REGION V SYSTEMS

Promoting Comprehensive Partnerships in Behavioral Health

Management Summary

FY 21-22

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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 persons served 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 21-22 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 22-23 PIP.

Indicator Number	FY 21-22 Threshold	Review	FY 22-23 PIP Status
1	100% of Region V Systems' employees complete CARF required trainings.	Approved	Continue
2	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, NPIRS (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 have an annual goal for 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 YAB 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 bi-annual performance evaluation and documentation completed.	Approved	Modify
11	100% of all staff members shall have an annual performance evaluation and documentation completed.	Approved	Modify
12	100% of drills completed per established schedule.	Approved	Continue
13	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 entered within two (2) business days.	Approved	Continue
14	100% of building occupants will be accurately documented on the pegboard during health and safety drills (Only Gas, Tornado, & Fire drills)	Approved	Modify
15	30% of persons served in the Rental Assistance Program with vouchers will reside in the rural counties.	Approved	Delete

(Cont.)

Indicator Number	FY 21-22 Threshold	Review	FY 22-23 PIP Status
16	Person served will decrease the average number of days between voucher issuance to enrollment of RAP SU below 41 days and RAP MH below 16 days and total average days below 19 days.	Approved	Modify
17	60% of people in mental health track and 85% of people in substance abuse 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 a 20-point (moderate impairment), 10-point (mild/minimal impairment) when comparing admission to discharge CAFAS scores (must have a 30 in any domain at admission to be included in the sample). (Traditional, Transitional, Prevention, Crisis Response, & Juvenile Justice Tracks).	Approved	Continue
19	70% of discharged youth's total CAFAS score will decrease by 20 points when comparing intake vs. discharged scores (Traditional, Transitional, Prevention, Crisis Response, & Juvenile Justice).	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, Crisis Response tracks).	Approved	Continue
21	75% of youth demonstrate improvement on one or more of the three outcome indicators (Traditional, Transitional, Prevention, and Juvenile Justice).	Approved	Continue
22	85% of all teams will have at least one identified informal support on their TEAM MEMBER LIST (Utilize FYI statewide consensus of informal support definition; Traditional, Transitional, Prevention, Juvenile Justice tracks, and Crisis Response) (2003 Wraparound study-60% of teams had no informal resources, 32 had one, 8% had two or more.).	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 (utilizing FYI statewide consensus of informal support definition; Traditional, Transition, Prevention, Juvenile Justice, & Crisis Response tracks). (2003 wraparound study – 60% of teams had no informal resources; 32% had one; 8% had two or more).	Approved	Continue
24	100% of FYI youth will be living in their home while served in the FYI program (if youth resides out of their home for less than two (2) consecutive weeks during the month, it will not be considered an out-of-home placement; Traditional, Transition, Prevention, Juvenile Justice, and Crisis Response)	Approved	Continue
25	90% of families will have a team meeting every month (all FYI).	Approved	Continue
26	30% of clients in the FYI program will reside in rural counties (Traditional Track).	Approved	Continue

(Cont.)

Indicator Number	FY 21-22 Threshold	Review	FY 22-23 PIP Status
27	95% of FYI Professional Partners performance will be met on all of 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 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	Delete
31	4,440 Outreach Worker contacts in the Crisis Counseling Program-CCP are documented by December 2021.	Approved	Delete
32	Of all Crisis Counseling Program-CCP encounters, 67% will be direct encounters (group or individual/family encounter).	Approved	Delete
33	100% of Outreach Workers performance will average 20 hours of field work each week.	Approved	Delete
34	100% of independent clinical assessments will be completed within 30 days of a youth being placed in a Qualified Residential Treatment Program.	Approved	Delete
35	The Rural & Lincoln Permanent Housing program will maintain 100% of capacity (32 rural housing units and 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 abuse vouchers (2,958) will be issued by April 2022 (Counties of Antelope, Boone, Buffalo, Burt, Butler, Colfax, Cuming, Custer, Hall, Hold, Howard, Knox, Madison, Nance, Nemaha, Pierce, Platte, Richardson, Saline, Saunders, Stanton, & Thurston).	Approved	Delete

The second part of this section is a summary of Performance Indicators for Fiscal Year 2021-2022. 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 county community prevention coalitions (16) in southeast Nebraska will participate in substance abuse annual assessments and quarterly BH5 reporting, NPIRS (Nebraska Prevention Information Resource System).

Standard	Threshold	Quarter 4 FY 20-21	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:	Increase the number of visits to the website/social media site (www.talkheart2heart.com) above the baseline (Users: Repeat 3,471, Unique 1,942; Social Media: Engagement-Views/Shares 1,883, Readership 746, Impressions 65,921) by June 30, 2022.

Standard		Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
Above baseline numbers	Users: Repeat	3,471	5,250	4,104	2,996	2,007	5,250	3,479
	Users: Unique	1,942	3,385	2,315	2,270	1,149	3,385	2,206
	Social Media: Engagement - Views/ shares	1,883	3,205	1,113	976	648	3,205	1,371
	Readership	746	812	779	784	798	818	818
	Impressions	65,921	180,210	177,062	131,178	47,379	180,210	130,874

Indicator # 5:	Coalition sustainability plans.
Threshold:	100% of all funded coalitions will have an annual goal for sustainability strategies.

Standard	Threshold	Quarter 4 FY 20-21	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, 2022.

Standard	Threshold	Quarter 4 FY 20-21	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 (16) are represented on YAB membership.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	75%	44%	44%	44%	44%	44%	44%

Indicator # 8:	Hope Squads.
Threshold:	50% of the counties (16) within Region V Systems geographical territory will have a minimum of one Hope Squad.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	50%	56%	56%	56%	69%	75%	64%

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	100%	100%	100%	100%	100%	100%

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
30%	30%	36%	22%	21%	23%	19%	21%

Indicator # 16:	Time between voucher issuance to enrollment in a Rental Assistance Program-Substance Use & Mental Health (RAP SU/MH) Housing Transition Plan.
Threshold:	Person served will decrease the average number of days between voucher issuance to enrollment of RAP SU below 41 days and RAP MH below 16 days and total average days below 19 days.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
Within 5 Days	SU 41 MH 16 All 19	New Goal	SU 27 MH 31 All 30	SU 26 MH 32 All 31	SU 29 MH 32 All 32	SU 23 MH 25 All 24	SU 26.25 MH 30 All 29.25

Adult Services Department (cont.)

Indicator # 17:	Consumers of the Rental Assistance Program will bridge to Section 8 or other housing program or become self-sufficient.
Threshold:	60% of people in mental health track and 85% of people in substance abuse use track housed in Region V Systems Rental Assistance Program will bridge to Section 8, another household program, or become self-sufficient.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
TBD	70%	New Goal	78%	83%	65%	76%	75%

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	75%	N/A	N/A	N/A	82%	82%

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	N/A	N/A	N/A	N/A	91%

Indicator # 30:	Consumer representation on provider agency boards.
Threshold:	100% of all the Network Providers governing boards will have consumer representation (consumer voice) on their governing board.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	83%	NA	NA	N/A	80%	80%

Indicator # 31:	Documentation of Outreach Worker 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, and York).
Threshold:	4,440 Outreach Work contacts in the Crisis Counseling Program-CCP are documented by December 2021.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	4,440	16,234	42%	64%	N/A	N/A	53%

Adult Services Department (cont.)

Indicator # 32:	Documentation of Outreach Worker 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, and York).
Threshold:	Of all Crisis Counseling Program-CCP encounters, 67% will be direct encounters. (Group or individual/family encounter.)

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
67%	67%	32%	31%	28%	N/A	N/A	30%

Indicator # 33:	Provide in-person crisis counseling services directly in the 16 counties or Region V Systems (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 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	100%	67%	56%	N/A	N/A	62%

Indicator # 37:	Individuals will be provided vouchers to cover the expense of outpatient mental health and substance use services.
Threshold:	90% of mental health and substance abuse vouchers (2,958) will be issued by April 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).

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
100%	90%	304%	91%	115%	115%	115%	115%

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, Crisis Response, and Juvenile Justice Tracks).

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	60%	57%	50%	59%	59%	52%	52%
Traditional		51%	56%	62%	57%	52%	52%
Transition		71%	33%	55%	63%	37%	37%
Prevention		61%	60%	71%	71%	42%	42%
Juvenile Justice		33%	50%	33%	33%	25%	25%

Children and Family Services Department (cont.):

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	70%	67%	67%	72%	74%	64%	64%
Traditional		60%	64%	67%	69%	61%	61%
Transition		74%	67%	73%	81%	84%	84%
Prevention		75%	80%	86%	75%	44%	44%
Juvenile Justice		33%	50%	67%	67%	75%	75%

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) (Traditional, Transitional, Prevention, Juvenile Justice, Crisis Response tracks).

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	40%	54%	59%	62%	63%	54%	54%
Traditional		55%	70%	64%	64%	59%	59%
Transition		53%	50%	64%	69%	68%	68%
Prevention		65%	75%	83%	71%	40%	40%
Juvenile Justice		33%	10%	10%	10%	N/A	10%

Indicator # 21:	The three outcome indicators for FYI program using the Child Adolescent Functioning Assessment Scale (CAFAS). (1) Change 20 points of total score; (2) decrease severe impairment (30) of any domain, and (3) decrease total CAFAS score below 80 points.)
Threshold:	75% of youth demonstrate improvement on one or more of the three outcome indicators (Traditional, Transition, Prevention, Crisis Response, and Juvenile Justice).

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	75%	72%	67%	75%	75%	65%	65%
Traditional		62%	64%	67%	69%	61%	61%
Transition		84%	67%	82%	88%	89%	89%
Prevention		80%	80%	86%	75%	44%	44%
Juvenile Justice		75%	50%	67%	67%	75%	75%

Children and Family Services Department (cont.):

Indicator # 22:	Documentation of informal supports on wraparound meetings.
Threshold:	85% of all teams will have at least one identified informal support on their TEAM MEMBER LIST (Utilize FYI statewide consensus of informal support definition: Traditional, Transitional, Prevention, Juvenile Justice, and Crisis Response) (2003 Wraparound study-60% of teams had no informal resources, 32 had one, 8% had two or more.).

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	85%	89%	93%	90%	77%	85%	86%
Traditional		86%	94%	86%	62%	82%	81%
Transition		96%	100%	95%	92%	94%	93%
Prevention		85%	80%	90%	95%	80%	86%
Juvenile Justice		85%	100%	100%	100%	N/A	100%

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 (utilizing FYI statewide consensus of informal support definition; Traditional, Transition, Prevention, Juvenile Justice, and Crisis Response tracks). (2003 wraparound study – 60% of teams had no informal resources; 32% had one; 8% had two or more).

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	70%	68%	82%	75%	75%	84%	79%
Traditional		68%	65%	66%	66%	86%	70%
Transition		67%	94%	92%	100%	94%	95%
Prevention		67%	100%	61%	50%	58%	67%
Juvenile Justice		100%	100%	100%	100%	N/A	100%

Indicator # 24:	Place of residence.
Threshold:	100% of FYI youth will be living in their home while served in the FYI program (if youth resides out of their home for less than two (2) consecutive weeks during the month, it will not be considered an out-of-home placement; Traditional, Transition, Prevention, Juvenile Justice, and Crisis Response)

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	99%	99%	99%	98%	99%	99%
Traditional		99%	100%	99%	98%	99%	99%
Transition		99%	100%	100%	98%	100%	99%
Prevention		100%	98%	100%	100%	98%	99%
Juvenile Justice		100%	100%	100%	100%	100%	100%

Children and Family Services Department (cont.):

Indicator # 25:	Team meeting summary.						
Threshold:	90% of families will have a team meeting every month (all FYI.)						
Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	100%	93%	96%	94%	94%	94%
Traditional		100%	94%	97%	93%	94%	95%
Transition		100%	91%	96%	96%	95%	95%
Prevention		100%	96%	91%	95%	98%	95%
Juvenile Justice		100%	100%	100%	100%	50%	88%

Indicator # 26:	County of residence at monthly review.						
Threshold:	30% of clients in the FYI program will reside in rural counties (Traditional track)						
Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
30%	30%	46%	43%	38%	34%	36%	38%

Indicator # 27:	Professional Partner performance gauges.						
Threshold:	95% of FYI Professional Partners performance will be met on all of their gauges.						
Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	95%	99%	100%	100%	98%	99%	99%

Indicator # 35:	Rural & Lincoln Permanent Housing Units.						
Threshold:	The Rural & Lincoln Permanent Housing program will maintain 100% of capacity (32 rural housing units and 12 Lincoln housing units).						
Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	88% Rural; Lincoln N/A	96%	90%	86%	92%	91%

Indicator # 36:	Rural & Lincoln Permanent Housing performance gauges.						
Threshold:	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).						
Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	95%	100% Rural; Lincoln N/A	Data not collected due to revision of PIP for FY 22-23				

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 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	New Goal	100%	N/A	N/A	N/A	100%

Operations/Human Resources Department:

Indicator # 1:	Completion of CARF & Region V required trainings.
Threshold:	100% of Region V Systems' employees complete CARF required trainings.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	97%	N/A	16%	34%	97%	97%

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Average
90%	85%	93%	93%	95%	92%	96%	94%

Indicator # 10:	Documented semi-annual performance evaluation forms turned in by the 5th business day following the supervision deadline.
Threshold:	90% of all staff members shall have bi-annual performance evaluation and documentation completed.

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	N/A	85%	47%	43%	100%	69%

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	100%	100%	100%	56%	89%

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	100%	100%	100%	100%	100%

Operations/Human Resources Department (cont.):

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

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	98%	96.75%	99.35%	100%	100%	99%

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 Gas, Tornado, and Fire Drills).

Standard	Threshold	Quarter 4 FY 20-21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	95%	94%	100%	96%	94%	96%

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 persons served, 2) people'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.

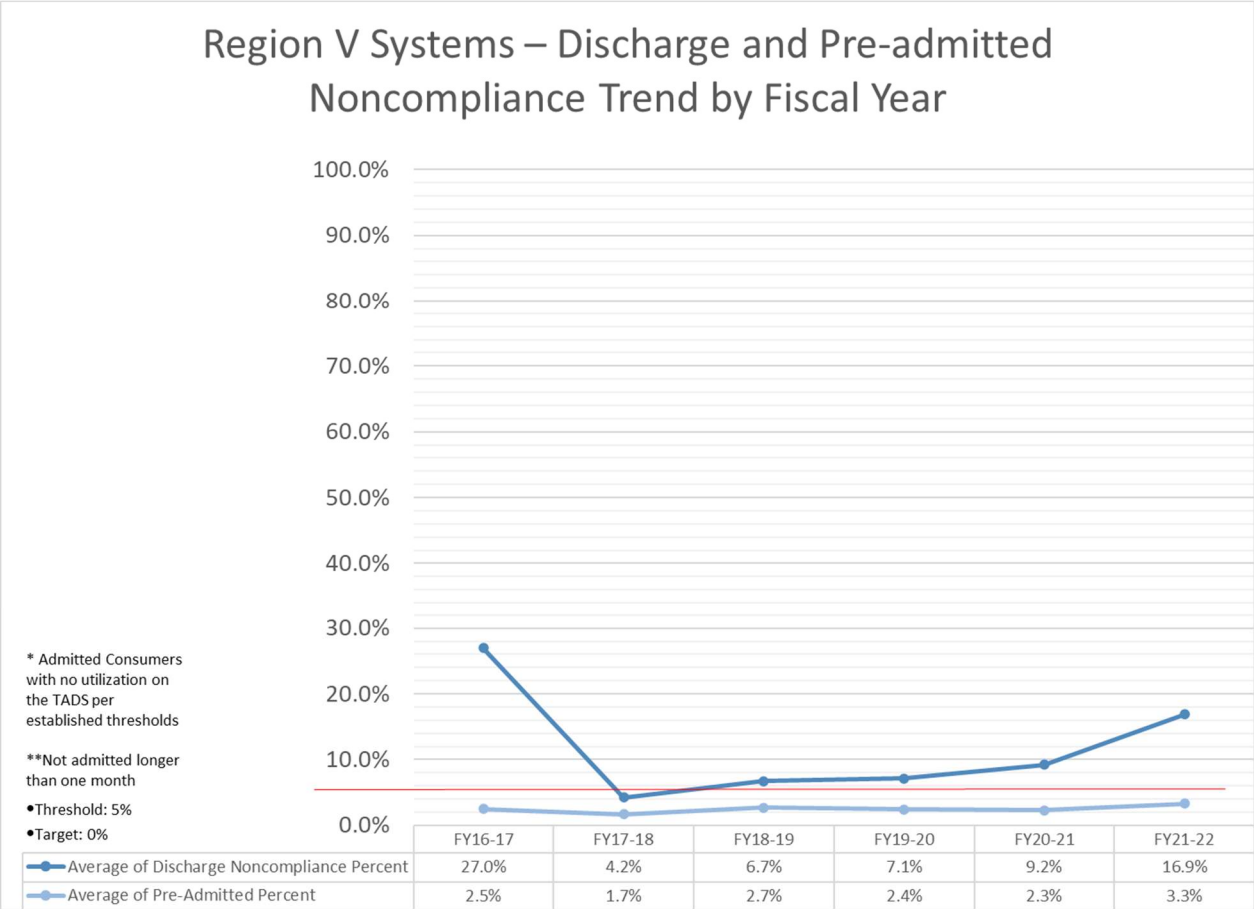
Data Management:

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 people 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 people who have been entered in CDS but never actually registered for a service and assesses if the encounter 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 encounters in CDS.

The following graph (next page) shows a decrease in the percent of persons served over the identified thresholds with no service utilization as monitored in fiscal year 2016-2017 at 27% to 16.9% in Fiscal Year 2021-22. Region V Systems' target is to have 0% of people in discharge noncompliance. The number of encounters over the pre-admitted noncompliance status increased from 2.5% for the time period of Fiscal Year 2016-2017 to 3.3% for the time period of Fiscal Year 2021-2022.

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 the current fiscal year and therefore the percentage for has risen to 16.9%.



	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22
Average of Discharge Noncompliance Percent	27.0%	4.2%	6.7%	7.1%	9.2%	16.9%
Average of Pre-Admitted Percent	2.5%	1.7%	2.7%	2.4%	2.3%	3.3%

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 person is to wait for treatment services, ensures people are placed into the appropriate recommended treatment services as soon as possible, and provide information necessary in planning, coordinating, and allocating resources.

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

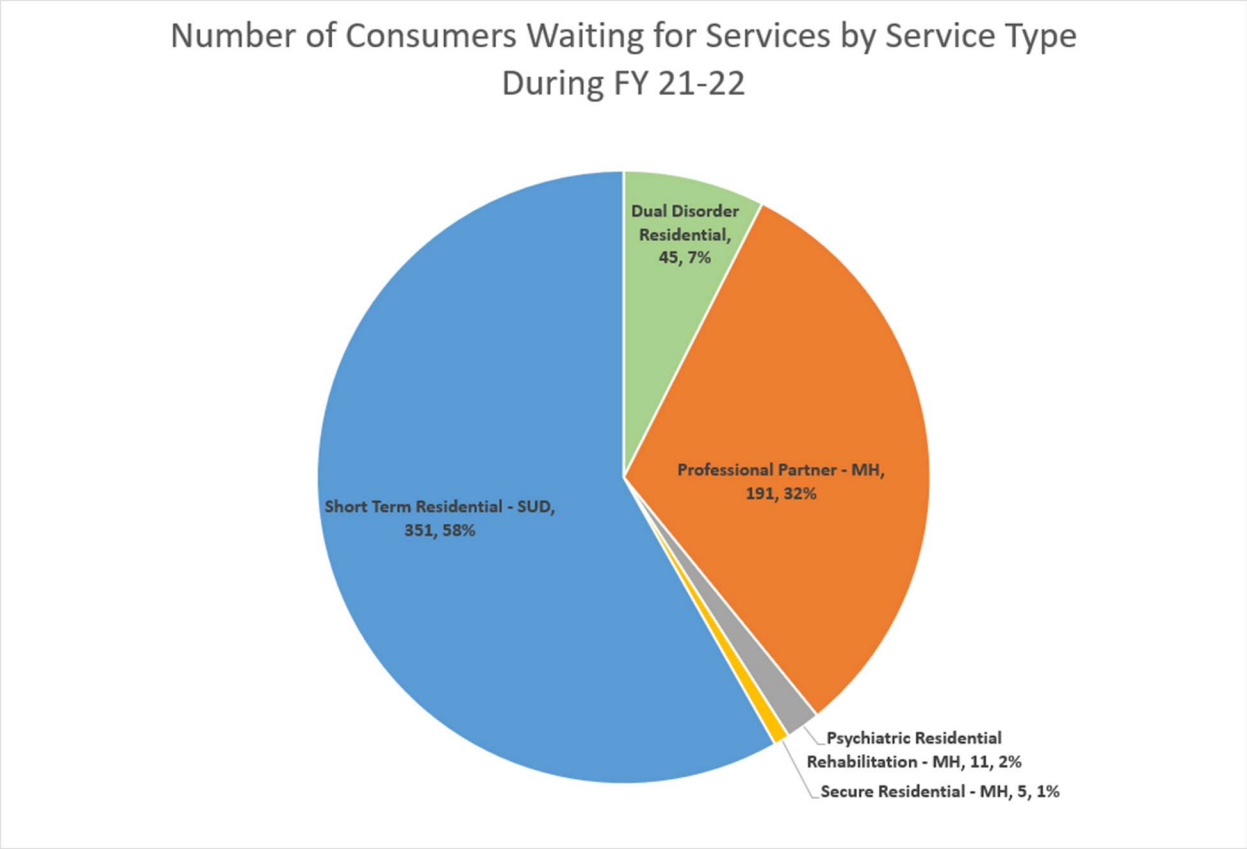
Starting in FY 17-18 information for persons served was entered into the Division of Behavioral Health's Central Data System (CDS). There was a learning curve by the Region and the network providers with utilizing this new system. New ways of entering data, managing the waitlist, and the regions approach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

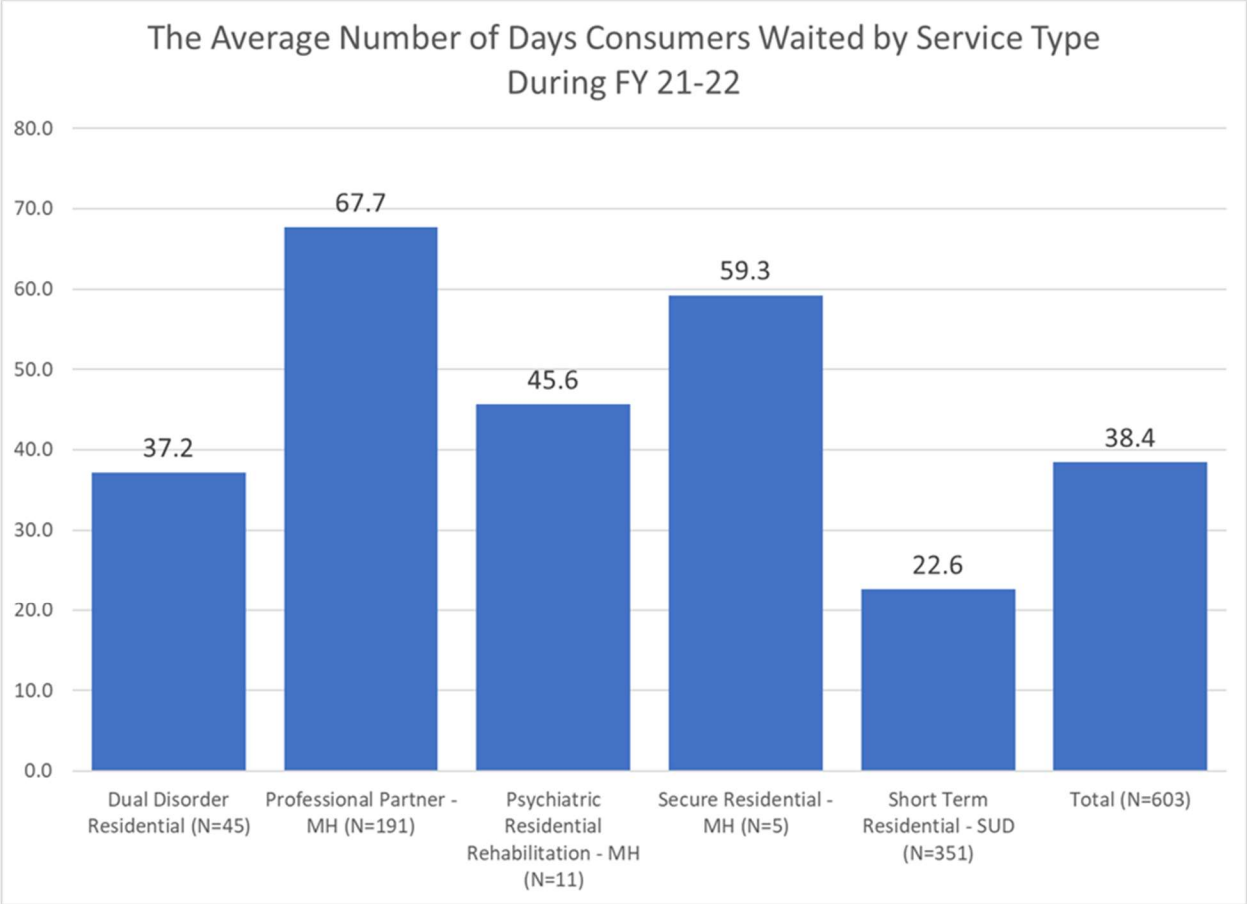
Mental Health Services	Substance Use Disorder Services
ACT (Assertive Community Treatment – MH)	Community Support – SUD
Community Support – MH	Dual Disorder Residential – SUD
Dual Disorder Residential – MH	Halfway House – SUD
Mental Health Respite – MH	IOP (Intensive Outpatient / Adult – SUD)
Professional 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 people who waited for services in Fiscal Year 21-22.

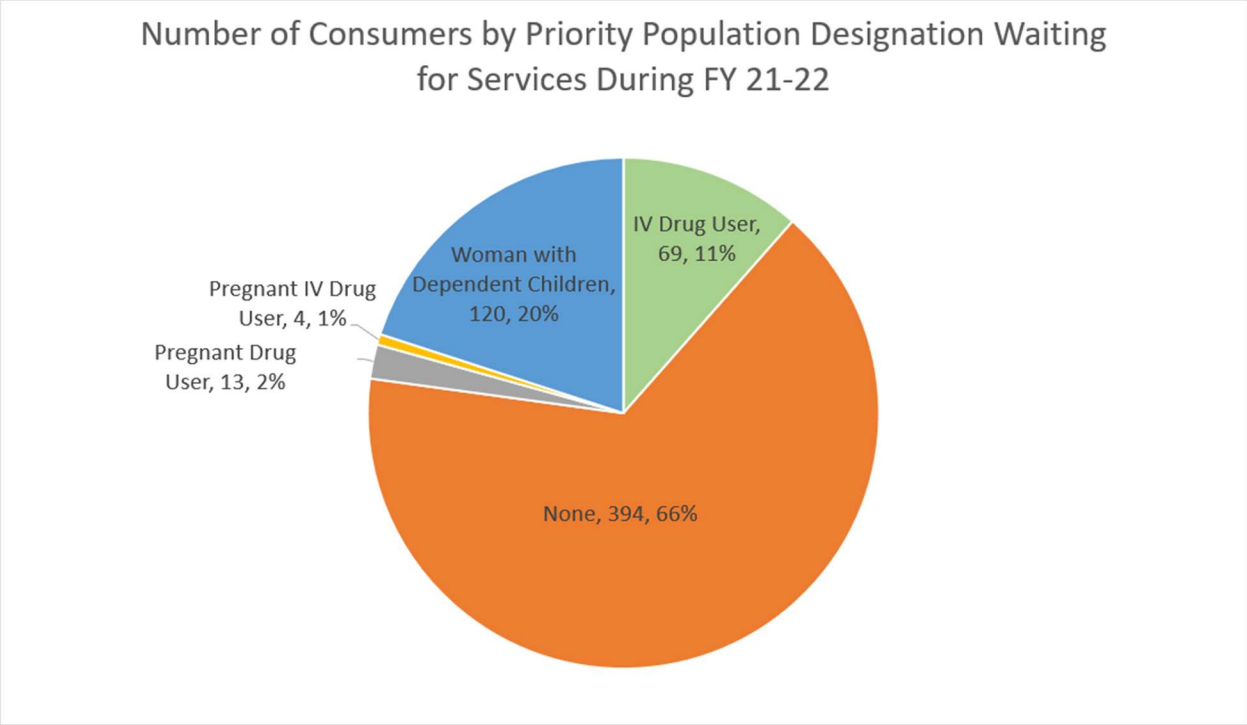


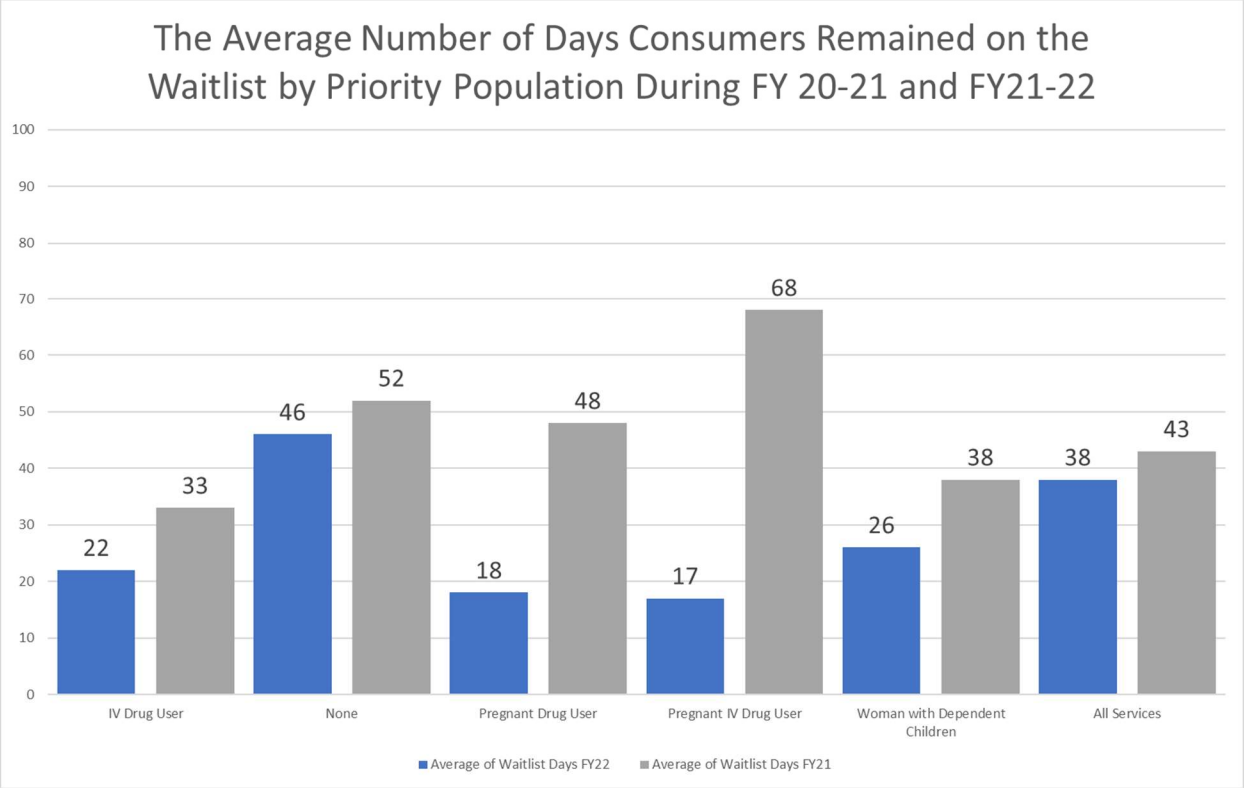
Below is a listing of substance abuse and mental health services available in the Region V Systems' network. This is a listing of the average number of days persons served remained on the waitlist until they were removed for various reason (entering treatment, unable able to be located, refused treatment,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

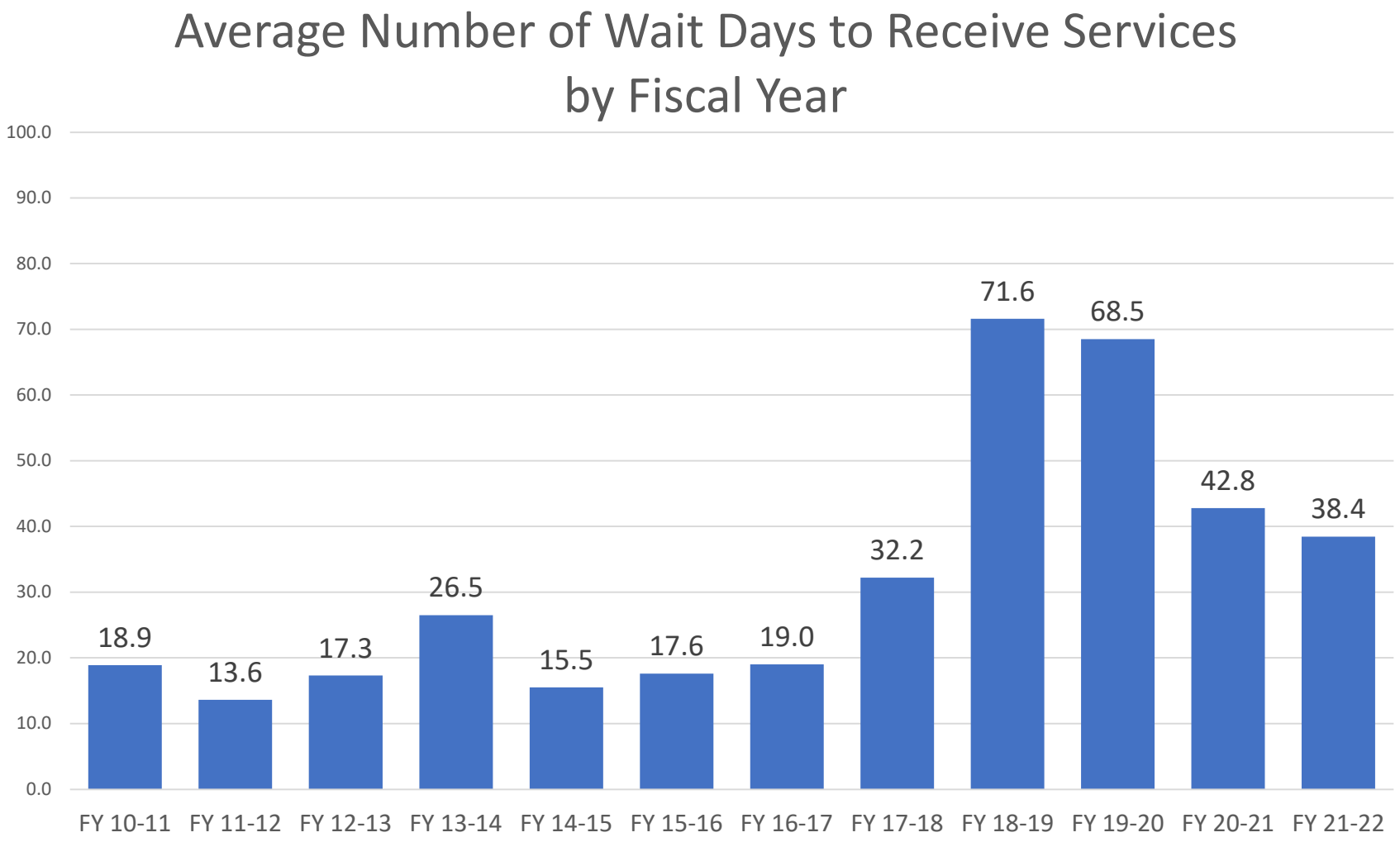


Entrance into substance abuse programs is determined by priority levels identified by the state and federal government. Persons served presenting with these problems take priority in entering treatment over others who do not present with these problems. IV drug users and Women with dependent children were the highest priority population identified at 31%.

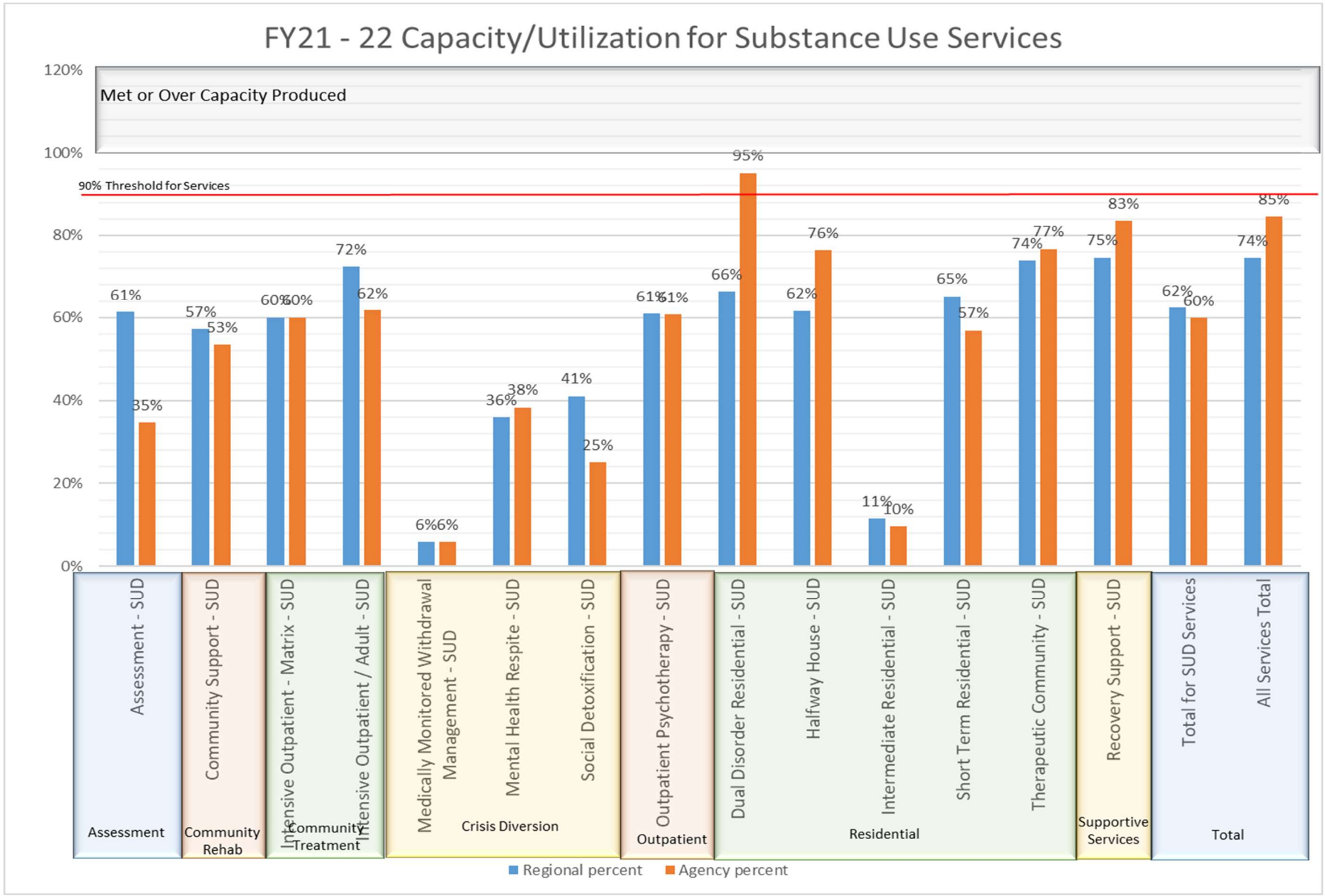


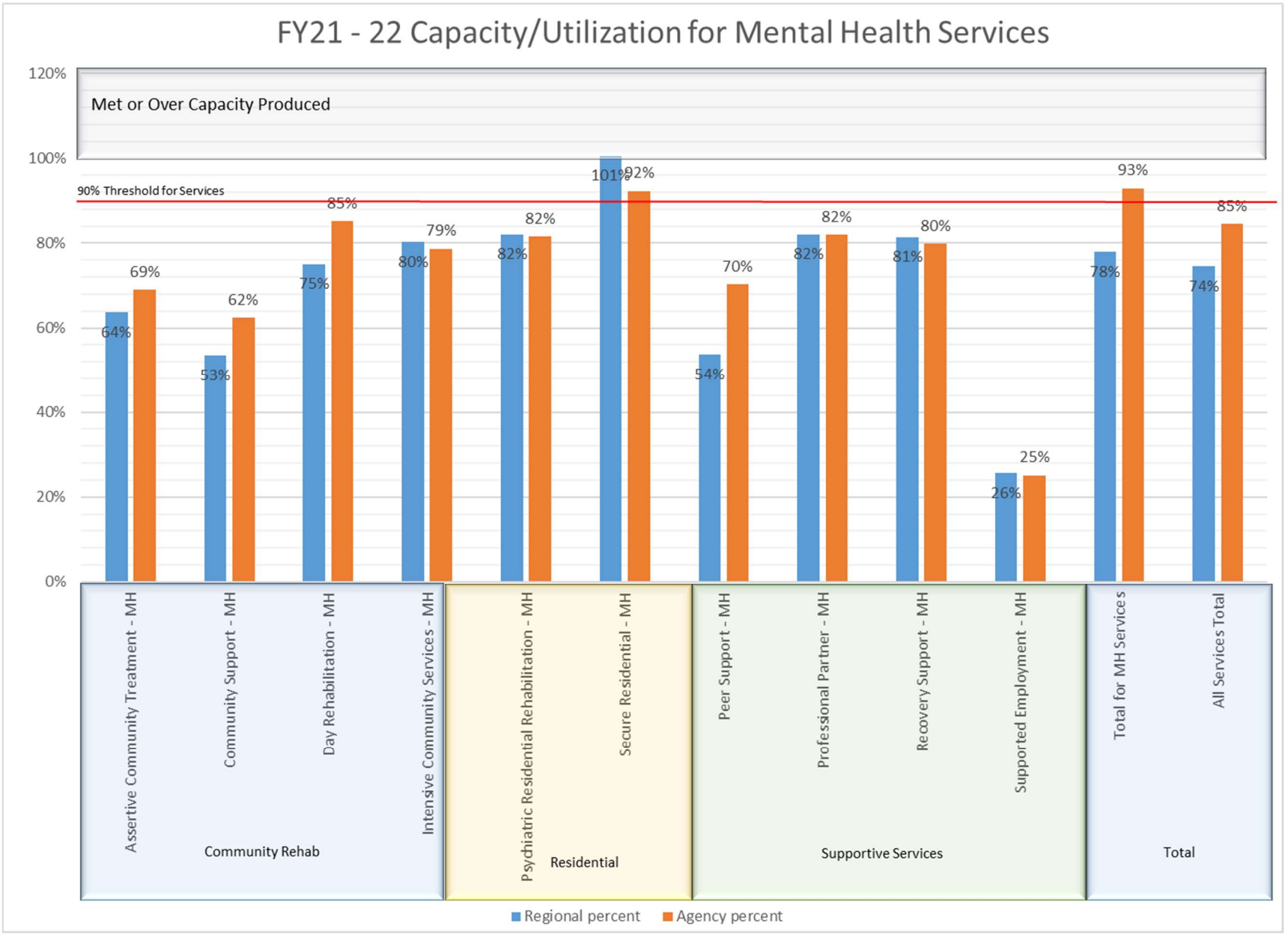


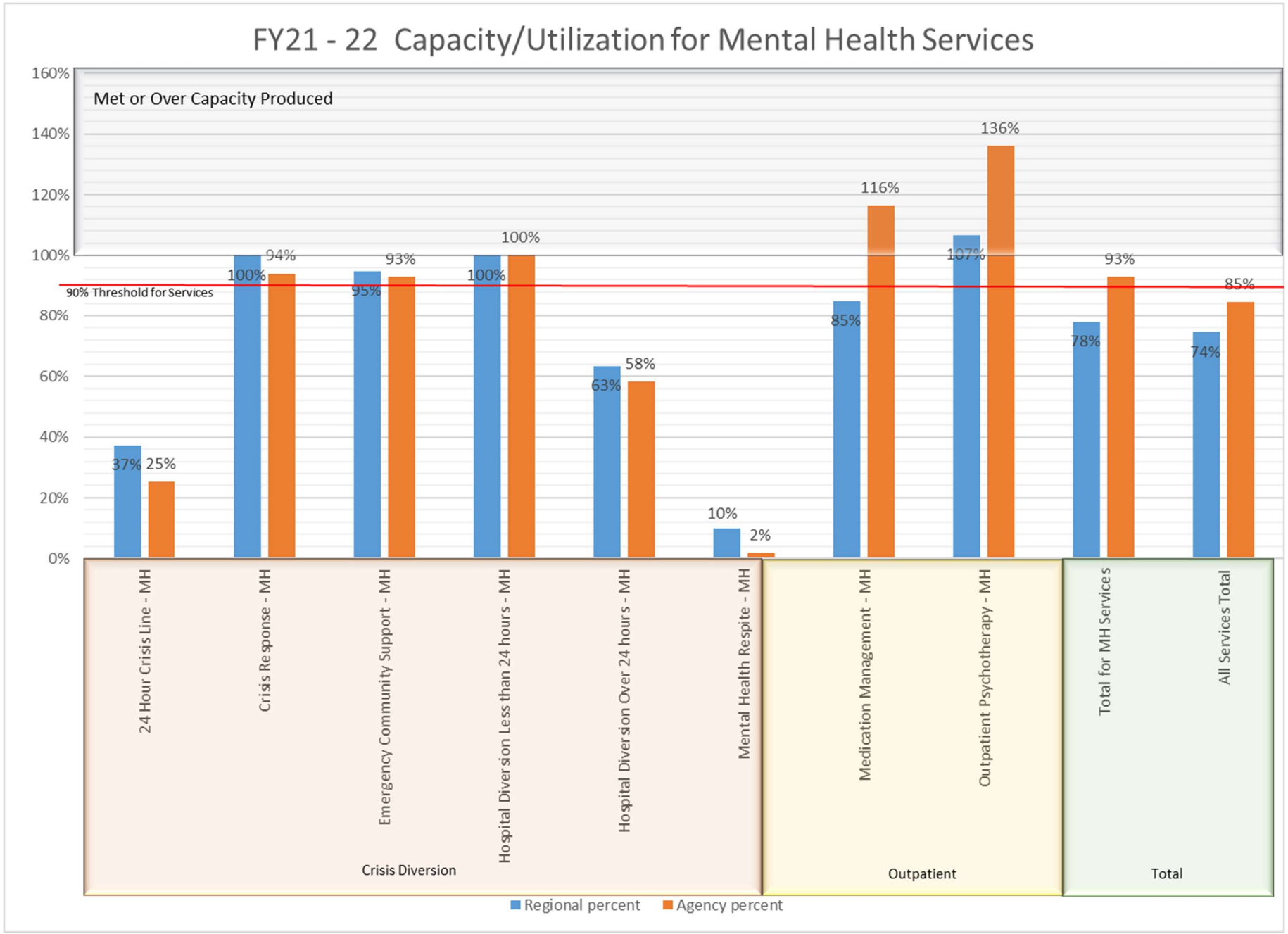
The graph below illustrates the average number of days people wait for all substance abuse services within the Region V Systems geographical area.



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.




FY21 - 22 Capacity/Utilization for Mental Health Services
120%
100%
80%
60%
40%
20%
0%
Met or Over Capacity Produced
90% Threshold for Services
64%
69%
53%
62%
75%
85%
80%
79%
82%
82%
101%
92%
54%
70%
82%
82%
81%
80%
26%
25%
78%
93%
74%
85%
Assertive Community Treatment - MH
Community Support - MH
Day Rehabilitation - MH
Intensive Community Services - MH
Psychiatric Residential Rehabilitation - MH
Secure Residential - MH
Peer Support - MH
Professional Partner - MH
Recovery Support - MH
Supported Employment - MH
Total for MH Services
All Services Total
Community Rehab
Residential
Supportive Services
Total
Regional percent
Agency percent

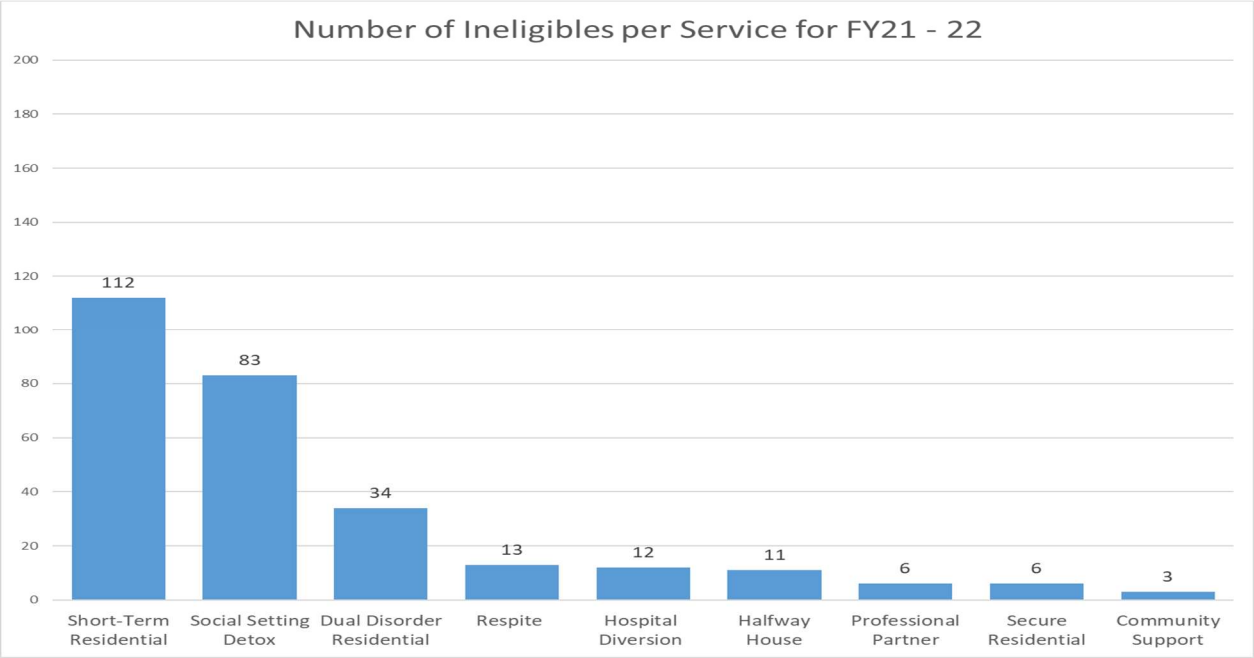

FY21 - 22 Capacity/Utilization for Mental Health Services
Met or Over Capacity Produced
90% Threshold for Services
160%
140%
120%
100%
80%
60%
40%
20%
0%
37%
25%
100%
94%
95%
93%
100%
100%
63%
58%
10%
2%
85%
116%
107%
136%
78%
93%
74%
85%
24 Hour Crisis Line - MH
Crisis Response - MH
Emergency Community Support - MH
Hospital Diversion Less than 24 hours - MH
Hospital Diversion Over 24 hours - MH
Mental Health Respite - MH
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 people served in the Region V Systems provider network, providers document their reasons for either denying or finding a person that is ineligible for services.

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

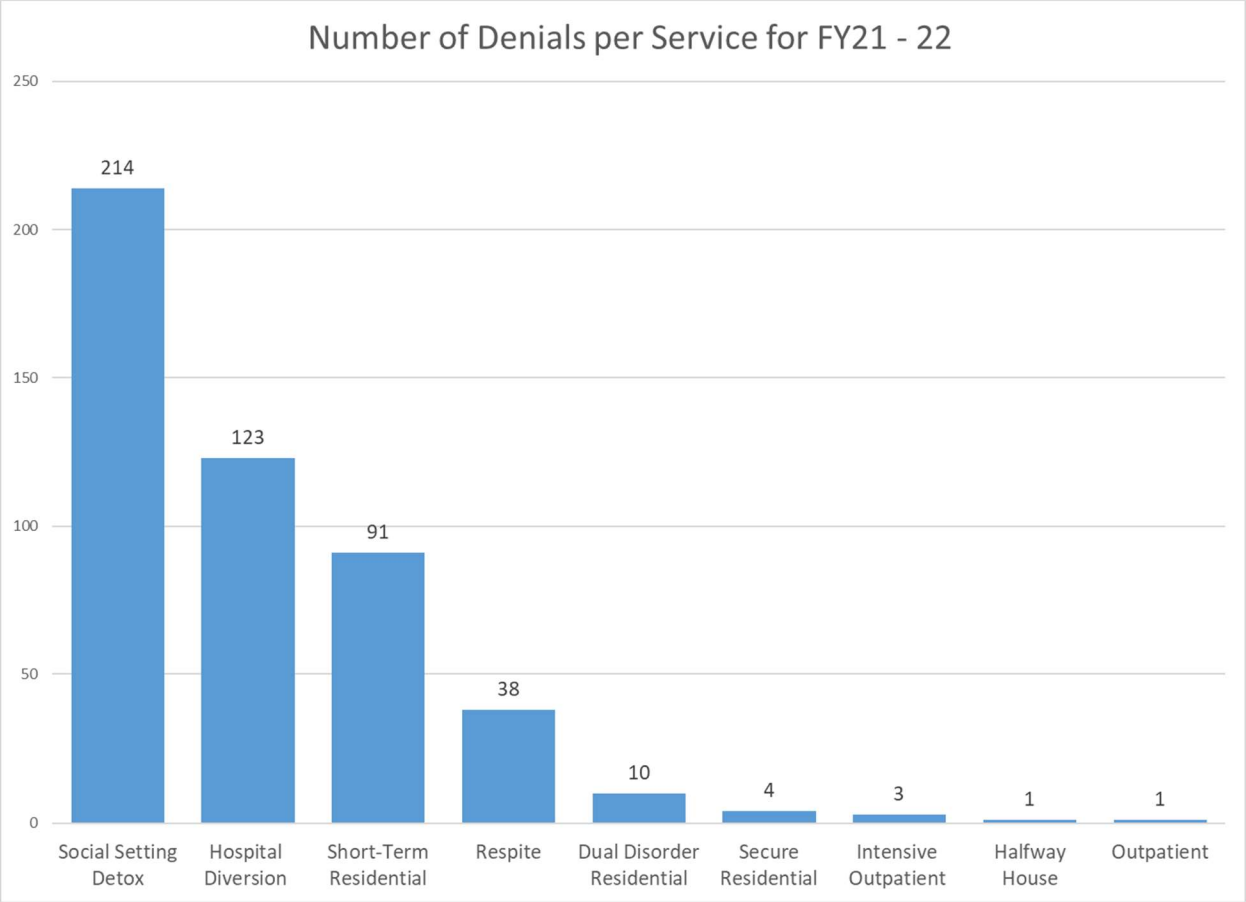
The first chart below identifies the number of people found to be ineligible for services during the FY 21-22 by service.



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	Short-Term Residential	Social Setting Detox	Halfway House	Respite	Professional Partner	Hospital Diversion	Secure Residential	Psychiatric Residential Rehabilitation	Total	Total Percent
Doesn't have required functional deficits	2	32	2	4	-	2	4	-	1	-	47	17%
Doesn't meet date of last use criteria	-	2	22	4	-	1	-	3	-	-	32	11%
Doesn't meet frequency of use	-	-	3	-	-	-	-	-	-	-	3	1%
Doesn't meet other admission criteria (please specify):	-	-	1	1	11	-	-	6	-	-	19	7%
Extensive MH, not managed/unstable	-	-	57	6	-	3	-	-	-	-	66	23%
Medically Unstable	1	-	13	65	-	7	-	3	3	1	93	33%
Referred by Non-Region V Funding	-	-	12	3	-	-	2	-	-	-	17	6%
Significant Cognitive Impairment	-	-	2	-	-	-	-	-	2	-	4	1%
Total	**3**	**34**	**112**	**83**	**11**	**13**	**6**	**12**	**6**	**1**	**281**	**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 people found to be ineligible for services during the FY 21-22 by service.



The majority of the denials were from the category "Other". Not being able to serve people due to insufficient capacity accounted for 97% of these "Other" denials. Typically, providers would waitlist people for services, but the Hospital Diversion, Social Setting Detoxification, and Respite services appropriately do not offer waitlists. For short-term residential, the most common reason for denial was the person served was recommended for other level of care.

Reason for Denial	Dual Disorder Residential	Halfway House	Hospital Diversion	Intensive Outpatient	Outpatient	Respite	Secure Residential	Short-Term Residential	Social Setting Detox	Total	Total Percent
Conflict of interest	-	-	1	-	-	-	1	4	1	7	1%
Consumer is Homeless	-	-	52	-	-	-	-	-	-	52	11%
Legal History	-	-	-	-	-	-	1	20	-	21	4%
Other* (please specify):	1	-	58	-	-	34	-	-	192	285	59%
Out of Region	1	-	7	-	-	-	-	4	-	12	2%
Recent Aggression	-	-	2	-	-	2	-	10	17	31	6%
Recommend Other Level of Care	8	1	3	3	1	2	2	53	2	75	15%
Sexual Offender	-	-	-	-	-	-	-	-	2	2	0%
Total	10	1	123	3	1	38	4	91	214	485	100%

Complaints and Appeals:

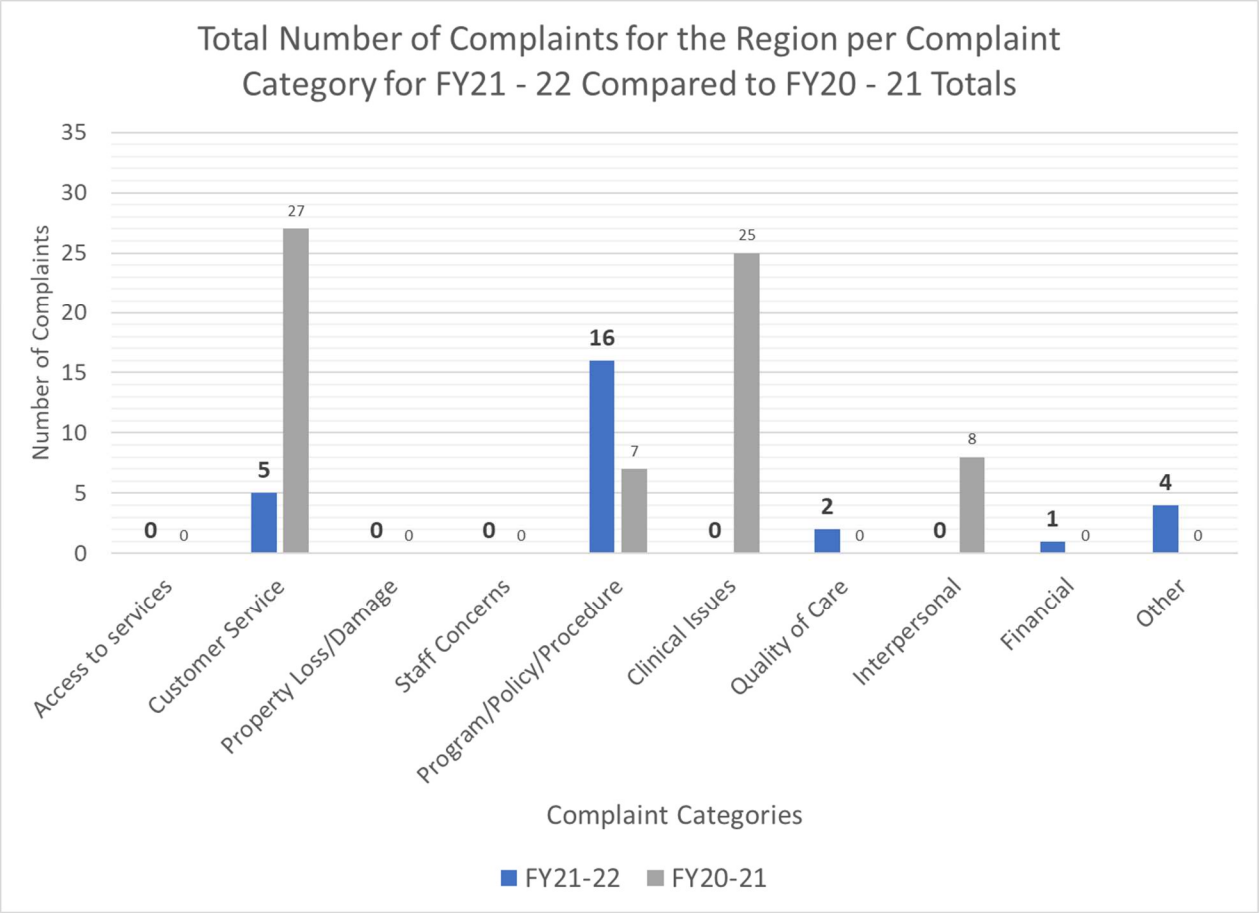
To improve quality standards for people served in the Region V Systems network, providers report on their complaints and appeals received.

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

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

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

1. **Access to Services:** defined as any service that the person requests which is not available or any difficulty the person experiences in trying to arrange for services at any given facility. (Difficulty scheduling initial appointments or subsequent ones, concerns with wait times for services, hours of operation, location not easily accessible.)
2. **Access to Staff:** defined as any problem the person 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 person in resolving his/her issue.
5. **Environmental:** defined as any person's served complaint about the condition of the place in which services are being received (temperature, hazards, lighting, cleanliness, noise levels, lack of privacy).
6. **Financial:** defined as any issue involving budget, billing, or financial issues.
7. **Interpersonal:** defined as any personality issue between the person served and staff member.
8. **Program/Policy/Procedure**: defined as any issue a person expresses about the program, policies, procedures (visiting hours, phone access, smoking policy, UA policy, etc.).
9. **Quality of Care:** defined as any issue which deals with the quality of care that the person is receiving as it relates to services being rendered. (The consistency of service, etc.)
10. **Transportation:** defined as any issue involving transportation.
11. **Other:** defined as any issue not addressed above, please specify the issue.



No appeals were received for the year.

Critical Incidents:

Region V Systems' providers submit consumer 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:** Person served harms/assaults another person verbally/physically/ psychologically).
2. **Abuse-Consumer to Staff:** Person harms/assaults staff (verbal/physical/psychological).
3. **Abuse-Staff to Consumer:** Staff member harms/assaults a person (verbal/ physical/ psychological)
4. **Biohazardous Accidents:** An accident, injury, spill, or release. Some examples include needle stick, puncture wounds, splash, environmental release of an agent or organism.
5. **Communicable Disease:** Person admitted with or became exposed to a communicable/ infectious disease. Examples include Tuberculosis, Hepatitis, whooping cough, Measles, Influenza.
6. **Death by Homicide:** One person causes the death of another person.
7. **Death by Suicide Completion:** A person completes suicide, purposely ending their life.
8. **Death-Other:** Death that was not anticipated.
9. **Elopement:** Person served is in residential treatment and left without notifying the agency of their intent to leave.
10. **Illegal Substance Found:** An agency finds illegal substances in or around the facility.

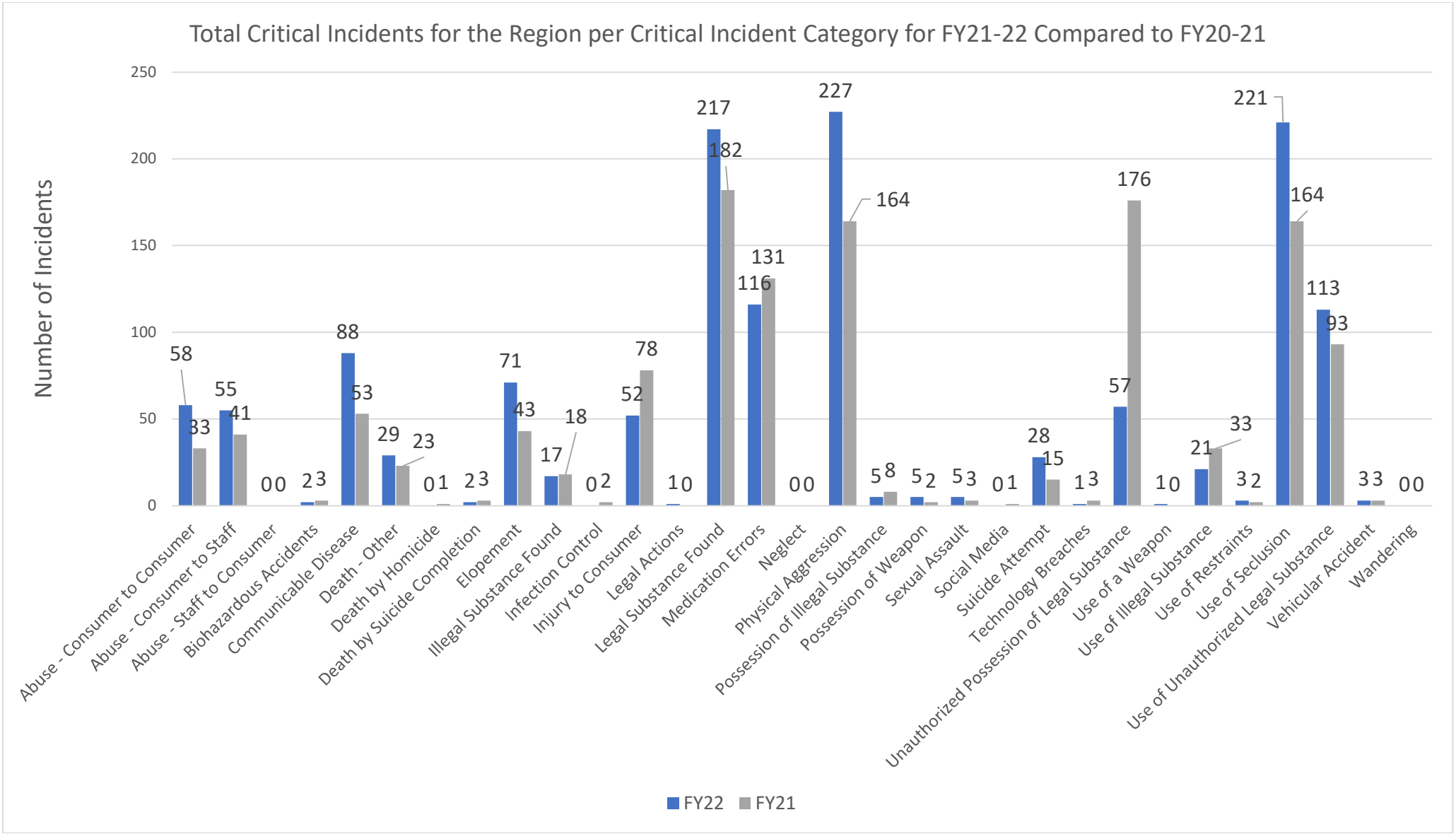
11. **Infection Control:** Agency did not apply infection control practices to prevent pathogens being transferred from one person to another.
12. **Injury to Consumer:** Not Self Harming. Accidental in nature.
13. ***Legal Actions:** Network provider is involved in a legal action/lawsuit that involves persons served regardless of who is the plaintiff or defendant.
14. **Legal Substance Found:** An agency finds legal substances which are not appropriately tracked, monitored, and safeguarded.
15. **Medication Errors:** Medical or human error when a healthcare provider chooses an inappropriate method of care or improperly executes an appropriate method of care.
16. **Neglect:** Agency/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:** Person who has possession of an illegal substance.
19. **Possession of Weapon:** Person possesses a weapon on agency property and/or violates program rules/policies.
20. **Sexual Assault:** Sexual act in which a person is coerced or physically forced to engage against their will, or non-consensual sexual touching of a person. A form of sexual violence.
21. ***Social Media:** Disclosing inappropriate 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 person's confidential information that was transmitted/maintained electronically.
24. **Unauthorized Possession of Legal Substance:** Person who has possession of an unauthorized legal substance which is against program rules/policies.
25. **Use of a Weapon:** Person served uses a weapon.
26. **Use of Illegal Substance:** Person served is found to be using or admits to using illegal substances.
27. **Use of Restraints:** An agency utilizes restraints to manage a person's behavior.
28. **Use of Seclusion:** An agency utilizes seclusions to manage a person's behavior.
29. **Use of Unauthorized Legal Substance:** Person served is found or admits to using unauthorized legal substances that are against the program rules/policies.
30. **Vehicular Accident:** Person served is involved in a vehicular accident; the vehicle is driven by a staff member.
31. **Wandering:** Person served cognitively impacted with a memory loss such as Alzheimer's/dementia who experiences unattended wandering that goes out of agency awareness/supervision.

*Region 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.

Quality Improvement Actions

Every provider who has a critical incident indicates whether the incidents reported were part of a larger trend in agency or program and what quality improvement actions were undertaken to prevent or reduce further incidents. Some examples of these from FY22 were trainings to reduce medication errors, DBT skills for de-escalation of aggression, and tobacco cessation products to decrease tobacco use at residential services.

The following chart illustrates the type and number of critical incidents received comparing FY 20-21 & FY 21-22.



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

Incident by Domain of Incident Type by Fiscal Year

Incident Domain	Incident Type	FY18	FY19	FY20	FY21	FY22Q3	Total
Abuse/Aggression	Abuse - Consumer to Consumer	37	49	26	33	58	203
	Abuse - Consumer to staff	55	45	24	42	55	221
	Neglect	-	7	-	-	-	7
	Physical Aggression	163	165	154	168	227	877
	Possession of Weapon	6	3	2	2	5	18
	Sexual Assault	4	5	1	3	5	18
	Use of a Weapon	-	1	1	-	1	3
	Total for Abuse/Aggression	**265**	**275**	**208**	**248**	**351**	**1347**
Death/Suicide	Death - Other	10	10	21	23	29	93
	Death by Suicide Completion	2	2	3	3	2	12
	Death by Homicide	-	-	-	1	0	1
	Suicide Attempt	13	5	12	15	28	73
	Total for Death/Suicide	**25**	**17**	**36**	**42**	**59**	**179**
Exiting Treatment	Elopement	123	128	108	45	71	475
	Wandering	-	1	3	1	-	5
	Total for Exiting Treatment	**123**	**129**	**111**	**46**	**71**	**480**
Health	Biohazardous Accidents	6	7	1	3	2	19
	Communicable Disease	13	3	18	53	88	175
	Infection Control	0	2	1	3	-	6
	Injury to Consumer	46	55	58	82	52	293
	Vehicular Accident	5	4	5	3	3	20
	Total for Health	**70**	**71**	**83**	**144**	**145**	**513**
Legal	Legal Actions	1	2	2	-	1	6
	Social Media	7	4	3	1	1	16
	Technology Breaches	-	2	1	1	-	4
	Total for Legal	**8**	**8**	**6**	**2**	**2**	**26**
Medication Errors	Medication Errors	130	69	153	134	116	**602**
Restraints/Seclusions	Use of Restraints	10	3	3	2	3	21
	Use of Seclusion	175	187	166	164	221	913
	Total for Restraints/Seclusions	**185**	**190**	**169**	**166**	**224**	**934**
Substance Related	Illegal Substance Found	8	14	17	18	17	74
	Legal Substance Found	16	156	143	182	217	714
	Possession of Illegal Substance	6	11	7	11	5	40
	Unauthorized Possession of Legal Substance	35	46	224	185	57	547
	Use of Illegal Substance	25	25	33	33	21	137
	Use of Unauthorized Legal Substance	95	69	102	94	113	473
	Total for Substance Related	**185**	**321**	**526**	**523**	**430**	**1985**
Total		991	1080	1292	1305	1398	6066

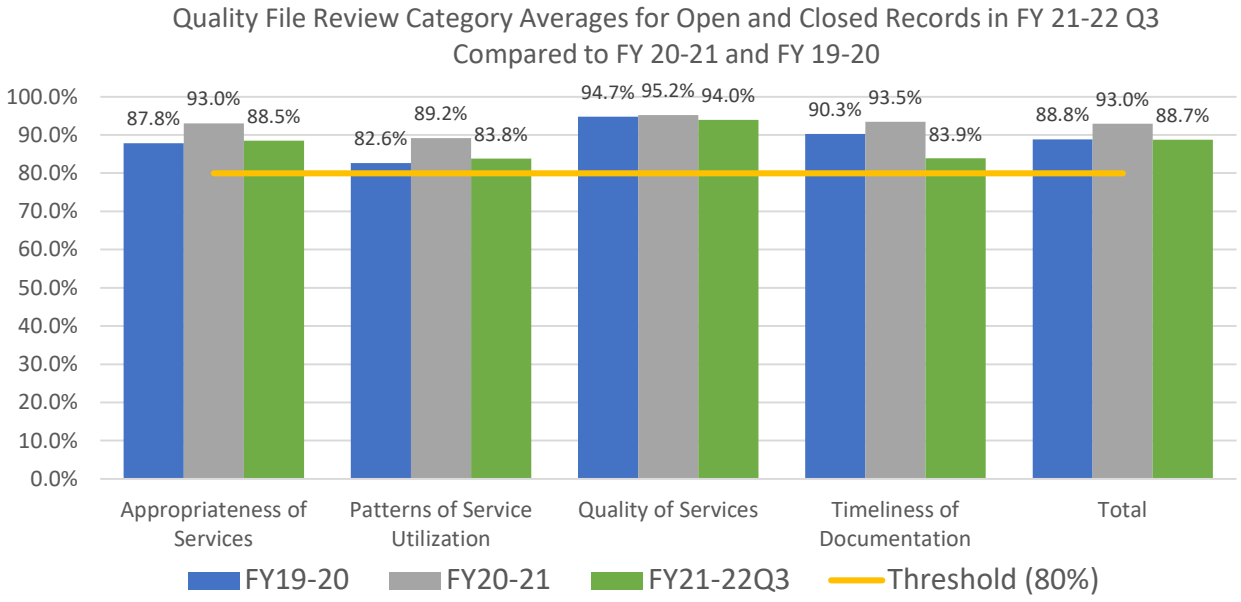
The following is a diagram used to help people served and providers understand the difference between incidents, critical incidents/events, deaths, and sentinel events.

Quality File Review:

Region V Systems' 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 person served, etc.).
3. Patterns of Service Utilization (e. g., discharge summary, referral to another agency).
4. Timeliness of Documentation (e. g., documentation completed within 36 hours).

Based on these designations, an aggregate was compiled for each category. The aggregate data, percentage of complete files for July 1, 2021, through June March 31, 2022, 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 - 22 Q3 CARF Accreditation areas	Sum of Compliant File Observations (Numerator)	Sum of Possible File Observations (Denominator)	Average Percent Compliant
Appropriateness of Services	12,520.00	14,147.00	88.5%
Patterns of Service Utilization	4,523.00	5,396.00	83.8%
Quality of Services	7,821.00	8,322.00	94.0%
Timeliness of Documentation	2,379.00	2,837.00	83.9%
Grand Total	**27,243.00**	**30,702.00**	**88.7%**

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.

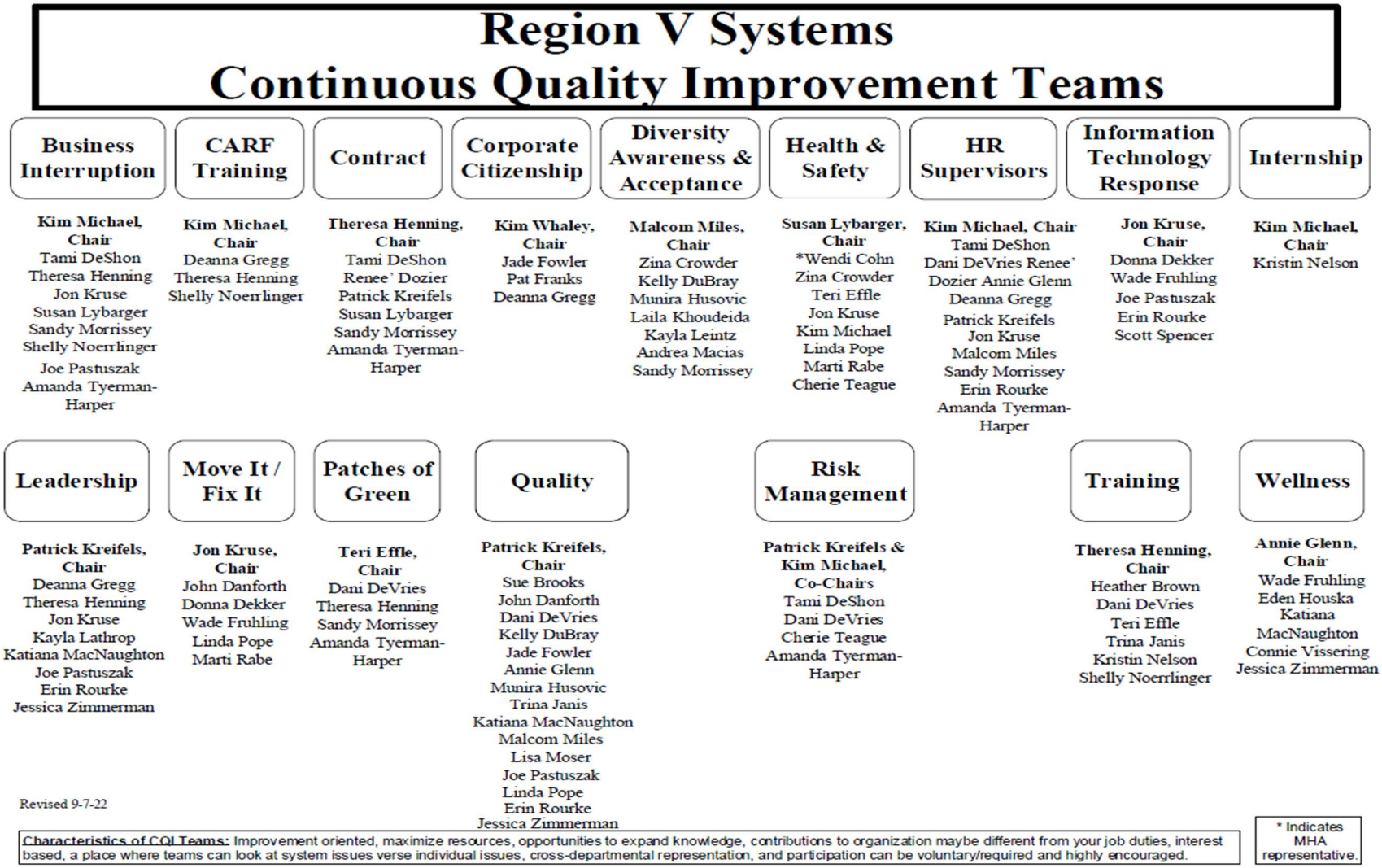
The following chart represents the CQI Concerns Requests submitted by staff members in FY 21-22. There was a total of three (3) concerns/requests submitted.

CQI Concerns Requests submitted by staff members

Date Received	CQI Concern/Request	Recommendation/Action Taken
2/2/2022	1) Replace office trash can liners daily. 2) Cell Phone lightening cords in cars for charging. 3) Blankets in cars for safety.	1) Continue current practice of replacing trashcan liners as deemed necessary by the cleaning company. Food is to be disposed of in the kitchen trashcans. 2) Employees are issued a cell phone and lightening cord for charging and can utilize this in the vehicles. Ensure vehicles have capability for charging. 3) Approved to purchase blankets in vehicles for safety.
1/10/2022	Consider finding a new home for some of the unused filing cabinet in Lower Level. Cabinets are unused due to the convergence from paper to Electronic Health Record System.	Approved-Assess RVS business needs; Offer to provider network/employees; and lastly donate.
11/22/2021	Create a more efficient way to complete the FYI Financial Eligibility Form.	Initial / annual financial eligibility FYI complete both: 1) Excel version. 2) Custom assessment within participant record.

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-EZ:

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.

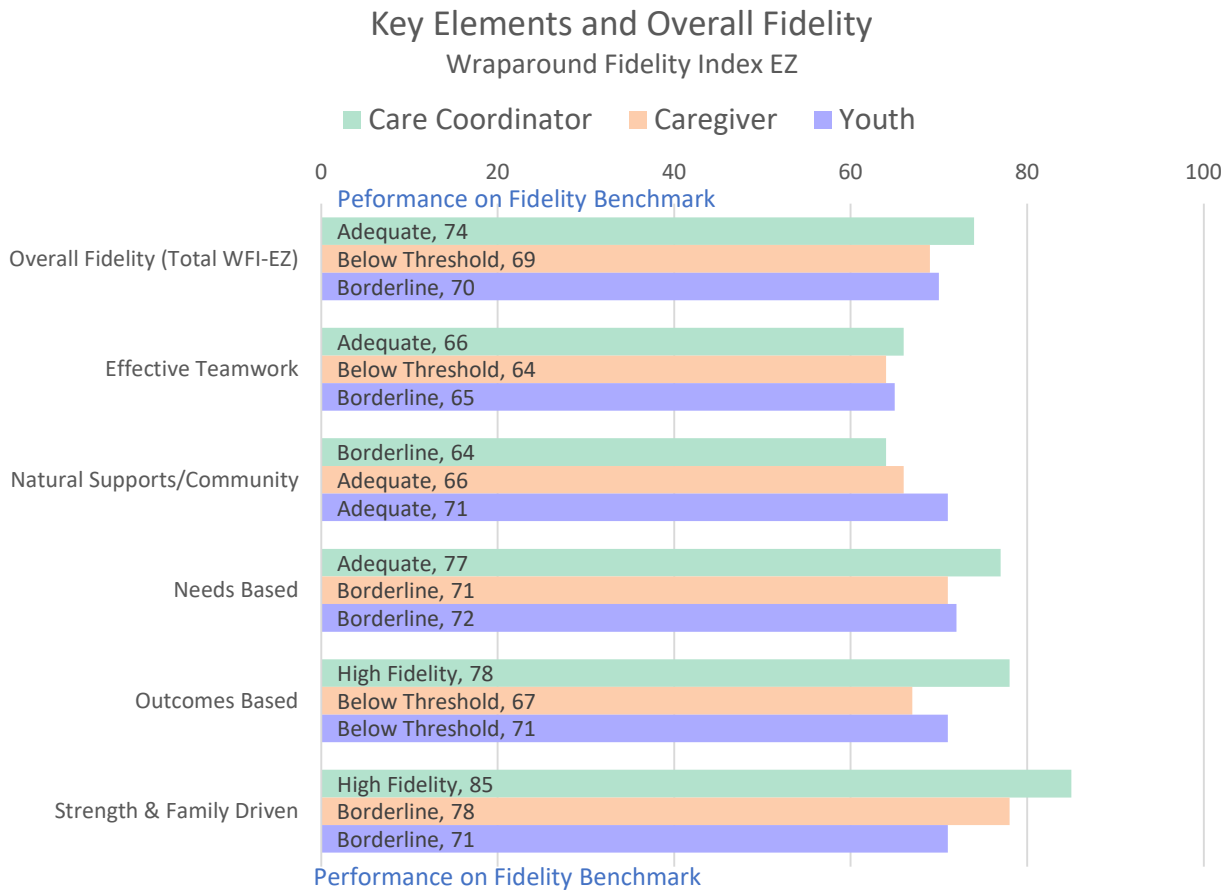
The following ten elements are evaluated:

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

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

The following table of Region 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 2022. Responses were collected from 43 professional partners, 30 caregivers, and 20 youth.



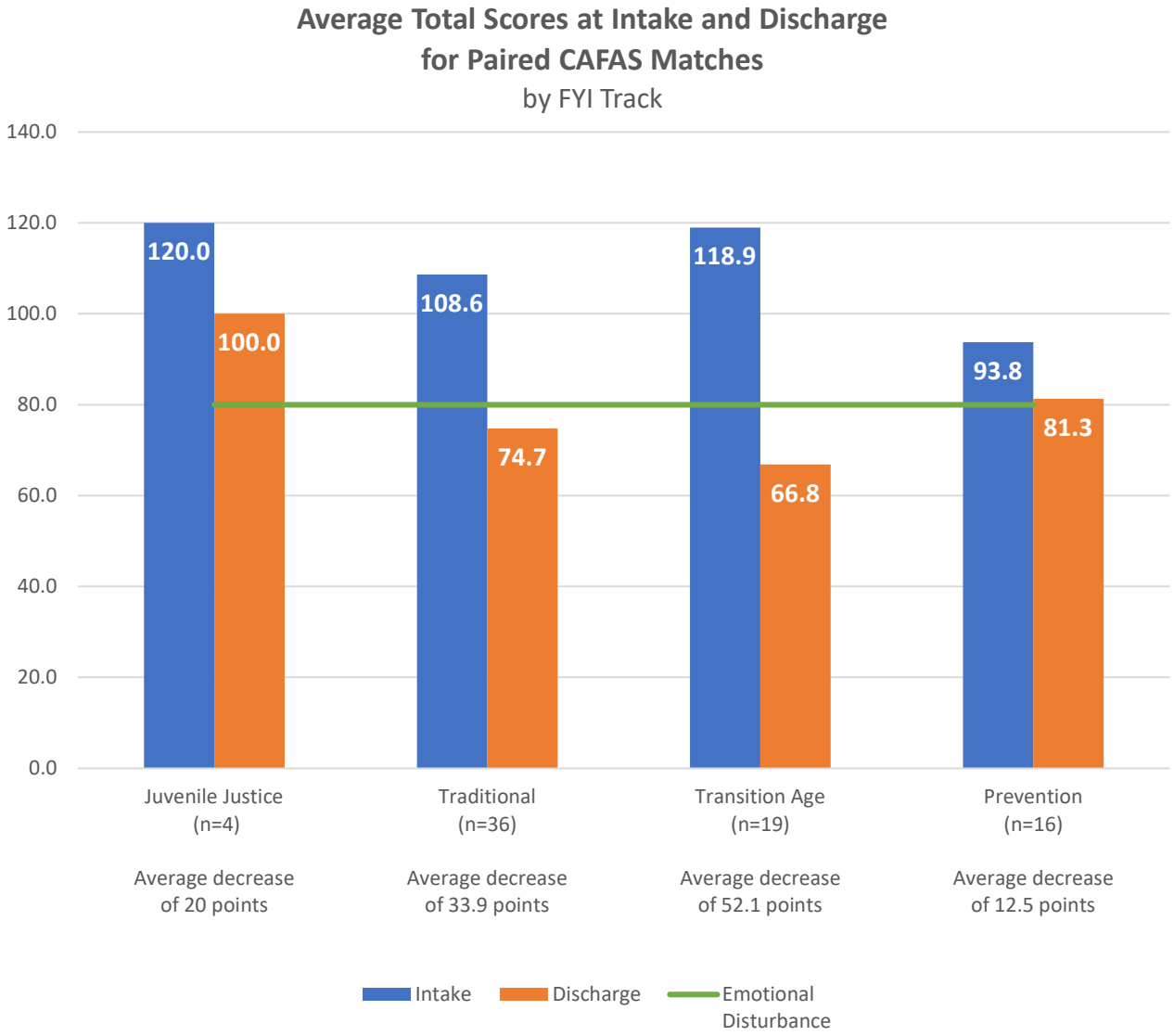
Child Adolescent Functional Assessment Scale (CAFAS):

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

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

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

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



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.

Appendix B
Comparison by Quarter
FY 21-22

RECORDS REVIEW		FY 20-21 Quarter 4	FY 21-22 Quarter 1	FY 21-22 Quarter 2	FY 21-22 Quarter 3	FY 21-22 Quarter 4
Open Records	**Total Completeness of All Items**	**90%**	**90%**	**95%**	**89%**	**92%**
	General Information - 1	88%	93%	100%	92%	91%
	Team Planning - 2	84%	94%	95%	89%	95%
	FYI Clinical Supervision Notes - 3	91%	81%	70%	95%	90%
	Formal Services - 4	92%	83%	100%	90%	91%
	Evaluation Info - 5	92%	92%	98%	84%	95%
	Legal - 6	100%	89%	89%	82%	83%
	School - 7	100%	78%	89%	91%	83%
Closed Records	**Total Completeness of All Items**	**89%**	**96%**	**89%**	**93%**	**95%**
	General Information - 1	89%	96%	85%	98%	98%
	Team Planning - 2	84%	95%	95%	94%	98%
	FYI Clinical Supervision Notes - 3	76%	93%	78%	73%	90%
	Formal Services - 4	87%	94%	83%	83%	91%
	Evaluation Info - 5	90%	95%	90%	95%	95%
	Legal - 6	94%	100%	85%	89%	81%
	School - 7	91%	100%	77%	89%	85%
	Section Closed	100%	98%	100%	97%	95%
EHR REPORTS REVIEW						
Interpretive Summary		97%	96%	100%	93%	100%
Initial POC		97%	92%	100%	100%	100%
Monthly POC Update		87%	78%	97%	98%	86%
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 for FY 21-22. Areas that are below 80% required the program to complete a quality improvement action plan.

FY 21 - 22 Rental Assistance Program File Review					
Section		**FY 21-22 Quarter 1**	**FY 21-22 Quarter 2**	**FY 21-22 Quarter 3**	**FY 21-22 Quarter 4**
Open Records	**Total Completeness of All Items**	**79%**	**85%**	**91%**	**90%**
	Application/Eligibility	95%	95%	94%	99%
	Application Supporting Documentation	68%	76%	83%	89%
	Voucher Issuance	75%	77%	94%	84%
	Housed	70%	86%	90%	89%
	Annual Review	84%	93%	77%	100%
Closed Records	**Total Completeness of All Items**	**80%**	**83%**	**85%**	**78%**
	Application/Eligibility	95%	93%	95%	95%
	Application Supporting Documentation	81%	87%	67%	69%
	Voucher Issuance	75%	78%	83%	72%
	Housed	75%	84%	88%	85%
	Annual Review	50%	100%	55%	58%
	Discharge	83%	66%	87%	47%

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

Region V Systems' Quality CQI Team conducts quarterly internal reviews on 25% of open persons served records, all closed records, and 10 property records within the Rural & Lincoln Permanent Housing Program. Below is a summary of FY 21-22. Areas that are below 80% required the program to complete a quality improvement action plan.

FY 21 - 22 Permanent Housing File Review - PARTICIPANT					
Section		**FY 21-22 Quarter 1**	**FY 21-22 Quarter 2**	**FY 21-22 Quarter 3**	**FY 21-22 Quarter 4**
Open Records	**Total Completeness of All Items**	**79%**	**83%**	**86%**	**94%**
	Section 1 – Application and Annual Review	90%	90%	82%	93%
	Section 2 – Income and Sublease	64%	64%	93%	96%
	Section 4 – Persons Needs	82%	82%	82%	93%
	Section 5 – Releases of Information	86%	86%	96%	97%
Closed Records	**Total Completeness of All Items**	Started review in Quarter 3		**84%**	**88%**
	Section 1 – Application and Annual Review			87%	87%
	Section 2 – Income and Sublease			84%	93%
	Section 4 – Persons Needs			70%	81%
	Section 5 – Releases of Information			85%	94%
	Discharge			86%	67%

FY 21-22 Permanent Housing File Review - PROPERTY				
Section	**FY 21-22 Quarter 1**	**FY 21-22 Quarter 2**	**FY 21-22 Quarter 3**	**FY 21-22 Quarter 4**
Total Completeness of All Files	**70%**	**69%**	**87%**	**90%**
Section 1 – Lease and Environmental Reviews	75%	79%	92%	85%
Section 2 – Sublease	100%	55%	82%	82%
Section 3 – Rent Reasonableness	52%	82%	86%	91%
Section 4 – Utility Allowance	68%	65%	89%	93%
Section 5 – Housing Quality Standard Inspections	73%	59%	88%	91%