REGION V SYSTEMS

Promoting Comprehensive Partnerships in Behavioral health

Network Performance Improvement Plan

FY 21-22

Submitted by: C.J. Johnson Regional Administrator
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I. Purpose of the Network Performance Improvement Plan

Region V Systems' culture follows the principles of a learning organization and shall be committed to continually improving its organization and service delivery to persons served. Data shall be collected, and information used to manage and improve service delivery. The organization shall share and provide Network organization members, persons served, and other stakeholders with ongoing information about its actual performance as a business entity and its ability to achieve optimal outcomes for the persons served through its programs and services.

Region V Systems shall implement and maintain an organized information management system which provides for the confidentiality, security, and privacy of electronic data interchange, records of persons served, and administrative records. The information management system shall be in accordance with applicable federal, state, and provincial laws.

Region V Systems believes in a team-driven process for all Network Providers 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. Areas of focus include access, efficiency, effectiveness, and satisfaction.

Outcomes Region V Systems strives for include:

a. Professional accountability and appropriate resource allocation throughout the organization and network.
b. Active participation by all Network Providers with opportunities for involvement in decision making and correction of problems that impact them directly.
c. Awareness and understanding among all Network Providers that quality is an essential element in service provision and management.
d. The best possible outcomes for our consumers and customers.

From time to time actual performance does not meet expected targets or minimum thresholds. When this occurs a quality improvement action plan maybe requested from network provider agencies with the intent on affecting positive change in the delivery of services to consumers. An aggregate report outlining the areas observed needing improved and actions taken to improve the identified areas will be communicated through Region V Systems' CQI communication cycle. The CQI communication cycle consists of Consumer and behavioral health advisory committees, regional quality improvement team, network providers, and governing board. There are also multiple reports that are created, monitored and communicated through the CQI communication cycle which directly relate to Region V Systems mission and the best possible outcomes for consumers.

Region V Systems implements and maintains an organized information management system, "Compass," which provides for the confidentiality, security, and privacy of electronic data interchange, records of persons served, and administrative records. The Compass information management system is in accordance with applicable federal, state, and provincial laws.

II. Access: A – Waitlist

Area of Observation:	Waitlist		
Expectation:	Consumers will have timely access to services.		
Quality Indicator:	Date placed on waitlist as compared to date removed from the waitlist in the Central Data System		
Measure:	Consumers will enter treatment within 14 days of being screened and eligible for services.		
Service(s):	MH/SUD	Adult/Youth	Service
	MH	Adult	ACT
	MH-SA	Adult	Community Support
	MH	Adult	Day Treatment
	MH/SUD	Adult	Dual Res
	MH	Adult	Respite
	MH	Youth	Professional Partner
	MH	Adult	Psych Res Rehab
	MH	Adult	Secure Res
	MH/SUD	Adult	Supported employment
	MH/SUD	Adult/Trans	Supported Housing
	SUD	Adult	Halfway House
	SUD	Adult	IOP
	SUD	Adult	Intermediate Res
	SUD	Adult	Short Term Res
	SUD	Adult	Therapeutic Community
Data Source:	Compass/Centralized Data System		
Frequency of Collection:	In real time.		
Frequency of Review:	Monthly reviews		
Who Reviews Information:	Region V Systems administration, Waitlist sub-committee, Regional Quality Improvement Team.		
Instructions:	Providers are to enter consumer information on the Centralized Data System (CDS). • Specific directions can be found: ▪ Region V Waitlist Procedures PowerPoint ▪ CDS user manual (starting at page 72) Waitlist entry requirements • Must be available for treatment that day to be put on and remain on the wait list • Any necessary assessments have already taken place • Appropriateness of services has been verified (i.e., eligible and not denied for service) • Prioritization hierarchy for waitlist and admission: Priority population, community referrals, incarcerated consumers • Division of Behavioral Health wants consumers in CDS regardless of funding source		

	Substance use priority populations are to be admitted <u>within 14 days or 120 days (if no capacity exists)</u> • Mental Health Priority Populations (highest to lowest): 1st – MHB Discharged from Regional Center 2nd – MHB Inpatient Commitment 3rd – MHB Outpatient Commitment • Substance Use Priority Populations (highest to lowest): 1st – Pregnant IV Drug User 2nd – Pregnant Drug User 3rd – IV Drug User 4th – Woman With Dependent Children Waitlist times: • Target: Consumers are to be admitted to services within **14 days** • Substance use priority populations are to admit within 14 days(or 120 days if no capacity exists), contractually • Providers are to contact consumers **Weekly** while they are on the waitlist to ensure they still would like to admit to services • If a provider has had **no contact with a consumer for 21 days** despite multiple attempts to contact them, they are to be removed from the waitlist with the removal reason **cannot be located.** Waitlist process overview (full instructions, see page 72 of CDS user manual): 1. Click "Add to Waitlist" 2. Complete waitlist form and save 3. Click "Remove from Waitlist" 4. Complete removal form (if removal reason was anything other than admit to program, you are done with CDS steps) 5. IF you <u>ARE</u> using an EHR that automates with CDS **and** the removal reason was Admit to Program, click "Cancel without Admission 6. IF you <u>ARE NOT</u> using an EHR that automates with CDS, complete additional required information in CDS (e.g., submit for authorization, enter demographics, diagnoses, etc.) Waitlist Data Entry Process Step 1 - Create an encounter. Step 2 – In the encounter, click "Add to Waitlist" Step 3 – Fill out the waitlist form (information on the fields below) • <u>Waitlist/Service Confirmation Date</u>: The date the consumer stated they were **available** to enter treatment **after** any required assessment **after** appropriateness of service has been verified **Do not** use this field for incarcerated release date (use referral date) Waitlist/Service Confirmation Date for <u>Incarcerated Consumers</u>: If the consumer is incarcerated, the provider must also ensure that the consumers expected release date is within two weeks before entering a Waitlist/Service Confirmation Date.

	If the consumers release date is more than 2 weeks in the future OR the release date is not known, enter the date the consumer was referred for service in the Referral Date field. For consumers not funded by DBH/Regions, use the month and day of the referral date for the month and day in Date of Birth field, along with the consumer's birth year. • Priority Population: Select the most appropriate population status • MHB Status: Mental health board status Select the appropriate MHB or select No MHB Commitment • Commitment Date: Only complete if the consumer has a mental health board commitment • Interim Services Delivered Date: Health counseling provided (e.g., information on needle sharing, effects of alcohol on fetal development, etc.) See page 76 of the CDS User Manual for more details. • Engagement Service: Select the service the consumer will receive while they are waiting for admission (e.g., outpatient – SUD while waiting for short term residential) • Additional Client Engagement: If a second engagement service is provided, select one • Assessment Date: The date of the assessment that indicates the consumer requires this level of care • Referral Date: Date of the referral source For incarcerated consumers, use this field as their release date (NOT waitlist confirmation date) • Referral Source: Choose the type of service provider or entity referring this consumer to the agency from the drop-down menu. • (Offered) Admit Date: the projected date that the consumer is to be admitted to the service • Primary Funding Source: Division of Behavioral Health (DBH) funded or other funding **IF NON-DBH Funding:** First Name: XXXX Last Name: place four x's followed by "f" if female, "m" if male, or "u" unknown (XXXXf, XXXXm, XXXXu) Date of Birth: enter Waitlist/Service Confirmation month and day with consumer birth year (if 90 or older use "1901" for year) SSN, Zip Code and Gender: can be left blank. Step 4. Click "Add to the Waitlist" Step 5. Once consumer is ready to admit to service, click "Remove from Waitlist" Step 6. Removal options: • **Remove from Waitlist** – Use when a consumer will admit or will not admit but be removed from the waitlist. Always click this first unless encounter was entered in error. • **Cancel Without an Admission**: the encounter is NOT removed from CDS, but it will be cancelled without admission to any program within CDS. For EHR-Automated providers: ONLY use this option, **after** completing "Remove from Waitlist" when the removal reason is **Admit to Program**

	• **Remove Encounter** – ONLY click this if the encounter was entered in error Step 7: If selecting Remove from Waitlist, fill out Remove from Waitlist form (information on fields below) • Waitlist Removal Date: Date of the removal of the consumer from the waitlist. Always complete this field with the day that the decision was made to remove the consumer from the waitlist, because of either an admission, consumer choice, or other removal reason If not admitted, the date of the contact where consumer said they would not be admitting into treatment If consumer cannot be located, record **last attempt date** • Waitlist Removal Reason: **Admitted to Program**: the consumer was admitted to the service as described in the initial service to be provided for this encounter **Admitted to Program – Other Funding**: the consumer has been admitted to the program, but funds other than Behavioral Health funds were used **Admitted to Other Program**: the consumer has been admitted to another program, and this encounter is being cancelled without an admission **Cannot Be Located:** If consumer cannot be contacted for **21 days** despite multiple attempts, remove them from the waitlist using this option **Refused Treatment**: the consumer has declined to participate in the service listed, and the encounter is being cancelled without an admission. **Succeeding at A Lower Level of Care**: the consumer has participated in another less-intense level of care and is doing well. **Requires A Higher Level of Care:** after further assessing the consumers situation, agency staff determine that a higher level of care is required. **Deceased:** The consumer has died **Incarcerated**: the consumer is in a lockup facility and will not be available for the service over an extended period of time. **No Longer Qualifies for Program**: the consumer is not qualified for the program because of changing conditions, either programmatically or financially. The encounter can be cancelled without an admission. • MHB Status: Select the appropriate response to update the MHB status • Commitment Date: Date on which a Mental Health Board ordered a commitment (if applicable) or needs updating Ways to monitor the agency's waitlist: 1. Open Waitlist Report within Region V Compass • Shared with agency staff. To find, navigate to Region V Compass, click "Dashboards", then "Shared with me", then the report titled "Open Waitlist Report – 0 to 120+ Days" 2. Search within CDS

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Navigate to CDS, click the “Search” button, select “Pre-admitted – Waitlist” for the encounter status, and click “Search” or “Export Results.” Note, Search limits the number of encounters shown to 200, so to see all encounters that are waitlisted and the details of them, Region V recommends exporting your results. The field “Last Status” is often the waitlist confirmation date.

MH Priority Populations (ranked from highest priority)
<table>
<tr><td>If consumer is waiting for admission to a Mental Health Service:</td></tr>
<tr><td>1st – MHB Discharged from Regional Center</td></tr>
<tr><td>2nd – MHB Inpatient Commitment</td></tr>
<tr><td>3rd – MHB Outpatient Commitment</td></tr>
</table>
SUD Priority Populations (ranked from highest priority)
<table>
<tr><td>If consumer is waiting for admission to a Substance Use Disorder Service:</td></tr>
<tr><td>1st – Pregnant IV Drug User</td></tr>
<tr><td>2nd – Pregnant Drug User</td></tr>
<tr><td>3rd – IV Drug User</td></tr>
<tr><td>4th – Woman With Dependent Children</td></tr>
</table>

Monthly, providers are sent their waitlisted encounters per service

For encounters on the waitlist longer than 14 days, providers are to respond within 7 days that:

The number of waitlisted encounters removed from the waitlist (e.g., admitted, removed without an admission)
The number of waitlisted encounters from the list that are still waiting

No names of persons served are to be emailed between the provider and Region V Systems. If the need to reference/discuss an individual person served, please use the encounter number in place of the name.

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II. Access: B – Capacity

Area of Observation:	Capacity-Utilization of services.
Expectation:	Utilization of contracted service capacity with network providers will be monitored to ensure services are available to consumers through the network continuum of care.
Quality Indicator:	Weekly capacity reports in CDS.
Measure:	Service capacity will be monitored to identify when above 90 percent threshold.
Service(s):	All services with the exception of Emergency Protective Custody.
Data Source:	Centralized Data System
Frequency of Collection:	Weekly reporting to Region V Systems/Division of Behavioral Health
Frequency of Review:	Monthly
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.

Instruction:	Providers are to enter their capacity/utilization data in CDS every Monday by 12:00 p.m. 1. Log in to https://dbhcds-dhhs.ne.gov/ 2. Click "Capacity" on the left side of the screen 3. Select provider location if necessary 4. Select the appropriate week 5. Enter the capacity and utilization (based on service-specific formula provided) into the "Region 5" and Provider Location columns 6. Click "Save"

II. Access: C – Ineligibles

Area of Observation:	Consumers found to be ineligible for services. A consumer 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.
Expectation:	Network Provider Agencies will document the reasons a consumer is found ineligible for services. Assists with monitoring the systems access, flow, and understanding reasons consumers are found ineligible when trying to access services.
Quality Indicator:	Date/reason consumer is found to be ineligible for services as documented through monthly reporting submissions to Region V Systems
Measure:	To be developed by RQIT.
Service(s):	All services, excluding emergency protective service, crisis response, and crisis line.
Data Source:	Ineligible and Denial excel form
Frequency of Collection:	Monthly
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	Submission of completed Ineligible and Denial forms are to be submitted the first Monday of every month for the prior month's ineligibles and denials. Instructions below: 1. Date field-enter the date that the referral was denied. 2. Referral Source-enter the agency that you received the referral from i.e. Bryan LGH, LRC or person i.e. family member, self-referral. 3. Payer Source-select appropriate payer, Medicaid or Region V, from the drop-down menu. 4. Provider Name-select your provider agency name from the drop-down menu. 5. Service Type-select applicable service type from the drop-down menu. Report for both MH and SA services. 6. Consumer Identifier- enter the first four characters of the individual's last name the individual's date of birth (YYYYMMDD)+the last four digits of the his/her social security number. 7. Reason for Ineligibility/Denial- select. From drop down menu; if Other is selected, please specify in column H. 8. Specify, if other-only enter comments if you have selected "Other" from the drop-down menu in Column G.

II. Access: D – Denials

Area of Observation:	Consumers denied for services. Denials are decisions made by the provider agency at screening not to serve a referral because of agency established exclusionary criteria.
Expectation:	Network Provider Agencies will document the reasons a consumer is denied services. Assists in monitoring the systems access, flow, and reasons consumers are denied when trying to access services.
Quality Indicator:	Date/reason consumer is found to be denied for services as documented through monthly reporting submissions to Region V Systems
Measure:	To be developed by RQIT
Service(s):	All services, excluding emergency protective service, crisis response, and crisis line.
Data Source:	Ineligible and Denial excel form
Frequency of Collection:	Monthly
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	Submission of completed Ineligible and Denial forms are to be submitted the first Monday of every month for the prior month's ineligibles and denials. Instructions below: 1. Date field-enter the date that the referral was denied. 2. Referral Source-enter the agency that you received the referral from i.e. Bryan LGH, LRC or person i.e. family member, self-referral. 3. Payer Source-select appropriate payer, Medicaid or Region V, from the drop-down menu. 4. Provider Name-select your provider agency name from the drop-down menu. 5. Service Type-select applicable service type from the drop-down menu. Report for both MH and SA services. 6. Consumer Identifier- enter the first four characters of the individual's last name the individual's date of birth (YYYYMMDD)+the last four digits of the his/her social security number. 7. Reason for Ineligibility/Denial- select. From drop down menu; if Other is selected, please specify in column H. 8. Specify, if other-only enter comments if you have selected "Other" from the drop-down menu in Column G.

II. Access: E – Emergency Protective Custody

Area of Observation:	The number of consumers that law enforcement takes into emergency protective custody (EPC)/warrant and who is admitted for crisis stabilization.
Expectation:	Persons experiencing an acute emotional distress (mentally ill and dangerous) will have access to emergency crisis stabilization when a crisis occurs.
Quality Indicator:	Consumers taken into EPC/warrant and access crisis stabilization.
Measure:	No more than 60/month or 180/quarter.
Service(s):	Crisis Stabilization/EPC at Crisis Center & respective hospitals.
Data Source:	Compass/Centralized Data System

Frequency of Collection:	In real time.
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	Providers enter EPC encounters into the Centralized Data System. If a consumer is admitted to a hospital, the director of the Lancaster County Crisis Center will monitor and report to Region V Systems on a monthly basis.

Area of Observation:	The number of consumers emergency protective custody (EPC) readmissions or warrants by law enforcement and who is admitted for crisis stabilization.
Expectation:	Persons experiencing an acute emotional distress (mentally ill and dangerous) will have access to emergency crisis stabilization when a crisis occurs.
Quality Indicator:	Consumers readmitted (a month look back over the prior 13 months) and access crisis stabilization.
Measure:	No more than 80% of consumers per month (a month look back over the prior 13 months) will be readmitted and access crisis stabilization.
Service(s):	Crisis Stabilization at Crisis Center & respective hospitals.
Data Source:	Compass and Centralized Data System.
Frequency of Collection:	In real time.
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	Providers enter EPC encounters into the Centralized Data System. If a consumer is admitted to a hospital, the director of the Lancaster County Crisis Center will monitor and report to Region V Systems on a monthly basis.

III. Effectiveness: A – Consumer Recovery Outcomes

Each provider has selected a functional assessment tool to assess consumers functioning as they enter, during, and exit services within the Network. Each provider has determined the frequency of administering the tool they selected by service. The table below illustrates each tool, what the tool is measuring, and which providers utilize the tool.

Identified Tool	Measures	Provider Utilizing the Tool
Basis-24	Behavioral & Symptom Identification Scale. Measures 5 domains: Understanding of self, daily living skills/role functioning, depression, anxiety, suicidality...	Lancaster County Crisis Center
Child Adolescent Functioning Assessment Scale	Measures 8 domains of youths functioning in the areas of school, home, substance use, thinking……	Region V Systems--Professional Partner Service
Daily Living Activities-20	Assesses 20 domains of daily living skills. For example: health practices, housing, communication, safety, money, nutrition . . .	The Bridge Behavioral Health, CenterPointe, HopeSpoke, Houses of Hope, Integrated Behavioral Health Services, Lutheran Family Services, St. Monica's, TASC, Telecare, Touchstone
Outcome Questionaire-45, Y-OQ & Y-OQ Self Report	Symptom distress, interpersonal relationships, social role performance, somatic critical items, behavioral dysfunction…	Blue Valley Behavioral Health
Quality of Life Scale	General categories: knowledge of resources, housing, transportation, health, safety, support, education…	Mental Health Association of Nebraska

Area of Observation:	Consumers leave services with improved functioning based on the agency's self-selected functional assessment tool
Expectation:	Persons served experience a reduction in symptomology and/or improved functioning. The consumers get better.
Quality Indicator:	A consumer baseline functional assessment score at admission to services as compared to discharge or last administered functional assessment score
Measure:	The number and proportion of persons served whose discharge/last administered functional assessment score is statistically significantly (based on the tool, or a

	medium or large effect size) changed as compared to their admission score and are at/above the target or no lower than the threshold.
Service(s):	See above
Data Source:	Compass
Frequency of Collection:	Quarterly
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	Submission of assessments completed in the quarter are due 30 days past the end of the quarter. Unless there are arrangements otherwise, instructions are as below: 1. Log in to https://rvc.h4-technology.com/ 2. Click your name on the upper right side of the screen 3. Select 'Import Assessment Files' 4. Select the appropriate Provider, Assessment, and file to be uploaded The assessment import templates can be found by: 1. Log in to https://rvc.h4-technology.com/ 2. Click your name on the upper right side of the screen 3. Select 'System Documentation and Training' 4. Under 'Templates', click on the name of the assessment tool for which a template is needed

Level of Care	Overall Performance FY19-FY21Q2	Target (Avg. Highest Performing Agency + 5%)	Lower Threshold (FY19-FY21Q2 Perf. - 1 SD (12%))
Assertive Community Treatment - MH +	65%	71%	51%
Community Support – MH +	55%	66%	41%
Community Support – SUD +	48%	53%	34%
Day Rehabilitation – MH +	52%	56%	38%
Dual Disorder Residential - MH & SUD	57%	65%	43%
Emergency Community Support - MH	52%	57%	38%
Emergency Protective Custody - MH	33%	39%	19%
Halfway House - SUD	81%	84%	67%
Hospital Diversion	35%	41%	21%
Intensive Community Services – MH +	54%	60%	40%
Intensive Outpatient / Adult - SUD	58%	62%	44%
Intermediate Residential - SUD	29%	35%	15%
Outpatient Psychotherapy - MH +	44%	61%	30%
Outpatient Psychotherapy - SUD +	58%	76%	44%
Psychiatric Residential Rehabilitation - MH +	74%	79%	60%
Recovery Support-MH +	32%	38%	18%
Recovery Support - SUD +	49%	79%	35%
Secure Residential - MH	60%	67%	46%
Short Term Residential - SUD	56%	76%	42%

Supported Employment - MH & SUD +	79%	80%	65%
Therapeutic Community - SUD	67%	65%	53%

+: denotes those services where change will be measured between admission and most recent assessment, monitor for year to determine if it makes sense to establish targets/thresholds using most recent assessment

Exclusionary reasons consumers functioning scores do not need to be reported:

Service/Service Grouping	Excluded
Residential (STR, IR, HH)	Stays of less than 20 days.
Residential (DDR, TC)	Stays of less than 20 days.
Community Tx, Outpatient, Community Rehab	Stays less than 30 days and 3 or less contacts
Recovery Support	Stays less than 3 months and 3 or less contacts
Supported Employment	Stays less than 3 months
Emergency Community Support	3 or less contacts

Service/Service Grouping	Excluded
Emergency Protective Custody	1. Persons who cannot complete questionnaire within 24 hours of admission due to being too impaired (i.e. under the influence, psychotic) 2. Non-informed discharges: may have completed initial assessment but will not be given the discharge assessment due to nature of discharge. Inform client of discharge when transportation is present. 3. Uncooperative: consumers who refuse to complete paperwork.

III. Effectiveness: B – Outcomes vs. Utilization

Viewing consumer outcomes and their utilization in a quadrant format helps us understand the proportion of consumers that are making gains in their recovery while being mindful of the amounts of service usage. Reports are produced on as needed basis.

III. Effectiveness: C – National Outcome Measures

Area of Observation:	National Outcome Measures (Employment/Education, Crime & Criminal Justice, Stability in Housing, Abstinence from Drug and Alcohol Use.

Expectation:	As a result of the behavioral health services and a consumer's recovery process the National Outcome Measures should be positively impacted.		
Quality Indicator:	Change of consumers status regarding employment, education, crime, housing, and abstinence when comparing admission to discharge.		
Measure:	The number and proportion of persons served whose discharge status is positive and are at/above the target or no lower than the threshold		
Service(s):	Service Type	Adult/Youth	Service
	MH	Adult	Acute Inpatient Hospitalization
	MH	Adult	Assertive Community Treatment
	MH/SUD	Adult	Community Support
	MH	Adult	Day Rehabilitation
	MH/SUD	Adult	Dual Disorder Residential
	MH	Adult	Emergency Community Support
	SUD	Adult	Halfway House
	MH	Adult	Intensive Community Services
	SUD	Adult	Intensive Outpatient (IOP)
	SUD	Adult	Intermediate Residential
	MH	Adult/Youth	Medication Management
	MH/SUD	Adult/Youth	Outpatient Psychotherapy
	MH	Youth/Trans.	Professional Partner
	MH	Adult	Psychiatric Residential Rehabilitation
	MH/SUD	Adult	Recovery Support
	MH	Adult	Secure Residential
	SUD	Adult	Short Term Residential
	MH/SUD	Adult	Supported Employment
	MH/SUD	Adult/Trans.	Supported Housing
	MH	Adult	Supportive Living
	SUD	Adult	Therapeutic Community
Data Source:	Compass/Central Data System		
Frequency of Collection:	In real time.		
Frequency of Review:	Quarterly review		
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.		
Instruction:	Providers are to update CDS encounters, specifically the NOMS related fields, at admit, Continuation of Care and Continuation of Stay reviews, and at discharge. NOMS related fields:		
	Measure	Tab	Notes
	Employment Status	Demographics	Ensure 'Unemployed-Laid Off/Looking' is only selected if person served has participated in active job searching in the last 30 days
	Num Arrests in Past 30 Days	Demographics	
	Living Arrangements	Demographics	

	Substance Used	Substance Use	List under Primary, Secondary, Tertiary Substance, *as applicable,* if treatment is addressing use
	Frequency of Use (Admission)	Substance Use	List under Primary, Secondary, Tertiary Substance, *as applicable,* if treatment is addressing use
	Frequency of Use (Discharge)	Substance Use	List under Primary, Secondary, Tertiary Substance, *as applicable,* if treatment is addressing use

III. Effectiveness: D - Nebraska Social Determinants of Health Measures

<table>
<tr><td>Area of Observation:</td><td colspan="3">Stable Living and Employment</td></tr>
<tr><td>Expectation:</td><td colspan="3">As a result of the behavioral health services and a consumer's recovery process, stability in housing and employment status should be positively impacted.</td></tr>
<tr><td>Quality Indicator:</td><td colspan="3">Consumers' living arrangement and employment status at discharge.</td></tr>
<tr><td>Measure:</td><td colspan="3">The number and proportion of persons served whose discharge status is positive and are at/above the target or no lower than the target.</td></tr>
<tr><td rowspan="6">Service(s):</td><td>Measure</td><td>Target</td><td>Service</td></tr>
<tr><td rowspan="3">Living Arrangements</td><td>85%</td><td>All services entered in CDS</td></tr>
<tr><td>65%</td><td>Residential Services</td></tr>
<tr><td>88%</td><td>Supported Housing – MH & SUD</td></tr>
<tr><td rowspan="2">Employment Status</td><td>65%</td><td>All services entered in CDS, except Crisis/Emergency, Hospitalization and Assessment Services</td></tr>
<tr><td>75%</td><td>Supported Employment – MH & SUD</td></tr>
<tr><td>Data Source:</td><td colspan="3">Compass/Central Data System</td></tr>
<tr><td>Frequency of Collection:</td><td colspan="3">In real time.</td></tr>
<tr><td>Frequency of Review:</td><td colspan="3">Quarterly review</td></tr>
<tr><td>Who Reviews Information:</td><td colspan="3">Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.</td></tr>
<tr><td rowspan="4">Instruction:</td><td colspan="3">Providers are to update CDS encounters, specifically the Living Arrangements and Employment Status fields, at admit, Continuation of Care and Continuation of Stay reviews, and at discharge.</td></tr>
<tr><td>Measure</td><td>Tab</td><td>Notes</td></tr>
<tr><td>Living Arrangements</td><td>Demographics</td><td>Positive: all options except Homeless and Homeless Shelter</td></tr>
<tr><td>Employment Status</td><td>Demographics</td><td>• Only those in the labor force (Employed – Part Time or Full Time, Active/Armed Forces, and Unemployed-Laid Off/Looking) at discharge are included in the measure
• Ensure Unemployed-Laid Off/Looking is only selected if person served has participated in active job searching in the last 30 days</td></tr>
</table>

IV. Efficiency: A – Assessments-SUD

Area of Observation:	Substance use assessments are completed in a timely manner.
Expectation:	Consumers are receiving substance use assessments in a timely manner to expedite identifying a treatment path towards recovery.
Quality Indicator:	Comparing the admission (assessment/interview date) and discharge (Evaluation report completed-signed by evaluator) dates in CDS to evaluate the time it takes to complete the substance use assessment.
Measure:	Substance use assessments will be completed within 7 days.
Service(s):	Substance Use Assessments.
Data Source:	Compass/Central Data System
Frequency of Collection:	In real time.
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	Providers are to use the following dates when entering Assessment-SUD encounters in CDS: • Admission Date- date of assessment/interview • Discharge Date- date the evaluation report is completed and signed by evaluator

IV. Efficiency: B – Discharge & Pre-Admitted Non-Compliance

Area of Observation:	Consumers registered for services are discharged in the Central Data System when they are no longer receiving servicers.
Expectation:	The Central Data System is valid, accurate, and reliable and network providers are discharging consumers from this software system when they are no longer receiving services.
Quality Indicator:	Consumer encounters within Central Data System are discharged within the respective designated timeframes.
Measure:	Consumers discharge non-compliance will be under 5% and the pre-admitted non-compliance will be under 1%.
Service(s):	See table below.
Data Source:	Compass/Central Data System
Frequency of Collection:	In real time.
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Network Providers.
Instruction:	1. Log into Region V Systems Compass (https://rvc.h4-technology.com/) 2. Click the “Dashboards” button 3. Click the 3 horizontal white lines and select “Compliance Discharge/Pre-Admission” from the reports listed 4. View list of encounters that are identified as needing to be discharged

	5. Discharge the identified encounters via provider's EHR or CDS (https://dbhcds-dhhs.ne.gov) if deemed appropriate

Level of Care	Service Type	Service	Discharge Compliance Threshold Based on No Utilization	Contractual Expectation for Discharge
Adult Community Integration/Support	Authorized	Assertive Community Treatment - MH	No TADS units claimed for 1 month	10 days
		Community Support - MH	No TADS units claimed for **2** months	10 days
		Community Support - SUD	No TADS units claimed for **2** months	10 days
		Day Rehabilitation - MH	No TADS units claimed for 1 month	10 days
	Registered	Mental Health Respite - MH	No TADS units claimed for 1 month	10 days
		Recovery Support - MH	No TADS units claimed for **3 months**	10 days
		Supported Employment - MH	No TADS units claimed for **12 months**	10 days
		Supportive Living - MH	No TADS units claimed for 1 month	10 days
Adult Emergency Services	Registered	Inpatient Post Commitment Treatment D	No TADS units claimed for 1 month	10 days
		24 Hour Crisis Line - MH	No TADS units claimed for 1 month	10 days
		CPC Services - SUD	No TADS units claimed for 1 month	10 days
		Crisis Assessment - SUD	No TADS units claimed for 1 month	10 days
		Crisis Response Teams - MH	No TADS units claimed for 1 month	10 days
		Emergency Community Support - MH	No TADS units claimed for 1 month	10 days
		Emergency Protective Custody - MH	No TADS units claimed for 1 month	10 days
		Hospital Diversion Less than 24 hours - MI	No TADS units claimed for 1 month	10 days
		Hospital Diversion Over 24 hours - MH	No TADS units claimed for 1 month	10 days
		Social Detoxification - SUD	No TADS units claimed for 1 month	10 days
Adult Inpatient	Authorized	Acute Inpatient Hospitalization - MH	No TADS units claimed for 1 month	10 days
		Sub-acute Inpatient Hospitalization - MH	No TADS units claimed for 1 month	10 days
Adult Non-Residential	Authorized	Intensive Outpatient / Adult - SUD	No TADS units claimed for 1 month	10 days
	Registered	Assessment - SUD	No TADS units claimed for 1 month	10 days
		Intensive Community Services - MH	No TADS units claimed for 1 month	10 days
		Medication Management - MH	No TADS units claimed for **12 months**	10 days
		Outpatient Psychotherapy - MH	No TADS units claimed for **3 months**	10 days
		Outpatient Psychotherapy - SUD	No TADS units claimed for **3 months**	10 days
Adult Residential	Authorized	Dual Disorder Residential - SUD	No TADS units claimed for 1 month	10 days
		Halfway House - SUD	No TADS units claimed for 1 month	10 days
		Intermediate Residential - SUD	No TADS units claimed for 1 month	10 days
		Psychiatric Residential Rehabilitation - M	No TADS units claimed for 1 month	10 days
		Secure Residential - MH	No TADS units claimed for 1 month	10 days
		Short Term Residential - SUD	No TADS units claimed for 1 month	10 days
		Therapeutic Community - SUD	No TADS units claimed for 1 month	10 days
Youth Non-Residential	Authorized	Intensive Outpatient / Youth	No TADS units claimed for 1 month	10 days
	Registered	Assessment - SUD (Youth)	No TADS units claimed for 1 month	10 days
		Outpatient Psychotherapy - MH	No TADS units claimed for **3 months**	10 days
		Outpatient Psychotherapy - SUD	No TADS units claimed for **3 months**	10 days
		Professional Partner - MH	No TADS units claimed for 1 month	10 days

IV. Efficiency: C – Quality File Reviews

Area of Observation:	Network Provider person served files are reviewed to ensure they are monitoring quality, appropriateness, utilization of services provided, and timeliness of documentation.
Expectation:	Network Provider Agencies conduct and document reviews of services quarterly to address evidence by the record of the person served: the quality of service delivery, appropriateness of services, patterns of service utilization, and timeliness of documentation.
Quality Indicator:	Note the number of complete files and items that are observed per file with a numerator of areas that are complete over the denominator of total areas observed.
Measure:	Total completeness goal is 100% and a threshold of 80%.
Service(s):	All services excluding: crisis line.

Data Source:	File Review spreadsheet
Frequency of Collection:	Quarterly
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	1. Data is due 120 days after the end of the quarter (e.g., July – September data due January 31st) 2. Providers are to submit their own internal file review a. Each item of observation must have a numerator (number of compliant observations) b. Each item of observation must have a denominator (number of all observations) 3. Data is to be submitted via email to cqi@region5systems.net

IV. Efficiency: D – Critical Incidents

Area of Observation:	Critical incidents are actual or alleged events or situation that create a significant risk of substantial or serious harm or trauma to the physical, mental health, safety, or well-being of a person served or the Network Provider.
Expectation:	Network Provider Agencies assess if any of the 31 identified critical incidents occur and report them to Region V Systems.
Quality Indicator:	**Critical Incidents include:** **1. Abuse-Consumer to Consumer:** Consumer harms/assaults another consumer verbal/physical/psychological) **2. Abuse-Consumer to Staff:** Consumer harms/assaults staff (verbal/physical/psychological) **3. Abuse-Staff to Consumer:** Staff member harms/assaults a consumer (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:** Consumer 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:** All deaths that occurred and not specifically due to homicide or suicide completion **9. Elopement:** Consumer 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, in an effort to prevent pathogens being transferred from one person to another. **12. Injury to Consumer:** Not Self Harming. Accidental in nature.

	13. ***Legal Actions:** Network provider is involved in a legal action/lawsuit that involves a consumer 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/staff 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:** Consumer who has possession of an illegal substance. 19. **Possession of Weapon**: Consumer 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 consumer information on social media (Facebook, Twitter, LinkedIn, Websites, Blogs, etc.). 22. **Suicide Attempt**: An unsuccessful attempt/action to ends one's life. 23. ***Technology Breaches**: Failure of an agency to safeguard a consumer's confidential information that was transmitted/maintained electronically. 24. **Unauthorized Possession of Legal Substance**: Consumer who has possession of an unauthorized legal substance which is against program rules/polices. 25. **Use of a Weapon**: Consumer uses a weapon. 26. **Use of Illegal Substance**: Consumer is found to be using or admits to using illegal substances. 27. **Use of Restraints**: An agency utilizes restraints to manage a consumer's behavior. 28. **Use of Seclusion**: An agency utilizes seclusions to manage a consumer's behavior. 29. **Use of Unauthorized Legal Substance**: Consumer is found or admits to using unauthorized legal substances that are against the program rules/policies. 30. **Vehicular Accident**: Consumer is involved in a vehicular accident; the vehicle is driven by a staff member. 31. **Wandering**: Consumer cognitively impacted with a memory loss such as Alzheimer's/dementia who experiences unattended wandering that goes out of agency awareness/supervision. *Region V 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.
Measure:	Monitoring the number of critical incidents. Comparing them by fiscal year.
Service(s):	All
Data Source:	Critical Incident Spreadsheet
Frequency of Collection:	Quarterly
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.

Instruction:	1. Data is due 30 days after the end of the quarter 2. The "Critical Incident" and "Critical Incident Narrative" tabs in the CACI Reporting Form (Complaints Appeals Critical Incidents) a. Critical Incident tab: Enter the number of times a particular incident occurred, at a particular service, for the prior quarter (e.g., elopements from the short-term residential service). Options are to be selected from the drop-down list. b. Critical Incident Narrative Tab: Provider is to detail any emerging issues or trends they have observed for the quarter or fiscal year in the "Observations of emerging issues and trends" section. Providers are then to detail any actions or quality improvement activities undertaken (or will be taken) in the "Any action taken, or to be taken, for quality improvement" section. 3. Data is to be submitted via email to cqi@region5systems.net

IV. Efficiency: E – Annual Network Provider Site Visit

Area of Observation:	Services purchased, federal block grant requirements, program fidelity, minimum standards, and contract requirements.
Expectation:	Network provider agencies agree to follow guidelines and requirements as outlined in Title 206 regulations (includes service definitions) and their contract with Region V Systems.
Quality Indicator:	Unit, Financial, and Fidelity Audit.
Measure:	Services purchased audit & financial audit will have an overall compliance score of 95%. Fidelity audit will have an overall "substantial" compliance score.
Service(s):	Unit Audit = Fee for Service Funded Services Financial Audit = Expense Reimbursement Services Fidelity Audit = All Services
Data Source:	Compass/Central Data System/Client Records/Financial Records/Policies & Procedures
Frequency of Collection:	Site visit one time per year at minimum
Frequency of Review:	Annual at minimum
Who Reviews Information:	Region V Systems Network Management, Network Providers, BHAC, RGB.
Instruction:	• Confirm availability of essential staff and absence of conflicts with the site visit audit dates proposed by the region. • Make files accessible to the review team, a work area, computer access (if necessary). • An agency point person should be available to the review team throughout the duration of the site visit. • Agency employees available for an entry and exit conference as needed.

IV. Efficiency: F – Provider Meeting Attendance

Area of Observation:	Network Provider agency participation in administrative meetings (Network Provider & Regional Quality Improvement meetings).

Expectation:	Network provider agencies agree to participate in Network Provider and RQIT meetings for the purposes of planning, program development, and regional coordination of services.
Quality Indicator:	Participation in Network Provider and RQIT meetings.
Measure:	Network provider agencies shall participate in a minimum of 80% (cumulative average) of all meetings (Network Provider & RQIT Meetings).
Service(s):	All Provider Agencies
Data Source:	Meeting Minutes
Frequency of Collection:	As outlined in the frequency of meeting schedules.
Frequency of Review:	Monthly
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	• Providers are to let regional administrative employees know when they are participating in meetings remotely (telephone/Zoom). • Sign in sheets are utilized to monitor attendance.

V. Satisfaction: A - Perception of Care

Area of Observation:	Persons served complete a survey of their perception of care received by Network providers.
Expectation:	Network Provider Agencies assess persons served perception of care by survey at the providers determined timeframe of collection (interim, discharge, etc.) and report this information to Region V Systems.
Quality Indicator:	**<u>Perception of Care Questions Include:</u>** **General Satisfaction:** 1) If I had other choices, I would still get services from this agency. 2) I would recommend this agency to a friend or family member. **Quality & Appropriateness:** 3) Staff were sensitive to my cultural background (race, religion, language, etc.). **Access:** 4) Services were available at times that were good for me. **Participation in Treatment Plan:** 5) I not staff, decided my treatment goals. **Functioning:** 6) I am better able to handle things when they go wrong. **Outcomes:** 7) I deal more effectively with daily problems. 8) I am better able to deal with crisis. **Social Connectedness:** 9) In a crisis, I would have the support I need from family or friends. **Other (involuntary services):** 10) Staff treated me with respect and dignity. 11) The program was sensitive to any experienced or witness trauma in my life.
Measure:	Target for each question is 100% and the threshold is 85%.
Service(s):	All services excluding crisis line and crisis response.

Data Source:	Providers total positive responses (numerator)/total responses (denominator).
Frequency of Collection:	2 times per year (July-December & January -June)
Frequency of Review:	Bi-annual.
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	1. Data is due 30 days after the end of the quarter 2. For each question, include the number of persons served responding positively and the total number of responses in the reporting timeframe. 3. If there are 1 or more questions/statements that fall below the threshold (85%), Providers are to include a quality improvement action plan to address the applicable areas. 4. Data and quality improvement action plans are to be submitted via email to cqi@region5systems.net

V. Satisfaction: B – Complaints/Appeals

Area of Observation:	People receiving services by a Network Provider can complain and appeal decisions made by the agency.
Expectation:	Network Provider Agencies have a formal mechanism to collect persons served complaints and a written policy to outline what the appeals process is for the person to follow.
Quality Indicator:	Network Providers collect person served complaints, known as a formal written grievance by a person to express dissatisfaction with any aspect of the operations, activities, trauma or behavior of a Network Provider for which such grievance cannot be resolved at an informal level. Network Providers report complaints to Region V Systems. **<u>Complaints include:</u>** **1) Access to Services:** defined as any service that the consumer requests which is not available or any difficulty the consumer e 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 Staff:** defined as any problem the consumer experiences in relation to staff's accessibility. (Return of phone calls, staff's 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 staff member, failure to provide requested information which would assist the consumer in resolving his/her issue. **5) Environmental:** defined as any consumer's 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 consumer and staff member 8) **Program/Policy/Procedure**: defined as any issue a consumer 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 consumer 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, please specify the issue. Providers collect persons served **appeals**, which is a formal request made for review and reconsideration of the outcome of their formal written complaint when the person served is unhappy with the action taken by the Network Provider to remediate the complaint. Network Providers report appeals to Region V Systems.
Measure:	Monitoring the number of complaints. Comparing them by fiscal year.
Service(s):	All
Data Source:	Complaint & Appeals Spreadsheets.
Frequency of Collection:	Quarterly
Frequency of Review:	Quarterly review
Who Reviews Information:	Region V Systems administration, Regional Quality Improvement Team, Consumer Advisory Committee, Network Providers, BHAC, RGB.
Instruction:	1. Data is due 30 days after the end of the quarter 2. The "Complaints" and "Appeals" tabs in the CACI Reporting Form (Complaints Appeals Critical Incidents) a. Complaint tab: For each complaint received, providers are to enter the date, type/category of the complaint, what service the consumer was in, and the resolution/actions taken for the complaint. b. Appeals Tab: For each appeal that occurred in the quarter, providers are to enter the date, type/category of the original complaint, and any resolution/actions taken from the appeal 3. Data is to be submitted via email to cqi@region5systems.net