REGION V SYSTEMS

Promoting Comprehensive Partnerships in Behavioral Health

Management Summary

FY 22-23

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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. This 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 22-23 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 23-24 PIP.

Indicator Number	FY 22-23 Threshold	Review	FY 23-24 PIP Status
1	100% of Region V Systems' employees complete required trainings according to assigned deadline.	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, 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: 3,471, Unique 1,942, Social Media: Engagement-Views/Shares 1,883, Readership 746, Impressions 65,921) by June 30, 2023.	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 sustain an active community prevention coalition by June 30, 2023.	Approved	Modify
7	75% of the counties (16) are represented on YAB membership.	Quality Improvement Action Plan	Continue
8	50% of all counties within Region V Systems geographical territory will have a minimum of one Hope Squad.	Approved	Modify
9	100% of all counties will have a minimum of one school district utilizing the evidence based-Second Step Social/Emotional learning curriculum.	Approved	Modify
10	100% of all staff members shall have a documented, signed semi-annual performance evaluation.	Approved	Continue
11	100% of all staff members shall have a documented, signed annual performance evaluation.	Approved	Continue
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.	Approved	Continue
15	100% of Region V Systems staff will be accurately documented on the pegboard.	Approved	Modify

(Cont.)

Indicator Number	FY 22-23 Threshold	Review	FY 23-24 PIP Status
16	The number of persons successfully completing RentWise training offered by Region V will increase by 50%.	Quality Improvement Action Plan	Modify
17	Decrease the average number of days between voucher issuance date and housing offered date to below 41 days for RAP SUD, 16 days for RAP MH, and 19 days for combined (SUD & MH).	Delete	Discontinued
18	70% (SUD/MH track combined) of RAP voucher participants (excluding one-time housing costs/flex fund recipients) will successfully discharge/bridge.	Approved	Modify
19	The average number of days people are on the waitlist will decrease by 10%. MH Priority 1: 22 days or less. MH priority 2: 78 days or less. SUD Priority 1: 15 days or less. SUD Priority 2: 22 days or less.	Approved	Continue
20	60% of youth with a 30-point (severe impairment) admission CAFAS score on any of the 8 domains will decrease to 20-point (moderate impairment), 10-point (mild/minimal impairment) when comparing admission to discharge CAFAS scores. (Must have a 30 in any domain at admission to be included in the sample). (Traditional, Transitional, Prevention, Crisis Response, and Juvenile Justice Tracks).	Approved	Continue
21	70% of discharged youth's total CAFAS score will decrease by 20 points when comparing intake vs. discharge scores (Traditional, Transitional, Prevention, and Juvenile Justice tracks).	Approved	Modify
22	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, and Juvenile Justice tracks).	Approved	Continue
23	75% of youth demonstrate improvement on one or more of the three outcome indicators. (Traditional, Transitional, Prevention, Crisis Response, and Juvenile Justice tracks).	Approved	Modify
24	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).	Approved	Modify
25	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).	Quality Improvement Action Plan	Continue

(Cont.)

Indicator Number	FY 22-23 Threshold	Review	FY 22-23 PIP Status
26	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 tracks).	Approved	Continue
27	90% of families will have a team meeting every month (all FYI track participants).	Approved	Continue
28	30% of clients in the FYI program will reside in rural counties (Traditional track).	Approved	Continue
29	95% of the FYI Professional Partners performance will be met on all of their gauges.	Approved	Modify
30	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.	Quality Improvement Action Plan	Continue
31	Exit conferences will be completed with 100% of Network Providers at completion of each agency/program site visit.	Approved	Continue
32	Evidenced-based implementation training sponsored by Region V Systems will result in an overall satisfactory rating of 85% or above.	Approved	Continue
33	75% of approved evidence-based practice applicants will complete all evidence-based training during the fiscal year. (Example of reporting: In Quarter 3, 89% (89/100) of approved evidence-based practice applicants completed required evidence-based training)	Approved	Continue
34	80% of approved evidence-based programs will complete all model fidelity and outcomes reporting requirements to maintain evidence-based practice delivery at the end of the fiscal year. (Example of reporting: In Quarter 3, 80% (8/10) of approved programs, per evidence-based practice, completed requirements)	Approved	Modify
35	The RPH, LPH, and RTPH Programs will maintain 100% of program unit capacity (RPH: 32 Units; LPH: 12 Units; RTPH: 8 Units {NOTE: The RTPH program receives its funding award in October 2022 and has projected to house the first transition-age program participant in December 2022}).	Quality Improvement Action Plan	Continue
36	95% of the RPH, LPH, and RTPH Housing programs performance will be met on the program gauges: • Clarity Enrollments (program participants are enrolled in Clarity NMIS within the required timeframe) • Annual HQS Inspections Conducted (Annual HQS inspections are conducted within 30 days of initial enrollment date) • Annual HQS Inspection Data (Annual HQS Inspection dates are input into the Clarity HQS no later than 30 days after initial enrollment date)	Approved	Continue

The second part of this section is a summary of Performance Indicators for Fiscal Year 2022-2023. 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 & 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 21-22	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, 2023.

Standard		Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year
Above baseline numbers	Users: Repeat average	3,471	3,589	3,016	2,740	3,961	3,780	3,374
	Users: Unique average	1,942	2,280		2,542	2,772	3,096	2,803
	Social Media: Engagement - Views/ shares average	1,883	1,485	1,173	1,530	2,895	1,082	1,670
	Readership average	746	818	831	834	858	895	854
	Impressions average	65,921	133,958	78,043	76,516	58,893	38,591	63,010

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

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	100%	100%	100%	100%	100%	100%

Adult Services Department (cont.):

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, 2023.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	85%	100%	100%	100%	94%	100%	100%

Indicator # 7:	YAB youth representation.
Threshold:	75% of the counties (16) are represented on YAB membership.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	75%	44%	75%	69%	81%	69%	73%

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 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	50%	75%	75%	75%	50%	56%	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 # 16:	Number of persons successfully completing RentWise training.
Threshold:	The number of persons successfully completing RentWise training offered by Region V will increase by 50% (to 18).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
TBD	18	12	6	0	7	0	13

Adult Services Department (cont.):

Indicator # 17:	Time between voucher issuance (admission date) to housing offered date (date of passed inspection) for ongoing RAP participants.
Threshold:	Decrease the average number of days between voucher issuance date and housing offered date to below 41 days for RAP SUD, 16 days for RAP MH, and 19 days for combined (SUD & MH).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
Within 5 Days	SU 41 MH 16 All 19	SUD – 26 days, MH – 30 days, Total – 29 days	MH 25 SUD 32 All 27	MH 21 SUD 28 All 23	Discontinued	Discontinued	Discontinued

Indicator # 18:	Persons served within the Rental Assistance Program (RAP) will experience a successful discharge (bridge to Section 8 or other housing, bridge to self-sufficiency or self-terminate assistance).
Threshold:	70% (SUD/MH track combined) of RAP voucher participants (excluding one-time housing costs/flex fund recipients) will successfully discharge/bridge.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
TBD	70%	Combined 75% MH 67% SUD 96%	MH 60% SUD 33% All 57%	MH 70% SUD 71% All 70%	MH 69% SUD 100% All 72%	MH 74% SUD 50% All 71%	67%

Indicator # 19:	Persons served within the Rental Assistance Program (RAP) Mental Health (MH) and Substance Use (SUD) programs will experience timely access. People receiving one-time housing assistance are excluded from this measure.
Threshold:	The average number of days people are on the waitlist will decrease by 10%. MH Priority 1: 22 days or less. MH priority 2: 78 days or less. SUD Priority 1: 15 days or less. SUD Priority 2: 22 days or less.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
14 days MH 60 days SUD	MH1: 22, MH2: 78 SUD1: 15 SUD2: 28	New Goal	MH 62 MH1 22 MH2 101 SUD 60 SUD1 45 SUD2 61	MH 38 MH1 17 MH2 60 SUD 20 SUD1 22 SUD2 13	MH 42 MH1 26 MH2 65 SUD 5 SUD1 6 SUD2 0	MH 21 MH1 26 MH2 16 SUD 29 SUD1 13 SUD2 37	MH 41 MH1 23 MH2 61 SUD 29 SUD1 22 SUD2 28

Indicator # 30:	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 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	82%	N/A	100%	33%	66%	66%

Adult Services Department (cont.):

Indicator # 31:	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 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	91%	NA	100%	100%	100%	100%

Indicator # 32:	Training evaluations from evidence-based implementation programs.
Threshold:	Evidenced-based implementation training sponsored by Region V Systems will result in an overall satisfactory rating of 85% or above.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
90%	85%	New Goal	95.8%	95.5%	95.4%	94.5%	95.3%

Indicator # 33:	Training attendance at all Region V Systems evidence-based practice trainings.
Threshold:	75% of approved evidence-based practice applicants will complete all evidence-based training during the fiscal year. (Example of reporting: In Quarter 3, 89% (89/100) of approved evidence-based practice applicants completed required evidence-based training).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
90%	75%	New Goal	97.5%	82.5%	86.6%	74%	85.2%

Indicator # 34:	Adherence to fidelity and outcomes reporting required in maintaining evidence-based program delivery.
Threshold:	80% of approved evidence-based programs will complete all model fidelity and outcomes reporting requirements to maintain evidence-based practice delivery at the end of the fiscal year. (Example of reporting: In Quarter 3, 80% (8/10) of approved programs, per evidence-based practice, completed requirements).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	80%	New Goal	100%	100%	83.3%	80%	90.83%

Children and Family Services Department:

Indicator # 20:	Aggregated Average Child Adolescent Functioning Assessment Scale (CAFAS).
Threshold:	60% of youth with a 30-point (severe impairment) admission CAFAS score on any of the 8 domains will decrease to 20-point (moderate impairment), 10-point (mild/minimal impairment) when comparing admission to discharge CAFAS scores. (Must have a 30 in any domain at admission to be included in the sample). (Traditional, Transitional, Prevention, Crisis Response, and Juvenile Justice Tracks).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	60%	52%	26%	53%	59%	35%	44%
Traditional		52%	43%	44%	65%	35%	49%
Transition		63%	33%	100%	60%	100%	54%
Prevention		42%	11%	33%	100%	50%	22%
Juvenile Justice		25%	N/A (no discharges)				

Indicator # 21:	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, and Juvenile Justice tracks).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	70%	64%	50%	76%	79%	58%	66%
Traditional		61%	63%	70%	81%	65%	68%
Transition		84%	100%	100%	100%	33%	86%
Prevention		44%	22%	67%	100%	50%	37%
Juvenile Justice		75%	N/A (no discharges)				

Indicator # 22:	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, and Juvenile Justice tracks).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	40%	45%	20%	47%	68%	33%	50%
Traditional		66%	25%	50%	67%	35%	57%
Transition		68%	33%	50%	100%	100%	60%
Prevention		40%	11%	33%	100%	50%	22%
Juvenile Justice		0%	N/A (no discharges)				

Children and Family Services Department (cont.):

Indicator # 23:	The three outcome indicators for the FYI program using the Child Adolescent Functioning Assessment Scale (CAFAS). (1) Change 20 points of total score; 2) Decrease severe impairment (30) of any domain; and 3) Decrease total CAFAS score below 80 points.)
Threshold:	75% of youth demonstrate improvement on one or more of the three outcome indicators. (Traditional, Transitional, Prevention, Crisis Response, and Juvenile Justice tracks).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	75%	65%	55%	76%	82%	58%	68%
Traditional		61%	75%	70%	86%	65%	75%
Transition		89%	100%	100%	100%	33%	86%
Prevention		44%	22%	67%	100%	50%	33%
Juvenile Justice		75%	N/A (no discharges)				

Indicator # 24:	Documentation of informal supports on wraparound teams.
Threshold:	85% of all teams will have at least one identified informal support on their team member list (utilize FYI statewide consensus of informal support definition; Traditional, Transitional, Prevention, Juvenile Justice tracks, and Crisis Response).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Whole Year
100%	85%	86%	83%	79%	82%	84%	81%
Traditional		81%	78%	78%	78%	80%	78%
Transition		95%	94%	84%	92%	94%	91%
Prevention		86%	100%	88%	80%	86%	86%
Juvenile Justice		100%	N/A	100%	100%	0%	67%

Indicator # 25:	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).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	70%	79%	63%	53%	64%	68%	61%
Traditional		70%	57%	41%	56%	53%	51%
Transition		95%	85%	84%	94%	94%	89%
Prevention		67%	16%	43%	33%	86%	51%
Juvenile Justice		100%	N/A	100%	0%	0%	33%

Children and Family Services Department (cont.):

Indicator # 26:	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 tracks).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	99%	99%	100%	99%	99%	99%
Traditional		99%	98%	100%	99%	98%	98%
Transition		99%	99%	100%	100%	100%	99%
Prevention		99%	100%	100%	100%	100%	100%
Juvenile Justice		100%	N/A	100%	100%	100%	100%

Indicator # 27:	Team meeting summary.
Threshold:	90% of families will have a team meeting every month (all FYI track participants).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	94%	95%	94%	94%	88%	94%
Traditional		95%	95%	94%	94%	88%	92%
Transition		95%	96%	95%	96%	88%	94%
Prevention		95%	94%	84%	93%	87%	89%
Juvenile Justice		88%	N/A	100%	100%	100%	100%

Indicator # 28:	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 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
30%	30%	46%	34%	30%	30%	28%	30%

Indicator # 29:	Professional Partners performance gauges.
Threshold:	95% of the FYI Professional Partners performance will be met on all of their gauges.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	95%	99%	100%	99%	100%	99%	99%

Children and Family Services Department (cont.):

Indicator # 35:	Rural (RPH), Lincoln (LPH), and Rural Transition-age (RTPH) Permanent Housing Units.
Threshold:	The RPH, LPH, and RTPH Programs will maintain 100% of program unit capacity (RPH: 32 Units; LPH: 12 Units; RTPH: 8 Units {NOTE: The RTPH program receives its funding award in October 2022 and has projected to house the first transition-age program participant in December 2022}).

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	91% (combined: LPH April-June 2022 & RPH whole FY)	90.9%	74.3%	73.1%	82.69%	79%

Indicator # 36:	Rural (RPH), Lincoln (LPH), and Rural Transition-age (RTPH) Permanent Housing Performance Gauges.
Threshold:	95% of the RPH, LPH, and RTPH Housing programs performance will be met on the program gauges: 1. Clarity Enrollments (program participants are enrolled in Clarity NMIS within the required timeframe) 2. Annual HQS Inspections Conducted (Annual HQS inspections are conducted within 30 days of initial enrollment date) 3. Annual HQS Inspection Data (Annual HQS Inspection dates are input into the Clarity HQS no later than 30 days after initial enrollment date)

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	95%	Data not collected due to revision of PIP for FY 22-23	93.8%	90.1%	90.2%	97%	92%

Operations/Human Resources Department:

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

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of Year Total
100%	100%	97%	13.9%	42%	61%	98%	98%

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

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Average
90%	85%	93%	91.6%	95.2%	95.1%	93.9%	93%

Operations/Human Resources Department (cont.):

Indicator # 10:	Completed semi-annual performance evaluations are submitted to HR by the 5th business day following the performance evaluation deadline (completed evaluation = conducted by the established deadline, documented on the correct form; password-protected and saved on the Y-Drive, hard copy signed by the employee and supervisor, and submitted to HR by the 5th business day following the performance evaluation deadline.).
Threshold:	90% of all staff members shall have bi-annual performance evaluation and documentation completed.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	69%	78%	95%	7%	100%	85%

Indicator # 11:	Completed annual performance evaluations are submitted to HR by the required deadline (completed evaluation = conducted by the established deadline, documented on the correct form; password-protected and saved on the Y Drive, hard copy signed by the employee and supervisor, and submitted to HR by the performance evaluation deadline.
Threshold:	100% of all staff members shall have a documented, signed annual performance evaluation.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	89%	60%	100%	75%	94%	85%

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

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	100%	100%	100%	100%	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 entered within two (2) business days.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	90%	99%	100%	99.3%	100%	99.4%	99%

Operations/Human Resources Department (cont.):

Indicator # 14:	Building occupants are accurately documented during health & safety drills, including pegboard status and visitor sign in, per standard procedures.
Threshold:	100% of building occupants will be accurately documented on the pegboard during health and safety drills.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	86%	90%			97%	93%

Indicator # 15:	Pegboard status is accurately documented, per standard procedures.
Threshold:	100% of Region V Systems staff will be accurately documented on the pegboard.

Standard	Threshold	Quarter 4 FY 21-22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average
100%	100%	New Goal		87%	94%	97%	93%

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.

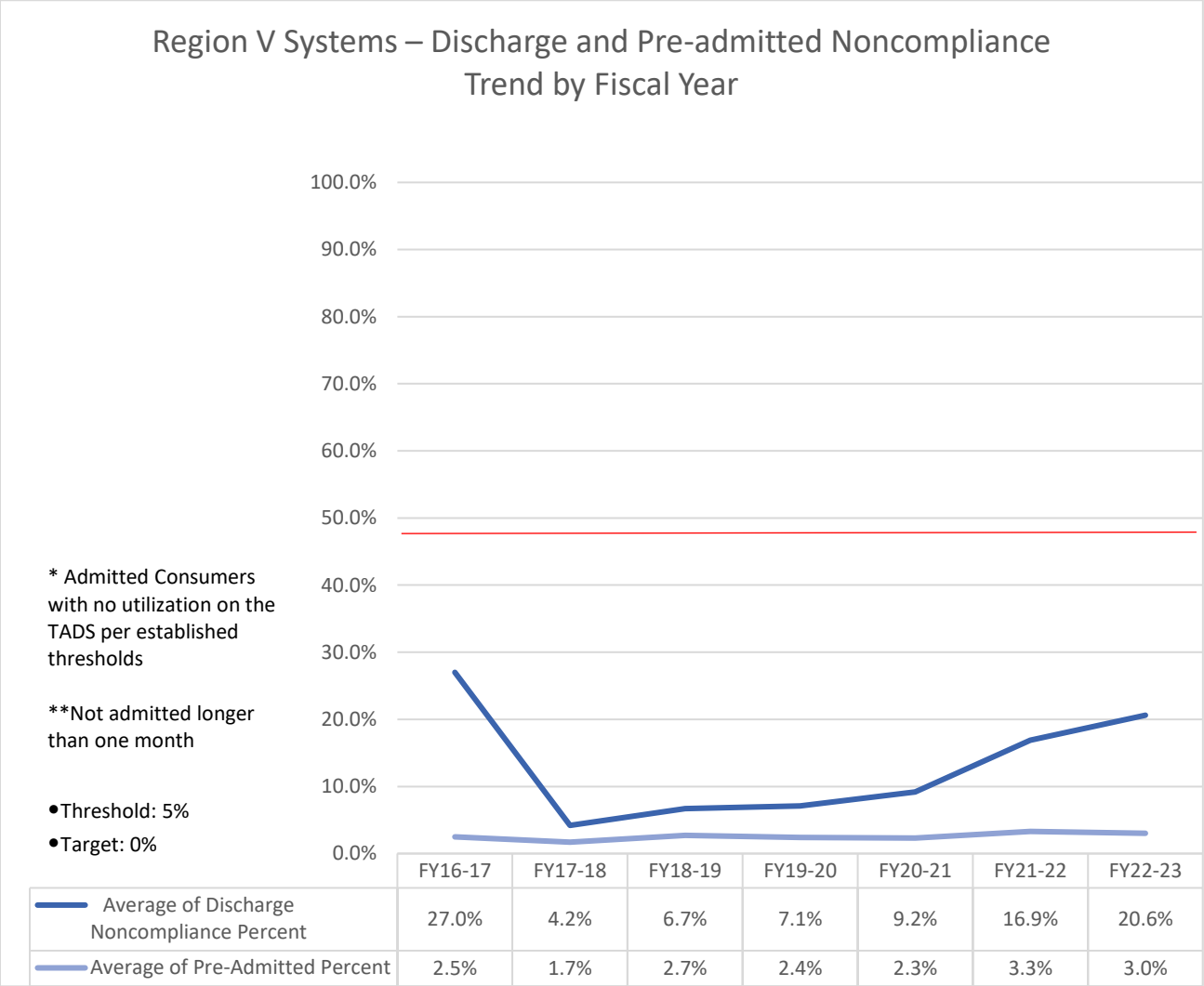
Data Management:

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 20.6% in Fiscal Year 2022-23. 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 3.0% for the time period of Fiscal Year 2022-2023.

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 20.6%.



	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FY22-23
Average of Discharge Noncompliance Percent	27.0%	4.2%	6.7%	7.1%	9.2%	16.9%	20.6%
Average of Pre-Admitted Percent	2.5%	1.7%	2.7%	2.4%	2.3%	3.3%	3.0%

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.

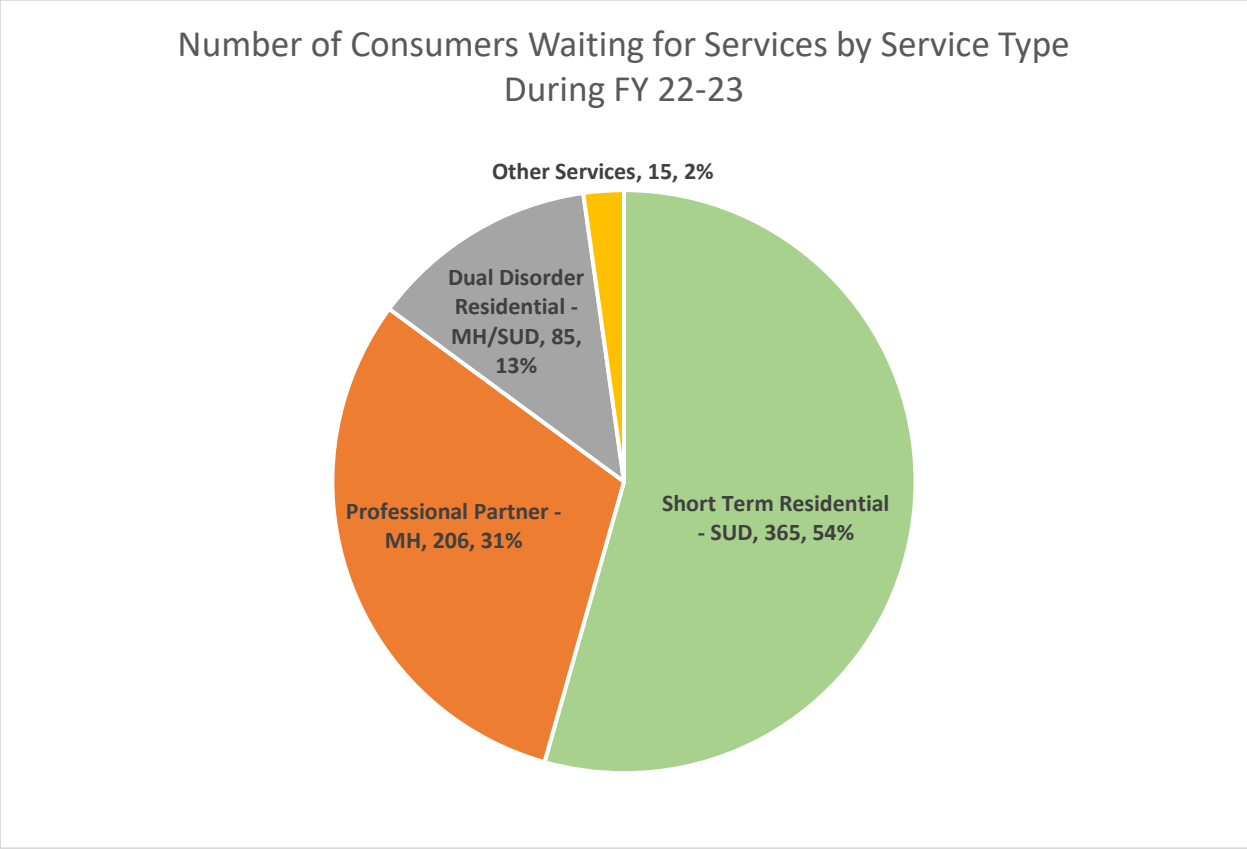
Starting in FY 17-18 information for persons served was entered into the Division of Behavioral Health's Central Data System (CDS). There was a learning curve by the Region and the network providers with utilizing this new system. New ways of entering data, managing the waitlist, and the regions approach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

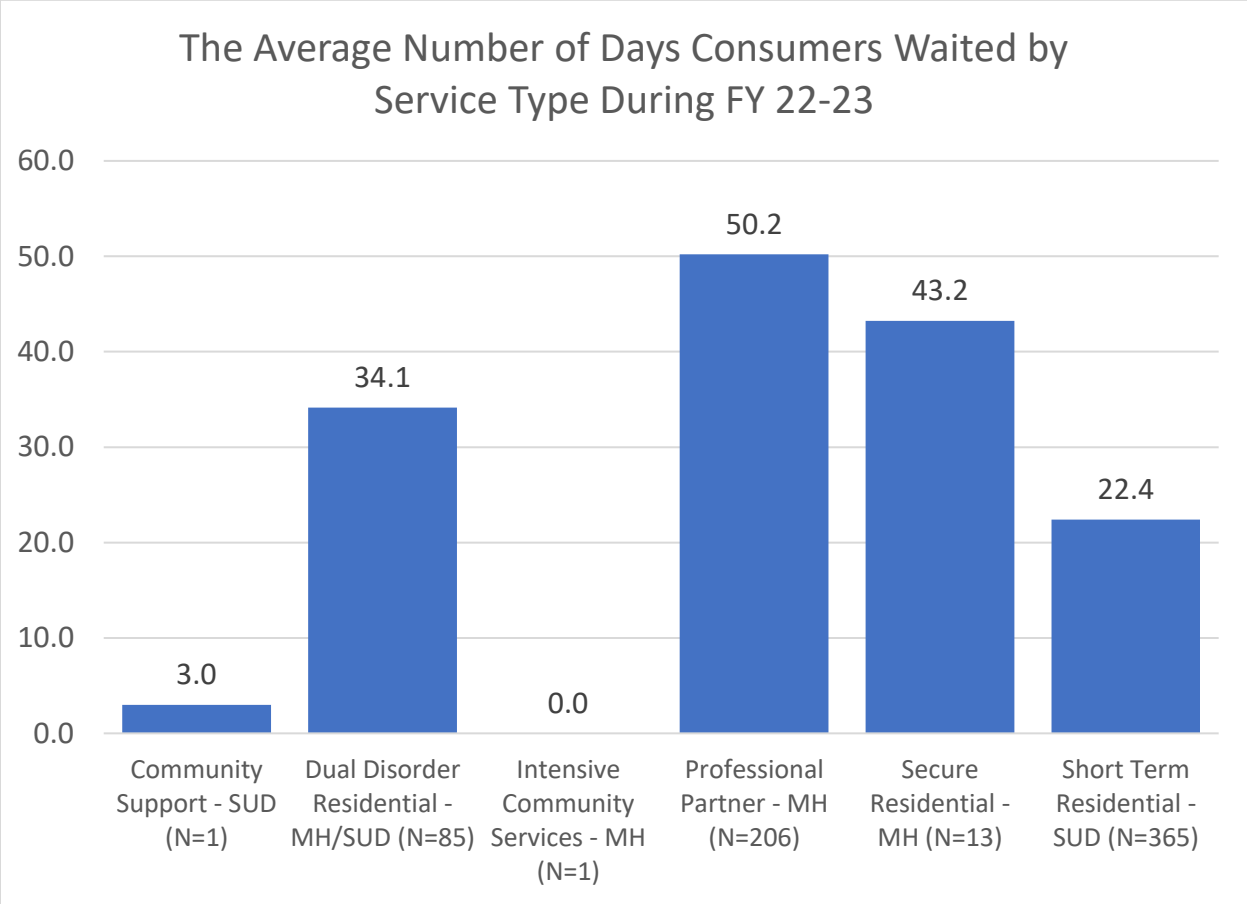
Mental Health Services	Substance Use Disorder Services
ACT (Assertive Community Treatment – MH)	Community Support – SUD
Community Support – MH	Dual Disorder Residential – SUD
Dual Disorder Residential – MH	Halfway House – SUD
Mental Health Respite – MH	IOP (Intensive Outpatient / Adult – SUD)
Professional 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 22-23.

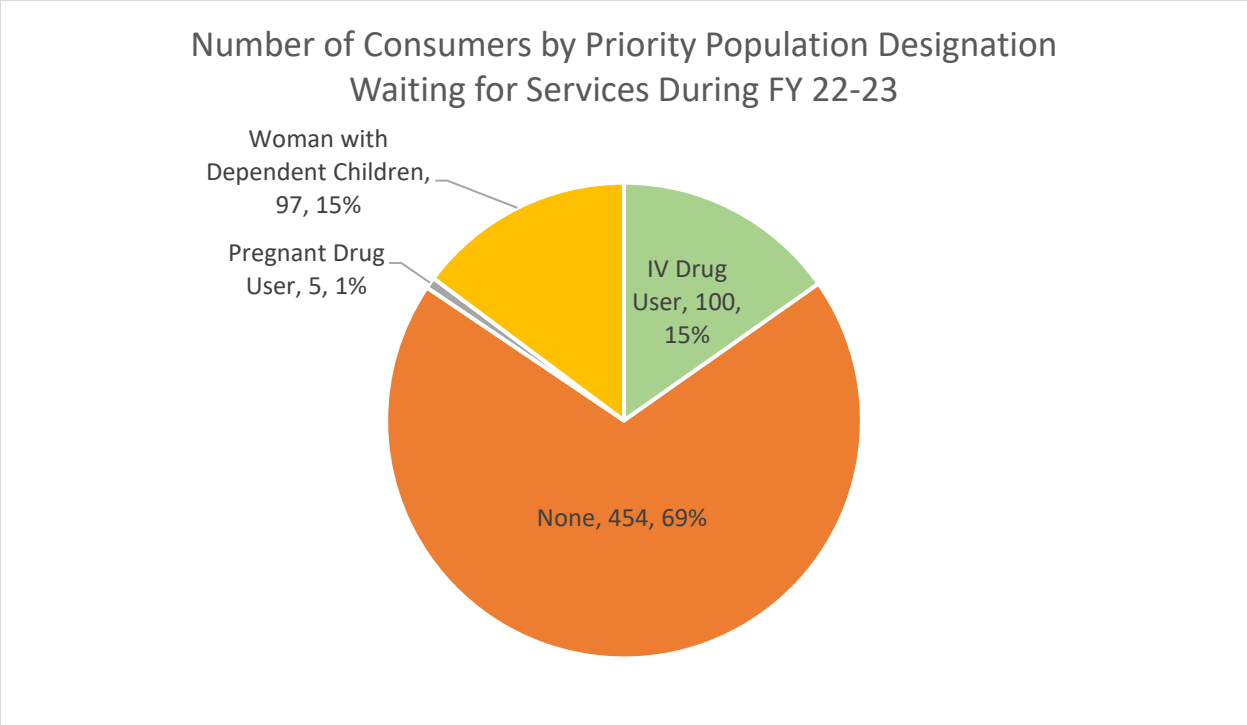


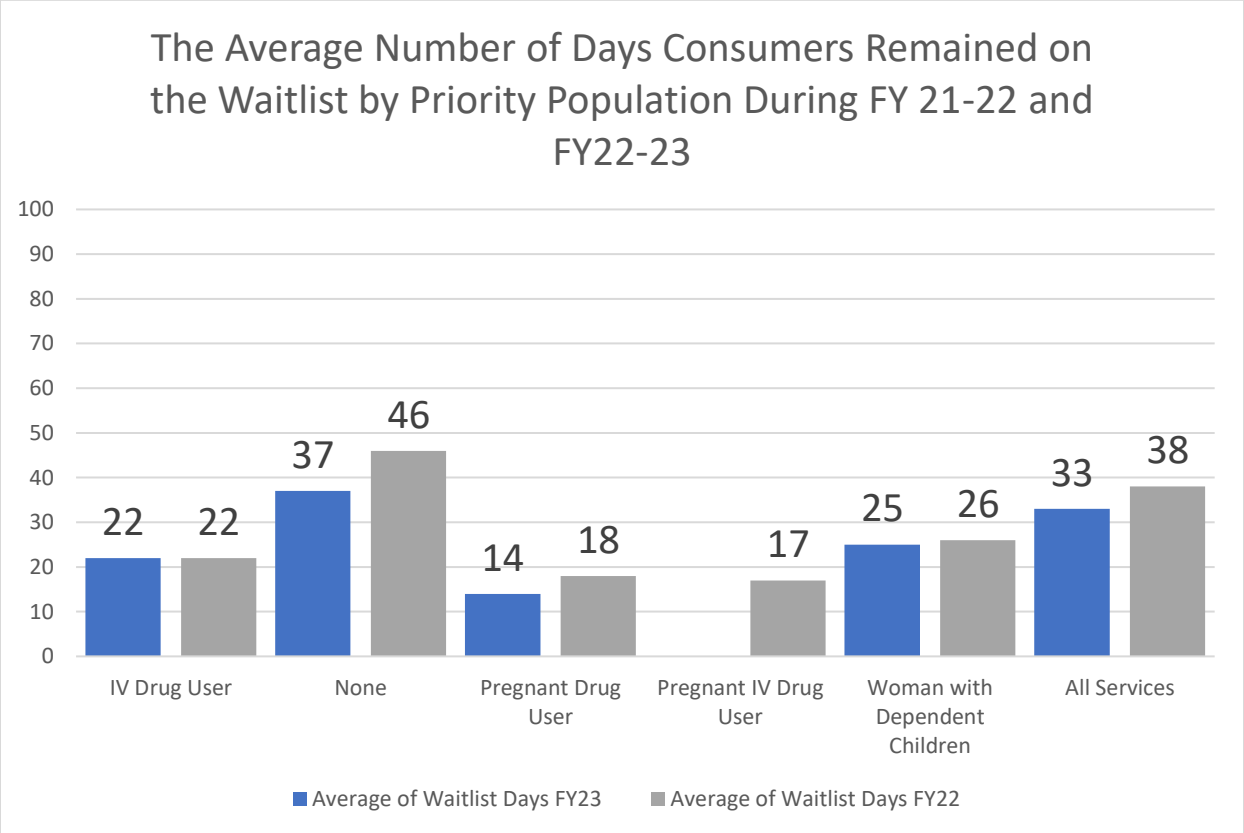
Below is a listing of substance abuse and mental health services available in the Region V Systems' network. This is a listing of the average number of days persons served remained on the waitlist until they were removed for various reason (entering treatment, unable able to be located, refused treatment,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

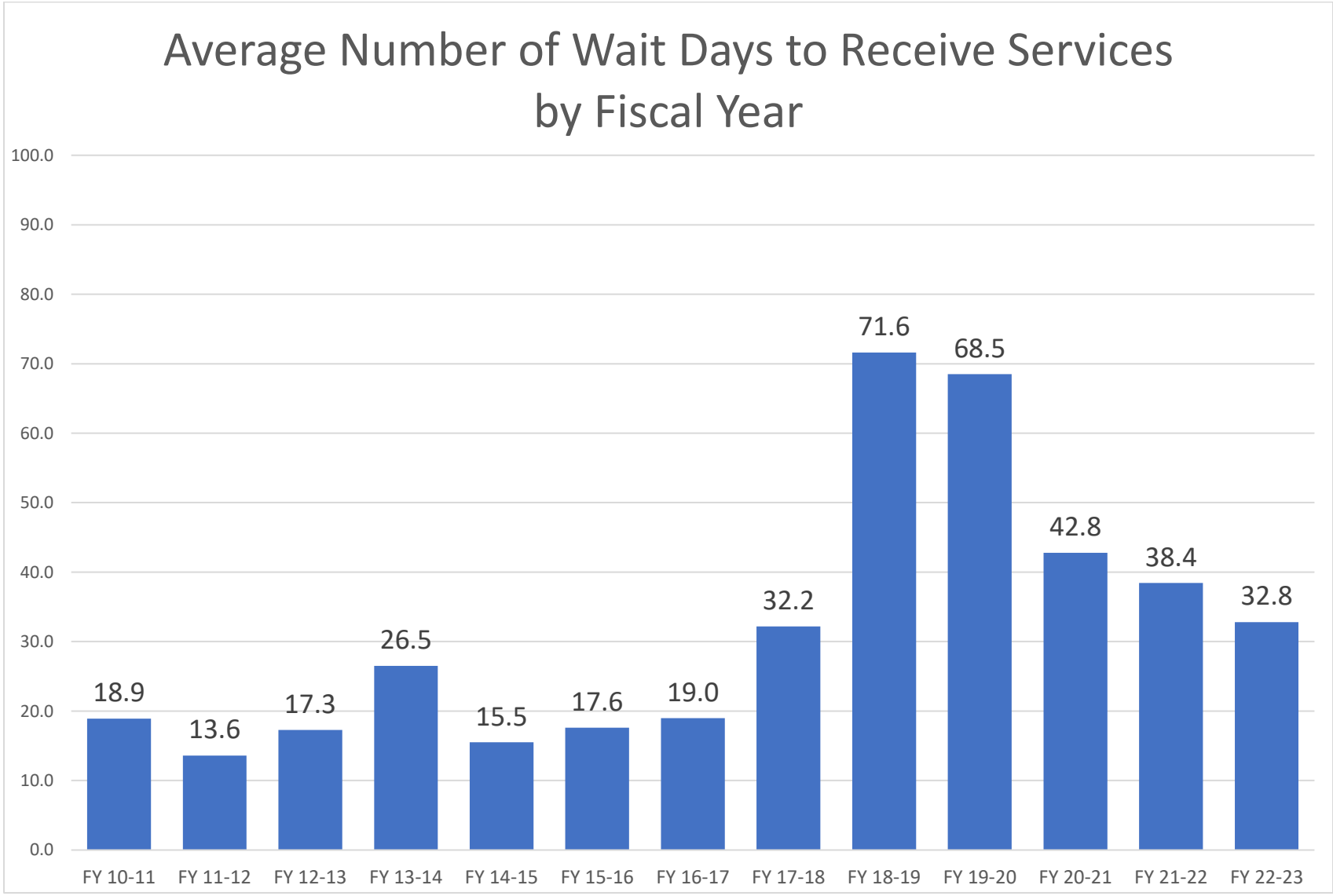


Entrance into substance abuse programs is determined by priority levels identified by the state and federal government. Persons served presenting with these problems take priority in entering treatment over others who do not present with these problems. IV drug users were the highest priority population identified at 15%.

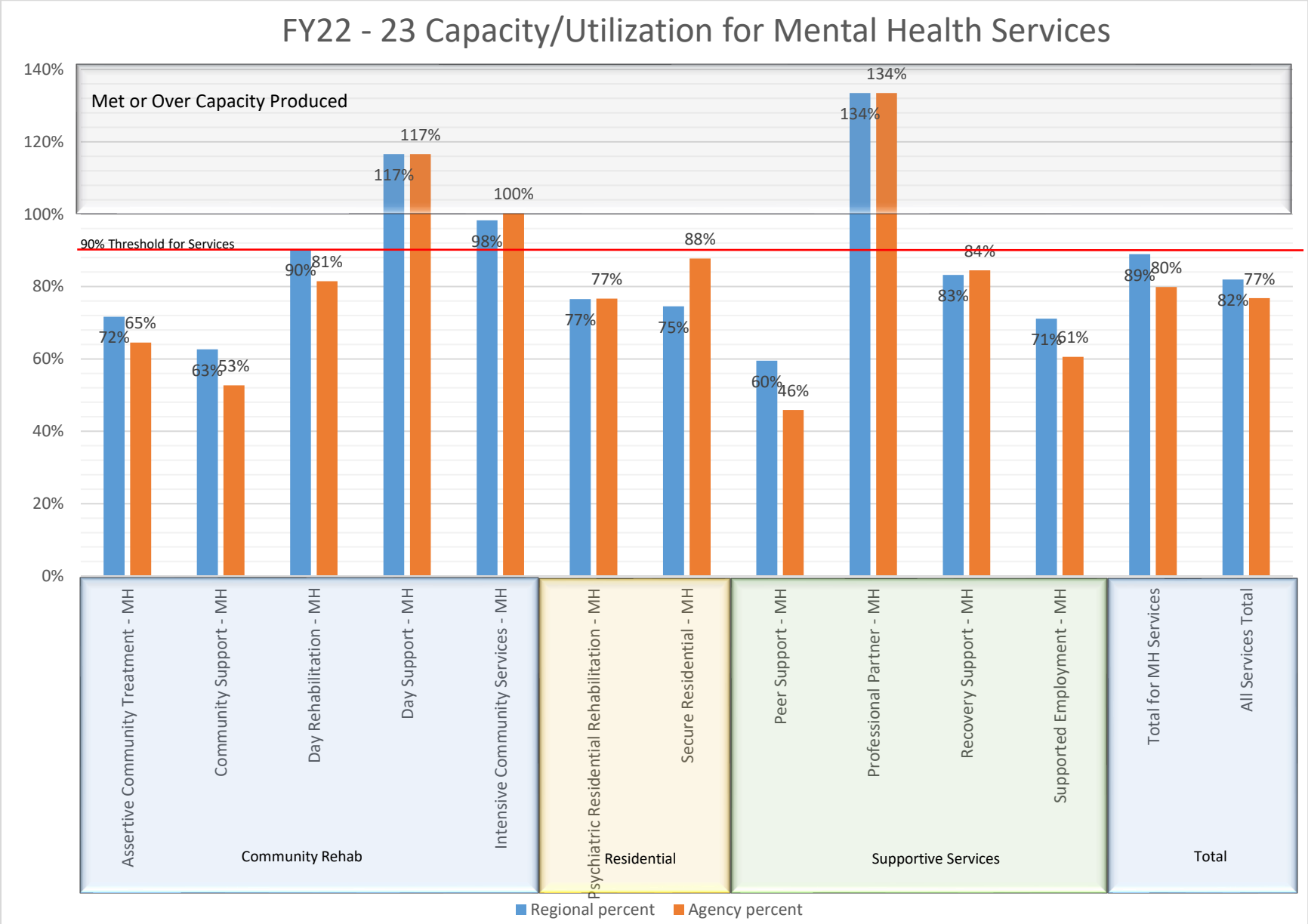


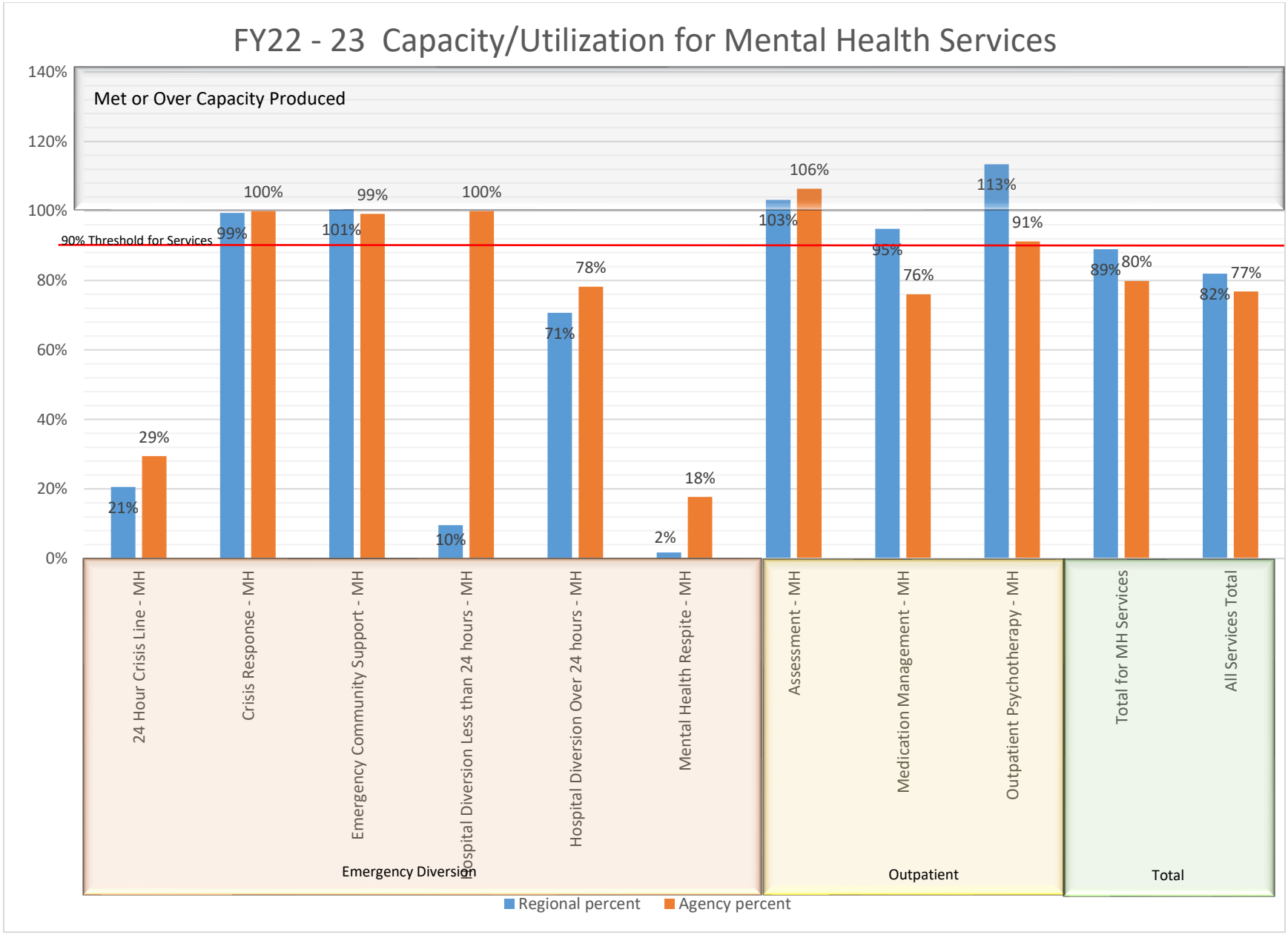


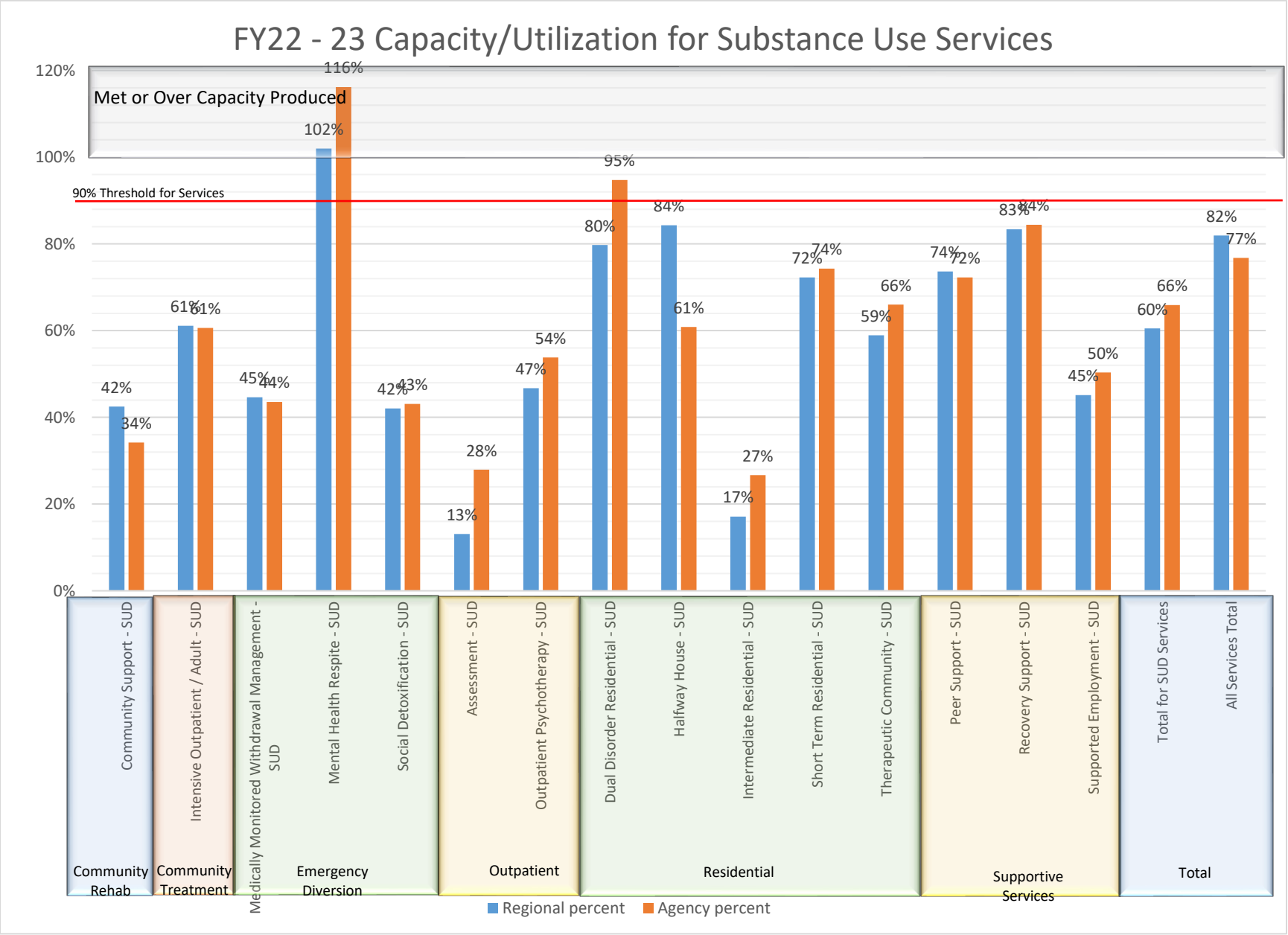
The graph below illustrates the average number of days people wait for all substance abuse services within the Region V Systems geographical area.



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 on services that did not meet capacity. The first two graphs are the Network Mental Health Capacity Report, and the third graph is the Substance Use Capacity Report.




FY22 - 23 Capacity/Utilization for Mental Health Services
Met or Over Capacity Produced
90% Threshold for Services
140%
120%
100%
80%
60%
40%
20%
0%
21%
29%
99%
100%
101%
99%
10%
100%
71%
78%
2%
18%
103%
106%
95%
76%
113%
91%
89%
80%
82%
77%
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
Assessment - MH
Medication Management - MH
Outpatient Psychotherapy - MH
Total for MH Services
All Services Total
Emergency Diversion
Outpatient
Total
Regional percent
Agency percent

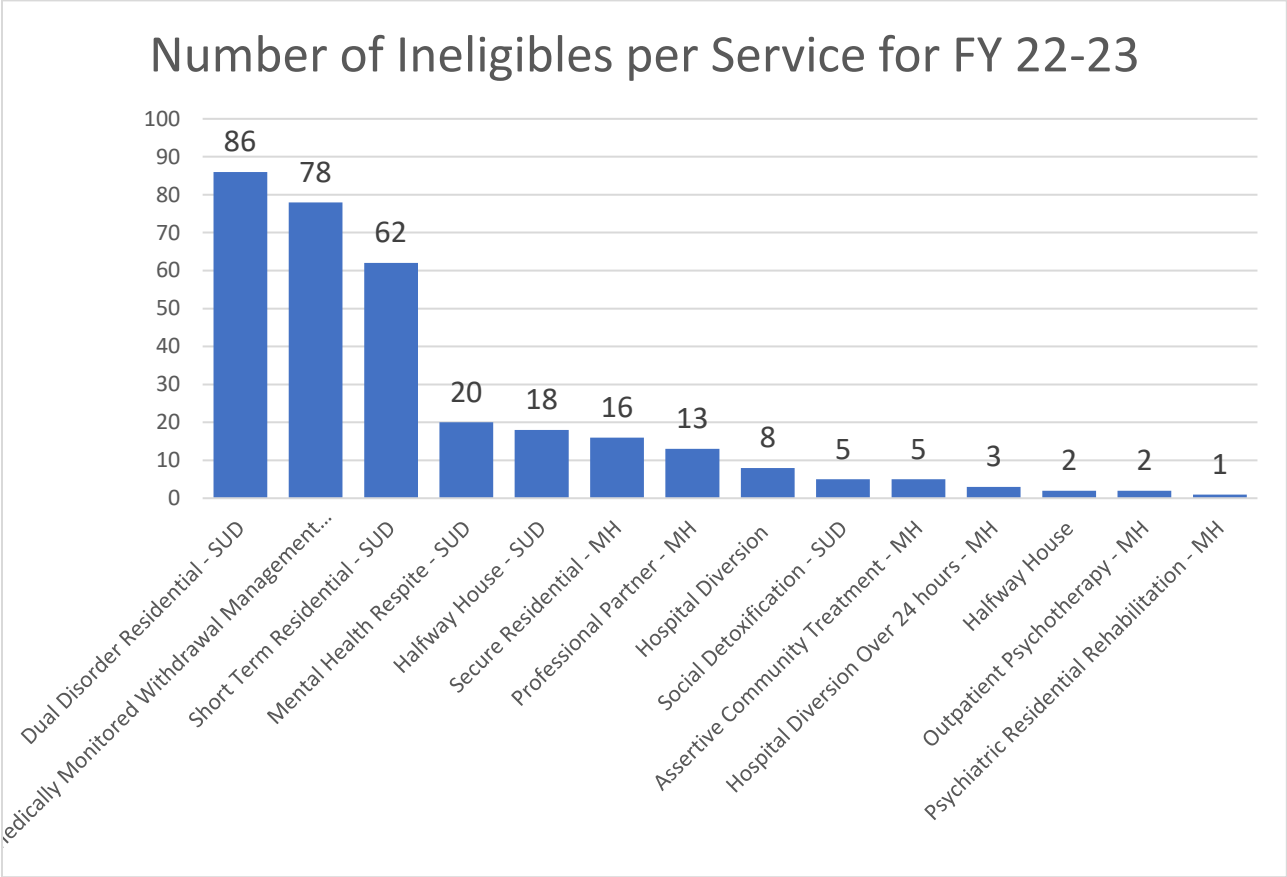

FY22 - 23 Capacity/Utilization for Substance Use Services
120%
100%
80%
60%
40%
20%
0%
Met or Over Capacity Produced
90% Threshold for Services
42%
34%
61%
61%
45%
44%
102%
116%
42%
43%
13%
28%
47%
54%
80%
95%
84%
61%
17%
27%
72%
74%
59%
66%
74%
72%
83%
84%
45%
50%
60%
66%
82%
77%
Community Support - SUD
Intensive Outpatient / Adult - SUD
Medically Monitored Withdrawal Management - SUD
Mental Health Respite - SUD
Social Detoxification - SUD
Assessment - SUD
Outpatient Psychotherapy - SUD
Dual Disorder Residential - SUD
Halfway House - SUD
Intermediate Residential - SUD
Short Term Residential - SUD
Therapeutic Community - SUD
Peer Support - SUD
Recovery Support - SUD
Supported Employment - SUD
Total for SUD Services
All Services Total
Community Rehab
Community Treatment
Emergency Diversion
Outpatient
Residential
Supportive Services
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.

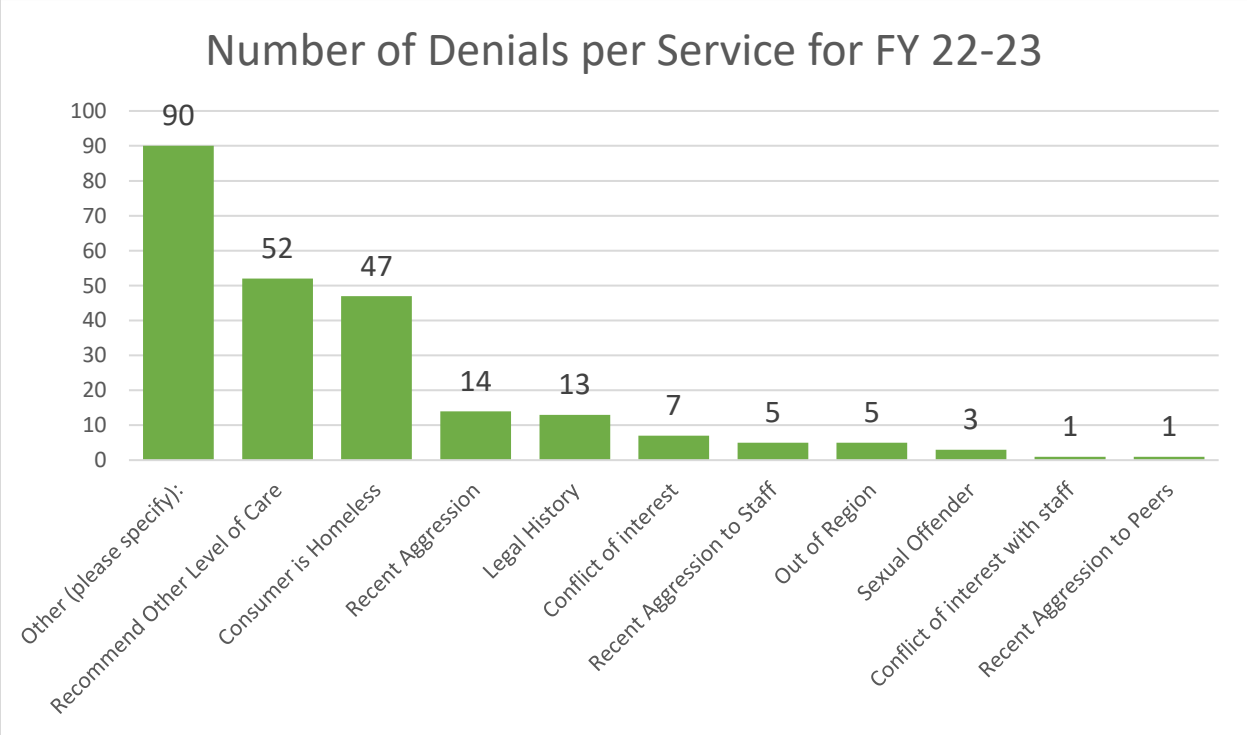
The first chart below identifies the number of people found to be ineligible for services during the FY 22-23 by service.



The following spreadsheet demonstrates the reasons a person served was found to be ineligible for a service type. Dual Disorder Residential and Medically Monitored Withdrawal Management accounted for the highest number of persons found to be ineligible. The majority of the ineligibles for these programs were related to persons served being medically unstable or not having the required functional deficits.

Reason for Ineligibility	Dual Disorder Residential	Medically Monitored Withdrawal Management	Short Term Residential	Mental Health Respite	Halfway House	Secure Residential	Professional Partner	Hospital Diversion	Assertive Community Treatment	Social Detoxification	Hospital Diversion Over 24 hours	Outpatient Psychotherapy	Psychiatric Residential Rehabilitation	Total	Total Percent
Doesn't have required functional deficits	74		3	4		3					1			85	27%
Doesn't meet date of last use criteria	4		12					2						18	6%
Doesn't meet frequency of use			10							2				12	4%
Doesn't meet other clinical criteria (please specify):	2		1				2	1				2		8	3%
Doesn't meet other admission criteria (please specify):	4	5	3		20	5	4	5	4		2		1	53	17%
Extensive MH, not managed/unstable		4	20	11		2			1	2				40	13%
Medically Unstable	1	68	6	5		1				1				82	26%
Referred by Non-Region V Funding		1	5			3	7							16	5%
Significant Cognitive Impairment	1		2			2								5	2%
Grand Total	**86**	**78**	**62**	**20**	**20**	**16**	**13**	**8**	**5**	**5**	**3**	**2**	**1**	**319**	**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 FY 22-23 by service.



The majority of the denials were from the category "Other". Not being able to serve people due to insufficient capacity accounted for 80% 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.

Denial Reason	Mental Health Respite - SUD	Short Term Residential - SUD	Hospital Diversion	Hospital Diversion Over 24 hours - MH	Dual Disorder Residential - SUD	Secure Residential - MH	Medically Monitored Withdrawal Management - SUD	Social Detoxification - SUD	Mental Health Respite - MH	Halfway House - SUD	Supported Employment - MH	Psychiatric Residential Rehabilitation - MH	Outpatient Psychotherapy - MH	Grand Total
Conflict of interest	1	3		1	1	1								7
Conflict of interest with staff		1												1
Consumer is Homeless			21	26										47
Legal History		13												13
Other (please specify):	42	4	16	10	1		7	3	4		2		1	90
Out of Region					3			1			1			5
Recent Aggression	7	1				4		2						14
Recent Aggression to Peers			1											1
Recent Aggression to Staff	3						1		1					5
Recommend Other Level of Care	1	22			13	11				3		2		52
Sexual Offender	1					1				1				3
Grand Total	**55**	**44**	**38**	**37**	**18**	**17**	**8**	**6**	**5**	**4**	**3**	**2**	**1**	**238**

Complaints and Appeals:

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

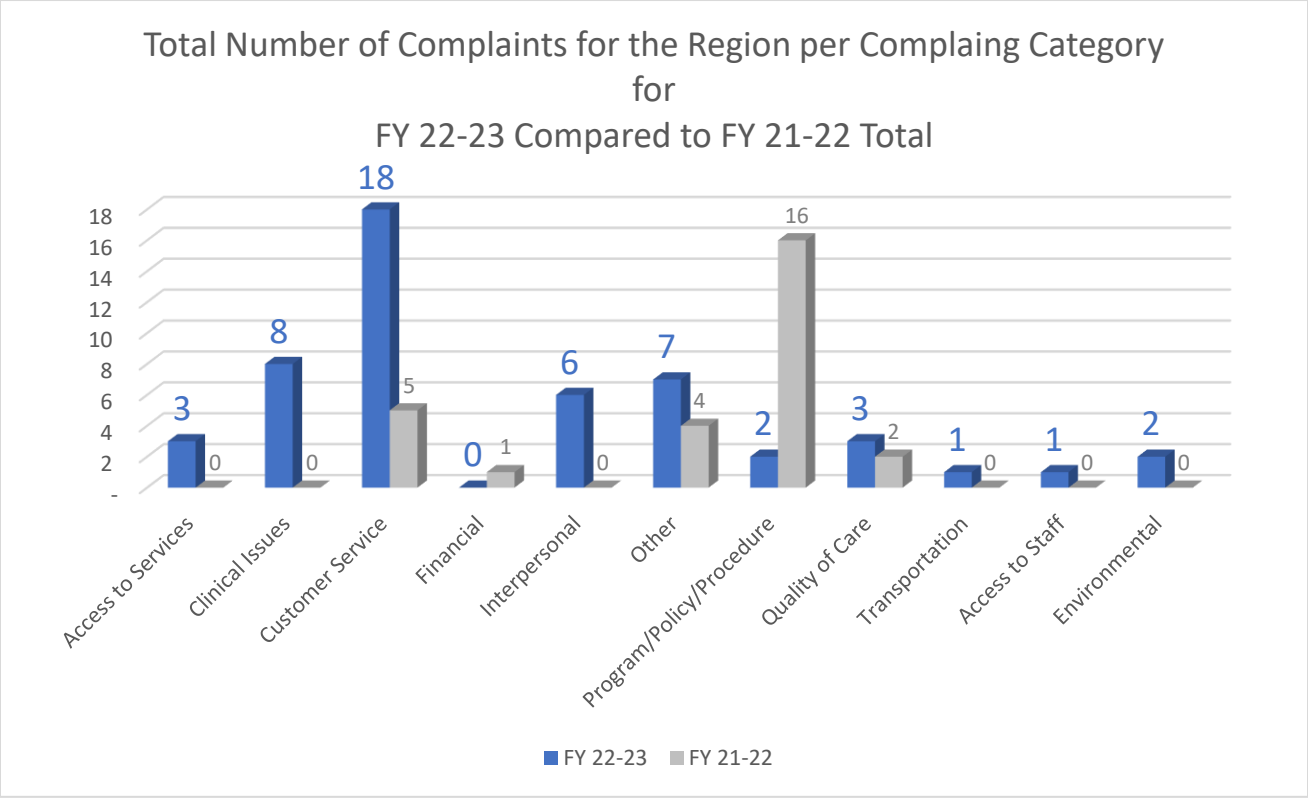
Complaints are defined as a formal written grievance by a person served to express dissatisfaction with any aspect of the operations, activities, or behavior of a Network Provider for which such grievance cannot be resolved at an informal level. Addressing such complaints will follow the Network Provider's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



One appeal was received in November 2022 related to a participant request to graduate treatment early. The participant was not granted the request.

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.

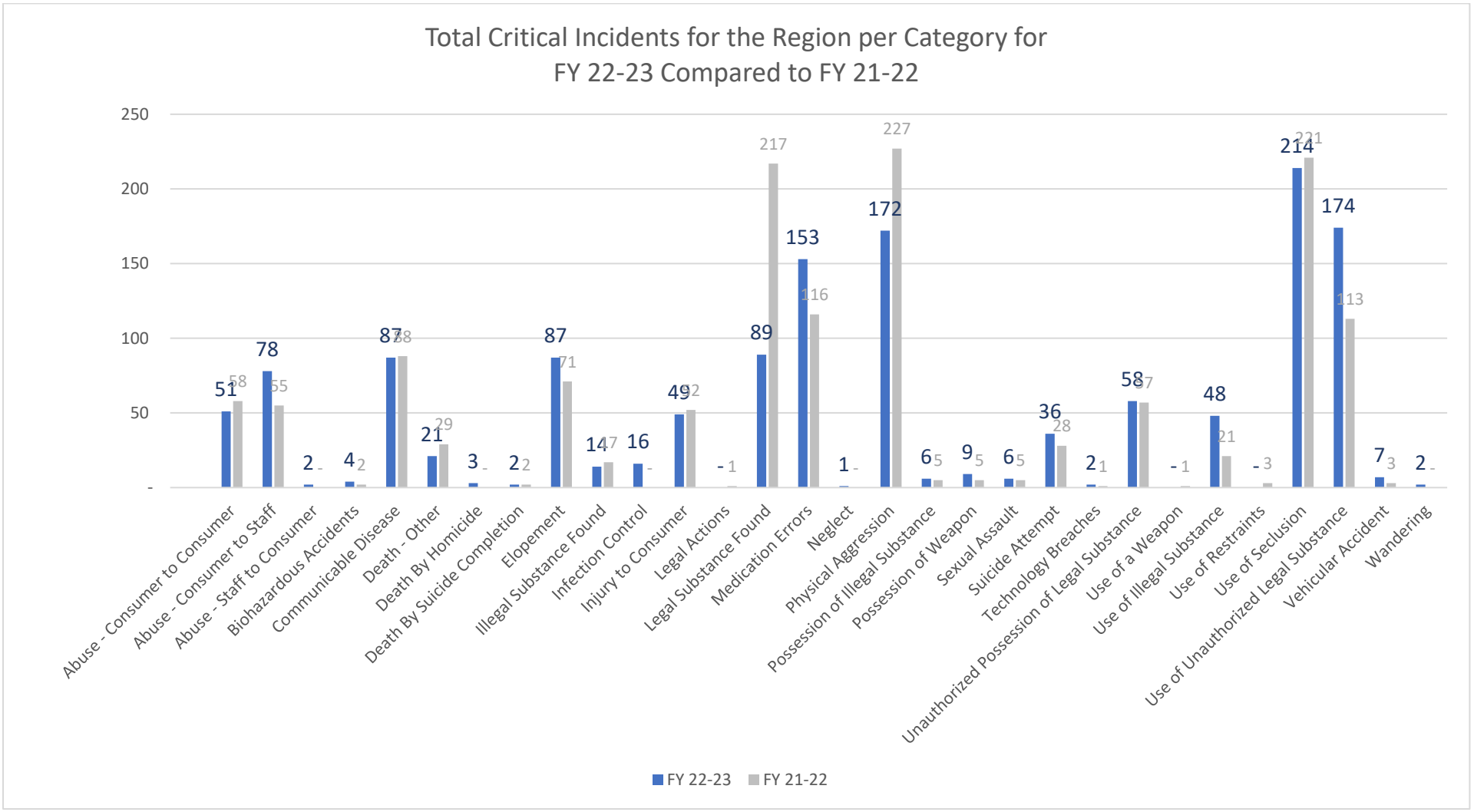
*Region V Systems considers these items to be critical incidents. The CARF standards manual does not list these as critical incidents in Section 1: Subsection H.9.f. categories for this report.

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 21-22 & FY 22-23.



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	FY 17-18	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	Total
Abuse/Aggression	Abuse - Consumer to Consumer	37	49	26	33	58	51	254
	Abuse - Consumer to Staff	55	45	24	42	55	78	299
	Abuse - Staff to Consumer						2	2
	Neglect		7				1	8
	Physical Aggression	163	165	154	168	227	172	1049
	Possession of Weapon	6	3	2	2	5	9	27
	Sexual Assault	4	5	1	3	5	6	24
	Use of a Weapon		1	1		1		3
Abuse/Aggression Total		**265**	**275**	**208**	**248**	**351**	**319**	**1666**
Death/Suicide	Death - Other	10	10	21	23	29	21	114
	Death By Homicide				1		3	4
	Death By Suicide Completion	2	2	3	3	2	2	14
	Suicide Attempt	13	5	12	15	28	36	109
Death/Suicide Total		**25**	**17**	**36**	**42**	**59**	**62**	**241**
Exiting Treatment	Elopement	123	128	108	45	71	87	562
	Wandering		1	3	1		2	7
Exiting Treatment Total		**123**	**129**	**111**	**46**	**71**	**89**	**569**
Health	Biohazardous Accidents	6	7	1	3	2	4	23
	Communicable Disease	13	3	18	53	88	87	262
	Infection Control	0	2	1	3		16	22
	Injury to Consumer	46	55	58	82	52	49	342
	Vehicular Accident	5	4	5	3	3	7	27
Health Total		**70**	**71**	**83**	**144**	**145**	**163**	**676**
Legal	Legal Actions	1	2	2		1		6
	Social Media		2	1	1			4
	Technology Breaches	7	4	3	1	1	2	18
Legal Total		**8**	**8**	**6**	**2**	**2**	**2**	**28**
Medication Errors	Medication Errors	130	69	153	134	116	153	755
Medication Errors Total		**130**	**69**	**153**	**134**	**116**	**153**	**755**
Restraints/Seclusions	Use of Restraints	10	3	3	2	3	0	21
	Use of Seclusion	175	187	166	164	221	214	1127
Restraints/Seclusions Total		**185**	**190**	**169**	**166**	**224**	**214**	**1148**
Substance Related	Illegal Substance Found	8	16	17	18	17	14	90
	Legal Substance Found	16	156	143	182	217	89	803
	Possession of Illegal Substance	6	11	7	11	5	6	46
	Unauthorized Possession of Legal Substance	35	46	224	185	57	58	605
	Use of Illegal Substance	25	25	33	33	21	48	185
	Use of Unauthorized Legal Substance	95	69	102	94	113	174	647
Substance Related Total		**185**	**323**	**526**	**523**	**430**	**389**	**2376**
Total		**991**	**1082**	**1292**	**1305**	**1398**	**1391**	**7459**

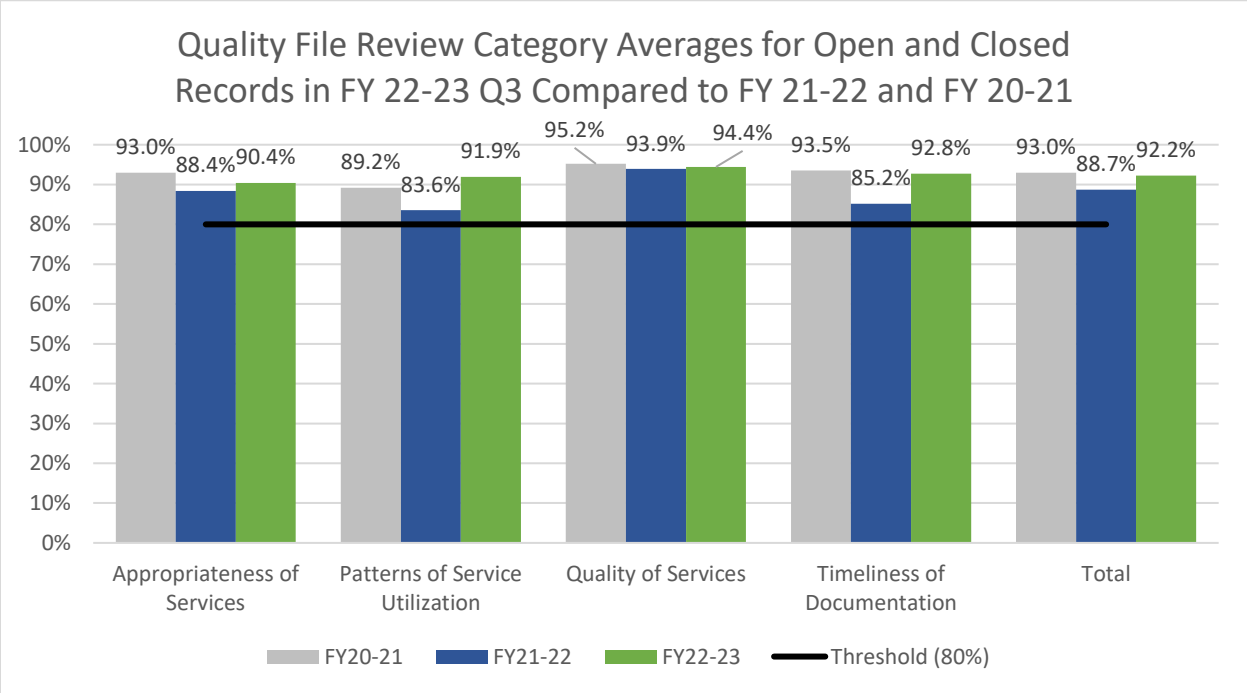
The following is a diagram used to help people served and providers understand the difference between incidents, critical incidents/events, deaths, and sentinel events.

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, 2022, through March 31, 2023, 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.



FY22-23 Q3 CARF Accreditation areas	Sum of Compliant File Observations (Numerator)	Sum of Possible File Observations (Denominator)	Average Percent Compliant
Appropriateness of Services	3,546	3,896	91.0%
Patterns of Service Utilization	1,462	1,555	94.0%
Quality of Services	2,582	2,722	94.9%
Timeliness of Documentation	639	692	92.3%
Grand Total	**8,29**	**8,865**	**92.8%**

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 22-23. There was a total of thirteen (13) concerns/requests submitted.

CQI Concerns Requests submitted by staff members:

Date Received	CQI Concern/Request	Recommendation/Action Taken
6/7/2023	Update Travel Policy to disburse stipend to staff ahead of travel to equal the maximum amount allowed for Meal and Incidental Expenses	Pending feasibility study
5/11/2023	Update Staff Development/Reservation Request form to streamline process and discontinue unnecessary questions	Approved for use beginning 9/20/23.
5/4/2023	Evaluate kitchen duty procedure to consider making changes that are in-line with modified/telework schedules (assigned days of week vs. whole week)	Retain current kitchen duty assignment process. Add recurring daily calendar invite for employees on their assigned week with information on tasks to be completed.
5/3/2023	Update FYI Release of Information form to simplify process and reflect current language/labels	Approved for use beginning 9/28/23.
4/3/2023	Hands-on CPR training	Employees should complete a *Staff Development Request* form if interested in attending a training outside the RVS required trainings
3/30/2023	Increase full-day retreat meal cap to $28 (from $25)	The retreat food limit will increase to $30 per person/per retreat, effective July 1. Annual department staff development budgets will not increase.

3/2/2023	Region V to design and purchase name badges with a magnetic backing for staff to utilize at functions in the community (e.g., lobby day, trainings, conferences).	Not approved due to associated cost. Employees can request a paper badge with plastic holder if desired for outside meetings.
2/24/2023	Post temporary banners on Region V's website recognizing various celebrations of diversity (e.g. Black History Month) & create an annual plan for diversity awareness postings on the intranet	Approved. The Diversity Team shall develop an annual plan for content to be placed on the Region V website and intranet and submit it to CCT for approval. The Social Media Team will decide where content will be placed on the website.
1/30/2023	Utilize CDS encounter number in place of FYI Eval Database number for tracking in Fidelity Electronic Health Record	Approved. The JJ/Probation generated (court case) number will be utilized for those not in CDS (non-DBH funded).
1/25/2023	Clean up clutter on main level hallway counter	Area was added to the current office storage assessment and planning
1/10/2023	Make FYI forms and accessibility survey available in languages other than English	Request forwarded to FYI Program Director and Supervisors for review and to consider options to meet the need
11/16/2022	Region V Systems website shares personnel information (emails, picture) and puts us at risk of spam, malicious emails that employees receive.	1) Pictures of employees will be removed. 2) Add landline phone number. 3) Restructure directory so personnel are organized by program/role
9/14/2022	Send reminder to all staff/building partners to clean up after selves in common areas (kitchen, bathroom, vehicles)	Approved. 1) Announcement at All Staff Meeting 2) Include in November's civility training. 3) Send email to building partners. 4) Post semi-annual reminder on ADP/Intranet

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.

Region V Systems
Continuous Quality Improvement Teams

Business Interruption	CARF Training	Contract	Corporate Citizenship	Diversity Awareness & Acceptance	Health & Safety	HR Supervisors	Information Technology Response
Kim Michael, Chair Tami DeShon Tyler Fernandez Therea Henning Jon Kruse Susan Lybarger Sandy Morrissey Shelly Noerrlinger Amanda Tyerman-Harper	**Kim Michael, Chair** Alicia Dreier Deanna Gregg Theresa Henning	**Theresa Henning, Chair** Tami DeShon Renee' Dozier Patrick Kreifels Susan Lybarger Sandy Morrissey Linda Pope Amanda Tyerman-Harper	**Jade Fowler, Chair** Alicia Dreier Pat Franks Deanna Gregg Scott Spencer	**Malcom Miles, Chair** Zina Crowder Kelly DuBray Munira Husovic Laila Khoudeida Kayla Lathrop Andrea Macias Sandy Morrissey Mariah Rivera	**Susan Lybarger, Chair** * Wendi Cohn Zina Crowder Teri Effle Wade Fruhling Jon Kruse Kim Michael Linda Pope Marti Rabe Cherie Teague	**Kim Michael, Chair** Danielle Belina Tami DeShon Dani DeVries Renee' Dozier Jade Fowler Annie Glenn Deanna Gregg Theresa Henning Patrick Kreifels Jon Kruse Malcom Miles Sandy Morrissey Erin Rourke Amanda Tyerman-Harper	**Jon Kruse, Chair** Donna Dekker Barb Forsman Wade Fruhling Joe Pastuszak Scott Spencer

Internship	Leadership	Move It / Fix It	Quality	Risk Management	Social Media	Training	Wellness
Kim Michael, Chair Alicia Dreier Kristin Nelson	**Patrick Kreifels, Chair** Deanna Gregg Theresa Henning Jon Kruse Kayla Lathrop Katiana MacNaughton Joe Pastuszak Jessica Zimmerman	**Jon Kruse, Chair** John Danforth Donna Dekker Wade Fruhling Linda Pope Marti Rabe	**Erin Rourke, Chair** Sue Brooks Sharon Dalrymple John Danforth Dani DeVries Renee' Dozier Kelly DuBray Tyler Fernandez Barb Forsman Jade Fowler Annie Glenn Munira Husovic Trina Janis Katiana MacNaughton Malcom Miles Lisa Moser Joe Pastuszak Linda Pope Jessica Zimmerman	**Kim Michael, Chair** Tami DeShon Dani DeVries Erin Rourke Cherie Teague Amanda Tyerman-Harper	**Wade Fruhling, Chair** Alicia Dreier Teri Effle Kayla Lathrop Andrea Macias Malcom Miles	**Theresa Henning, Chair** Danielle Belina Dani DeVries Alicia Dreier Teri Effle Trina Janis Kristin Nelson Shelly Noerrlinger	**Annie Glenn, Chair** Sharon Dalrymple Wade Fruhling Eden Houska Katiana MacNaughton Scott Spencer Connie Vissering Jessica Zimmerman

* MHA representative

J:/CQI Teams Chart 10-16-23

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

PROFESSIONAL PARTNER PROGRAM – FAMILY & YOUTH INVESTMENT – SECTION IV

Wraparound Fidelity Index-EZ:

Region 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.

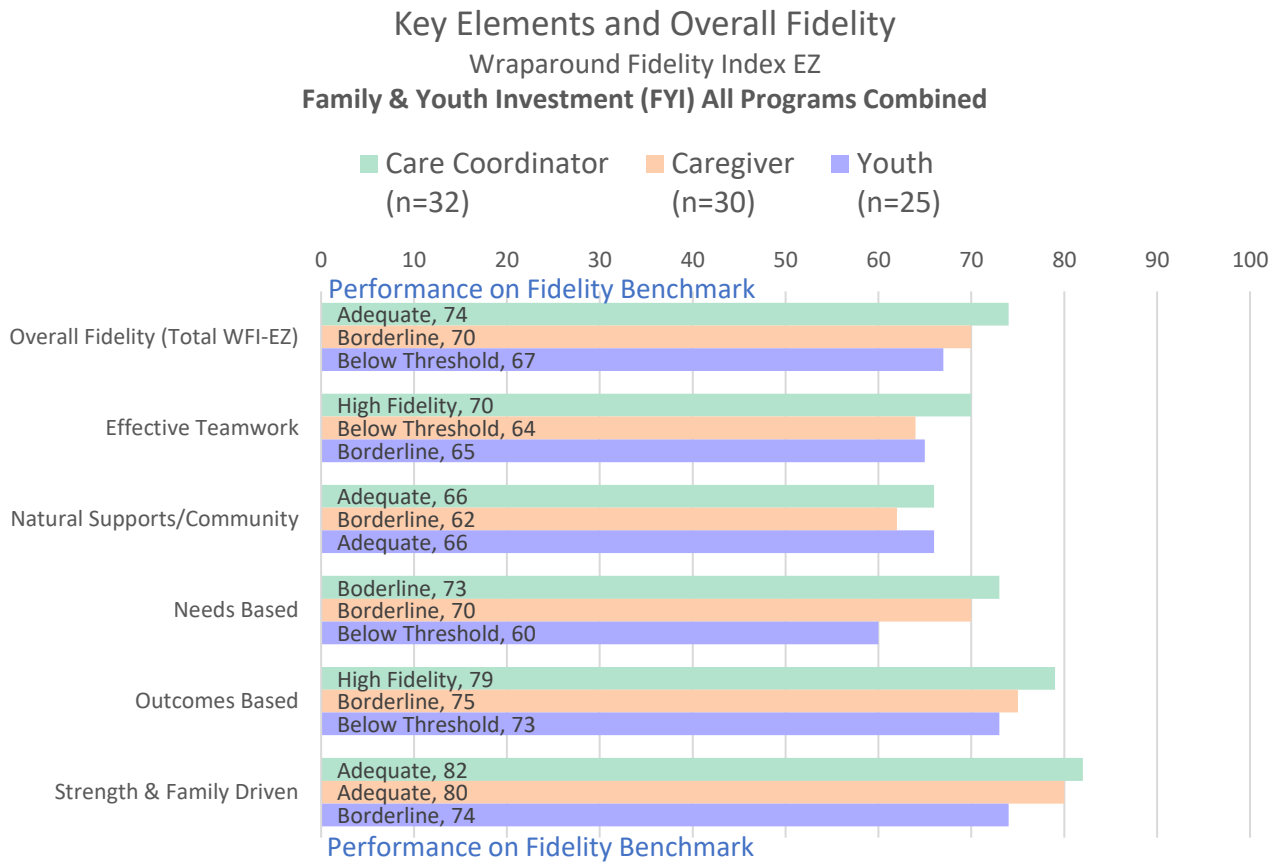
The following ten elements are evaluated:

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 2023. Responses were collected from 32 professional partners, 30 caregivers, and 25 youth.



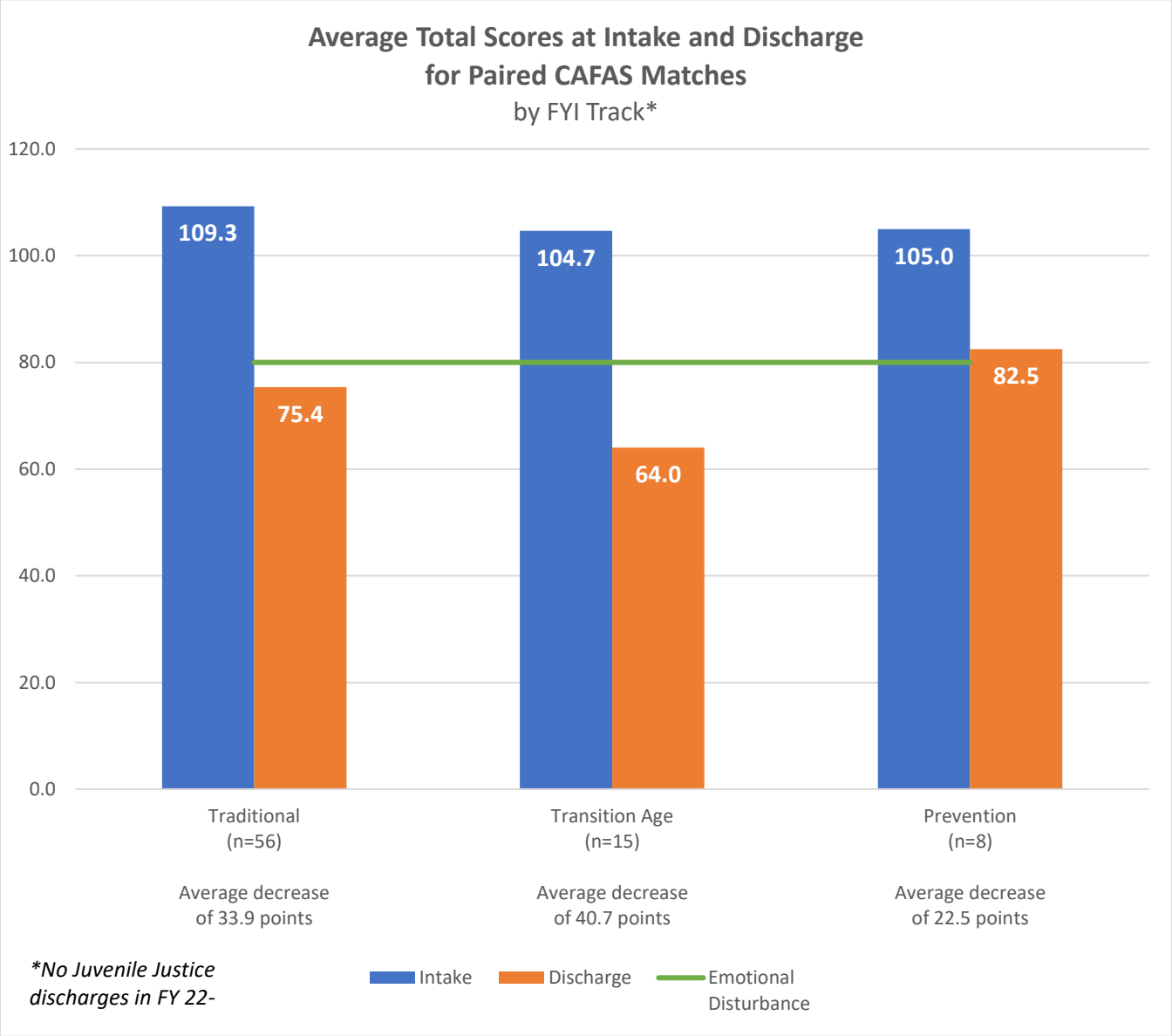
Child Adolescent Functional Assessment Scale (CAFAS):

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 22-23

RECORDS REVIEW		FY 21-22 Quarter 4	FY 22-23 Quarter 1	FY 22-23 Quarter 2	FY 22-23 Quarter 3	FY 22-23 Quarter 4
Open Records	Average completeness of All Items	92%	92%	96%	92%	93%
	General Information - 1	91%	95%	98%	88%	93%
	Team Planning - 2	95%	94%	100%	100%	96%
	FYI Clinical Supervision Notes - 3	90%	86%	95%	100%	94%
	Formal Services - 4	91%	91%	95%	87%	88%
	Evaluation Info - 5	95%	93%	98%	98%	93%
	Legal - 6	83%	77%	77%	77%	100%
	School - 7	83%	77%	77%	85%	90%
Closed Records	Average Completeness of All Items	95%	93%	96%	96%	93%
	General Information - 1	98%	96%	99%	98%	91%
	Team Planning - 2	98%	93%	96%	97%	91%
	FYI Clinical Supervision Notes - 3	90%	84%	92%	92%	90%
	Formal Services - 4	91%	94%	94%	92%	92%
	Evaluation Info - 5	95%	91%	97%	97%	96%
	Legal - 6	81%	78%	81%	71%	86%
	School - 7	85%	83%	81%	79%	93%
	Section Closed	95%	99%	99%	98%	96%
EHR REPORTS REVIEW						
Interpretive Summary		100%	94%*	92%	100%	90%
Initial POC		100%	100%	96%	88%	82%
Monthly POC Update		86%	90%	89%	94%	84%
BILLING AND CODING PRACTICES						
Team Meeting Documentation		100%	100%	100%	100%	80%
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 22-23. Areas that are below 80% required the program to complete a quality improvement action plan.

FY 22 - 23 Rental Assistance Program File Review					
Section		**FY 22-23 Quarter 1**	**FY 22-23 Quarter 2**	**FY 22-23 Quarter 3**	**FY 22-23 Quarter 4**
Open Records	**Total Completeness of All Items**	**90%**	**91%**	**90%**	**95%**
	Application/Eligibility	99%	100%	99%	98%
	Application Supporting Documentation	95%	95%	93%	98%
	Voucher Issuance	76%	96%	85%	91%
	Housed	96%	79%	89%	96%
	Annual Review	94%	100%	81%	86%
Closed Records	**Total Completeness of All Items**	**93%**	**94%**	**93%**	**98%**
	Application/Eligibility	99%	100%	100%	100%
	Application Supporting Documentation	94%	96%	96%	94%
	Voucher Issuance	92%	93%	88%	95%
	Housed	91%	91%	97%	99%
	Annual Review	68%	80%	94%	100%
	Discharge	87%	85%	65%	93%

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 22-23. Areas that are below 80% required the program to complete a quality improvement action plan.

FY 22-23 Permanent Housing File Review - PARTICIPANT					
Section		**FY 22-23 Quarter 1**	**FY 22-23 Quarter 2**	**FY 22-23 Quarter 3**	**FY 22-23 Quarter 4**
Open Records	**Total Completeness of All Items**	**94%**	**90%**	**91%**	**93%**
	Section 1 – Application and Annual Review	94%	92%	91%	92%
	Section 2 – Income and Sublease	100%	98%	92%	92%
	Section 4 – Persons Needs	94%	94%	84%	100%
	Section 5 – Releases of Information	93%	77%	95%	96%
Closed Records	**Total Completeness of All Items**	**91%**	**88%**	**90%**	**100%**
	Section 1 – Application and Annual Review	100%	94%	91%	100%
	Section 2 – Income and Sublease	100%	100%	100%	100%
	Section 4 – Persons Needs	100%	85%	60%	100%
	Section 5 – Releases of Information	50%	73%	100%	100%
	Discharge	75%	75%	75%	100%

FY 22-23 Permanent Housing File Review - PROPERTY				
Section	**FY 22-23 Quarter 1**	**FY 22-23 Quarter 2**	**FY 22-23 Quarter 3**	**FY 22-23 Quarter 4**
Total Completeness of All Files	**88%**	**88%**	**92%**	**90%**
Section 1 – Lease and Environmental Reviews	100%	91%	92%	92%
Section 2 – Sublease	100%	89%	100%	100%
Section 3 – Rent Reasonableness	86%	85%	82%	89%
Section 4 – Utility Allowance	80%	90%	86%	82%
Section 5 – Housing Quality Standard Inspections	90%	87%	100%	90%