threshold for those individuals in Priority 2 status. In March 2025, additional funding was approved for the Rental Assistance Program to aid in reducing the waitlist.





Rental Assistance Program - Internal Records File Review:

Region 5 Systems' Quality CQI Team conducts quarterly internal reviews on open (20% of open records) and all closed records within the Rental Assistance Program. Below is a summary for FY 23-24. Areas that are below 80% require the program to complete a quality improvement action plan.

For FY24-25, the program maintained a total completeness of 89-96% for open and closed records. The program focused efforts on improving procedures and monitoring of the housing inspections (HQS), monthly staffing reviews, and discharge letters to the landlord.

FY 24-25 Rental Assistance Program File Review					
Section		Q1	Q2	Q3	Q4
Open Records	**Total Completeness of All Items**	**95%**	**92%**	**89%**	**93%**
	Application/Eligibility	99%	100%	100%	100%
	Application Supporting Documentation	98%	100%	96%	96%
	Voucher Issuance	97%	99%	100%	99%
	Housed	90%	80%	74%	83%
	Annual Review	92%	96%	100%	94%
Closed Records	**Total Completeness of All Items**	**96%**	**94%**	**92%**	**89%**
	Application/Eligibility	98%	99%	98%	95%
	Application Supporting Documentation	100%	94%	100%	94%
	Voucher Issuance	91%	94%	93%	94%
	Housed	97%	93%	81%	77%
	Annual Review	86%	100%	93%	86%
	Discharge	100%	86%	96%	88%

Rural & Lincoln Permanent Housing Program - Internal Records File Review:

Region 5 Systems' Quality CQI Team conducts quarterly internal reviews on 25% of open persons served records, all closed records, and 10 property records within the Rural & Lincoln Permanent Housing Program. Below is a summary of FY 24-25. Areas that are below 80% require the program to complete a quality improvement action plan.

FY 24-25 Permanent Housing File Review - PARTICIPANT					
Section		**Q1**	**Q2**	**Q3**	**Q4**
Open Records	**Total Completeness of All Items**	**100%**	**98%**	**94%**	**96%**
	Section 1 – Application and Annual Review	100%	99%	94%	99%
	Section 2 – Income and Sublease	100%	100%	93%	94%
	Section 4 – Persons Needs	100%	88%	96%	73%
	Section 5 – Releases of Information	100%	100%	100%	85%
Closed Records	**Total Completeness of All Items**	**98%**	**98%**	**97%**	**100%**
	Section 1 – Application and Annual Review	98%	98%	99%	100%
	Section 2 – Income and Sublease	100%	100%	100%	100%
	Section 4 – Persons Needs	100%	75%	100%	100%
	Section 5 – Releases of Information	100%	100%	100%	100%
	Discharge	100%	100%	50%	100%

FY 24-25 Permanent Housing File Review - PROPERTY				
Section	**Q1**	**Q2**	**Q3**	**Q4**
Total Completeness of All Files	**98%**	**100%**	**98%**	**93%**
Section 1 – Lease and Environmental Reviews	97%	100%	99%	90%
Section 2 – Sublease	100%	100%	100%	90%
Section 3 – Rent Reasonableness	98%	100%	88%	86%
Section 4 – Utility Allowance	94%	100%	100%	100%

Appendix A: Complaints and Appeals Category Definitions

1. **Access to Services:** defined as any service that the person requests which is not available or any difficulty the person experiences in trying to arrange for services at any given facility. (Difficulty scheduling initial appointments or subsequent ones, concerns with wait times for services, hours of operation, location not easily accessible.)
2. **Access to Employees:** defined as any problem the person experiences in relation to employees' accessibility. (Return of phone calls, employees' availability.)
3. **Clinical Issues:** defined as any issue involving treatment and service delivery. (Problems with accuracy of reports, treatment planning and/or medication, etc.)
4. **Customer Service:** defined as any customer service issue, i.e., rudeness, inappropriate tone of voice used by any employee, failure to provide requested information which would assist the person in resolving his/her issue.
5. **Environmental:** defined as any person's served complaint about the condition of the place in which services are being received (temperature, hazards, lighting, cleanliness, noise levels, lack of privacy).
6. **Financial:** defined as any issue involving budget, billing, or financial issues.
7. **Interpersonal:** defined as any personality issue between the person served and employee.
8. **Program/Policy/Procedure**: defined as any issue a person expresses about the program, policies, procedures (visiting hours, phone access, smoking policy, UA policy, etc.).
9. **Quality of Care:** defined as any issue which deals with the quality of care that the person is receiving as it relates to services being rendered. (The consistency of service, etc.)
10. **Transportation:** defined as any issue involving transportation.
11. **Other:** defined as any issue not addressed above, specifying the issue.

Appendix B: Critical Incident Category Definitions

1. **Abuse-Person Served to Person Served:** Person served harms/assaults another person verbally/physically/ psychologically).
2. **Abuse-Person Served to Employee:** Person harms/assaults employee (verbal/physical/psychological).
3. **Abuse-Employee to Person Served:** Employee harms/assaults a person (verbal/ physical/ psychological)
4. **Biohazardous Accidents:** An accident, injury, spill, or release. Some examples include needle stick, puncture wounds, splash, environmental release of an agent or organism.
5. **Communicable Disease:** Person admitted with or became exposed to a communicable/ infectious disease. Examples include Tuberculosis, Hepatitis, whooping cough, Measles, Influenza.
6. **Death by Homicide:** One person causes the death of another person.
7. **Death by Suicide Completion:** A person completes suicide, purposely ending their life.
8. **Death-Other:** Death that was not anticipated.
9. **Elopement:** Person served is in residential treatment and left without notifying the agency of their intent to leave.
10. **Illegal Substance Found:** An agency finds illegal substances in or around the facility.
11. **Infection Control:** Agency did not apply infection control practices to prevent pathogens being transferred from one person to another.
12. **Injury to Person Served:** Not Self Harming. Accidental in nature.
13. ***Legal Actions:** Network provider is involved in a legal action/lawsuit that involves persons served regardless of who is the plaintiff or defendant.
14. **Legal Substance Found:** An agency finds legal substances which are not appropriately tracked, monitored, and safeguarded.
15. **Medication Errors:** Medical or human error when a healthcare provider chooses an inappropriate method of care or improperly executes an appropriate method of care.
16. **Neglect:** Agency/employee failure to provide for a vulnerable adult or child.
17. **Physical Aggression:** Physical violence/use of physical force with the intention to injure another person or destroy property.
18. **Possession of Illegal Substance:** Person who has possession of an illegal substance.
19. **Possession of Weapon:** Person possesses a weapon on agency property and/or violates program rules/policies.
20. **Sexual Assault:** Sexual act in which a person is coerced or physically forced to engage against their will, or non-consensual sexual touching of a person. A form of sexual violence.
21. ***Social Media:** Disclosing inappropriate information about persons served on social media (Facebook, Twitter, LinkedIn, websites, blogs, etc.).
22. **Suicide Attempt:** An unsuccessful attempt/action to end one's life.
23. ***Technology Breaches:** Failure of an agency to safeguard a person's confidential information that was transmitted/maintained electronically.
24. **Unauthorized Possession of Legal Substance:** Person who has possession of an unauthorized legal substance which is against program rules/policies.
25. **Use of a Weapon:** Person served uses a weapon.
26. **Use of Illegal Substance:** Person served is found to be using or admits to using illegal substances.
27. **Use of Restraints:** An agency utilizes restraints to manage a person's behavior.
28. **Use of Seclusion:** An agency utilizes seclusions to manage a person's behavior.
29. **Use of Unauthorized Legal Substance:** Person served is found or admits to using unauthorized legal substances that are against the program rules/policies.

30. **Vehicular Accident:** Person served is involved in a vehicular accident; the vehicle is driven by an employee.
31. **Wandering:** Person served cognitively impacted with a memory loss such as Alzheimer's/dementia who experiences unattended wandering that goes out of agency awareness/supervision.

*Region 5 Systems considers these items to be critical incidents. The CARF standards manual does not list these as critical incidents in Section 1: Subsection H.9.f. categories for this report.