REGION V SYSTEMS

Promoting Comprehensive Partnerships in Behavioral Health

Management Summary

FY 20-21

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ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN (PIP) INDICATORS – SECTION I

Region V 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 V Systems strives for include:

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

During the annual PIP planning process, decisions are made regarding several components of the plan. All staff members at Region V 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 V 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 V Systems in jeopardy if the threshold is not met.
Expectation	Helps anticipate what should be occurring regarding Region V 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. Gives you a value to compare Region V 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 Team	The identified regularity that teams 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 20-21 indicators that have been reviewed by Region V Systems' departments, programs, Leadership Team, Corporate Compliance Team, and made available to all staff. 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 21-22 PIP.

Indicator Number	FY 20-21 Threshold	Review	FY 21-22 PIP Status
1	100% of Region V Systems' employees complete CARF-required trainings.	Approved	Continue
2	Community trainings sponsored by Region V Systems will result in an overall satisfactory rate of 85% or above.	Approved	Continue
3	100% of organized county community prevention coalitions (16) in southeast Nebraska will participate in substance abuse annual assessments and quarterly BH5 reporting/NIPRS (Nebraska Prevention Information Resource System).	Approved	Continue
4	Increase the number of visits to the website/social media site (www.talkheart2heart.com) above the baseline (users: Repeat 3,629, Unique 2,094; Social Media: Engagement-Views/Shares 2,120, Readership 746, Impressions 67,424) by June 30, 2022.	Approved	Modify
5	100% of all funded coalitions will report quarterly on regional coalition sustainability strategies.	Approved	Continue
6	85% of counties (16) in southeast Nebraska will have an active community prevention coalition by June 30, 2022.	Approved	Continue
7	75% of the counties (16) are represented on Youth Action Board membership.	Approved	Continue
8	50% of all counties within Region V Systems geographical territory will have a minimum of one Hope Squad.	Approved	Continue
9	100% of all counties will have a minimum of one school district utilizing the evidence based-Second Step Social/Emotional learning curriculum.	Approved	Continue
10	90% of all staff members shall have semi-annual performance evaluation and documentation completed.	Approved	Modify
11	100% of all staff members shall have an annual performance evaluation.	Approved	Continue
12	100% of drills completed per established schedule.	Approved	Continue
13	90% of service requests are assigned to an applicable Information Technology response team member, and initial documentation is entered within one business day: non-emergency requests within two business days.	Approved	Continue
14	100% of building occupants will be accurately documented on the pegboard during health and safety drills.	Approved	Continue
15	30% of consumers in the Rental Assistance Program with vouchers will reside in the rural counties.	Approved	Continue
16	Consumers of RAP SD will successfully participate in their housing transition plan 80% of the time.	Approved	Delete

(Cont.)

Indicator Number	FY 20-21 Threshold	Review	FY 21-22 PIP Status
17	60% of people in mental health track and 85% of people in substance use track housed in Region V Systems Rental Assistance program will bridge to Section 8, another household program, or become self-sufficient.	Approved	Modify
18	60% of youth with a 30-point (severe impairment) admission CAFAS score on any of the 8 domains will decrease to 20 points (moderate impairment), 10 points (mild/minimal impairment) when comparing admission to discharge CAFAS scores. (Must have a 30 in any domain at admission to be included in sample.) (Traditional, Transitional, Prevention, Juvenile Justice, and Crisis Response tracks).	Approved	Continue
19	70% of discharged youths' total CAFAS scores will decrease by 20 points when comparing intake vs. discharge scores (Traditional, Transitional, Prevention, Juvenile Justice, and Crisis Response tracks).	Approved	Continue
20	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) (Traditional, Transitional, Prevention, Juvenile Justice, and Crisis Response tracks).	Approved	Continue
21	75% of youth demonstrate improvement on one or more of the three outcome indicators (Traditional, Transition, Prevention, Juvenile Justice, and Crisis Response Tracks).	Approved	Continue
22	85% of all teams will have at least one informal support on their team member list.	Approved	Continue
23	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.	Approved	Continue
24	100% of FYI youth will be living in their home while served in the FYI program.	Approved	Continue
25	90% of families will have a team meeting every month.	Approved	Continue
26	30% of clients in the FYI program will reside in rural counties.	Approved	Continue
27	95% of FYI Professional Partners performance will be met on all their gauges.	Approved	Continue
28	100% of Network Providers will receive a copy of their agency's site visit report as prepared by Region V Systems' Network Administration within forty-five (45) days of completion of the site visit.	Approved	Continue
29	Exit conferences will be completed with 100% of Network Providers at the completion of each agency/program site visit.	Approved	Continue
30	100% of all the network providers' governing boards will have consumer representation (consumer voice) on their governing board.	Approved	Continue

(Cont.)

Indicator Number	FY 20-21 Threshold	Review	FY 21-22 PIP Status
31	4,440 Outreach Worker contacts in the Crisis Counseling Program-CCP are documented by December 23, 2021.	Approved	Modify
32	Of all Crisis Counseling Program-CCP encounters, 67% will be direct encounters. (group or individual/family encounter).	Approved	Modify
33	100% of Outreach Workers will perform an average of 20 hours of field work each week.	Approved	Modify
34	100% of independent clinical assessments will be completed within 30 days of a youth being placed in a Qualified Residential Treatment Program.	Approved	Continue
35	The Rural & Lincoln Permanent Housing program will maintain 100% of capacity (32 Rural Housing Units & 12 Lincoln Housing Units).	Approved	Modify
36	95% of the Rural & Lincoln Permanent Housing programs performance will be met on all their gauges (enrollment in Clarity, Annual HQS Inspections, Housing Specialist monthly documentation; needs assessments in Fidelity).	Approved	Modify
37	90% of mental health and substance use vouchers (2958) will be issued by April 30, 2022 (counties of Antelope, Boone, Buffalo, Burt, Butler, Colfax, Cuming, Custer, Hall, Holt, Howard, Knox, Madison, Nance, Nemaha, Pierce, Platte, Richardson, Saline, Saunders, Stanton, and Thurston).	Approved	Modify
38	280 community members will attend Mental Health First Aid by June 30, 2021 for individuals in the counties of Antelope, Boone, Buffalo, Burt, Butler, Colfax, Cuming, Custer, Hall, Holt, Howard, Knox, Madison, Nance, Nemaha, Pierce, Platte, Richardson, Saline, Saunders, Stanton, and Thurston.	Approved	Delete
39	90% of target Crisis Counselor contacts (2,333) are documented by June 30, 2021.	Approved	Delete

The second part of this section is a summary of Performance Indicators for Fiscal Year 2019-2020. The indicators are sorted by department: Adult Services, Operations/Human Resources, Children and Family Services, Fiscal, and Strategic Planning/Special Projects.

Adult Services Department:

Indicator # 3:	Substance abuse annual assessments and Quarterly BH5 Reporting, NPIRS Reporting
Threshold:	100% of organized 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	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	100%	100%	100%	100%	100%

Indicator # 4:	Number of visits to the website/social media site
Threshold:	Establish a baseline of the number of visits to the website/social media site (www.talkheart2heart.com) by June 2021

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
N/A	N/A	N/A	N/A	N/A	N/A	N/A	Users: Repeat 3,629; Unique 2,094; Social Media: Engagement-Views/Shares 2,120, Readership 746, Impressions 67424)

Indicator # 5:	Coalition sustainability plans
Threshold:	100% of all funded coalitions will report quarterly on regional coalition sustainability strategies.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	100%	100%	100%	100%	100%	100%

Indicator # 6:	Active community prevention coalitions throughout southeast Nebraska
Threshold:	85% of counties (16) in southeast Nebraska will have an active community prevention coalition by June 30, 2021.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	85%	100%	100%	100%	94%	100%	100%

Adult Services Department (cont.):

Indicator # 7:	YAB youth representation
Threshold:	75% of the counties are represented on the Youth Action Board membership.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	75%	75%	50%	50%	44%	44%	44%

Indicator # 8:	Hope Squads
Threshold:	50% of all counties within Region V Systems geographical territory will have a minimum of one Hope Squad.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	50%	69%	69%	69%	38%	56%	56%

Indicator # 9:	Evidence Based Practice-Second Step Social/Emotional learning curriculum
Threshold:	100% of all counites will have a minimum of one school district utilizing the evidence based-Second Step Social/Emotional learning curriculum.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	N/A	100%	100%	100%	100%	100%

Indicator # 15:	County of residence at enrollment
Threshold:	30% of consumers in the Rental Assistance Program with vouchers will reside in the rural counties.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
30%	30%	31.75%	34%	37%	28%	36%	36%

Indicator # 16:	Successful participation in the Rental Assistance Program-Substance Dependence (RAP SD) Housing Transition Plan
Threshold:	Consumers of the RAP SD will successfully participate in their housing transition plan 80% of the time.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
90%	80%	99%	100%	100%	100%	97%	99%

Adult Services Department (cont.):

Indicator # 17:	Consumers of Rental Assistance Program will bridge to Section 8 or other housing program or become self-sufficient within 36 months of admission or less
Threshold:	70% of people housed in Region V Systems Rental Assistance program will bridge to Section 8, other household program, or become self-sufficient within 36 months, or less of admission.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
TBD	70%	N/A	64%	63%	56%	78%	59%

Indicator # 28:	Time between completion of site visit and distribution of site visit reports
Threshold:	100% of Network Providers will receive a copy of their agency's site visit report as prepared by Region V Systems' Network Administration within 45 days of completion of the site visit.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	80%	NA	NA	75%	100%	75%

Indicator # 29:	Number of site visit exit conferences.
Threshold:	Exit conferences will be completed with 100% of Network Providers at the completion of each agency/program site visit.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	NA	100%	100%	100%	100%

Indicator # 30:	Consumer representation on provider agency boards
Threshold:	Assess the Network Providers' governing boards and determine the number/ percent of providers that have consumer's representation/consumer voice on their governing board.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	73%	N/A	N/A	N/A	83.33%	83.33%

Indicator # 31:	Documentation of Crisis Counselor contacts with communities/individuals within the 16 counties of Region V Systems (Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, & York)
Threshold:	100% (5550) of Crisis Counselor contacts are documented by June 26, 2021 (COVID-19 Grant) (Crisis Counseling Program-CPP).

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
100%	100%	New Goal	55.10%	161.26%	235.19%	292.50%	292.50%

Adult Services Department (cont.):

Indicator # 32:	Documentation of direct crisis counselor encounters
Threshold:	Of all (Crisis Counseling Program-CPP) encounters, 67% will be direct crisis counseling encounters. (Group Encounter or Individual/Family Crisis Counseling Services Encounter).

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
67%	67%	New Goal	23.05%	19.43%	49.17%	42.11%	32%

Indicator # 33:	Provide in-person crisis counseling services directly in the communities of Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York Counties
Threshold:	100% of Outreach Workers performance will average 20 hours of field work each week.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
100%	100%	New Goal	51.19%	87.63%	93.05%	120.21%	120.21%

Indicator # 37:	Individuals will be provided vouchers to pay for outpatient mental health and substance use services.
Threshold:	90% of mental health and substance use vouchers (700) will be issued by June 30, 2021 for individuals in the counties of Antelope, Boone, Buffalo, Burt, Butler, Colfax, Cuming, Custer, Hall, Holt, Howard, Knox, Madison, Nance, Nemaha, Pierce, Platte, Richardson, Saline, Saunders, Stanton, and Thurston.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
100%	90%	New Goal	21.7%	97.86%	243.14%	304.14%	304.14%

Indicator # 38:	The number of participants attending Mental Health First Aid Training.
Threshold:	100% (280) community members will attend Mental Health First Aid by June 30, 2021 in the counties of Antelope, Boone, Buffalo, Burt, Butler, Colfax, Cuming, Custer, Hall, Holt, Howard, Knox, Madison, Nance, Nemaha, Pierce, Platte, Richardson, Saline, Saunders, Stanton, and Thurston.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
100%	100%	New Goal	N/A	N/A	5%	71.07%	71.07%

Adult Services Department (cont.):

Indicator # 39:	Documentation of Crisis Counselor contacts with communities/individuals within the 23 impacted counties (Antelope, Boone, Buffalo, Burt, Butler, Colfax, Cuming, Custer, Hall, Holt, Howard, Knox, Madison, Nance, Nemaha, Pierce, Platte, Richardson, Saline, Saunders, Stanton, and Thurston)
Threshold:	90% of target Crisis Counselor Contacts (2,333) are documented by June 30, 2021.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
100%	90%	New Goal	29.66%	69.05%	213.37%	388.94%	388.94%

Children and Family Services Department:

Indicator # 18:	Individual Youth 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 points (moderate impairment), 10 points (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) (Traditional Transition, Prevention, Juvenile Justice, Crisis Response tracks)

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	60%	53%	53%	57%	62%	57%	57%
Traditional		75%	50%	53%	59%	51%	51%
Transition		61%	40%	70%	75%	74%	74%
Prevention		56%	67%	55%	58%	61%	61%
Juvenile Justice		30%	N/A	N/A	N/A%	33%	33%
Crisis Response		60%	67%	50%	0%	50%	50%

Indicator # 19:	Aggregated average Child Adolescent Functioning Assessment Scale (CAFAS) scores
Threshold:	70% of youth discharged from FYI will have a decrease in total CAFAS scores by 20 points when comparing intake vs. discharge scores. (Traditional, Transitional, Prevention, Juvenile Justice, Crisis Response)

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	70%	70%	60%	67%	73%	67%	67%
Traditional		67%	56%	59%	69%	60%	60%
Transition		90%	20%	50%	69%	74%	74%
Prevention		33%	80%	85%	86%	75%	75%
Juvenile Justice		33%	100%	100%	100%	75%	75%
Crisis Response		67%	80%	70%	0%	70%	70%

Children and Family Services Department (cont.):

Indicator # 20:	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).

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	40%	59%	50%	53%	59%	54%	54%
Traditional		59%	44%	53%	61%	55%	55%
Transition		75%	20%	44%	53%	53%	53%
Prevention		62%	80%	69%	71%	65%	65%
Juvenile Justice		18%	N/A	N/A	N/A	33%	33%
Crisis Response		61%	67%	38%	0%	38%	38%

Indicator # 21:	The three outcome indicators for FYI program using the 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 (Traditional, Transition, Prevention, Juvenile Justice Tracks).

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	75%	75%	64%	75%	78%	72%	72%
Traditional		72%	56%	65%	72%	62%	62%
Transition		95%	40%	70%	81%	84%	84%
Prevention		79%	80%	85%	86%	80%	80%
Juvenile Justice		33%	100%	100%	100%	75%	75%
Crisis Response		71%	80%	80%	80%	80%	80%

Children and Family Services Department (cont.):

Indicator # 22:	Documentation of informal supports on wraparound team
Threshold:	85% of all teams will have at least one identified informal support on their team member list (informal support definition developed by FYI will be used). (Traditional, Transition, Prevention, and Crisis Response tracks.)
National Standard:	Looking at plans and teams in the 2003 wraparound study - 60% of teams had no informal resources; 32% had one; 8% had two or more.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	85%	86%	88%	86%	86%	95%	89%
Traditional		92%	83%	84%	82%	93%	86%
Transition		93%	94%	94%	96%	97%	96%
Prevention		85%	94%	70%	76%	100%	85%
Juvenile Justice		64%	100%	100%	100%	100%	100%
Crisis Response		64%	80%	N/A	N/A	N/A	80%

Indicator # 23:	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 (informal support definition developed by FYI will be used). (Traditional, Transition, Prevention, and CFS tracks.)
National Standard:	Looking at plans and teams in the 2003 wraparound study - 60% of teams had no informal resources; 32% had one; 8% had two or more.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	70%	77%	64%	58%	69%	76%	68%
Traditional		73%	70%	53%	68%	74%	66%
Transition		99%	64%	52%	65%	81%	67%
Prevention		51%	52%	83%	69%	68%	67%
Juvenile Justice		99%	100%	100%	100%	100%	100%
Crisis Response		66%	50%	N/A	N/A	N/A	50%

Children and Family Services Department (cont.):

Indicator # 24:	Place of Residence
Threshold:	100% of FYI youth will be living in their home while served in the FYI program (if youth reside out of their home for less than two consecutive weeks during the month it will not be considered an out-of-home placement). (Traditional, Transition, Prevention, and CFS tracks.)

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	99%	98%	100%	99%	98%	99%
Traditional		98%	97%	100%	100%	97%	99%
Transition		100%	100%	100%	97%	99%	99%
Prevention		100%	100%	100%	100%	100%	100%
Juvenile Justice		94%	100%	100%	100%	100%	100%
Crisis Response		96%	100%	N/A	N/A	N/A	100%

Indicator # 25:	Team meetings summary
Threshold:	90% of families will have a team meeting every month. (All tracks.)

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	99%	100%	99%	100%	100%	100%
Traditional		100%	100%	99%	100%	100%	100%
Transition		100%	100%	98%	100%	100%	100%
Prevention		99%	100%	100%	100%	100%	100%
Juvenile Justice		100%	100%	100%	100%	100%	100%
Crisis Response		98%	100%	N/A	N/A	N/A	100%

Indicator # 26:	County of residence at monthly review
Threshold:	30% of FYI clients will reside outside of Lancaster County. (Traditional track.)

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
30%	30%	32%	42%	42%	49%	50%	46%

Indicator # 27:	Professional Partner performance gauges.
Threshold:	95% of the FYI Professional Partners performance will be met on all of their gauges.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	95%	99%	100%	99%	98%	97%	99%

Children and Family Services Department (cont.):

Indicator # 35:	Rural Permanent Housing units
Threshold:	The Rural Permanent Housing program will maintain 100% of capacity (32 Rural Housing Units).

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	New Goal	N/A	N/A	N/A	87.5%	87.5%

Indicator # 36:	Rural Permanent Housing performance gauges
Threshold:	95% of the Rural Permanent Housing Programs performance will be met on all their gauges (enrollment in Clarity, annual HQS inspections, housing specialist monthly documentation, and needs assessment in Fidelity).

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	95%	New Goal	N/A	N/A	N/A	100%	100%

Continuous Quality Improvement Department:

Indicator # 34:	Completed independent clinical assessment
Threshold:	100% of independent clinical assessments will be completed within 30 days of a youth being placed in a Qualified Residential Treatment Program.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	New Goal	100%	100%	100%	100%	100%

Operations/Human Resources Department:

Indicator # 1:	Completion of annual CARF & Region V Systems required trainings
Threshold:	100% of Region V Systems' employees complete required trainings according to the assigned deadline.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	91%	3%	20%	47%	97%	97%

Indicator # 2:	Training evaluations
Threshold:	Trainings sponsored by Region V Systems will result in an overall satisfaction rate of 85% or above.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Average
90%	85%	95%	78%	91%	92%	97%	97%

Operations/Human Resources Department (cont.):

Indicator # 10:	Documented quarterly supervision forms turned in by the 5th business day following the quarter
Threshold:	90% of all staff members shall have quarterly supervision and documentation complete.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	100%	100%	94%	100%	100%	98%

Indicator # 11:	Documented annual supervision within the required due date
Threshold:	100% of all staff members shall have an annual performance evaluation.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	100%	100%	100%	100%	100%

Indicator # 12:	Completion of drills according to established schedule
Threshold:	100% of drills completed per established schedule.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	N/A	N/A	N/A	100%	100%

Indicator # 13:	Service requests are addressed efficiently
Threshold:	90% of service requests are addressed efficiently. The request must be assigned to an applicable IT Response Team Member and have initial documentation entered within one (1) business day for emergency requests; non-emergency requests must be within two (2) business days.

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	97%	98.47%	97.22%	98.59	97%	98%

Indicator # 14:	Pegboard documentation per standard procedures.
Threshold:	100% of building occupants will be accurately documented on the pegboard during health and safety drills (Only Fire, Gas Leak, and Tornado Drills).

Standard	Threshold	Quarter 4 FY 19-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	93.5%	N/A	NA	NA	95%	95%%

NETWORK SERVICES – SECTION II

Region V 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 consumers, 2) consumer's access to services, 3) availability of high-quality behavioral health services, and 4) cost-effective behavioral health services.

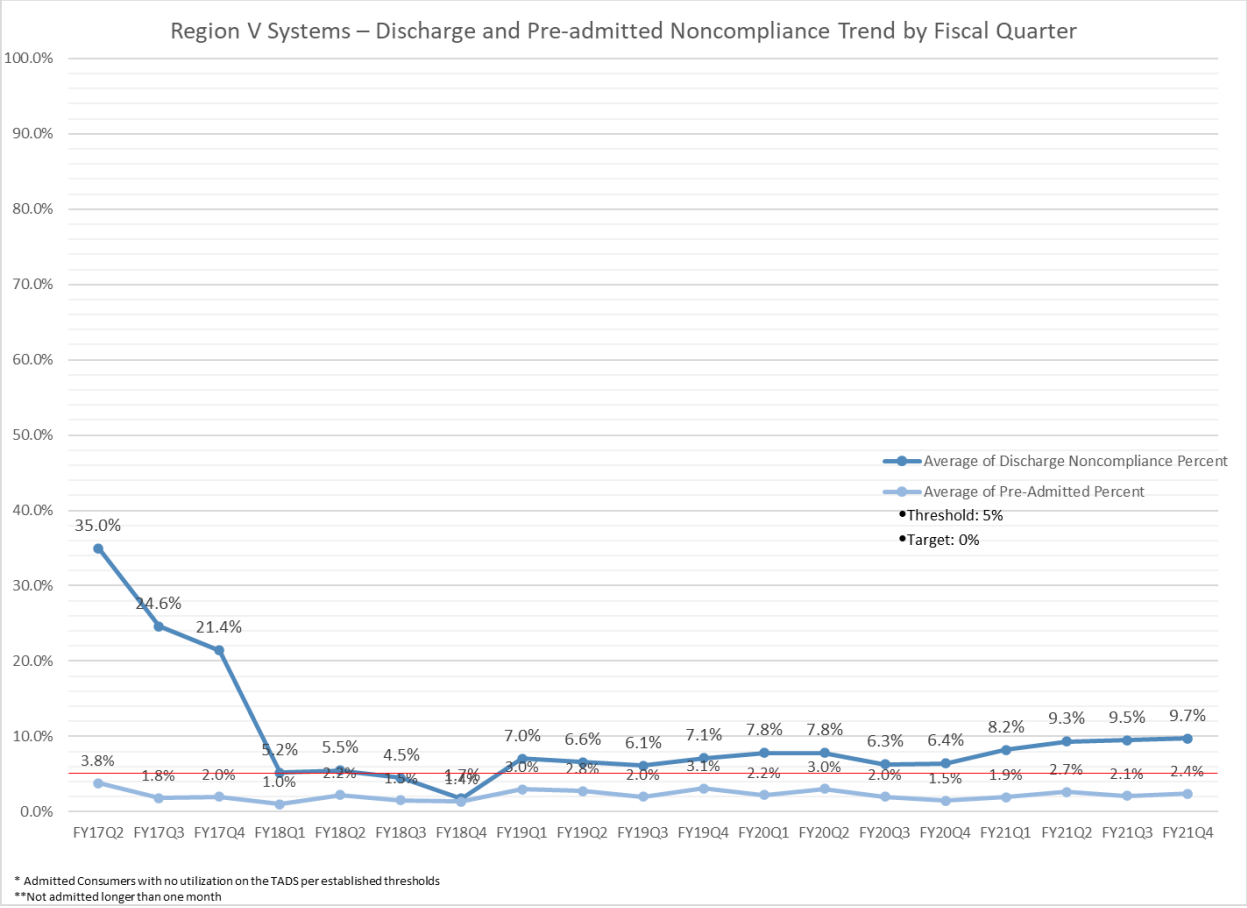
Region V Systems has created a "Regional Quality Improvement Team" (RQIT) to establish a network of accountability for continuous quality improvement by using data to plan, identify, analyze, implement, and report ongoing improvements, celebrate progress, change, and success. Membership includes a representative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

Data Management:
Continued focus over the last fiscal year has been to improve the accuracy of information that is input into the Division of Behavioral Health's Central Data System (CDS). Providers are accountable for entering "Persons Served with Life Experience" information into the CDS database. This is monitored by the *Discharge Noncompliance Report and Pre-Admitted Noncompliance Report*.

The Discharge Noncompliance Report monitors all consumers registered in CDS and assesses if there has been no utilization of services as claimed by providers per an identified threshold for each respective service. The Pre-Admitted Noncompliance Report monitors consumers who have been entered in CDS but never actually registered for a service and assesses if the consumer sits in the "pre-admitted" status for more than 30 days. Many educational opportunities have occurred over the year with providers to review and learn the various thresholds and monitoring of consumers in CDS.

The following graph (next page) shows a decrease in the percent of consumers over the identified thresholds with no service utilization as monitored in fiscal year 2016-2017, quarter 2 (FY17Q2) at 35% to 9.7% in fiscal year 2020-21, quarter 4 (FY21Q4). Region V Systems' target is to have 0% of consumers in discharge noncompliance.

The number of consumers over the Pre-admitted noncompliance status improved from 3.8% for the time period of FY17Q2 to 2.4% for the time period of FY21Q4. The Regional Quality Improvement Team established an upper limit of 5%. This allows providers to operate within a 0% to 5% acceptable range. The threshold is being monitored and assess if it continues to be appropriate. Due to Medicaid expansion the sample size/number of people served has decreased during this fiscal year and therefore the percentage has risen to 9.7% for discharge noncompliance.



Substance Abuse Waitlist and Mental Health/Substance Abuse Capacity:

Region V 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 consumer is to wait for treatment services, ensures consumers 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 consumers were waiting for treatment.

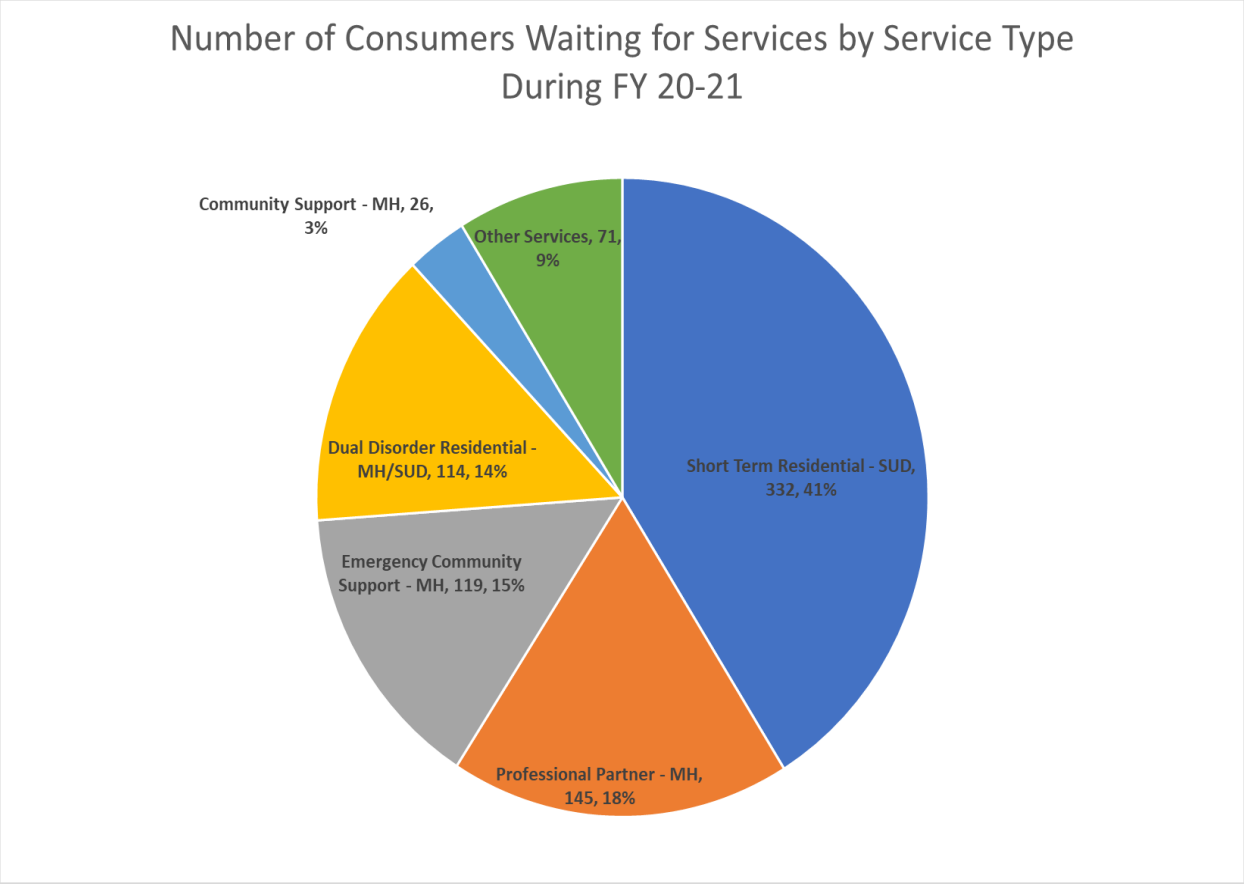
Starting in FY 17-18 consumer information was entered into the Division of Behavioral Health's Central Data System (CDS). There was a learning curve by the Region and the network providers with utilizing this new system. New ways of entering data, managing the waitlist, and the regions approach to monitoring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

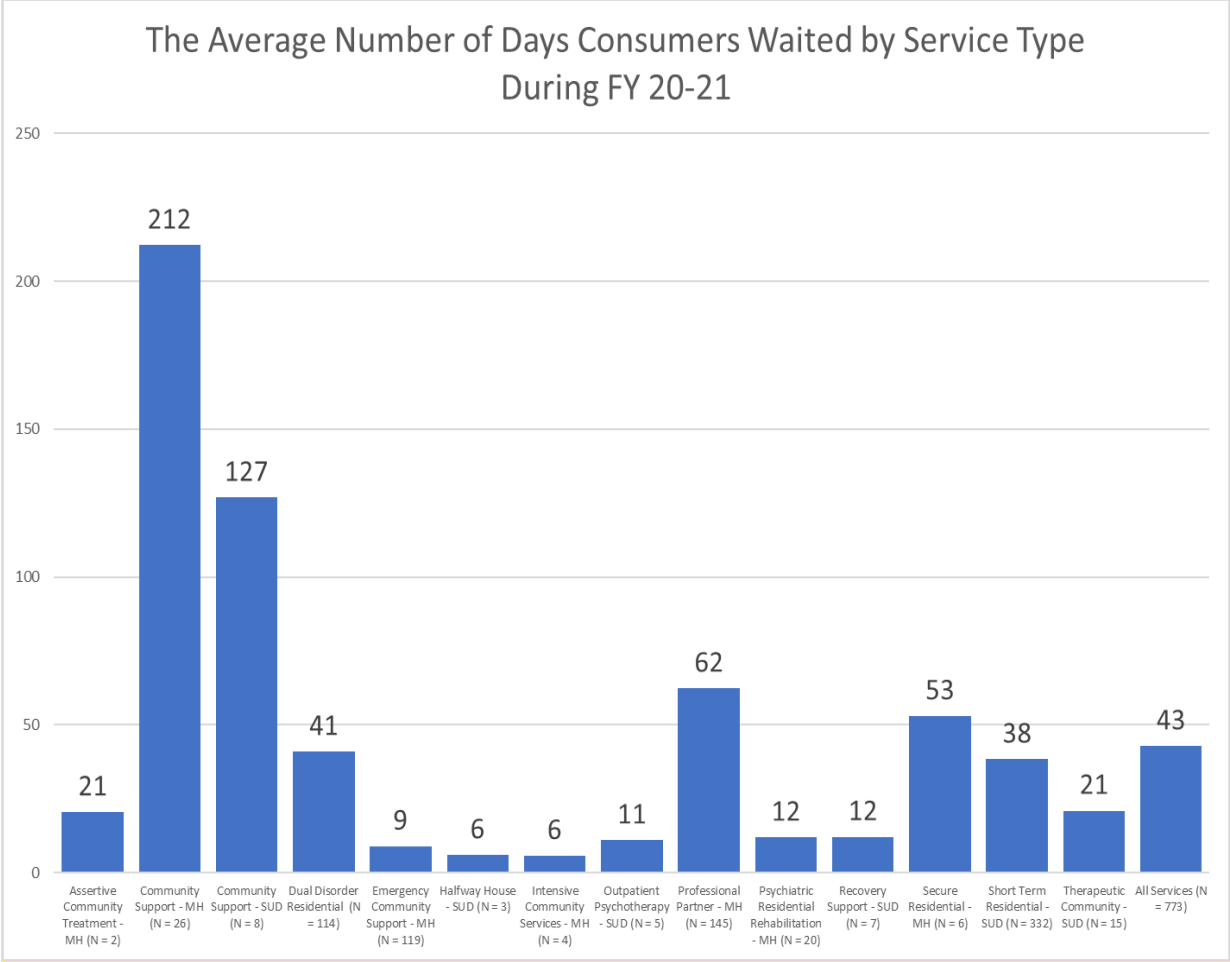
Mental Health Services	Substance Use Disorder Services
ACT (Assertive Community Treatment – MH)	Community Support – SUD
Community Support – MH	Dual Disorder Residential – SUD
Dual Disorder Residential – MH	Halfway House – SUD
Mental Health Respite – MH	IOP (Intensive Outpatient / Adult – SUD)
Professional 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 consumers who waited for services in fiscal year 20-21.

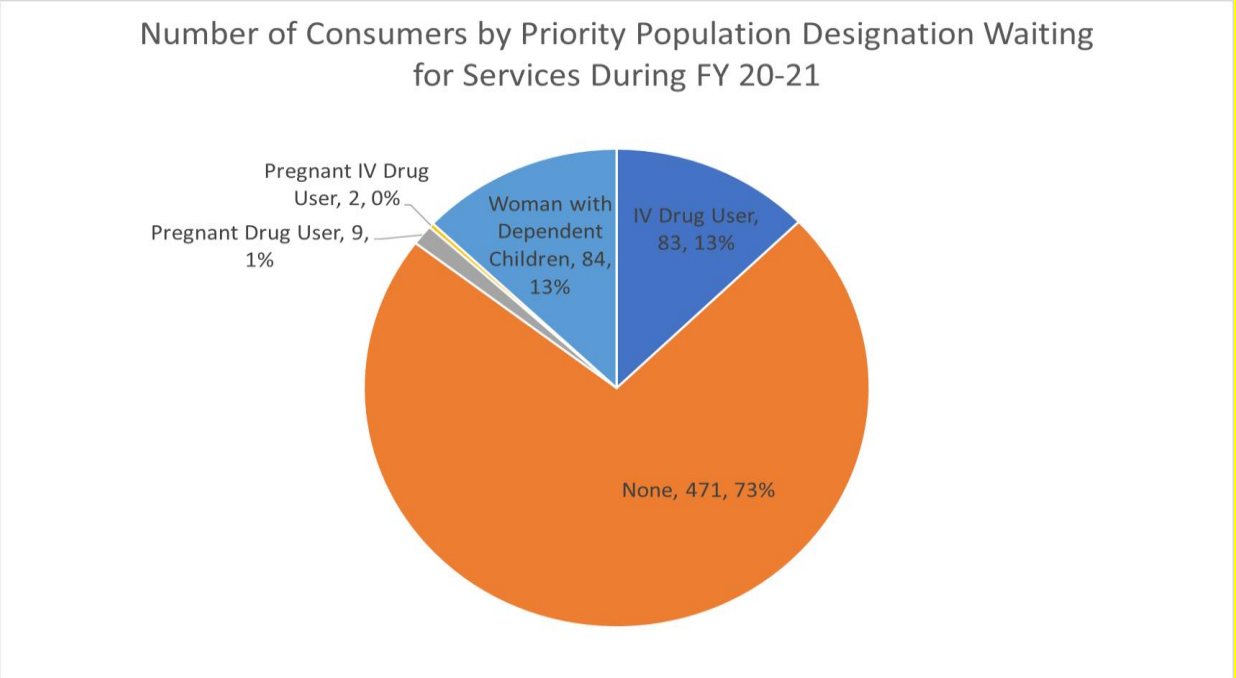


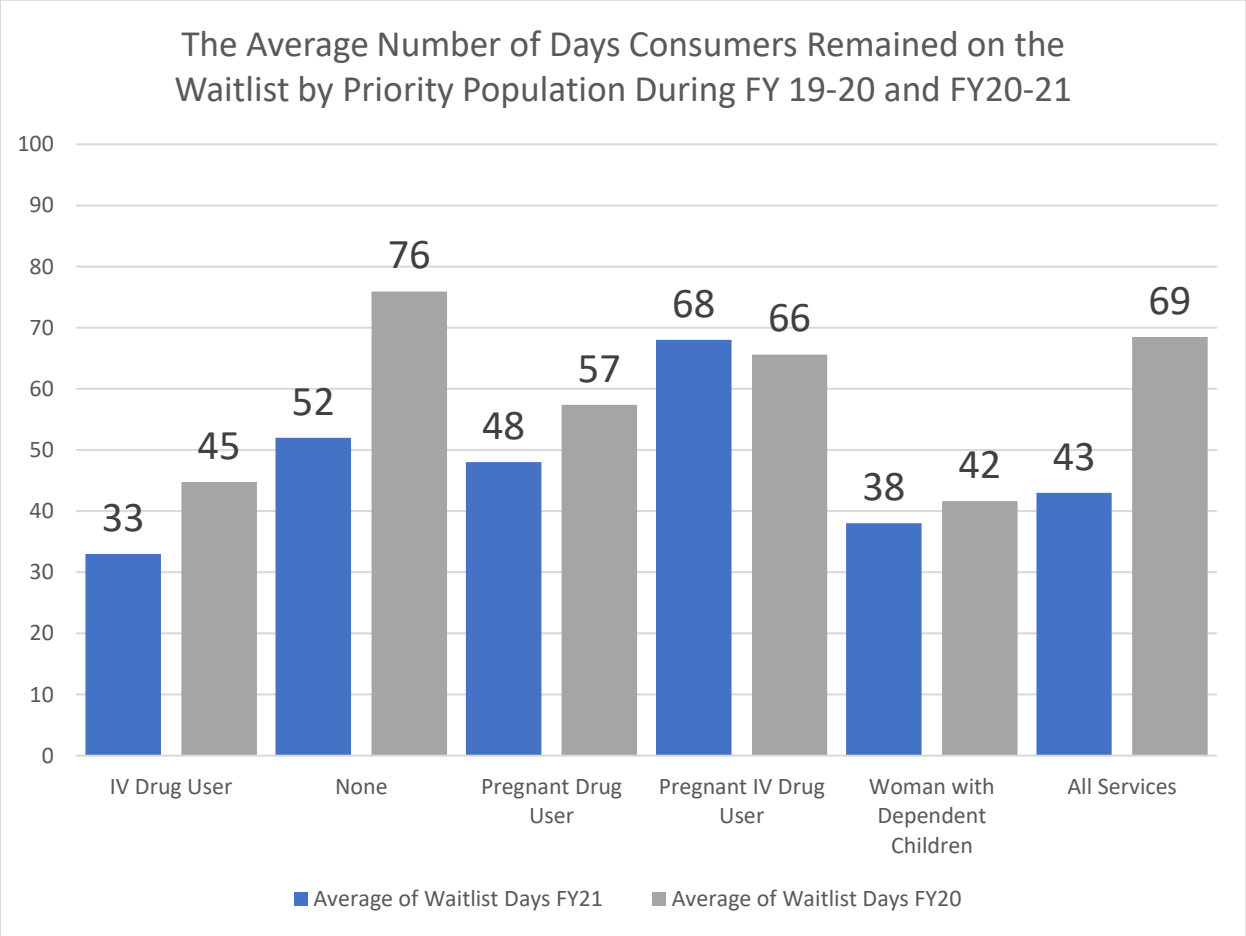
Below is a listing of substance abuse and mental health services available in the Region V Systems' network. This is a listing of the average number of days persons served remained on the waitlist until they were removed for various reason (entering treatment, unable able to be located, refused treatment,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

As compared to last fiscal year these average wait times have decreased 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.

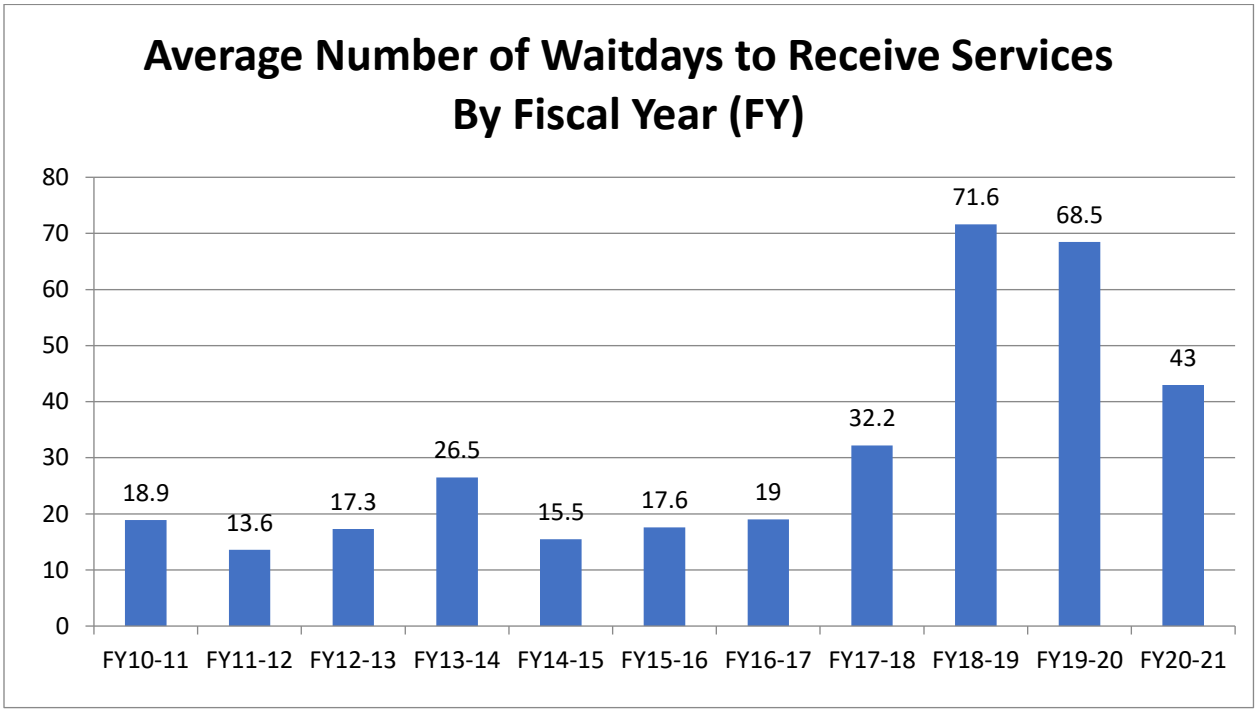


Entrance into substance abuse programs is determined by priority levels identified by the state and federal government. Persons served presenting with these problems take priority in entering treatment over others who do not present with these problems. IV drug users and Women with dependent children were the highest priority population identified at 14%.



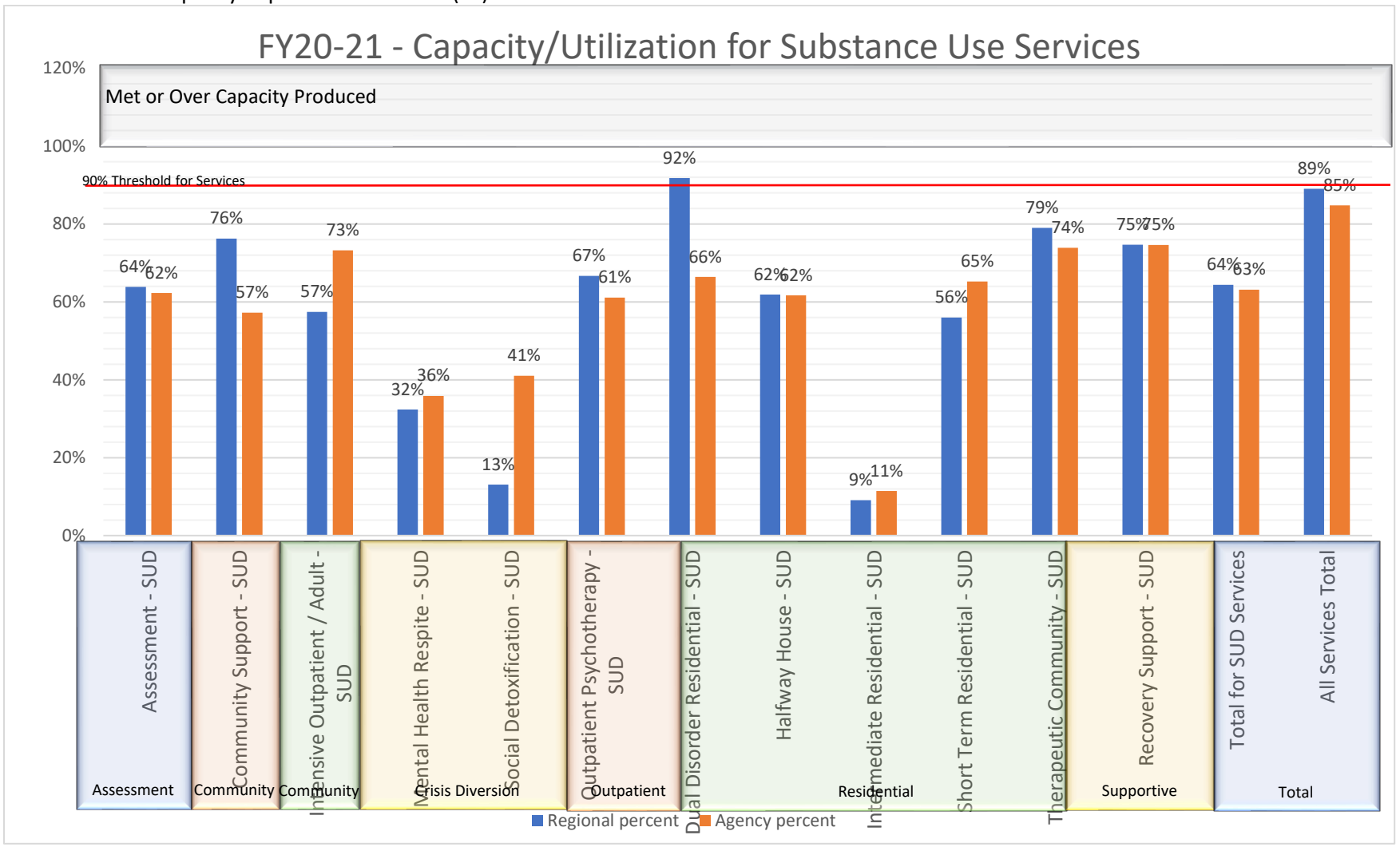


The graph below illustrates the average number of days people wait for all substance abuse services within the Region V Systems geographical area.

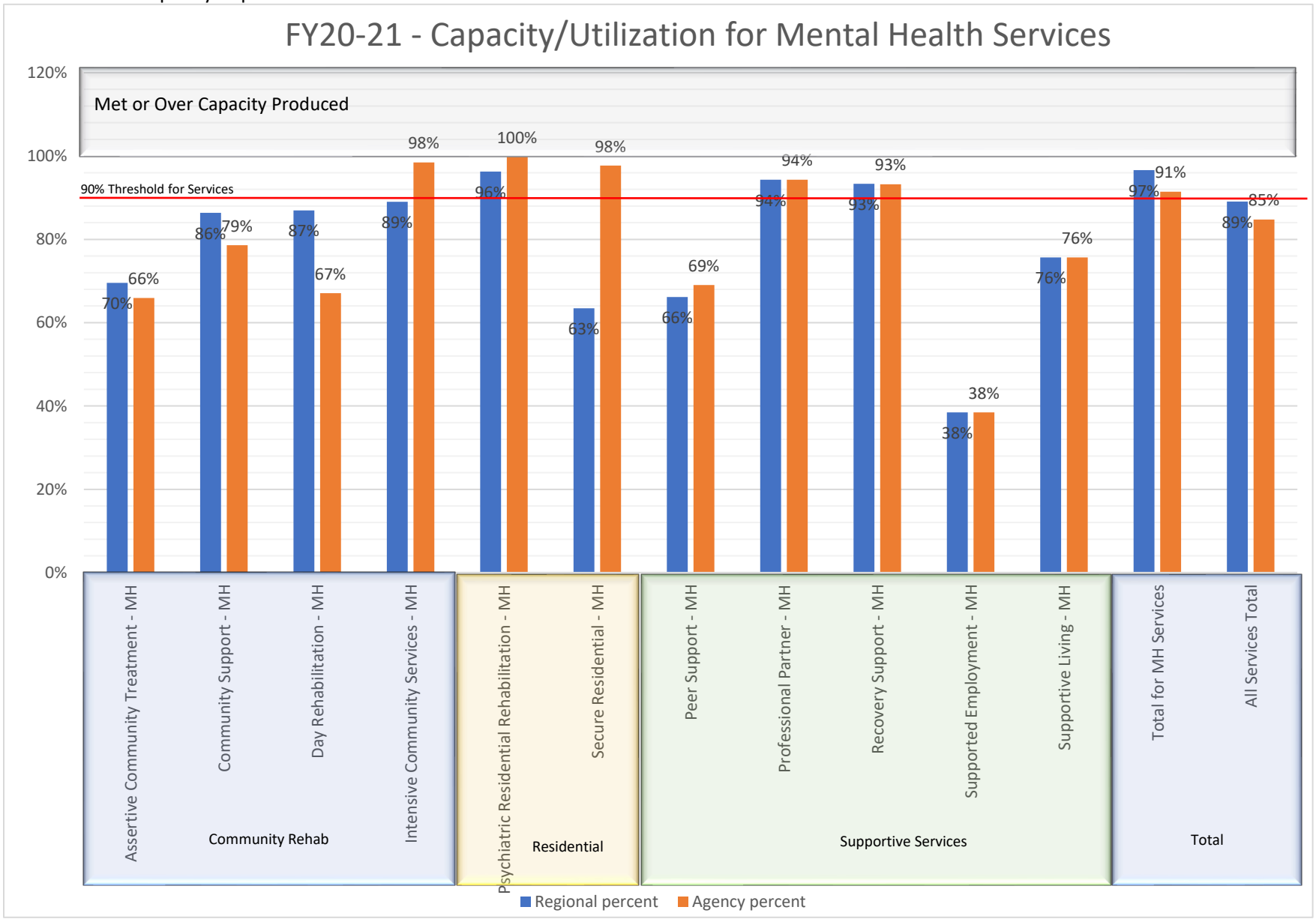


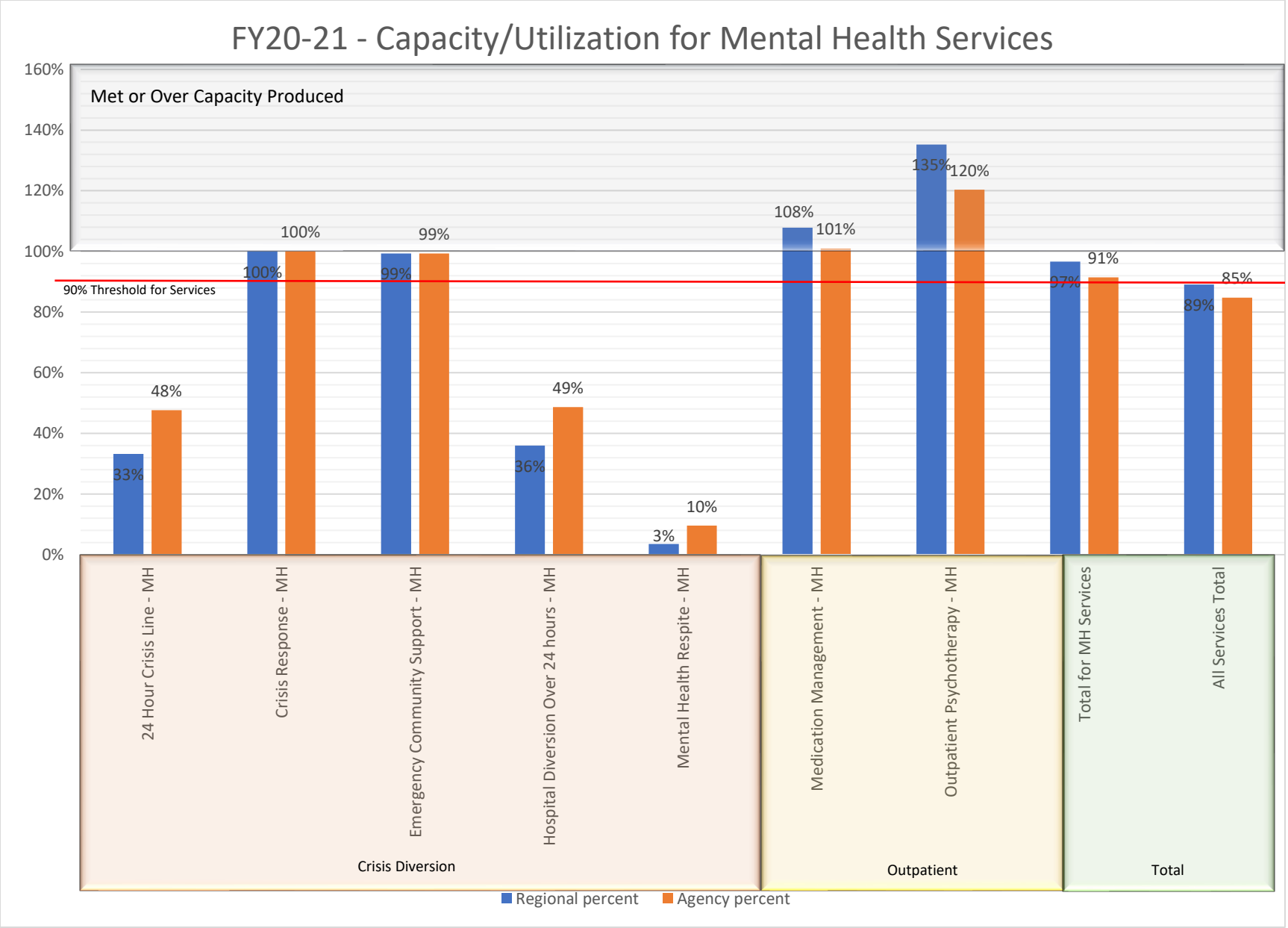
Region V Systems monitors agency capacity, the percent of capacity used of Region V Systems' contract funds, and the overall percent of capacity used within the network of providers. The agency using over 100% percent of Region V Systems' capacity is considered an overproduction on the part of the agency.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

Substance Use Capacity Report for Fiscal Year (FY) 20-21



Mental Health Capacity Report for FY 20-21



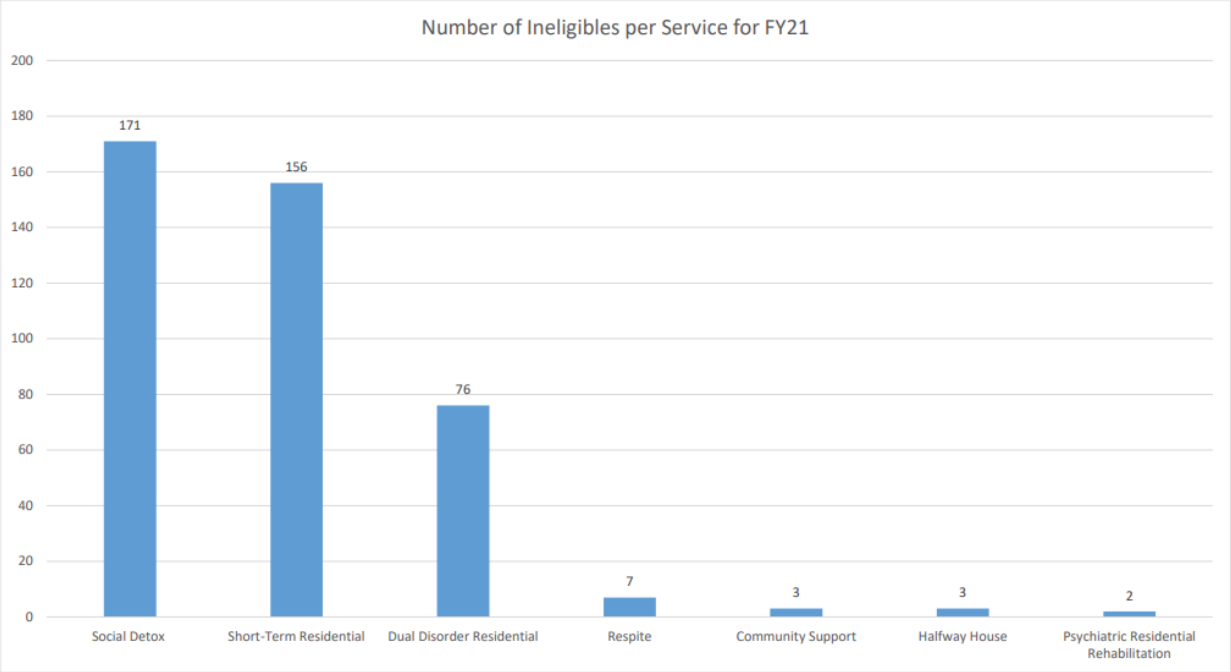

FY20-21 - Capacity/Utilization for Mental Health Services
Met or Over Capacity Produced
90% Threshold for Services
160%
140%
120%
100%
80%
60%
40%
20%
0%
33%
48%
100%
100%
99%
99%
36%
49%
3%
10%
108%
101%
135%
120%
97%
91%
89%
85%
24 Hour Crisis Line - MH
Crisis Response - MH
Emergency Community Support - MH
Hospital Diversion Over 24 hours - MH
Mental Health Respite - MH
Medication Management - MH
Outpatient Psychotherapy - MH
Total for MH Services
All Services Total
Crisis Diversion
Outpatient
Total
Regional percent
Agency percent

Ineligibles and Denials:

To improve quality standards for consumers who are served in the Region V Systems provider network, providers document their reasons for either denying or finding a consumer 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.

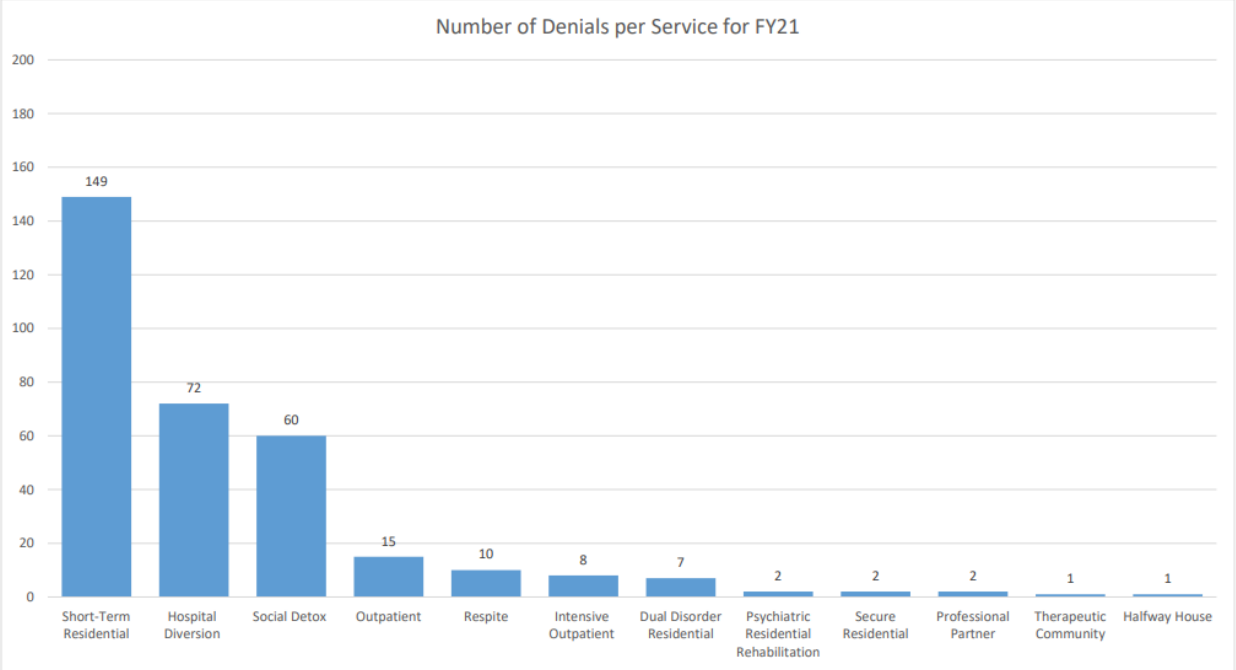
The first chart below identifies the number of consumers found to be ineligible for services during the FY 20-21 by service.



The following spreadsheet demonstrates the reasons a person served was found to be ineligible for a service type. Social Detox and Short Term Residential accounted for the highest number of persons found to be ineligible. The majority of the ineligibles for residential programs were related to persons served being medically unstable, not having required functional deficits required for the service, and extensive mental health, not managed or unstable conditions.

Reason for Ineligibility	Community Support	Dual Disorder Residential	Psychiatric Residential Rehabilitation	Respite	Short-Term Residential	Social Detox	Halfway House	Total	Total Percent
Doesn't have required functional deficits	2	74	1	1	6	11	1	96	23%
Doesn't meet date of last use criteria	-	-	-	-	6	3	-	9	2%
Doesn't meet other clinical criteria (please specify):	-	1	-	-	15	-	-	16	4%
Doesn't meet other admission criteria (please specify):	-	1	-	1	2	4	2	10	2%
Extensive MH, not managed/unstable	1	-	-	-	60	8	-	69	17%
Medically Unstable	-	-	1	3	21	107	-	132	32%
Referred by Non-Region V Funding	-	-	-	2	37	38	-	77	18%
Significant Cognitive Impairment	-	-	-	-	5	-	-	5	1%
Doesn't meet frequency of use	-	-	-	-	4	-	-	4	1%
Total	3	76	2	7	156	171	3	418	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 staff or peers, legal history including sexual offenses, or conflicts with peers or staff members. The following chart identifies the number of consumers found to be ineligible for services during the FY 20-21 by service.



The majority of the denials were from hospital diversion due to consumers being homeless or Keya House being full. For short-term residential, the most common reason for denial was the person served was recommended for other level of care.

Reason for Denial	Short-Term Residential	Hospital Diversion	Social Detox	Outpatient	Respite	Intensive Outpatient	Dual Disorder Residential	Professional Partner	Secure Residential	Psychiatric Residential Rehabilitation	Therapeutic Community	Halfway House	Total	Total Percent
Conflict of interest with staff	6	.	.	.	.	.	.	.	.	.	.	.	6	2%
Consumer is Homeless	.	40	.	.	.	.	.	.	.	.	.	.	40	12%
Legal History	25	.	.	.	.	.	.	.	.	1	.	.	26	8%
Other (please specify):	2	29	45	13	9	.	.	2	2	.	.	.	102	31%
Out of Region	37	1	1	.	.	.	.	.	.	.	.	.	39	12%
Recent Aggression to Peers	2	1	7	.	.	.	.	.	.	.	1	.	11	3%
Recent Aggression to Staff	6	.	7	.	.	.	.	.	.	.	.	.	13	4%
Recommend Other Level of Care	71	1	.	2	1	8	7	.	.	1	.	1	92	28%
Total	149	72	60	15	10	8	7	2	2	2	1	1	329	100%

Complaints and Appeals:

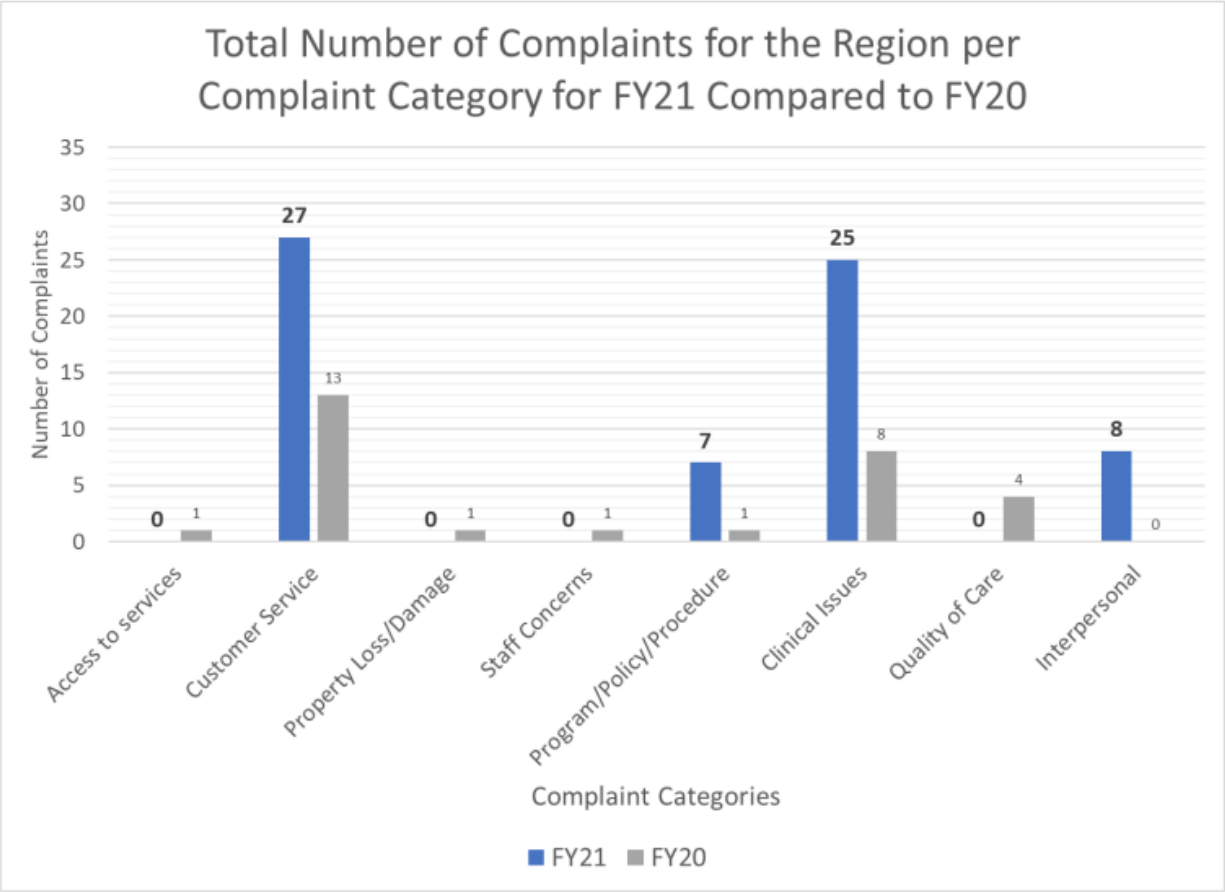
To improve quality standards for consumers served in the Region V Systems network, providers report on their complaints and appeals received from consumers.

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.

The following are the current categories of complaints and appeals being reported on:

1. **Access to Services:** defined as any service that the consumer requests which is not available or any difficulty the consumer 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.



No appeals were received for the year.

Critical Incidents:

Region V Systems member providers submit consumers critical incidents to Region V 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.

Critical Incidents fall into the following categories for this report:

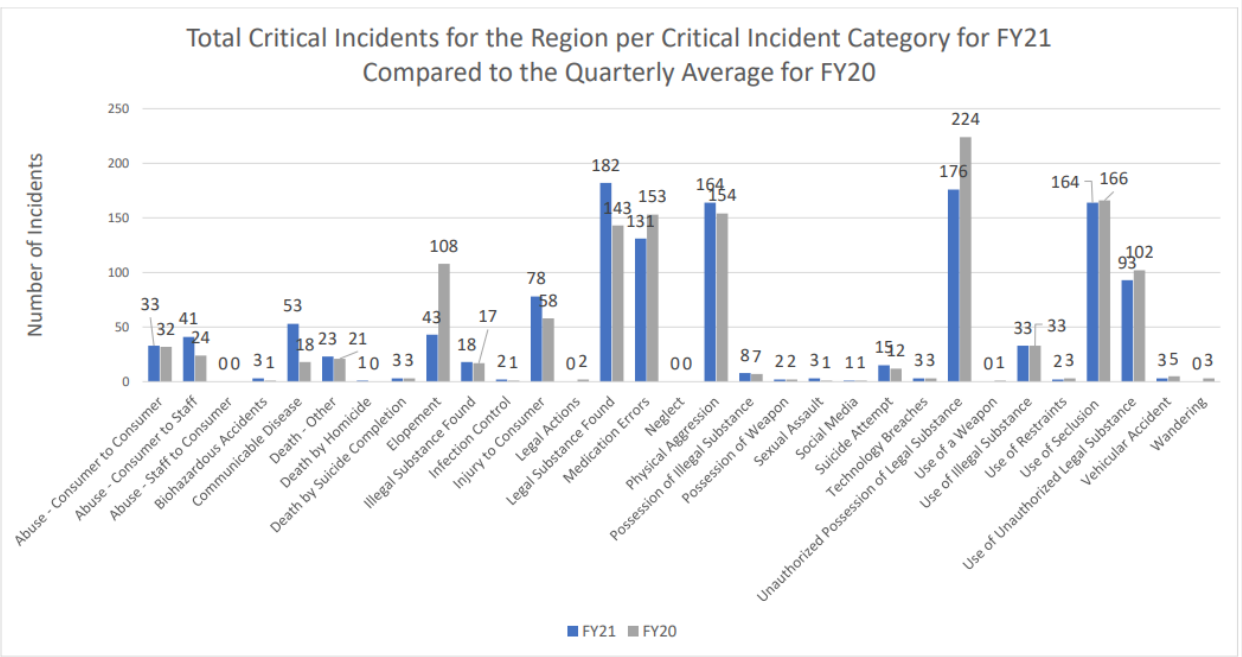
1. **Abuse-Consumer to Consumer:** Consumer harms/assaults another consumer verbal/physical/ psychological).
2. **Abuse-Consumer to Staff:** Consumer harms/assaults staff (verbal/physical/psychological).
3. **Abuse-Staff to Consumer:** Staff member harms/assaults a consumer (verbal/ physical/ psychological)
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-Unexpected:** Death that was not anticipated.
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 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 end 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/policies.
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. categories for this report.

The following chart illustrates the type and number of critical incidents received comparing FY 19-20 & FY 20-21.



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

Incident by Domain of Incident Type by Fiscal Year

Incident Domain	Incident Type	FY18	FY19	FY20	FY21	Total
Abuse/Aggression	Abuse - Consumer to Consumer	37	49	26	33	145
	Abuse - Consumer to staff	55	45	24	41	165
	Neglect	-	7	-	-	7
	Physical Aggression	163	165	154	164	646
	Possession of Weapon	6	3	2	2	13
	Sexual Assault	4	5	1	3	13
	Use of a Weapon	-	1	1	-	2
	Total for Abuse/Aggression	**265**	**275**	**208**	**243**	**991**
Death/Suicide	Death - Other	10	10	21	23	64
	Death by Suicide Completion	2	2	3	3	10
	Death by Homicide	-	-	-	1	1
	Suicide Attempt	13	5	12	15	45
	Total for Death/Suicide	**25**	**17**	**36**	**42**	**120**
Exiting Treatment	Elopement	123	128	108	43	402
	Wandering	-	1	3	-	4
	Total for Exiting Treatment	**123**	**129**	**111**	**43**	**406**
Health	Biohazardous Accidents	6	7	1	3	17
	Communicable Disease	13	3	18	53	87
	Infection Control	0	2	1	2	5
	Injury to Consumer	46	55	58	78	237
	Vehicular Accident	5	4	5	3	17
	Total for Health	**70**	**71**	**83**	**139**	**363**
Legal	Legal Actions	1	2	2	-	5
	Social Media	-	2	1	-	3
	Technology Breaches	7	4	3	1	15
	Total for Legal	-	-	-	**1**	**1**
Medication Errors	Medication Errors	130	69	153	131	**483**
Restraints/Seclusions	Use of Restraints	10	3	3	2	18
	Use of Seclusion	175	187	166	164	692
	Total for Restraints/Seclusions	**185**	**190**	**169**	**166**	**710**
Substance Related	Illegal Substance Found	8	14	17	18	57
	Legal Substance Found	16	156	143	182	497
	Possession of Illegal Substance	6	11	7	8	32
	Unauthorized Possession of Legal Substance	35	46	224	176	481
	Use of Illegal Substance	25	25	33	33	116
	Use of Unauthorized Legal Substance	95	69	102	93	359
	Total for Substance Related	**185**	**321**	**526**	**510**	**1542**
Total		991	1080	1292	1276	4639

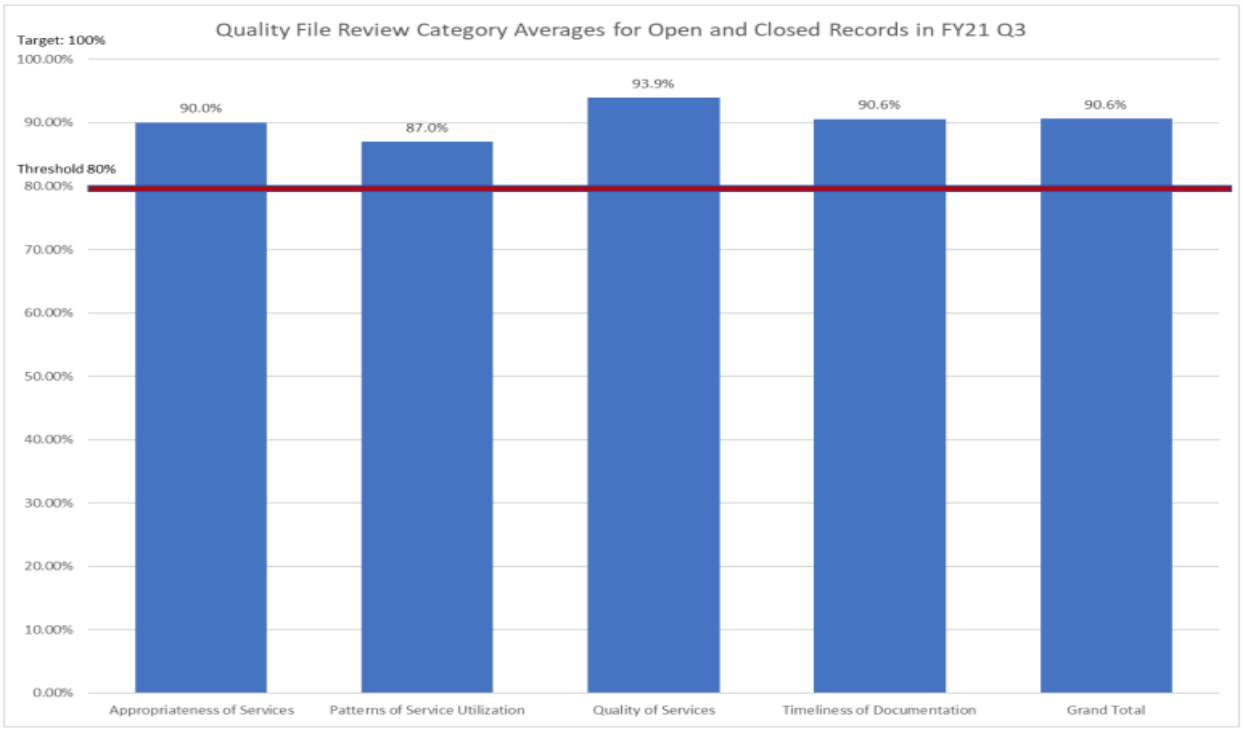
The following is a diagram used to help consumers and providers understand the difference between incidents, critical incidents/events, deaths, and sentinel events.

Quality File Review:

Region V Systems member providers submit their internal quality file review reports to Region V Systems on a quarterly basis. Providers conduct these file reviews as part of their own internal quality process as required by their chosen accreditation body (e.g., CARF, Joint Commission, COA). Providers report the number of complete files and items that they check for in their file review (e.g., consent signed, etc.). Region V Systems and providers then label these review items as one of four categories:

1. Quality of Services (e. g., consents signed, financial eligibility documents completed, etc.).
2. Appropriateness of Services (e. g., thorough assessment completed, goals selected by consumer, etc.).
3. Patterns of Service Utilization (e. g., discharge summary, referral to another agency).
4. Timeliness of Documentation (e. g., documentation completed within 10 days of session).

Based on these designations, an aggregate was compiled for each category. The aggregate data, percentage of complete files for July 1, 2020 through June March 31, 2021, are illustrated in the graph below. The Regional Quality Improvement Team and Network Providers established a target of 100% and minimum threshold of 80% of the range providers are striving to operate within.



FY21 Q1 CARF Accreditation areas	Sum of Compliant File Observations (Numerator)	Sum of Possible File Observations (Denominator)	Average Percent Compliant
Appropriateness of Services	12,118	13,462	90.0%
Patterns of Service Utilization	4,245	4,880	87.0%
Quality of Services	7,336	7,810	93.9%
Timeliness of Documentation	2,229	2,461	90.6%
Grand Total	25,928	28,613	90.6%

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

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

A. Staff member completes a Concerns Request Form, submitting it to the CQI Director for processing. The staff member 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 V Systems' Corporate Compliance Team to determine 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 staff members 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 V Systems' staff members.

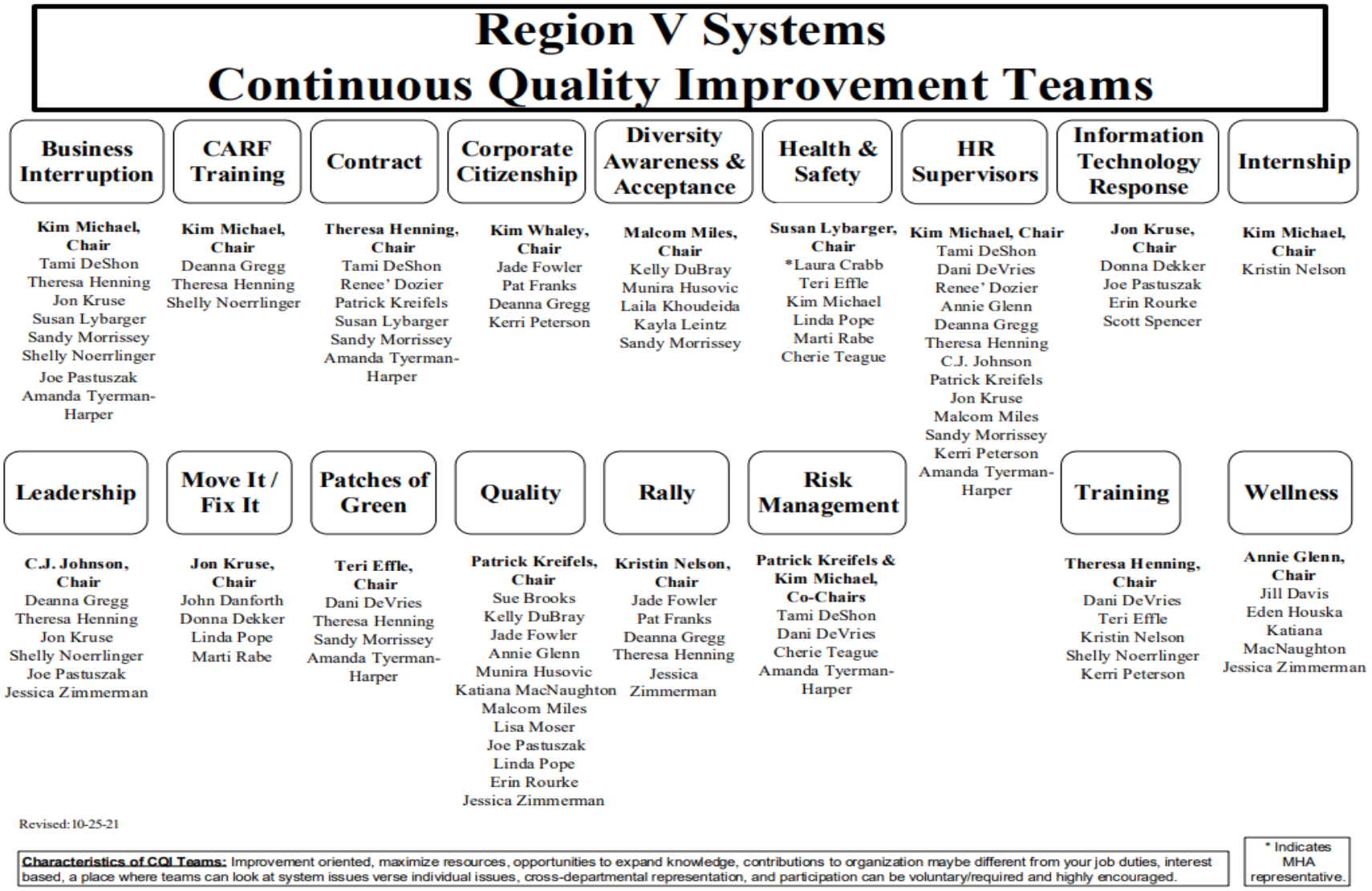
The following chart represents the CQI Concerns Requests submitted by staff members in FY 20-21. There was a total of three (3) concerns/requests submitted.

CQI Concerns Requests submitted by staff members

Date Received	CQI Concern/Request	Recommendation/Action Taken
03/01/2021	Changes to release of information form so it can be formatted for use with DocuSign.	Approved if no changes to release of information form content. If changes to content are needed consult with program supervisors/director of FYI.
1/18/2021	Reimbursement to employees for expense of treating pests/communicable diseases that were contracted from a family and affect an employee's home. Creation of a policy/procedure that address this issue. Involvement of employees in the development of procedures/making the decision surrounding this issue.	Reimbursement & Policy not approved. Current CQI concerns/request communication mechanism & CQI Teams continue for involvement of employees in development of procedures and decision making.
8/25/2020	Purchase software to allow employees the ability to obtain electronic signatures virtually.	DocuSign is approved to facilitate this process.

Continuous Quality Improvement Teams:

Region V 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 out on activities during all staff meetings.



PROFESSIONAL PARTNER PROGRAM – FAMILY & YOUTH INVESTMENT – SECTION IV

Wraparound Fidelity Index:

Region V Systems evaluates the Professional Partner Program – Family & Youth Investment (FYI), to determine whether services and supports being received by Region V 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.

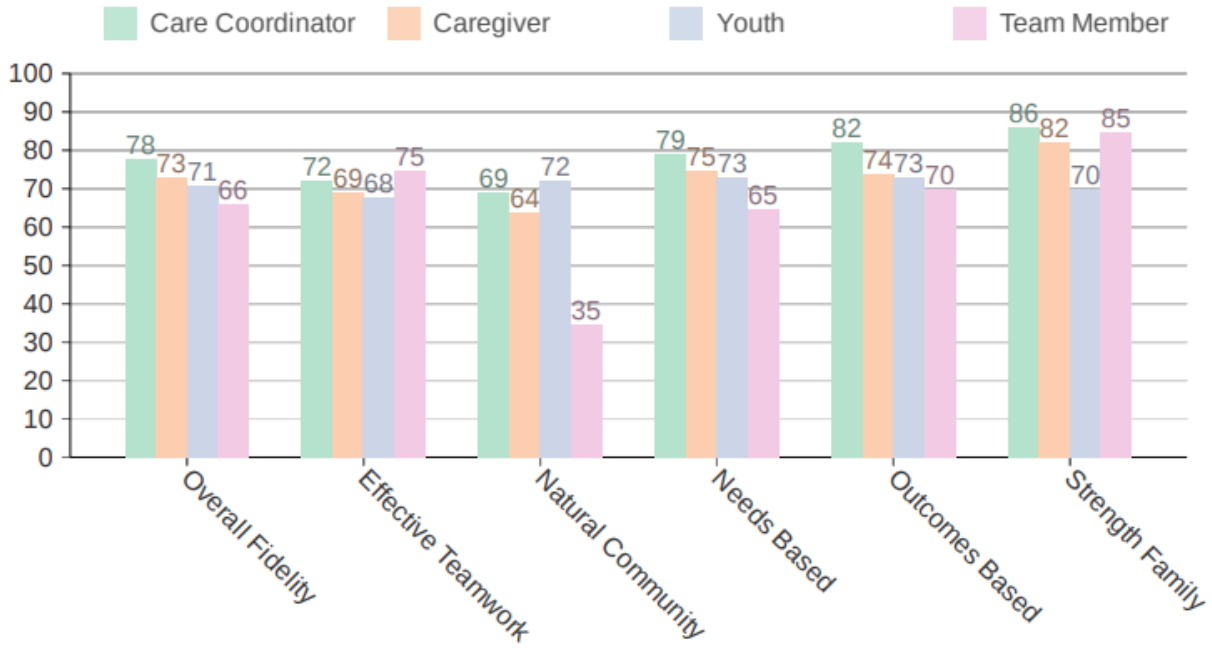
The following ten elements are evaluated:

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) assesses fidelity by having the respondent (facilitator, caregiver, youth, and team member) rate four questions or items that are regarded as essential service delivery practices for each element.

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 WFI national mean was derived from a national sample of 1,478 unique wraparound teams, based in 41 different collaborating sites across North America. Data originates from 1,234 wrap facilitators, 1,006 caregivers, and 221 team members. Reliability and validity results are based on specific validity and reliability studies that have been conducted and published in peer reviewed publications or presented at national conferences.

The following table of Region V Systems' Professional Partner Program Family & Youth Investment (FYI) is a comparison of the Care Coordinator (i.e., Professional Partner), Caregiver, Youth, and Team Member. Region V Systems' data in this graph covers the period of January through June 2021. Responses were collected from 25 professional partners, 21 caregivers, 19 youth, and 1 team member.



Child Adolescent Functional Assessment Scale (CAFAS):

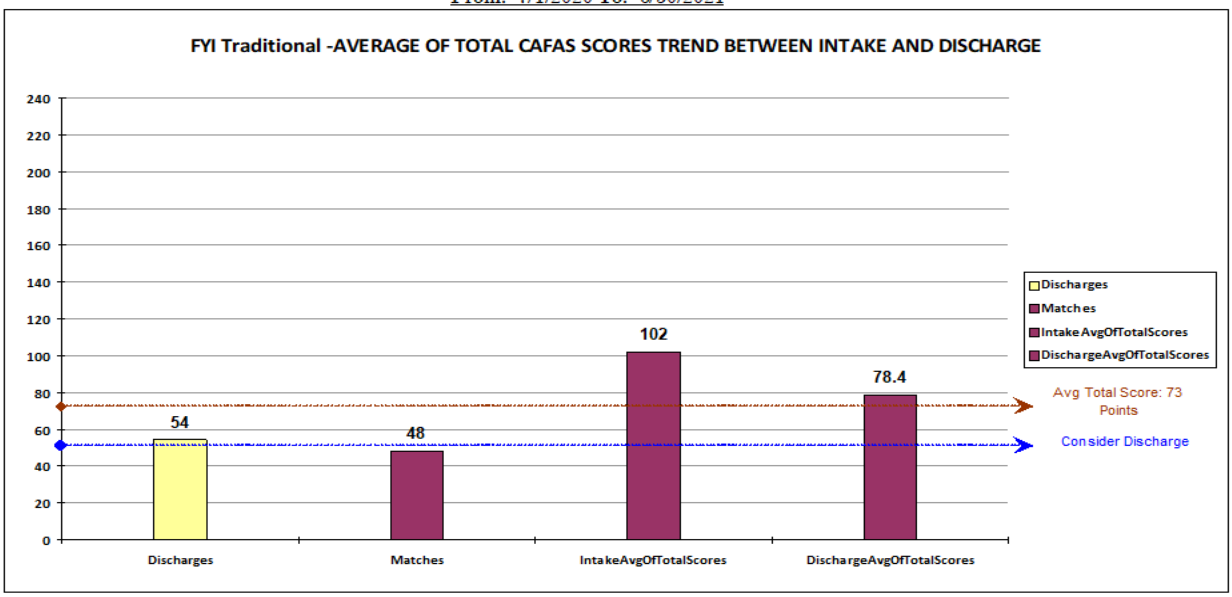
The Child and Adolescent Functional Assessment Scale (CAFAS) is administered to youth at enrollment, every six months, and at discharge. The purpose of the CAFAS is to measure impairment (i.e., the negative effect of problem behaviors and symptoms on functioning) in day-to-day functioning in children, 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.

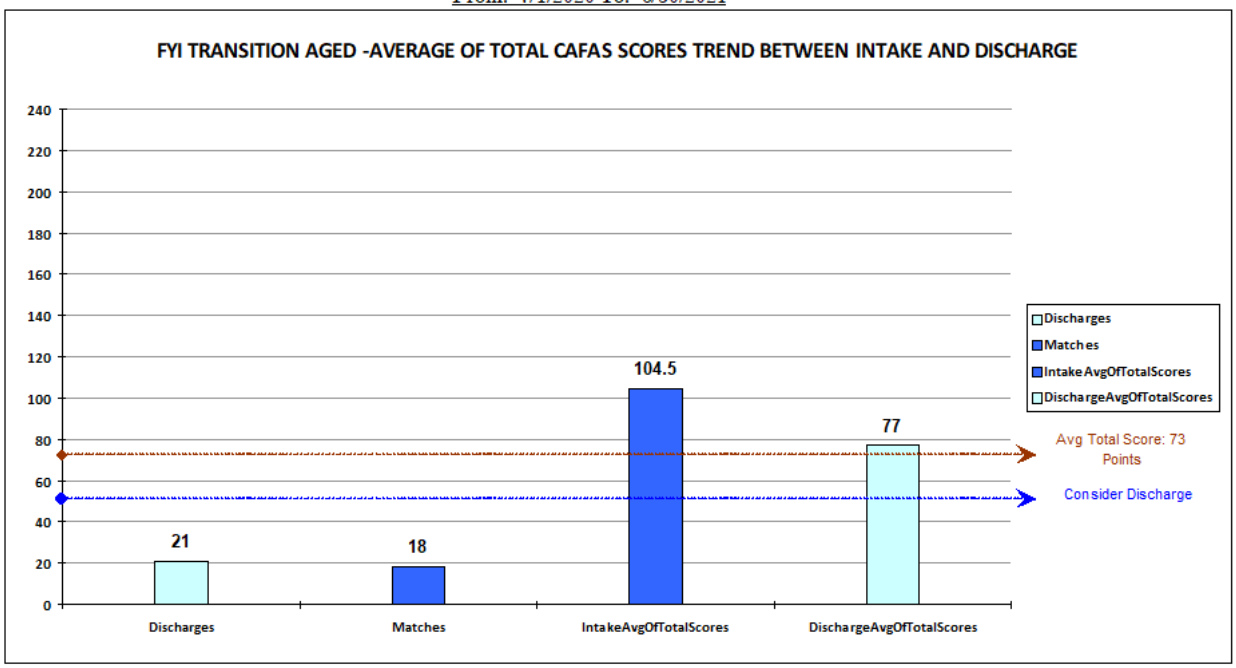
The following graphs illustrate youth who have discharged from the respective Professional Partner Program tracks (i.e., Traditional, Transition Age, Prevention) comparing an average total CAFAS score taken at enrollment/intake and comparing it to the discharge average total CAFAS score. The Traditional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

From: 7/1/2020 To: 6/30/2021



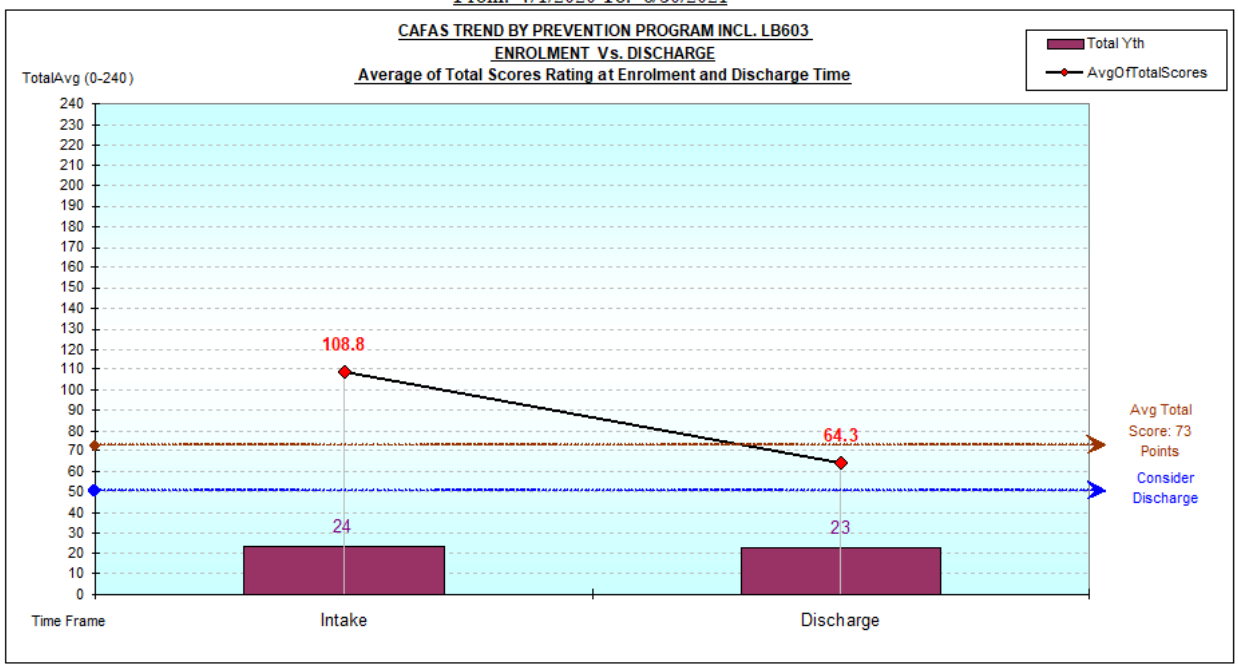
Clinically significant/meaningful change: Total score from "Intake" to last Cafas Evaluation is reduced by 20 or more points

From: 7/1/2020 To: 6/30/2021



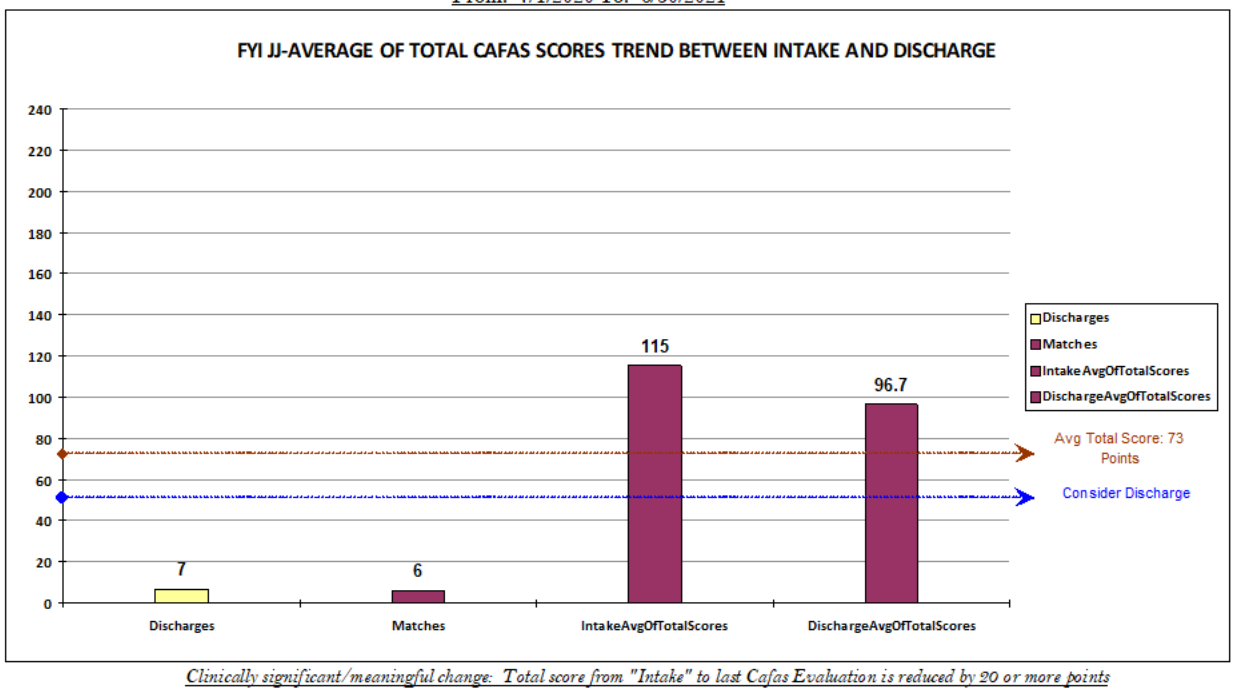
Clinically significant/meaningful change: Total score from "Intake" to last Cafas Evaluation is reduced by 20 or more points

From: 7/1/2020 To: 6/30/2021



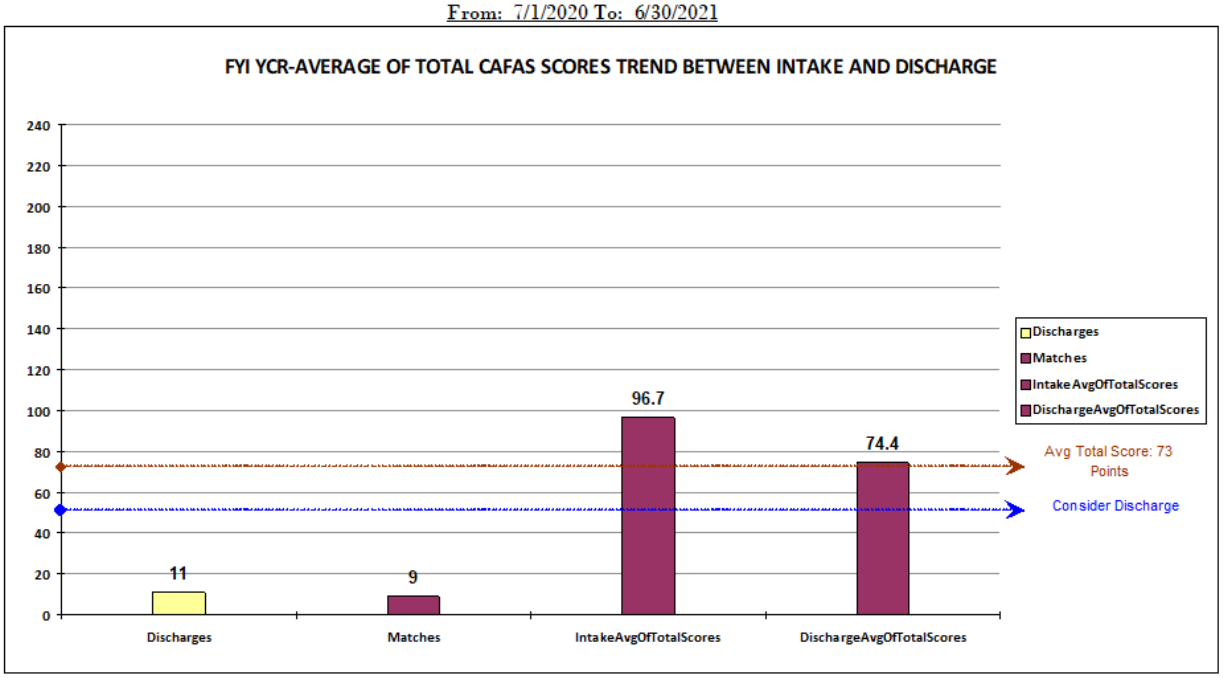
Clinically significant/meaningful change: Total score from "Intake" to last Cafas Evaluation is reduced by 20 or more points

From: 7/1/2020 To: 6/30/2021



Clinically significant/meaningful change: Total score from "Intake" to last Cafas Evaluation is reduced by 20 or more points

From: 7/1/2020 To: 6/30/2021



Clinically significant/meaningful change: Total score from "Intake" to last Cafas Evaluation is reduced by 20 or more points

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

Region V 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, assess 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% required the program to complete a quality improvement action plan.

RECORDS REVIEW		FY 19-20 Quarters 3 & 4	FY 20-21 1ST Quarter	FY 20-21 2nd Quarter	FY 20-21 3rd Quarter	FY 20-21 4th Quarter
Open Records	Average completeness of All Items	N/A will resume review of Open Records for FY 20-21 Q1	89%	93%	89%	90%
	General Information - 1		89%	94%	90%	88%
	Team Planning - 2		98%	90%	89%	84%
	FYI Clinical Supervision Notes - 3		75%	95%	77%	91%
	Formal Services - 4		73%	80%	87%	92%
	Evaluation Info - 5		88%	100%	93%	92%
	Legal - 6		100%	88%	88%	100%
	School - 7		90%	88%	88%	100%
Closed Records	Average Completeness of All Items	91%	93%	92%	91%	89%
	General Information - 1	96%	92%	91%	91%	89%
	Team Planning - 2	94%	91%	91%	92%	84%
RECORDS REVIEW		**FY 19-20**	**FY 20-21**	**FY 20-21**	**FY 20-21**	**FY 20-21**

		Quarters 3 & 4	1ST Quarter	2nd Quarter	3rd Quarter	4th Quarter
Closed Records cont.	FYI Clinical Supervision Notes - 3	85%	80%	81%	83%	76%
	Formal Services - 4	91%	98%	87%	87%	87%
	Evaluation Info - 5	97%	96%	94%	89%	90%
	Legal - 6	83%	94%	93%	92%	94%
	School - 7	85%	90%	89%	83%	91%
	Section Closed	75%	98%	100%	97%	100%
EHR REPORTS REVIEW						
Interpretive Summary		97%	100%	89%	100%	97%
Initial POC		98%	100%	89%	95%	97%
Monthly POC Update		67%	89%	88%	86%	87%
BILLING AND CODING PRACTICES						
Team Meeting Documentation		100%	100%	100%	100%	100%
Family or Participant Contact Note		100%	100%	100%	100%	100%
Was Not Discharged Prior to Billing Period		100%	100%	100%	100%	100%

HOUSING – SECTION V

Rental Assistance Program - Internal Records File Review:

Region V 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 the 4th quarter of FY 20-21. Areas that are below 80% required the program to complete a quality improvement action plan. The RAP file review process is in the process of being revamped and that is why only one quarter for FY 20-21 was completed.

Results **Criteria Reviewed**	**RAP-MH**		**RAP-SD**		**Total**		**Quality Improvement Action Plan**
	Open	Closed	Open	Closed	Open	Closed	
Section: Application/Eligibility							
BH Services	95%	100%	100%	100%	96%	100%	No
Individualizer Service Plan	90%	100%	100%	100%	91%	100%	No
Section 8 Status	96%	91%	33%	33%	88%	79%	Yes – Closed
Citizenship/Immigration Status	100%	100%	100%	100%	100%	100%	No
Income Verification	100%	91%	100%	100%	100%	94%	No
Diagnosis	100%	91%	100%	86%	100%	89%	No
Application Signatures	96%	82%	100%	100%	96%	89%	No
Section: Application Supporting Documentation							
Copy of ISP	94%	71%	0%	100%	89%	75%	Yes – Closed
Documentation of Income	77%	57%	67%	100%	75%	70%	Yes – Open/Closed
Proof of App to Housing Authority	57%	67%	0%	-	53%	67%	Yes – Open/Closed
SAVE Verification	-	-	-	-	-	-	No
Section: Voucher Issuance							
Voucher Issuance Checklist	91%	100%	100%	86%	92%	94%	No
Rights and Responsibilities	87%	82%	100%	71%	89%	78%	Yes – Closed
Voucher Issuance Letter	50%	100%	100%	25%	56%	70%	Yes – Open/Closed
Citizenship Attestation Form	86%	100%	100%	33%	87%	75%	Yes – Closed
Authorization(s) for Release/Request for Information	59%	73%	75%	71%	62%	72%	Yes – Open/Closed
Section: Housed							
HQS	91%	57%	100%	86%	92%	71%	Yes – Closed
Subsidy Letter	82%	83%	100%	86%	85%	85%	No
Rental Calculation	59%	75%	50%	25%	58%	50%	Yes – Open/Closed
Lease	64%	100%	100%	86%	69%	93%	Yes – Open
RAP Landlord Contract	73%	67%	50%	57%	69%	62%	Yes – Open/Closed
Monthly Staffing	57%	88%	25%	17%	64%	79%	Yes – Open/Closed
Section: Annual Review							
Rap Annual Review	27%	0%	100%	33%	33%	17%	Yes – Open/Closed
Section: Discharge							
Consumer Termination Letter	-	64%	-	86%	-	72%	Yes – Closed
Discharge Letter to Landlord	-	57%	-	86%	-	71%	Yes – Closed
Discharge Summary	-	90%	-	100%	-	94%	No
TOTAL	**81%**	**83%**	**82%**	**77%**	**82%**	**81%**	**-**

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

Region V Systems' Quality CQI Team conducts quarterly internal reviews on 1/4th of open person served records and 10 property records within the Rural & Lincoln Permanent Housing Program. Below is a summary the 4th quarter of FY 20-21. Areas that are below 80% required the program to complete a quality improvement action plan. The RAP file review process is in the process of being revamped and therefore is why only one quarter for FY 20-21 was completed.

Property File – Open Only	RPH			LPH			Total Items Present	Total Items Possible	Percentage of Completeness by Item
	Present	Possible	RPH Percent	Present	Possible	LPH Percent			
Section One									
Master Lease	6	8	75%	2	2	100%	8	10	80%
Initial Environmental Review Approval Document	6	8	75%	2	2	100%	8	10	80%
5 year Environmental Review Document(s)	3	3	100%				3	3	100%
Section Two	**0**	**0**							
Occupancy or Sublease Agreement	6	8	75%	2	2	100%	8	10	80%
Section Three	**0**	**0**							
Rent Reasonableness Document*	16	36	44%	2	2	100%	18	38	47%
Section Four	**0**	**0**							
Utility Allowance Document(s)*	23	36	64%	0	2	0%	23	38	61%
Section Five	**0**	**0**							
Housing Quality Standard Inspection(s) [HQS] Initial	4	9	44%	1	2	50%	5	11	45%
Housing Quality Standard Inspection(s) [HQS] Annual	16	28	57%				16	28	57%
Total	80	136	59%	9	12	75%	89	148	60%

Participant File – Open Only	RPH			LPH			Total Items Present	Total Items Possible	Percentage of Completeness by Item
	Present	Possible	RPH Percent	Present	Possible	LPH Percent			
Section 1:									
RPH Program Application	1	10	10%	0	3	0%	1	13	8%
Save Verification Request Form	1	1	100%	3	3	100%	4	4	100%
Chronic Homelessness Documentation Checklist		10	0%	3	3	100%	4	13	31%
Disability Verification	8	8	100%	2	2	100%	10	10	100%
Third Party Homelessness Verification	8	9	89%	3	3	100%	11	12	92%
Homelessness Recertification 24 hrs prior to move-in	5	9	56%	3	3	100%	8	12	67%
Rights and Responsibilities Form (Termination Policy)	19	20	95%	3	3	100%	22	23	96%
Annual Review Form	2	10	20%				2	10	20%
Section 2:									
Rent Calculation	1	18	6%	0	2	0%	1	20	5%
Proof of Income/Income Verification/Zero Income Documents	7	20	35%	3	3	100%	10	23	43%
Sublease	5	7	71%	2	2	100%	7	9	78%
Section 4:									
VI-SPDAT	7	7	100%	3	3	100%	10	10	100%
Needs Assessment(s)	4	18	22%	3	3	100%	7	21	33%
Section 5:									
Release of Information - Landlord	15	19	79%	1	3	33%	16	22	73%
Release of Information- Utility Company	16	19	84%	3	3	100%	19	22	86%
Standard NMIS - annually for all in household	8	19	42%	3	3	100%	11	22	50%
Total	**107**	**204**	**52%**	**35**	**42**	**83%**	**143**	**246**	**58%**