REGION 5 SYSTEMS

Supporting Wellness and Recovery in Behavioral Health

SINCE 1974

Management Summary

FY26

DRAFT

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Published Date: **DRAFT**

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ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN (PIP) INDICATORS – SECTION I

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

Outcomes Region 5 Systems strives for include:

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

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

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

Component of PIP	Definition
Department, Program, CQI Team	Areas of Region 5 Systems that will be accountable and responsible for carrying out business activities and the PIP indicator.
Scope	Gives range/span to the PIP indicator, with a determination being made to achieve, avoid, eliminate, or preserve.
Organizational Risk Exposure	Illustrates if the PIP indicator is an area that could put Region 5 Systems in jeopardy if the threshold is not met.
Expectation	Helps anticipate what should be occurring regarding Region 5 Systems' business activities.
Quality Indicator	States what is being measured.
Threshold	Identifies a minimum or maximum limit in relationship to the expectation.
Measurement Type	Indicates 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, providing a value to compare Region 5 Systems' future quarterly performance.
Data Source	Indicates where the information gathered will come from.
Data Collector	The person responsible for gathering the information.
Frequency of Collection	How often information will be collected and reported.
Frequency of Comparison to Threshold by Program/Department	The identified regularity that programs or departments 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 FY26 indicators that have been reviewed by Region 5 Systems' departments, programs, Leadership Team, Corporate Compliance Team, and made available to all employees. Upon Leadership and Corporate Compliance Team's review, a decision point occurred by accepting the PIP as reported, giving other recommendations, approving, or asking for a quality improvement action plan. The spreadsheet is a breakdown of each indicator, a status of the year's review, and determination if the goal will continue within the FY27 PIP.

Indicator	FY26 Threshold	Review	FY27 PIP Status
CQI-1	Overall stakeholder satisfactory rate will be at 85% or above	Approved	Continue
FISC-1	95% of allocated State and Federal Block Grant funds will be utilized by the end of the fiscal year	Approved	Continue
FYI-1	70% of discharged youth's total CAFAS score will decrease by 20 points when comparing intake vs. discharge scores (All Tracks)	Approved	Modify
FYI-2	40% of youth with an admission score of 80 or more will leave the FYI program with a total CAFAS score below 80 (the required admission score). (All Tracks)	Approved	Modify
FYI-3	60% of youth with a 30-point (severe impairment) admission CAFAS score on any of the 8 domains will decrease to 20-point (moderate impairment), 10-point (mild/minimal impairment) when comparing admission to discharge CAFAS scores. (Must have a 30 in any domain at admission to be included in the sample). (All tracks)	Approved	Modify
FYI-4	75% of youth demonstrate improvement on one or more of the three outcome indicators. (All tracks)	Approved	Modify
FYI-5	85% of all teams will have at least one identified informal support on their team member list (utilize FYI statewide consensus of informal support definition; All Tracks)	Approved	Continue
FYI-6	70% of all teams with an informal support on their team member list will have at least one informal support on their team member list attend child/family monthly team meetings or participate in POC goals (utilizing FYI statewide consensus of informal support definition; All Tracks)	Approved	Continue
FYI-7	100% of FYI youth will be living in their home while served in the FYI program (if youth resides out of their home for less than two [2] consecutive weeks during the month, it will not be considered an out-of-home placement; All Tracks)	Approved	Continue
FYI-8	90% of families will have a team meeting every month (all FYI track participants)	Approved	Continue
FYI-9	30% of clients in the FYI program will reside in rural counties (Traditional track)	Approved	Continue
FYI-10	95% of the FYI Professional Partners' performance will be met on all of their gauges	Approved	Continue

(Cont.)

Indicator	FY26 Threshold	Review	FY27 PIP Status
FYI-11	50% of team meetings each month will have at least one formal support present	Approved	Modify
HOUS-1	70% (SUD/MH track combined) of RAP voucher participants (excluding one-time housing costs/flex fund recipients) will successfully discharge/bridge	Approved	Modify
HOUS-2	The average number of days people are on the waitlist will decrease by 10%. Priority 1 MH: 22 days or less. SUD: 15 days or less. Priority 2 MH: 78 days or less. SUD: 22 days or less.	Approved	Continue
HOUS-3	The RPH, LPH, and RTPH Programs will maintain housing units at no lower than 95% of program unit capacity/utilization (Threshold: RPH 30 Units; LPH 11 Units; RTPH 7 Units) (Capacity: RPH 32; LPH 12; RTPH 8)	Approved	Modify
HOUS-4	90% of program participants will remain housed or exit program successfully to other permanent housing (annual measurement)	Approved	Continue
HOUS-5	Less than 10% of program participants will return to unhoused status within 6 months of program enrollment	Approved	Continue
HOUS-6	Less than 15% of program participants will return to unhoused status within 12 months of program enrollment	Approved	Continue
HOUS-7	The average length of time (days) from program enrollment to housing move-in date will be 60-days or less	Approved	Continue
HOUS-8	80% of gauges met per program and housing specialist	Approved	Continue
HOUS-9	100% of funds will be utilized (RAP)	Approved	Continue
NETW-1	100% of Network Providers will receive a copy of their agency's site visit report as prepared by Region 5 Systems' Network Administration within forty-five (45) business days of completion of the site visit	Approved	Continue
NETW-2	Exit conferences will be completed with 100% of Network Providers at completion of each agency/program site visit	Approved	Continue
OPS.HR-1	100% of all employees shall have a documented, signed semi-annual performance evaluation	Approved	Continue
OPS.HR-2	100% of all employees shall have a documented, signed annual performance evaluation	Approved	Continue
OPS.HR-3	100% of drills completed per established schedule	Approved	Modify
OPS.HR-4	100% of building occupants will be accurately documented on the pegboard during health and safety drills	Approved	Discontinue

(Cont.)

Indicator	FY26 Threshold	Review	FY27 PIP Status
PREV-1	100% of organized county community prevention coalitions (16) in southeast Nebraska will participate in substance use annual assessments and quarterly BH5 reporting, NPIRS (Nebraska Prevention Information Resource System).	Approved	Modify
PREV-2	Increase the number of visits to the www.talkheart2heart.com website above the baseline (Users: Repeat: 3,471, Unique 1,942) by June 30, 2026	Approved	Modify
PREV-3	100% of all counties will have a local LOSS team serving their area	Approved	Continue
PREV-4	85% of counties (16) in southeast Nebraska will be engaged in an active community prevention coalition by the end of the fiscal year.	Approved	Modify
PREV-5	75% of the counties (16) are represented on YAB membership	Approved	Continue
PREV-6	100% of counties (16) will report on deaths identified and documented as suicide	Approved	Modify
PREV-7	100% of all schools receiving Federal Block Grant dollars will utilize an evidence-based program	Approved	Discontinue
SPEC.PROJ-1	100% of Region 5 Systems' employees complete required trainings according to assigned deadline	Approved	Continue
SPEC.PROJ-2	Community trainings sponsored by Region 5 Systems will result in an overall satisfactory rate of 85% or above	Approved	Continue
SPEC.PROJ-3	Required internal employee training offered by external speakers will result in an overall satisfactory rate of 85% or above.	Approved	Continue
SPEC.PROJ-4	80% of approved evidence-based programs will complete all model fidelity and outcomes reporting requirements to maintain evidence-based practice delivery at the end of the fiscal year.	Approved	Continue
SPEC.PROJ-5	80% of grant awardees will submit outcomes as outlined in their contract each quarter	Approved	Modify
SPEC.PROJ-6	24% (6 priority areas) of priority abatement strategies will be funded through grants or obvious expenditures each fiscal year	Approved	Discontinue
SPEC.PROJ-7	100% of funding received from LB1355 in FY 25-26 will be awarded/obligated to address the opioid epidemic within Region 5 Systems' catchment area	Approved	Modify
SPEC.PROJ-8	Region 5 Systems will audit 100% of agencies/entities identified as needed an audit annually. (Opioid funding)	Approved	Modify

The second part of this section is a summary of Performance Indicators for FY26. The indicators are sorted by department/program: Continuous Quality Improvement, Family & Youth Investment, Housing, Network, Operations/Human Resources, Prevention, and Special Projects.

Continuous Quality Improvement:

CQI-1:	Stakeholder surveys						
Threshold:	Overall stakeholder satisfactory rate will be at 85% or above.						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
90%	85%	87%	N/A	N/A	85%	N/A	85%

Fiscal:

FISC-1:	Utilization of State and Federal Block Grant allocated funds in fiscal year						
Threshold:	95% of allocated State and Federal Block Grant funds will be utilized by the end of the fiscal year						
Standard	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
100%	95%	New in 25-26	25%	51%	76%	98%	98%

Family & Youth Investment:

FYI-1:	Aggregated Average Child Adolescent Functioning Assessment Scale (CAFAS).						
Threshold:	70% of discharged youth's total CAFAS score will decrease by 20 points when comparing intake vs. discharge scores (All Tracks).						
Standard 100%	Threshold 70%	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
All FYI		68%	65%	61%	56%	55%	55%
Traditional		64%	68%	59%	56%	51%	51%
Transition		86%	60%	65%	65%	73%	73%
Prevention		77%	50%	50%	33%	29%	29%

FYI-2:	Aggregated average Child Adolescent Functioning Assessment Scale (CAFAS).						
Threshold:	40% of youth with an admission score of 80 or more will leave the FYI program with a total CAFAS score below 80 (the required admission score). (All Tracks).						
Standard 100%	Threshold 40%	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
All FYI		62%	60%	50%	54%	53%	53%
Traditional		50%	67%	58%	57%	52%	52%
Transition		100%	50%	53%	55%	62%	62%
Prevention		100%	N/A	50%	33%	29%	29%

Family & Youth Investment (cont.):

FYI-3:	Individual Youth Aggregated Average Child Adolescent Functioning Assessment Scale (CAFAS) scores.
Threshold:	60% of youth with a 30-point (severe impairment) admission CAFAS score on any of the 8 domains will decrease to 20-point (moderate impairment), 10-point (mild/minimal impairment) when comparing admission to discharge CAFAS scores. (Must have a 30 in any domain at admission to be included in the sample). (All tracks).

Standard 100%	Threshold 60%	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
All FYI		73%	52%	46%	39%	42%	42%
Traditional		63%	59%	47%	38%	39%	39%
Transition Age		100%	38%	43%	41%	52%	52%
Prevention		100%	50%	50%	33%	29%	29%

FYI-4:	The three outcome indicators for the FYI program using the Child Adolescent Functioning Assessment Scale (CAFAS). (1) Change 20 points of total score; 2) Decrease severe impairment (30) of any domain; and 3) Decrease total CAFAS score below 80 points).
Threshold:	75% of youth demonstrate improvement on one or more of the three outcome indicators. (All tracks).

Standard 100%	Threshold 75%	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
All FYI		73%	68%	63%	59%	58%	58%
Traditional		65%	74%	63%	59%	56%	56%
Transition		100%	60%	65%	65%	73%	73%
Prevention		100%	50%	50%	33%	29%	29%

FYI-5:	Documentation of informal supports on wraparound teams.
Threshold:	85% of all teams will have at least one identified informal support on their team member list (utilize FYI statewide consensus of informal support definition; All Tracks).
Standard:	100% (Looking at plans and teams in the 2003 wraparound study - 60% of teams had no informal resources; 32% had one; 8% had two or more.)

	Threshold 85%	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
All FYI		85%	82%	89%	82%	94%	87%
Traditional		82%	81%	88%	80%	95%	86%
Transition		94%	89%	90%	91%	93%	91%
Prevention		88%	73%	100%	85%	88%	87%

Family & Youth Investment (cont.):

FYI-6:	Documentation of informal supports attending child/family monthly team meetings or participating in POC goals.
Threshold:	70% of all teams with an informal support on their team member list will have at least one informal support on their team member list attend child/family monthly team meetings or participate in POC goals (utilizing FYI statewide consensus of informal support definition; All Tracks).
Standard	100% (Looking at plans and teams in the 2003 wraparound study - 60% of teams had no informal resources; 32% had one; 8% had two or more.)

	Threshold 70%	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
All FYI		76%	66%	81%	62%	62%	68%
Traditional		73%	69%	83%	65%	65%	71%
Transition		86%	63%	79%	52%	50%	61%
Prevention		71%	38%	60%	55%	53%	52%

FYI-7:	Place of residence.
Threshold:	100% of FYI youth will be living in their home while served in the FYI program (if youth resides out of their home for less than two [2] consecutive weeks during the month, it will not be considered an out-of-home placement; All Tracks).

Standard 100%	Threshold 100%	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
All FYI		100%	99%	100%	100%	100%	100%
Traditional		100%	99%	100%	99%	100%	100%
Transition		100%	100%	100%	100%	100%	100%
Prevention		97%	97%	100%	100%	100%	99%

FYI-8:	Team meeting summary.
Threshold:	90% of families will have a team meeting every month (all FYI track participants).

Standard 100%	Threshold 90%	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
All FYI		94%	93%	94%	93%	92%	93%
Traditional		92%	94%	94%	93%	93%	94%
Transition		96%	90%	96%	94%	87%	92%
Prevention		98%	97%	93%	89%	87%	92%

FYI-9:	County of residence at monthly review.
Threshold:	30% of clients in the FYI program will reside in rural counties (Traditional track).

Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
30%	30%	36%	34%	34%	34%	34%	34%

Family & Youth Investment (cont.):

FYI-10:	Professional Partners performance gauges.						
Threshold:	95% of the FYI Professional Partners' performance will be met on all of their gauges.						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	95%	98%	100%	100%	99%	98%	99%

FYI-11:	Monthly Documentation Review						
Threshold:	50% of team meetings each month will have at least one formal support present.						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
75%	50%	30%	27%	31%	29%	25%	28%

Housing:

HOUS-1:	Persons served within the Rental Assistance Program (RAP) will experience a successful discharge (bridge to Section 8 or other housing, bridge to self-sufficiency or self-terminate assistance).
Threshold:	70% (SUD/MH track combined) of RAP voucher participants (excluding one-time housing costs/flex fund recipients) will successfully discharge/bridge.

Standard 100%	Threshold 70%	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
Combined		44%	67%	46%	52%	70%	59%
Mental Health		43%	71%	39%	60%	68%	60%
Substance Use Disorder		56%	40%	67%	20%	100%	57%

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

Standard: 14 days MH 60 days SUD	Threshold	FY25 Total	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
Priority 1 MH	22 days	3 Days	41 days	103 days	1 days	0 days	36 days
Priority 1 SUD	15 days	4 Days	N/A	N/A	99 days	0 days	50 days
Priority 2 MH	78 days	86 Days	112 days	146 days	246 days	164 days	167 days
Priority 2 SUD	22 days	81 Days	75 days	86 days	62 days	217 days	110 days

Housing (cont.):

HOUS-3:	Rural (RPH), Lincoln (LPH), and Rural Transition-age (RTPH) Permanent Housing Units
Threshold:	The RPH, LPH, and RTPH Programs will maintain housing units at no lower than 95% of program unit capacity/utilization (Threshold: RPH 30 Units; LPH 11 Units; RTPH 7 Units. Capacity: RPH 32; LPH 12; RTPH 8. LPH capacity change to 22 in Q3)

Standard 100%		Threshold	FY 24-25 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
Capacity	Overall	95%	83%	92%	99%	97%	90%	95%
	LPH	30	74%	86%	98%	96%	97%	94%
	RPH	22	95%	100%	100%	100%	77%	94%
	RTPH	7	74%	100%	100%	100%	100%	100%
Utilization	Overall			91%	94%	94%	87%	92%
	LPH			88%	90%	93%	91%	91%
	RPH			92%	100%	92%	73%	89%
	RTPH			100%	100%	100%	100%	100%

HOUS-4:	Persons within Permanent Housing will remain housed (within Region 5 Systems Permanent Housing or by discharging to other permanent housing.
Threshold:	90% of program participants will remain housed or exit program successfully to other permanent housing (annual measurement).

Standard 90%	Threshold 90%	FY 24-25 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
Overall		90%	100%	96%	95%	97%	97%
RPH		97%	100%	97%	100%	100%	99%
LPH		93%	100%	93%	88%	94%	94%
RTPH		88%	100%	100%	87%	89%	94%

HOUS-5:	Persons served by Permanent Housing will remain housed during the first 6 months of enrollment.
Threshold:	Less than 10% of program participants will return to unhoused status within 6 months of program enrollment.

Standard 10%	Threshold 10%	FY 24-25 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26
Overall		1%	0%	4%	4%	2%	3%
RPH		0%	0%	3%	0%	0%	1%
LPH		0%	0%	7%	15%	8%	8%
RTPH		0%	0%	0%	0%	0%	0%

HOUS-6:	Persons served by Permanent Housing will remain housed during the first 12 months of enrollment.
Threshold:	Less than 15% of program participants will return to unhoused status within 12 months of program enrollment.

Standard 15%	Threshold 15%	FY 24-25 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
Overall		4%	0%	0%	0%	0%	0%
RPH		2%	0%	0%	0%	0%	0%
LPH		0%	0%	0%	0%	0%	0%
RTPH		19%	0%	0%	0%	0%	0%

Housing (cont.):

HOUS-7:	Number of days between program enrollment and housing move-in date.
Threshold:	The average length of time (days) from program enrollment to housing move-in date will be 60-days or less.

Standard Less than 60 days	Threshold 60	FY 24-25 Average	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
Overall		18 Days	11 days	20 days	13 days	13 days	14 days
RPH		6 Days	16 days	18 days	16 days	14 days	16 days
LPH		4 Days	5 days	5 days	4 days	4 days	5 days
RTPH		27 Days	N/A	N/A	N/A	31	10 days

HOUS-8:	Performance gauges fully met by each Housing Specialist monthly
Threshold:	80% of gauges met per program and housing specialist

Standard 100%	Threshold 80%	FY 24-25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
Overall		New in FY26	74%	58%	69%	76%	69%
RPH			74%	52%	62%	69%	64%
LPH			80%	75%	82%	81%	80%
RTPH			67%	50%	69%	91%	69%
RAP			N/A	N/A	82%	75%	79%

HOUS-9:	Utilizing all allocated Housing Coordination Funds by June 30, 2026.
Threshold:	100% of Funds will be utilized.

Standard	Threshold	FY 24-25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
100%	100%	New in FY26	22%	45%	66%	100%	100%

Network:

NETW-1:	Time between completion of site visit and distribution of site visit report.
Threshold:	100% of Network Providers will receive a copy of their agency's site visit report as prepared by Region 5 Systems' Network Administration within forty-five (45) business days of completion of the site visit.

Standard	Threshold	FY 24-25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	100%	N/A	N/A	100%	100%	100%

NETW-2:	Number of site visit exit conferences.
Threshold:	Exit conferences will be completed with 100% of Network Providers at completion of each agency/program site visit.

Standard	Threshold	FY 24-25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	100%	N/A	100%	100%	100%	100%

Operations / Human Resources:

OPS.HR-1:	Completed semi-annual performance evaluations are submitted to HR by the 5th business day following the performance evaluation deadline (completed evaluation = conducted by the established deadline, documented on the correct form; password-protected and saved on the Y-Drive, hard copy signed by the employee and supervisor, and submitted to HR by the 5th business day following the performance evaluation deadline).
Threshold:	100% of all employees shall have a documented, signed semi-annual performance evaluation.

Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	88%	100%	100%	100%	100%	100%

OPS.HR-2:	Completed annual performance evaluations are submitted to HR by the required deadline (completed evaluation = conducted by the established deadline, documented on the correct form; password-protected and saved on the Y Drive, hard copy signed by the employee and supervisor, and submitted to HR by the performance evaluation deadline.
Threshold:	100% of all employees shall have a documented, signed annual performance evaluation.

Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	88%	100%	78%	100%	100%	95%

OPS.HR-3:	Completion of drills according to established schedule.
Threshold:	100% of drills completed per established schedule.

Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	100%	100%	100%	100%	100%	100%

OPS.HR-4:	Building occupants are accurately documented during health & safety drills, including pegboard status and visitor sign in, per standard procedures.
Threshold:	100% of building occupants will be accurately documented on the pegboard during health and safety drills.

Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	98%	100%	96%	98%	100%	99%

Prevention:

PREV-1:	Substance abuse annual assessments & quarterly BH5 Reporting, NPIRS Reporting.
Threshold:	100% of organized county community prevention coalitions (16) in southeast Nebraska will participate in substance use annual assessments and quarterly BH5 reporting, NPIRS (Nebraska Prevention Information Resource System).

Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
100%	100%	100%	100%	100%	100%	100%	100%

Prevention (cont.):

PREV-2:	Number of visits to the website							
Threshold:	Maintain the number of visits to the www.talkheart2heart.com website above the baseline (Users: Repeat: 3,471, Unique 1,942) by June 30, 2026.							
Website Users	Standard (*Above baseline numbers)*	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
Repeat	3,471	3471	15,594	19,055	17,825	14,000	10,684	10,684
Unique User Avg	1,942	1942	8,553	10,452	11,924	13,000	7,667	7,667

PREV-3:	LOSS Teams in Region 5 service area						
Threshold:	100% of all counties will have a local LOSS team serving their area.						
Standard	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
100%	100%	100%	100%	100%	100%	100%	100%

PREV-4:	Active community prevention coalitions throughout southeast Nebraska						
Threshold:	85% of counties (16) in southeast Nebraska will be engaged in an active community prevention coalition by the end of the fiscal year.						
Standard	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
100%	85%	100%	100%	100%	100%	100%	100%

PREV-5:	YAB youth representation						
Threshold:	75% of the counties (16) are represented on YAB membership						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	75%	69%	63%	63%	69%	69%	66%

PREV-6:	Reporting on deaths by suicide						
Threshold:	100% of counties (16) will report on deaths identified and documented as suicide						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	0%	0%	6%	44%	38%	22%

PREV-7:	School based Evidence Based Practices						
Threshold:	100% of all schools receiving Federal Block Grant dollars will utilize an evidence-based program						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	100%	100%	100%	100%	100%	100%	100%

Special Projects:

SPEC.PROJ-1:	Completion of CARF & Region 5 Systems required trainings.						
Threshold:	100% of Region 5 Systems' employees complete required trainings according to assigned deadline.						
Standard	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
100%	100%	100%	11%	33%	69%	100%	100%

SPEC.PROJ-2:	Training evaluations.						
Threshold:	Community trainings sponsored by Region 5 Systems will result in an overall satisfactory rate of 85% or above.						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
90%	85%	93%	93%	96%	94%	93%	94%

SPEC.PROJ-3:	Training evaluations.						
Threshold:	Required internal employee training offered by external speakers will result in an overall satisfactory rate of 85% or above.						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
90%	85%	New in FY 25-26	89%	100%	99%	95%	96%

SPEC.PROJ-4:	Adherence to fidelity and outcomes reporting required in maintaining evidence-based program delivery.						
Threshold:	80% of approved evidence-based programs will complete all model fidelity and outcomes reporting requirements to maintain evidence-based practice delivery at the end of the fiscal year. (Example of reporting: In Quarter 3, 80% (8/10) of approved programs, per evidence-based practice, completed requirements)						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	80%	88%	100%	60%	80%	80%	80%

SPEC.PROJ-5:	Adherence to Opioid Settlement grant and obvious expenditure outcome reporting as outlined in contracts.						
Threshold:	80% of grant and obvious expenditure awardees will submit outcomes as outlined in their contract each quarter.						
Standard	Threshold	FY25 Avg	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Average)
100%	80%	100%	50%	100%	94%	94%	85%

Special Projects (cont.):

SPEC.PROJ-6:	Region 5 Systems' Opioid Settlement funds will fund a minimum of six identified abatement strategies through grant awards and obvious expenditures.
Threshold:	24% (6 priority areas) of priority abatement strategies will be funded through grants or obvious expenditures each fiscal year. (Example of reporting: As of June 30, 2025, 6 unique priority abatement strategies have been funded this fiscal year through grants or obvious expenditures representing 12 different projects. 24% (6/25) of priority abatement strategies have been funded to-date.)

Standard	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
N/A	24%	38%	28%	52%	52%	58%	58%

SPEC.PROJ-7:	Funding received from LB 1355 in each fiscal year will be fully allocated each fiscal year to address the opioid epidemic within Region 5 Systems' catchment area.
Threshold:	100% of funding received from LB 1355 in FY 25-26 will be awarded/obligated to address the opioid epidemic within Region 5 Systems' catchment area.

Standard	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
N/A	100%	100%	100%	100%	100%	100%	100%

SPEC.PROJ-8:	Region 5 Systems will audit all funding awarded to Oxford houses and BayMark Health Services (BAART) during FY 25-26 to monitor for adherence to guidelines and contract deliverables.
Threshold:	Region 5 Systems will audit 100% of agencies/entities identified as needing an audit annually.

Standard	Threshold	FY25 Achieved	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY26 (Achieved)
N/A	100%	New in FY 25-26	4%	4%	100%	100%	100%

NETWORK SERVICES – SECTION II

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

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

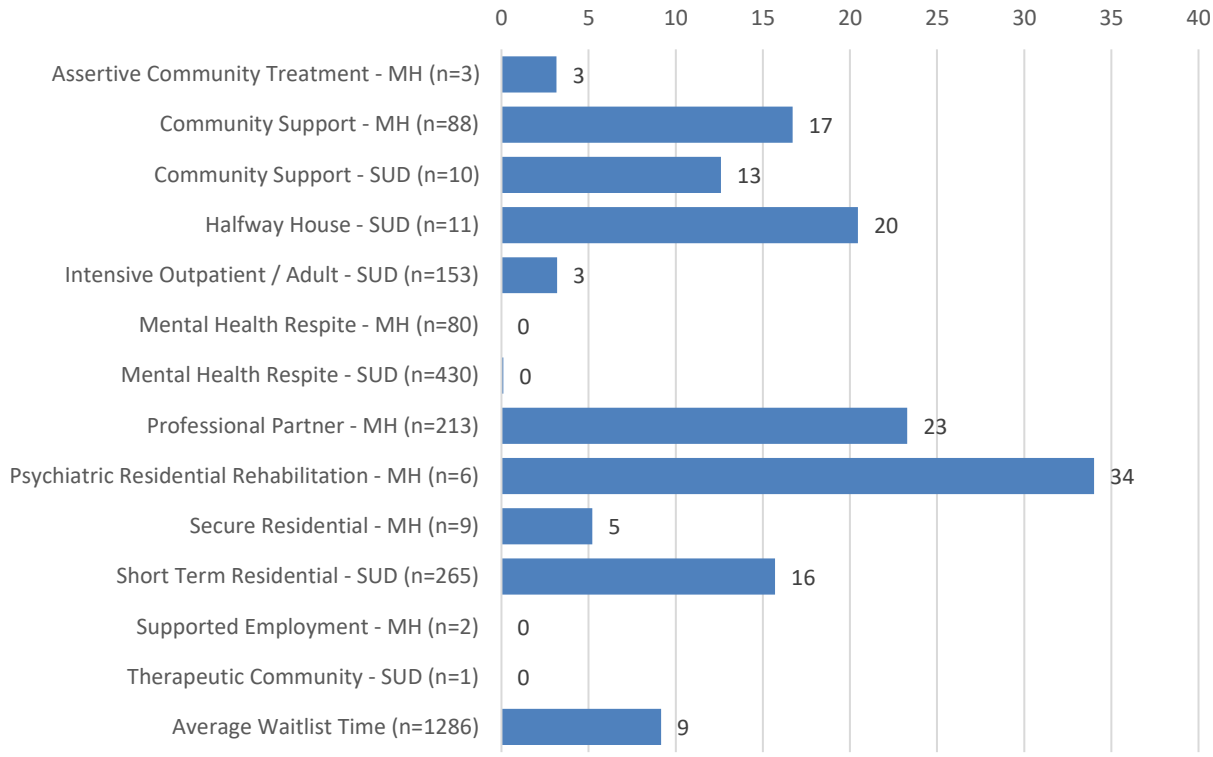
Waitlist and Capacity for Mental Health/Substance Use Disorder Services
Region 5 Systems collects information from Network Providers on the number of "Persons Served with Life Experiences" who are waiting to enter various levels of substance use and mental health care. Monitoring the waitlist helps determine access to treatment, ensures compliance with state and federal requirements for placing priority populations into services, shortens the time anyone waits for treatment, ensures people are placed into their recommended level of care as soon as possible, and provides the information needed to plan, coordinate, and allocate resources.

Network Providers enter waitlist encounters in the Centralized Data System (CDS) for the following services, regardless of funder:

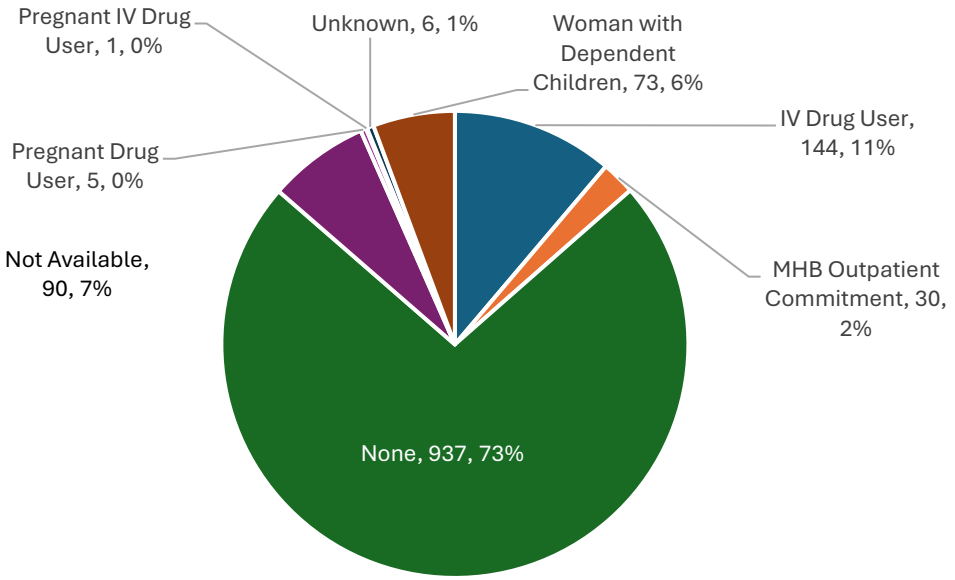
Mental Health Services	Substance Use Disorder Services
ACT (Assertive Community Treatment – MH)	Community Support – SUD
Community Support – MH	Dual Disorder Residential – MH/SUD
Coordinated Specialty Care - MH	Halfway House – SUD
Mental Health Respite – MH	IOP (Intensive Outpatient / Adult – SUD)
Professional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

The Region and Network Providers continue to carry out quality improvement activities to improve the accuracy and validity of the information entered in CDS. For providers receiving state or federal substance use funding, the Substance Abuse Block Grant priority populations for admission are: 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.

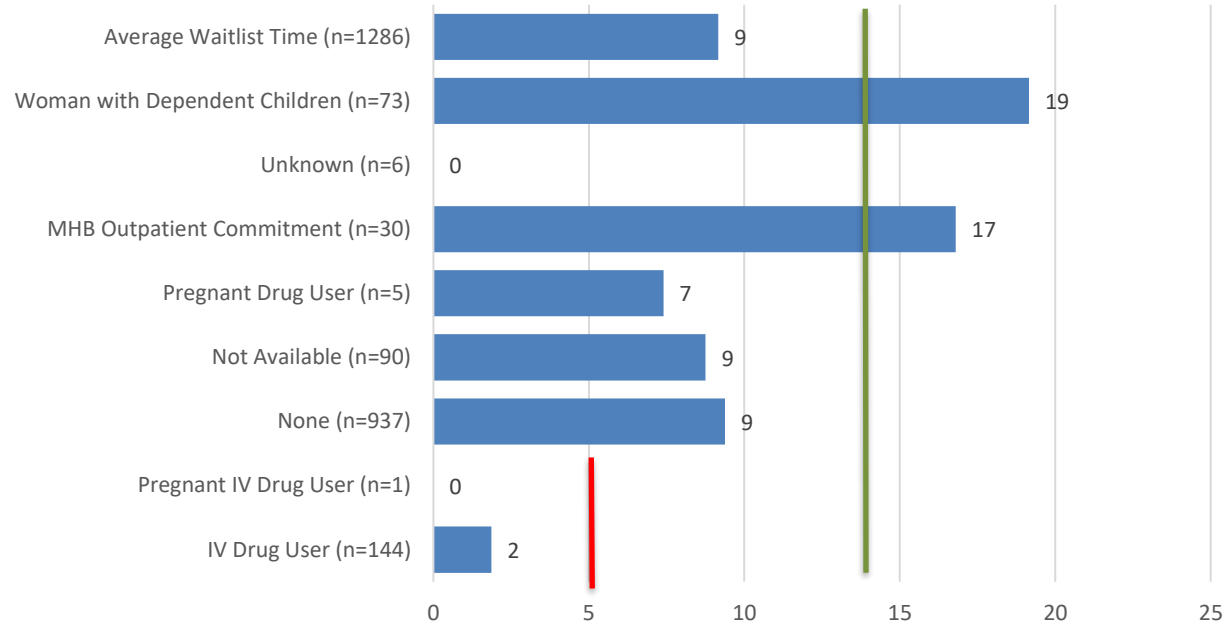
The average number of days individuals remained on the waitlist in the Region 5 Systems' network is shown below, by service. Individuals are removed from the waitlist for various reasons (e.g. entering treatment, unable to be located, refused treatment, went to treatment somewhere else).



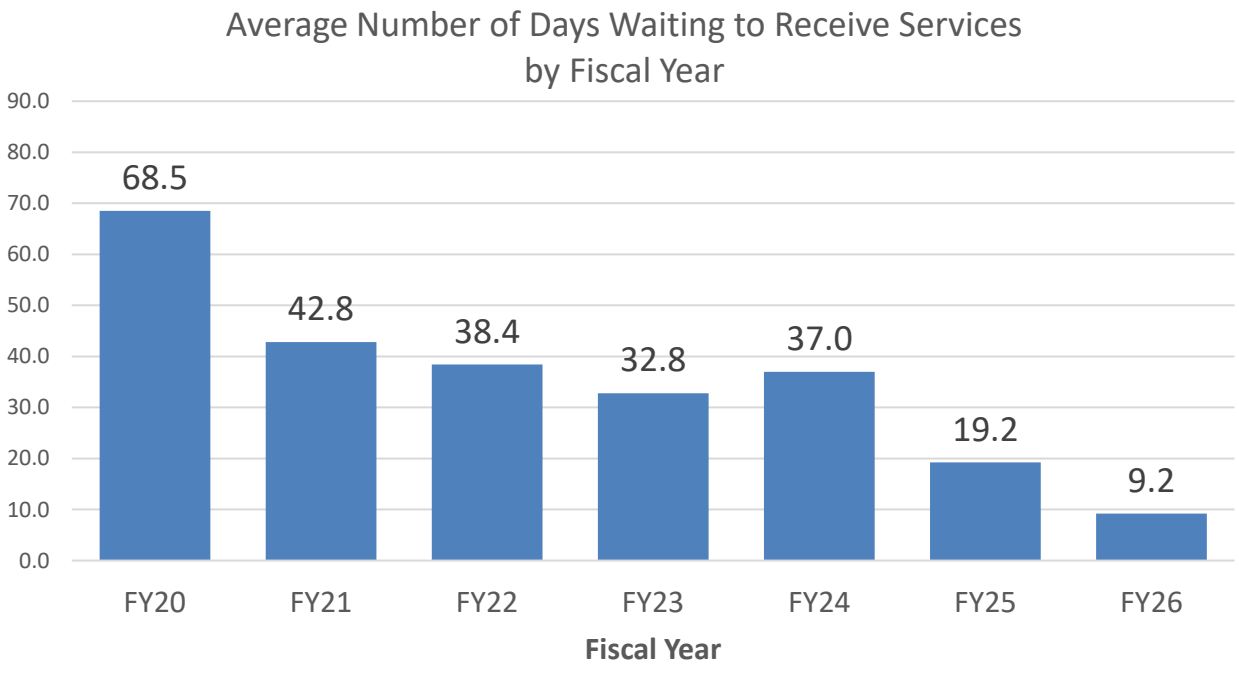
Entrance into substance use disorder programs is determined by priority levels identified by the state and federal government. Persons served presenting with these problems take priority in entering treatment over others who do not present with these problems. IV Drug Users were the highest priority population identified at 11%.



The average number of days individuals wait for services is shown below by their priority status. There is requirement for providers to immediately offer interim services to individuals if the provider does not have the capacity to admit them within 14 days. The FY26 State Block Grant target for individuals who use IV drugs to be admitted to treatment was 5 days.



The graph below illustrates the average number of days people wait for all services that require a waitlist to be maintained within the Region 5 Systems geographical area.



Region 5 Systems monitors overall agency capacity by service, the percentage of capacity used of Region 5 Systems' contract funds, and the overall percentage of capacity used within the network of providers. Network Providers enter their capacity in CDS weekly for the prior week's utilization.

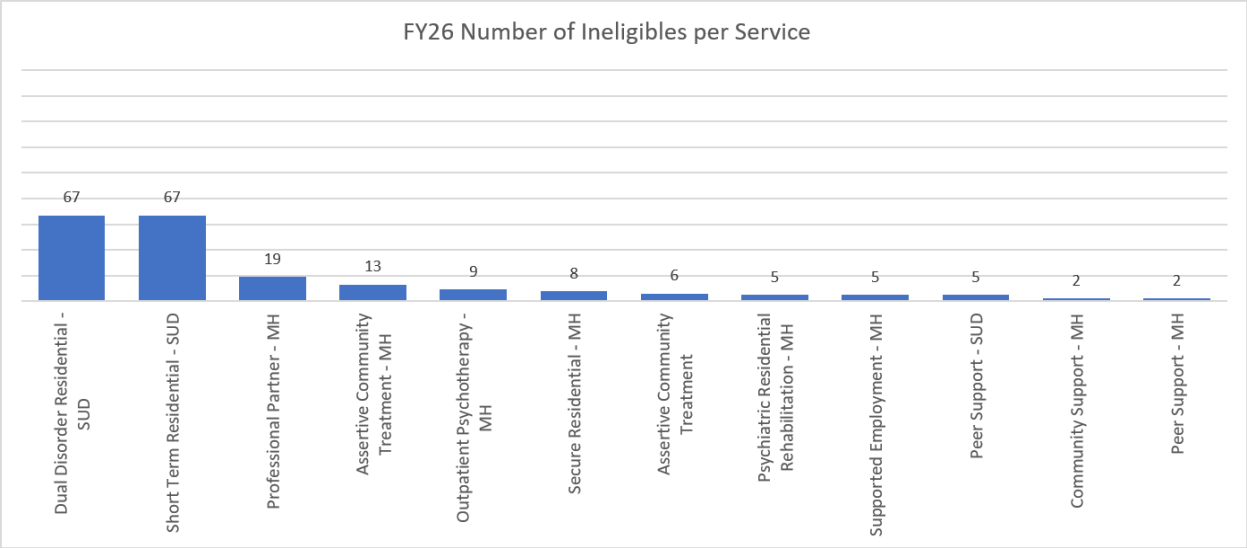
An agency using over 100% percent of their Region 5 Systems' allotted capacity is considered an overproduction on the part of the agency. Some reasons for underutilization include insufficient staffing (e.g. employee on leave), delayed start of new service, agency giving notice that they are no longer able to provide the service. Throughout the fiscal year, contract adjustments may be made to shift funds from providers/services with underproduction to those overproducing.

Ineligibles and Denials:

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

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

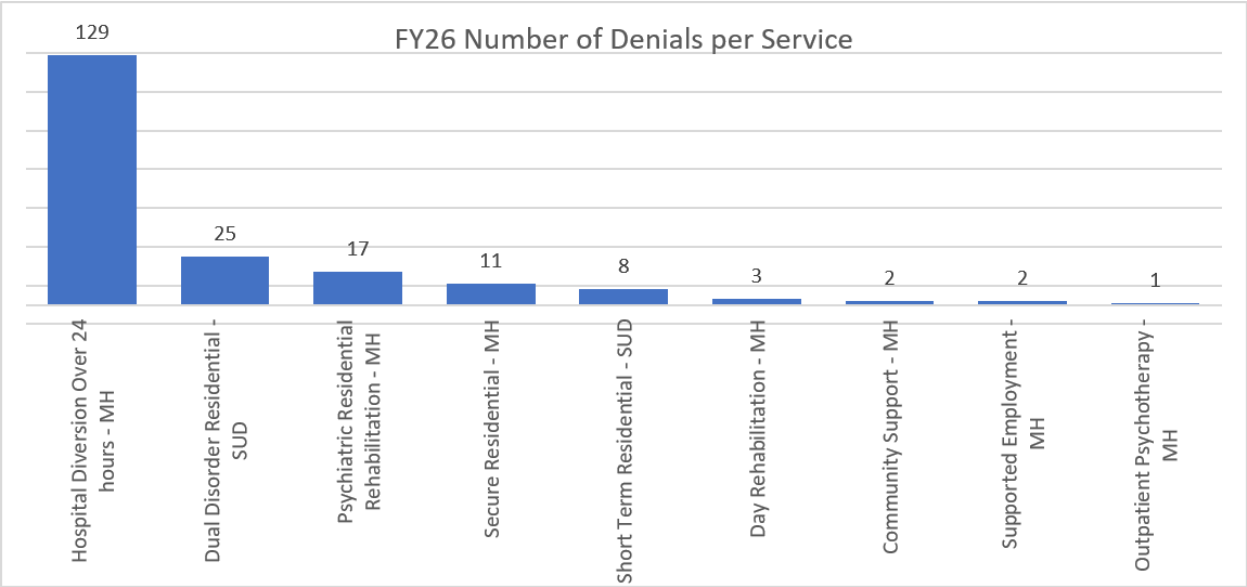
The first chart below identifies the number of people found to be ineligible for services during FY26, by service. Total ineligibles of 213 in FY26 are down from 449 ineligibles in FY25.



The following table demonstrates the reasons a person served was found to be ineligible for a service. "Doesn't have required functional deficits" and "Doesn't meet date of last use" accounted for the highest number of persons found to be ineligible.

Reason for Ineligibility	Short Term Residential	Dual Disorder Residential	Assertive Community Treatment	Professional Partner	Outpatient Psychotherapy	Secure Residential	Peer Support	Psych Res Rehab	Supported Employment	Community Support	Day Rehab	Halfway House	Med Management	Grand Total	Total Percent
Doesn't have required functional deficits		49	2	2										53	25%
Doesn't meet date of last use criteria	7	10												17	8%
Doesn't meet frequency of use	1													1	0%
Doesn't meet other clinical criteria		3	1			6		4		2	1			17	8%
Doesn't meet other admission criteria	17	5	9	17	10	1	8		5			1	1	74	35%
Extensive MH, not managed/unstable	31		6			1								38	18%
Medically Unstable	11		1					1						13	6%
Grand Total	**67**	**67**	**19**	**19**	**10**	**8**	**8**	**5**	**5**	**2**	**1**	**1**	**1**	**213**	**100%**

Denials are decisions made by the provider agency at screening to not serve a referral because of agency established exclusionary criteria. Denials may be based on recent aggression against employees or peers, legal history including sexual offenses, or conflicts with peers or employees. The following chart identifies the number of people found to be ineligible for services during FY26 by service. There were 198 total denials in FY26, down from 231 denials in FY25.



Most denials were from the category "Person Served is Homeless. This accounted for 44% of denials during FY26. This denial reason is only applicable to the Hospital Diversion service as it is written into their program plan.

Denial Reason	Hospital Diversion	Dual Disorder Residential	Psych Res Rehab	Secure Residential	Short Term Residential	Day Rehab	Comm Support	Supported Employment	Outpatient Psychotherapy	Grand Total	Total Percent
Person Served is Homeless	88									88	44%
Recommend Other Level of Care		23	15	11		3	2			54	27%
Other	16		1					2	1	20	10%
Capacity	11									11	6%
Recent Aggression	5	1			3					9	5%
Out of Region	7									7	4%
Conflict of Interest	2	1	1		3					7	4%
Legal History					1					1	1%
Sexual offender					1					1	1%
Grand Total	**129**	**25**	**17**	**11**	**8**	**3**	**2**	**2**	**1**	**198**	**100%**

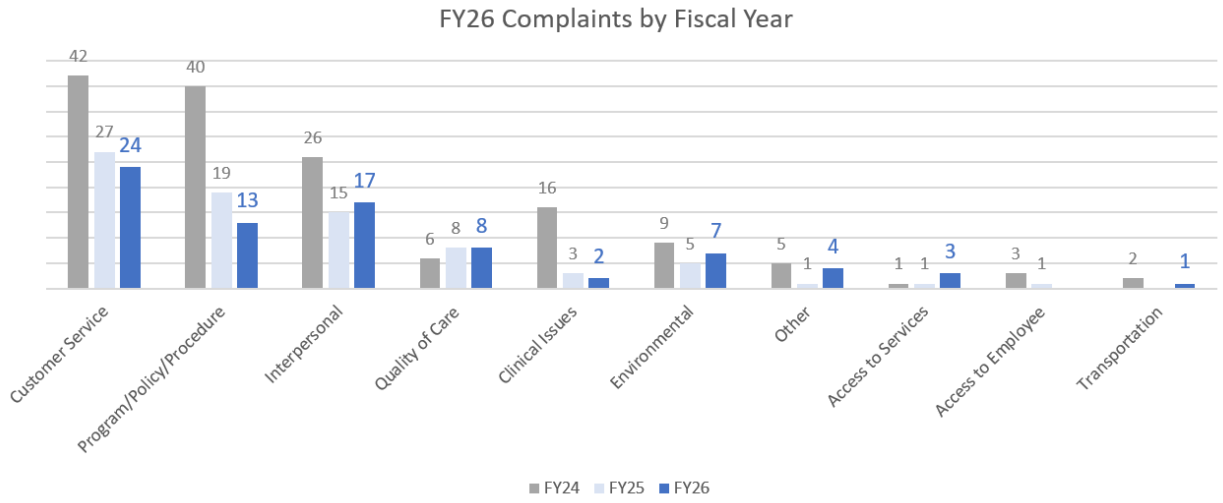
Complaints and Appeals:

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

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

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

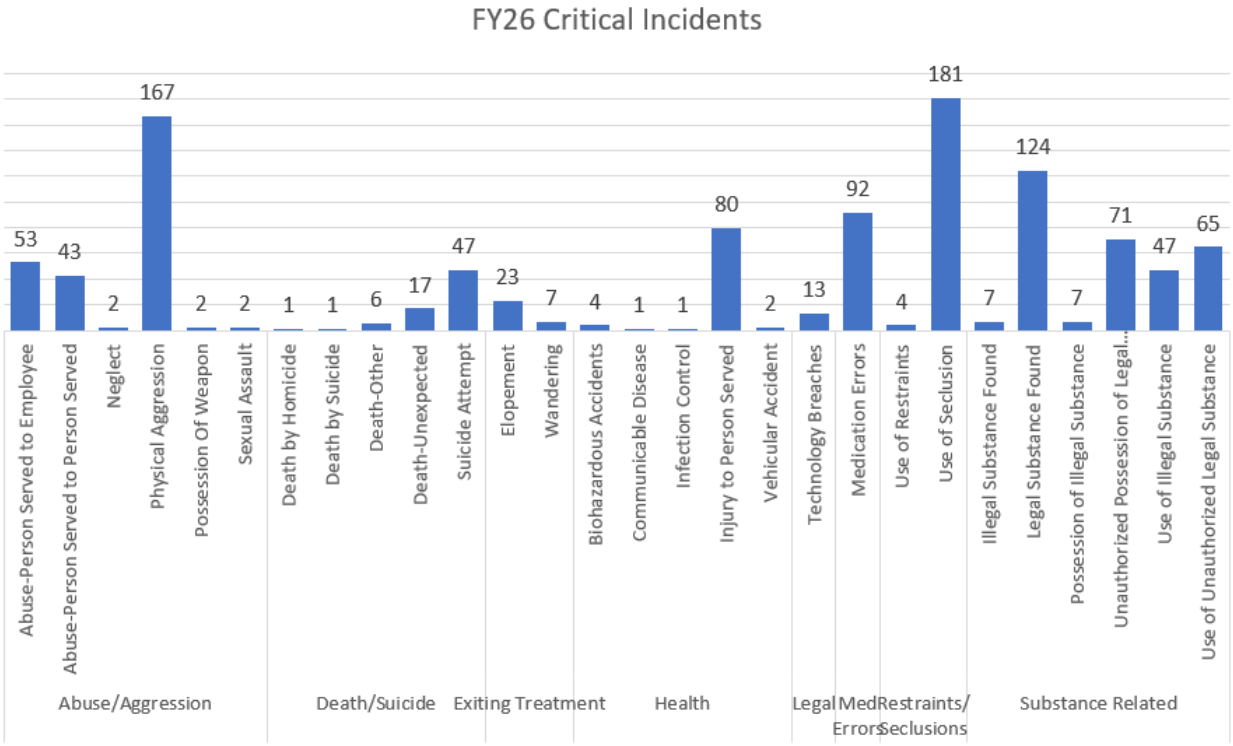
Please see Appendix A for the definition of each category of complaints and appeals being reported on.



There were no appeals in FY26.

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

The following chart illustrates the type and number of critical incidents received during FY26.



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

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 FY26 were:

- Coaching on how to avoid technology breaches as well as revision of onboarding process to ensure employees are aware of proper privacy practices
- Reviewing with staff ways to get persons served out of seclusion as soon as it is safe to do so
- Initiation of a new Relapse Prevention Program
- Education on med management
- More training to employees
- Increased supervision for high-risk situations

Incident Domain	FY24	FY25	FY26
Abuse/Aggression			
Abuse-Person Served to Employee	87	66	53
Abuse-Person Served to Person Served	57	45	43
Neglect	4		2
Physical Aggression	209	182	167
Possession of Weapon	2	3	2
Sexual Assault	1	2	2
Use of A Weapon		1	
Abuse/Aggression Total	**360**	**299**	**269**
Death/Suicide			
Death By Homicide	1		1
Death By Suicide	1	3	1
Death-Other	7	9	6
Death-Unexpected	2	10	17
Suicide Attempt	24	46	47
Death/Suicide Total	**35**	**68**	**72**
Exiting Treatment			
Elopement	87	65	23
Wandering	5	19	7
Exiting Treatment Total	**92**	**84**	**30**
Health			
Biohazardous Accidents	2		4
Communicable Disease	21	8	1
Infection Control	4	2	1
Injury to Person Served	59	52	80
Vehicular Accident	4	5	2
Health Total	**90**	**67**	**88**

Incident Domain	FY24	FY25	FY26
Legal			
Legal Actions		6	
Social Media		1	
Technology Breaches	4	10	13
Legal Total	**4**	**17**	**13**
Medication Errors			
Medication Errors	87	190	92
Medication Errors Total	**87**	**190**	**92**
Restraints/Seclusions			
Use of Restraints	1	0	4
Use of Seclusion	229	218	181
Restraints/Seclusions Total	**230**	**218**	**185**
Substance Related			
Illegal Substance Found	24	23	7
Legal Substance Found	108	90	124
Possession of Illegal Substance	11	17	7
Unauthorized Possession of Legal Substance	59	126	71
Use of Illegal Substance	24	35	47
Use of Unauthorized Legal Substance	59	45	65
Substance Related Total	**285**	**336**	**321**
Grand Total	**1183**	**1279**	**1070**

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

REGION 5 SYSTEMS

(Supporting Wellness and Recovery in Behavioral Health)

Understanding Incidents Diagram

10/21/2026 (Revised)



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

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

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

The following chart represents the CQI Concerns Requests submitted by employees in FY26. There was a total of six concerns/requests submitted.

Date Received	CQI Concern/Request	Recommendation/Action Taken
3/30/2026	Improve impression of Region 5 Systems physical building: • add sign behind front desk. • clean up goose droppings on walkways	Approved. • Sign was installed. • Weekly cleaning of walkway; will continue to assess effectiveness. Update: exploring other options for cleaning sidewalks.
2/13/2026	Reconsideration of the Leadership Team membership selection process	Pending. Leadership Team has been tasked with assessing the current process and making a recommendation for possible changes.
1/12/2026	A clear, standardized procedure for the use of iCloud, Apple IDs, and contact management on Region 5 Systems issued iPhones	Approved. The Cell Phone Usage Policy will document the expectations on R5S issued cell phones.
12/9/2025	Fiscal representatives, in email correspondence about making corrections on payment requests, include employee who submitted request along with employee's supervisor	Approved. The *Protocol for Payment Requests* was updated and shared with all employees on 2/16/26.

(Cont.)

Date Received	CQI Concern/Request	Recommendation/Action Taken
9/2/2025	Add hand sanitizer to all Hotspot/Hotel desks	Approved.
7/24/2025	Add fan to Touchdown Rooms	Approved. Fans were purchased and placed in each Touchdown room.

Continuous Quality Improvement Teams:

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

Region 5 Systems
Continuous Quality Improvement Teams

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

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

PROFESSIONAL PARTNER PROGRAM – FAMILY & YOUTH INVESTMENT – SECTION IV

Wraparound Fidelity Index-EZ:
The California Evidence-Based Clearinghouse, in its database of programs for serving children and families involved with the child welfare system, indicates there is promising research evidence in support of Wraparound as a model for serving children and youth with severe emotional, behavioral, or mental health difficulties who are either in, or at, risk of out-of-home placement and involved in multiple systems (e.g. mental health, special education, juvenile justice). As noted in the report from the Wraparound Evaluation and Research Team (WERT) at the University of Washington, *Trends in National WFI-EZ Data Care Coordinator Form* (June 2025), a meta-analysis of 16 controlled studies published in 2021 found that "programs and initiatives that achieved at least 'adequate' fidelity at the level of the benchmarks [identified within the report] were more likely to maintain youth at home, keep them in school, reduce mental health symptoms, and improve functioning".

Region 5 Systems evaluates the Professional Partner Program – Family & Youth Investment (FYI) to determine whether services and supports being received by Region 5 Systems Professional Partner Program's youth and families adhere to the basic characteristics of wraparound. Wraparound is an approach to treatment that helps families with challenging children function more effectively in the community. It provides a team 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:

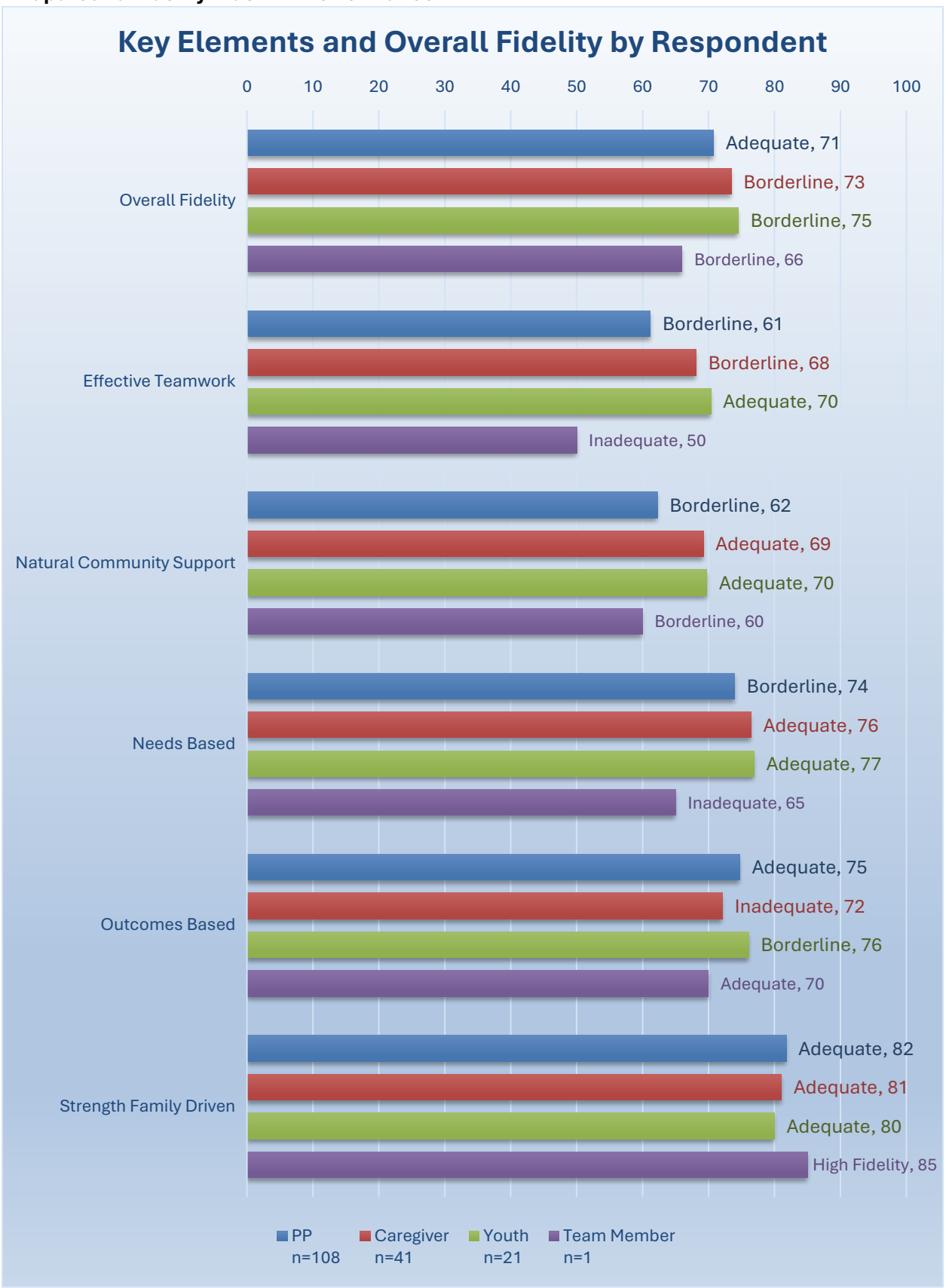
1. Family voice and choice
2. Youth and family team
3. Natural supports
4. Collaboration
5. Community-based services and supports
6. Cultural competence
7. Individualized services and supports
8. Strength-based services and supports
9. Outcome-based services and supports
10. Persistence

The Wraparound Fidelity Index (WFI-EZ) assesses fidelity by having the respondent (wraparound facilitator, caregiver, youth, and team member) rate 25 items on the extent to which they agree each indicator of Wraparound Fidelity has been achieved. WERT developed benchmarks (see below) to help programs interpret fidelity scores and assess the degree to which implementation meets basic standards. Norm-referencing and criterion-referencing was utilized, and mean scores were calculated on predictors of Wraparound fidelity.

High Fidelity: Meets top implementation standards
Adequate Fidelity: Meets baseline program standards
Borderline Fidelity: Below target standards, requiring quality improvement
Inadequate Fidelity: Substantially below model adherence

The following table of WFI-EZ scores for the Region 5 Systems' Professional Partner Program Family & Youth Investment (FYI) in the FY26 period is a comparison of the scores by respondent type: Wraparound Facilitator, or Professional Partner/PP (n=108), Caregiver (n=41), Youth (n=21), and Team Member (n=1). Across the professional partner, caregiver and youth respondents, *Adequate* was the most common rating. The *Adequate* rating applied to 3 domains for PP, 3 for Caregiver, and 4 for Youth. *Borderline* ratings were the second most common —3 for PP, 2 for Caregiver, and 2 for Youth—while *Inadequate* ratings were recorded for 1 Caregiver domain only. Youth had the highest number of *Adequate*-rated domains.

Wraparound Fidelity Index-EZ Performance:



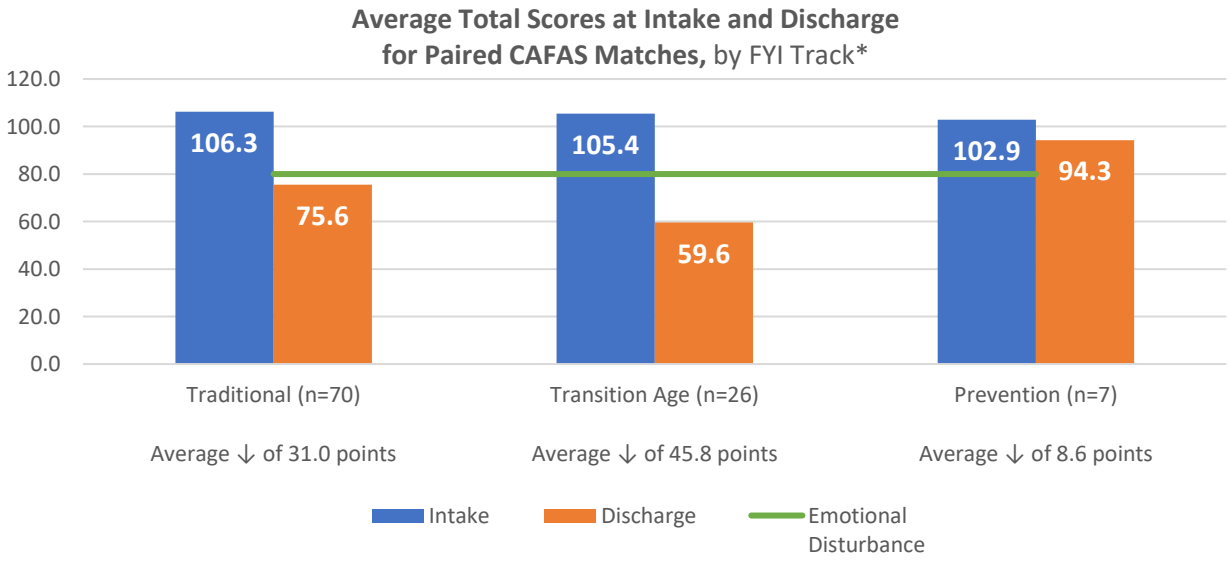
Child Adolescent Functional Assessment Scale (CAFAS):

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

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

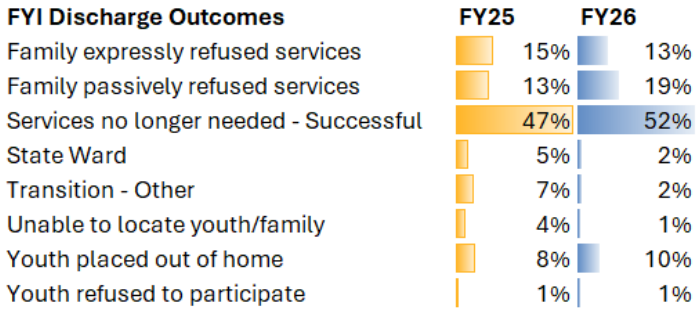
Total Score	Description
0-10	Youth exhibits no noteworthy impairment.
20-40	Youth likely can be treated on an outpatient basis, providing risk behaviors are not present.
50-90	Youth may need additional services beyond outpatient care.
100-130	Youth likely needs care which is more intensive than outpatient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

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



Discharge Status:

There were 163 youth/young adults who were discharged from FYI in FY26. The average length of stay was 14.8 months, and successful completion of the program accounted for 52% of discharges.



FYI Discharge Outcomes	FY25	FY26
Family expressly refused services	15%	13%
Family passively refused services	13%	19%
Services no longer needed - Successful	47%	52%
State Ward	5%	2%
Transition - Other	7%	2%
Unable to locate youth/family	4%	1%
Youth placed out of home	8%	10%
Youth refused to participate	1%	1%

When looking at individual track completions, there were 163, with 36 of those being internal transfers to other tracks. The average track duration was 14.8 months, with 45% of participants/families discharging, or transferring to another track, after more than 365 days.

Average Length of Track Stay (Months)	FY25	FY26
Justice	13.0	N/A
Prevention	7.5	9.0
Traditional	12.7	12.7
Transition Age	16.8	29.0
Overall Average Length of Stay	**12.4**	**14.8**

Post Discharge Survey:

The Professional Partner Program Survey of Discharged Families Questionnaire includes five- or seven-questions, depending on the track. It is utilized to assess whether families found FYI services beneficial, whether youth entered the juvenile justice or child welfare systems, and whether young adults entered the emergency mental health system within 90 days or 12 months after discharge. Results measure the Professional Partner Program's impact on preventing system involvement. In FY26, of families surveyed 3 months post discharge (n=60), the following results were found:

- 62% Did you find the Professional Partner services beneficial?
- 0% Were you hospitalized for mental health reasons, taken into emergency protective custody, placed in the Crisis Center or admitted to the Lincoln Regional Center?
- 3% Did your child/youth become a state ward?
- 3% Has your child been placed outside their home?

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

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

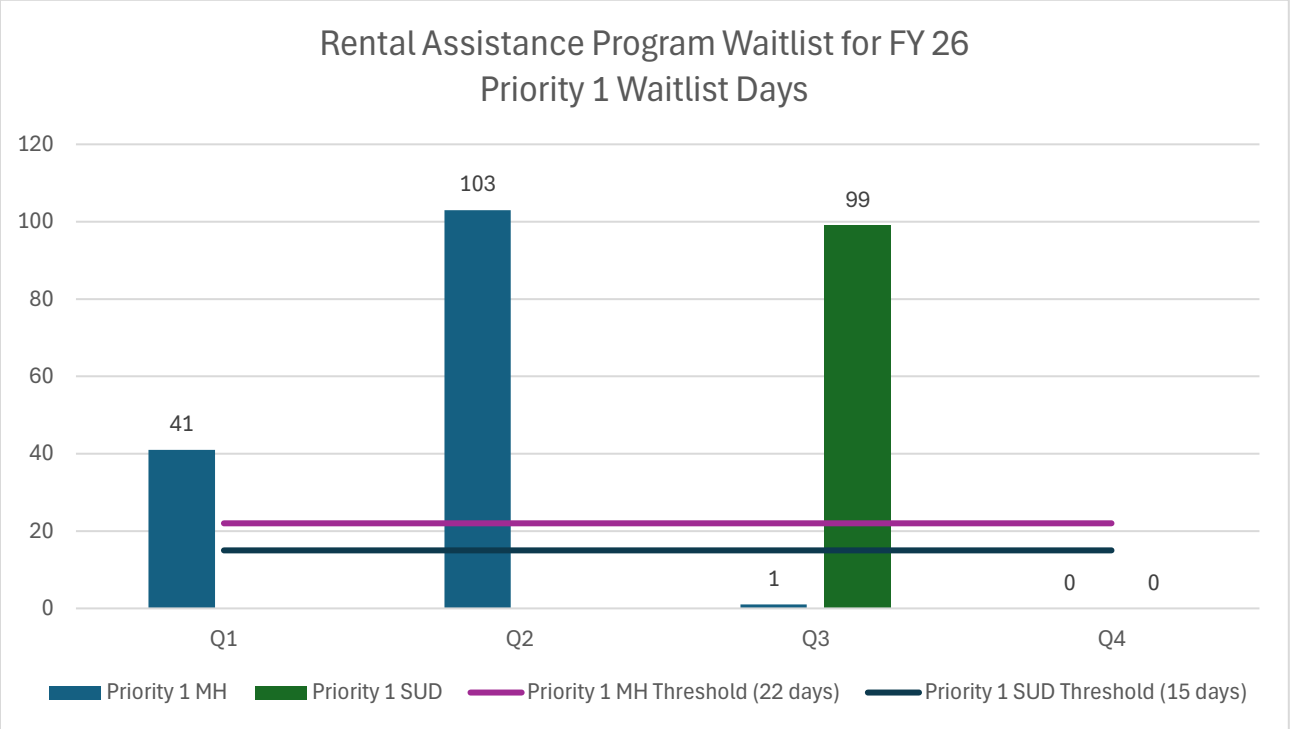
Comparison by Quarter
FY26

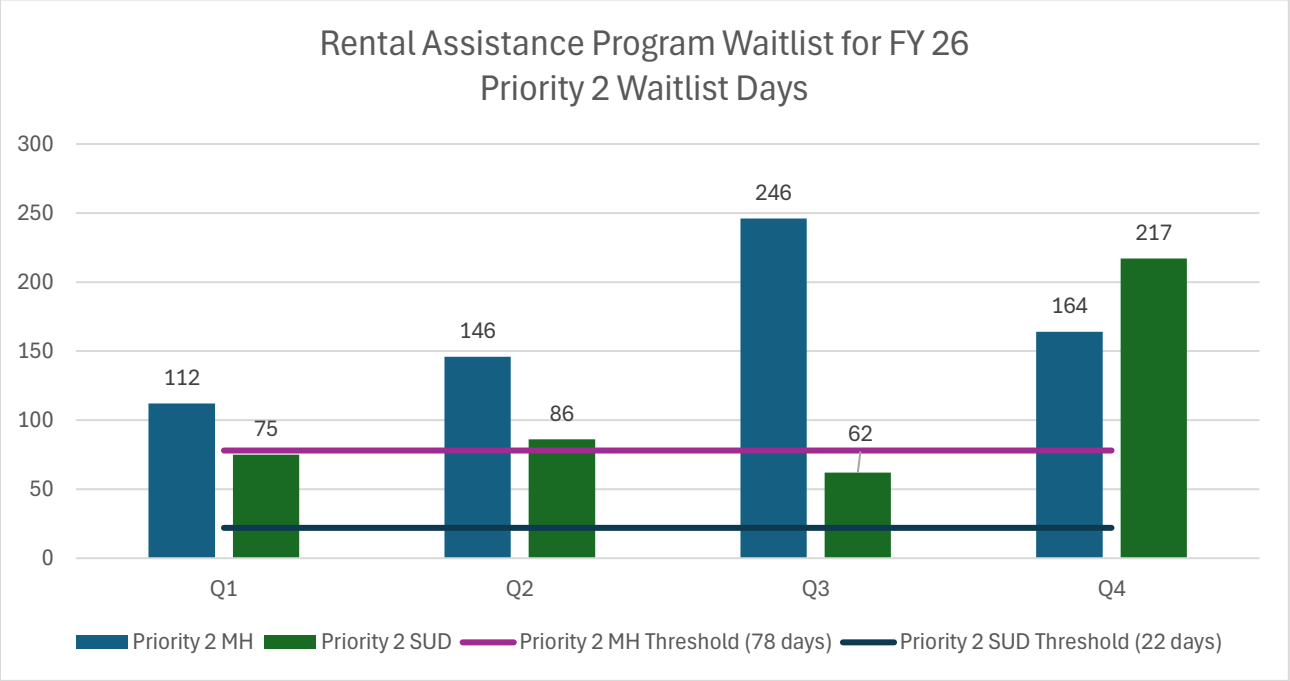
RECORDS REVIEW		Q1	Q2	Q3	Q4
Open Records	**Average completeness**	**92%**	**93%**	**96%**	**95%**
	General Information	92%	91%	93%	94%
	Team Planning	91%	92%	100%	99%
	FYI Clinical Supervision Notes	96%	89%	100%	97%
	Formal Services	92%	93%	100%	90%
	Evaluation Info	94%	100%	99%	97%
	Legal	77%	93%	93%	92%
	School	85%	93%	93%	100%
Closed Records	**Average completeness**	**96%**	**94%**	**95%**	**93%**
	General Information	95%	92%	92%	92%
	Team Planning	98%	97%	98%	93%
	FYI Clinical Supervision Notes	90%	94%	87%	89%
	Formal Services	94%	91%	97%	91%
	Evaluation Info	98%	97%	96%	97%
	Legal	93%	82%	90%	83%
	School	89%	86%	98%	72%
	Section Closed	99%	99%	98%	97%
EHR REPORTS REVIEW		**Q1**	**Q2**	**Q3**	**Q4**
Initial POC		96%	90%	97%	80%
Interpretive Summary		91%	96%	97%	100%
Monthly POC Update		89%	90%	91%	95%
BILLING AND CODING PRACTICES		**Q1**	**Q2**	**Q3**	**Q4**
Team Meeting Documentation		100%	100%	100%	100%
Family or Participant Contact Note		100%	100%	100%	100%
Was Not Discharged Prior to Billing Period		100%	100%	100%	100%

HOUSING – SECTION V

Rental Assistance Program Waitlist

Beginning in FY23, the Housing program has been striving to reduce the amount of time individuals wait for supported housing by 10% from the baseline (FY22 performance). The average length of time on the waitlist this fiscal year was above the program's established thresholds for each priority status. While additional funding was approved for the Rental Assistance Program in March 2025 to aid in reducing the waitlist, the need for housing assistance continues to outpace the availability of funding.





Internal Records File Review for the Rental Assistance Program:

Region 5 Systems' Quality CQI Team conducts quarterly internal reviews on open (20% of open records) and all closed records within the Rental Assistance Program. Areas scoring below 80% require the program to complete a quality improvement action plan.

For FY26, the program maintained a total completeness of 94-99% for open and closed records. The program focused efforts on improving procedures and monitoring of the housing inspections (HQS), monthly staffing reviews, and discharge letters to the landlord.

FY 26 Rental Assistance Program File Review					
Section		**Q1**	**Q2**	**Q3**	**Q4**
Open Records	**Total Completeness of All Items**	**95%**	**96%**	**97%**	**98%**
	Application/Eligibility	97%	99%	98%	100%
	Application Supporting Documentation	95%	90%	95%	92%
	Voucher Issuance	93%	97%	100%	99%
	Housed	95%	94%	93%	98%
	Annual Review	92%	88%	100%	100%
Closed Records	**Total Completeness of All Items**	**94%**	**95%**	**96%**	**99%**
	Application/Eligibility	99%	98%	99%	100%
	Application Supporting Documentation	94%	94%	100%	95%
	Voucher Issuance	92%	93%	91%	100%
	Housed	94%	94%	98%	99%
	Annual Review	85%	94%	86%	100%
	Discharge	90%	97%	98%	98%

Internal Records File Review for the Housing & Urban Development (HUD) Housing Program:

Region 5 Systems' Quality CQI Team conducts quarterly internal reviews on 25% of open persons served records, all closed records, and 13 property records within the Rural & Lincoln Permanent Housing Program. Below is a summary of FY26. Areas scoring below 80% require the program to complete a quality improvement action plan.

FY26 HUD Housing File Review - PARTICIPANT					
Section		**Q1**	**Q2**	**Q3**	**Q4**
Open Records	**Total Completeness of All Items**	**96%**	**96%**	**99%**	**97%**
	Section 1 – Application and Annual Review	97%	97%	98%	96%
	Section 2 – Income and Sublease	97%	97%	100%	100%
	Section 4 – Persons Needs	65%	65%	100%	100%
	Section 5 – Releases of Information	98%	98%	98%	93%
Closed Records	**Total Completeness of All Items**	**95%**	**95%**	**98%**	**93%**
	Section 1 – Application and Annual Review	97%	997%	100%	96%
	Section 2 – Income and Sublease	92%	92%	100%	94%
	Section 4 – Persons Needs	67%	67%	100%	100%
	Section 5 – Releases of Information	100%	100%	96%	92%
	Discharge	100%	100%	88%	67%

FY26 HUD Housing File Review - PROPERTY				
Section	**Q1**	**Q2**	**Q3**	**Q4**
Total Completeness of All Files	**93%**	**97%**	**98%**	**99%**
Section 1 – Lease and Environmental Reviews	92%	100%	85%	92%
Section 2 – Sublease	100%	92%	100%	100%
Section 3 – Rent Reasonableness	83%	94%	98%	100%
Section 4 – Utility Allowance	100%	100%	100%	100%

Appendix A: Complaints and Appeals Category Definitions

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

Appendix B: Critical Incident Category Definitions

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

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

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