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Performance & Quality Improvement

Q3 Report FY 2022-2023

(Jan-Mar 2023)

Introduction

The Performance and Quality Improvement Committee (PQI) was formed in May 2020. The PQI Committee meets monthly and reviews and analyzes data in order to identify progress and areas for improvement. The data in this report is evidence of the hard work that CONCERN's employees do every day.

The PQI Committee has developed data collection tools, reporting mechanisms and is continuing to work to improve the flow of information to make the data collection and analysis easier. We have several PQI sub-committees: Satisfaction Surveys, Meeting Prep, Measures, and Quarterly Reporting.

We have expanded the Measures sub-committee to focus on review of the logic models and outputs and outcomes collection tools. We have been updating, streamlining and clarifying our goals and collection of data and we will be working on this important project through this fiscal year and likely into the next.

The data contained in this report is for a period of 1 quarter-Q3, January 2023 to March 2023.

PQI Committee Members

Jennifer Peters, Electronic Health Records Administrator
Sue Holmgren, Administrative Assistant
Val Rheinheimer, Caseworker
Calista Alicea, IT Projects Coordinator
Kathy Stoica, IT Administrative Support
Kassie Irwin, Human Resources Manager
Crystal Boggs-Jennings, Director of Residential Services
Bambi Harmon, Social Services Clinical Director
Rebecca Brown, Quality Assurance Assistant
Flo Westley, Manager of Adoption and Permanency Services
Stacey Page-Miller, Region Director
Kelly Crum, Region Director
Maria Flores, Region Director
Jen Bowen, Region Director
Carrie Knebel, Region Director
Tanya Jones, Vice President
Scott Lubinski, Chief Administrative Officer
Carri Prior, Senior Executive Assistant
Gordon May, President/CEO
Chair-Cheryl Reeling, Director of Quality Assurance

Outputs & Outcomes

Data collection with purpose and passion

Each program has developed a Logic Model that captures the program's inputs, activities, outputs, and outcomes. Data collection tools have been developed to consistently collect the data. The collection tools are being revised to collect more data and be as user friendly as possible. This will result in more data to analyze and report on in the future. The PQI Committee oversees the data collection and aggregation of the data in order to measure performance and to improve our services and programs, which ultimately leads to better client outcomes.

This key is to be used with the charts on the following pages.

Key	
Goal met	
Trending close to goal or progressing toward goal	
Goal partially met	
Trending level or making progress towards goal	
Goal not met	
Trending low or regressing from goal	

Through PQI Committee discussion, our trend symbols will be revised and simplified for the Q4/Annual PQI report.

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Residential Program

Residential Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Average Clients Per Day	23.5	23.7	22.6	21	
Percent of Budget Days of Care	100%	99%	94%	88%	
Percent of Therapy Hours Delivered vs Prescribed	89%	78%	77%	93%	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Percent of Weekly Passed Behavior Management Program (80% is passing)	81%	78%	66%	73%	
Percent of Discharged Youths Attending School/Graduated	100%	100%			
Average Math Grade (60% is passing)	77%	N/A	No data at this time	78%	
Average English Grade (60% is passing)	74%	N/A	No data at this time	72%	

Q3 Results Detail
Some items were not able to be collected due to changes in management.

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Maryland Community Based Programs

Maryland Community Based Programs Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Number of Clients	16	13	13	17	
Number of Casework Contacts	358	422	305	518	
Number of After Hours Contacts	106	111	121	33	
Number of After Hours Crisis Contacts	0	0	0	0	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Number of Section 8 Code of Conduct Violations	0	0	0	0	
Number of Youth in School and/or Working	12	8.66	6	8	

Maryland Foster Care

Maryland Foster Care Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Caseworker Visits Completed as Required (2x/month)	93%	95%	86%	86%	
Treatment Plans Completed on Time	59%	54%	54%	64%	
CANS Completed for Each Client		51%	52%	57%	
Each Client has an Assigned Mental Health Therapist		73%	83%	86%	
Foster Family Recertifications Completed		85%	100%	86%	
Annual Goal of 4 New Foster Parents Per Year					
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
At Least 80% of Clients Achieved Their Permanency Plan Goal as Identified by the Court	100%	100%			
At least 80% of Clients Have Identified at Least One Supportive Adult to Whom They Can Turn for Assistance in an Emergency	100%	100%	100%	100%	
CANS Reflects Client Improvement Upon Discharge		67%	50%	100%	
85% of clients met or partially met their treatment plan goals by discharge		67%	75%	100%	
Clients consistently attended school or graduated from HS/obtained GED		100%	75%	100%	
Discharged Clients Experienced Two or Fewer Placements		100%	25%	100%	

Q3 Results Detail

Due to lack of training for new caseworkers to be certified to complete CANS assessments, not all clients were assessed during this quarter.

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Pennsylvania Foster Care

PA Foster Care Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Casework Contacts	99%	100%	100%	96%	
Training Hours Met	91%	100%	98%	92%	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Permanent Placement Achieved	83%	83%	77%	78%	
Placement Stability	97%	100%	88%	100%	

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Adoption

Adoption Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Number of New Adoption Finalization Referrals	8	20	4	4	
Number of Family Profile Referrals	12	12	9	12	
Number of Child Profiles Completed	31	27	39	33	
Number of Completed SWAN Services Invoiced	99	75	74	91	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Number of Families Approved	11	13	8	8	
Number of Finalized Adpotions	11	7	6	9	

Crisis

Crisis Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Number of Total Hours Provided	129	123	138	249	
Number of Hours of Mobile Service Provided	42	43	40	70	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Diversion from Hospitalization or a Higher Level of Care	79%	82%	81%	79%	
Provided Recommendations for Interventions, Skills and/or Services/Resources	85%	92%	85%	96%	

Partial Hospitalization Program

Partial Hospitalization Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Number of Biopsychosocial Assessments Completed	11	5	7	7	
Number of Initial Plans Completed within 5 Treatment Days	8	4	7	7	
Number of Clients	24	24	27	25	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
% of Children Returned to Home School District	75%	75%	50%	50%	
Attainment or Partial Attainment of Goals	50%	100%	50%	50%	

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Family Based Mental Health Services

Family Based Mental Health Services Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Number of Active Clients	40	45		37	
Number of Total Hours Delivered	1105	1252		1316	
Number of Team Delivered Hours	471	479		506	
Number of Individual Hours Delivered	634	773		810	
Number of Authorized Hours	2,298	1,211		1,436	
Authorized vs Delivered	48%	52%		92%	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Attainment of Treatment Goals	50%	77%		83%	

Q3 Results Detail

Intensive Behavioral Health Services

Intensive Behavioral Health Services Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Number of Initial and Ongoing CANS Assessments Completed	84	86	61	84	
Number of Treatment Plans Completed	108	148	114	142	
Number of Active Clients	297	291	267	284	
Number of Delivered Hours	8,135	7,426	8,037	9,245	
Authorized vs Delivered	49%		51%	52%	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Engagement in Services within 180 days	59%	70%	76%	59%	
Attainment or Partial Attainment of Goals	50%	80%	75%	79%	

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Outpatient Services

Outpatient Outputs	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Number of Referrals Made	657	670	920	747	
Number of First Assessments Completed	497	433	513	445	
Number of Hours of Service Delivered	11,853	11,885	13,001	14,297	
Outcome Goals	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q3 Results On Target**
Initial Engagement is Evidenced by the Client Attending the First Assessment Appointment After the Referral was Made		67%	80%	80%	
Attainment or Partial Attainment of Goals at Discharge	66%	67%	80%	68%	

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Finance

CORP-Finance	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q3 Results On Target
Timely Reporting of Final Financial Results within 30 days	20	29.7	27	24.3	
Timely Accounts Receivable (AR) Collections	58%	59%	68%	68%	
Payroll Completed in a Timely Manner	100%	100%	100%	100%	

Q3 Results Detail

Information Technology

Information Technology Outputs	Q3 22/23	Q3 Results On Target
Bi-Annual Staff Survey	100%	
Monthly Technology Trainings Offered to All Staff	100%	
Use Power BI to Provide Reports to Other Departments		
Use Technology Committee to Implement Technological Imrpovements	100%	
Approved Tech Requests are Completed in a Timely Manner (21 days)	350%	
Outcome Goals	**Q3 22/23**	**Q3 Results On Target**
Increased Staff Skills, Abilities, and Proficiency of Technology (% of staff participating in training)	19%	
Power BI Drives Decisions		
Paper Usage is Significantly Reduced	2%	
Staff Have the Technology Needed to Complete Their Job Tasks (number of tech requests completed per quarter)	100%	

Q3 Results Detail

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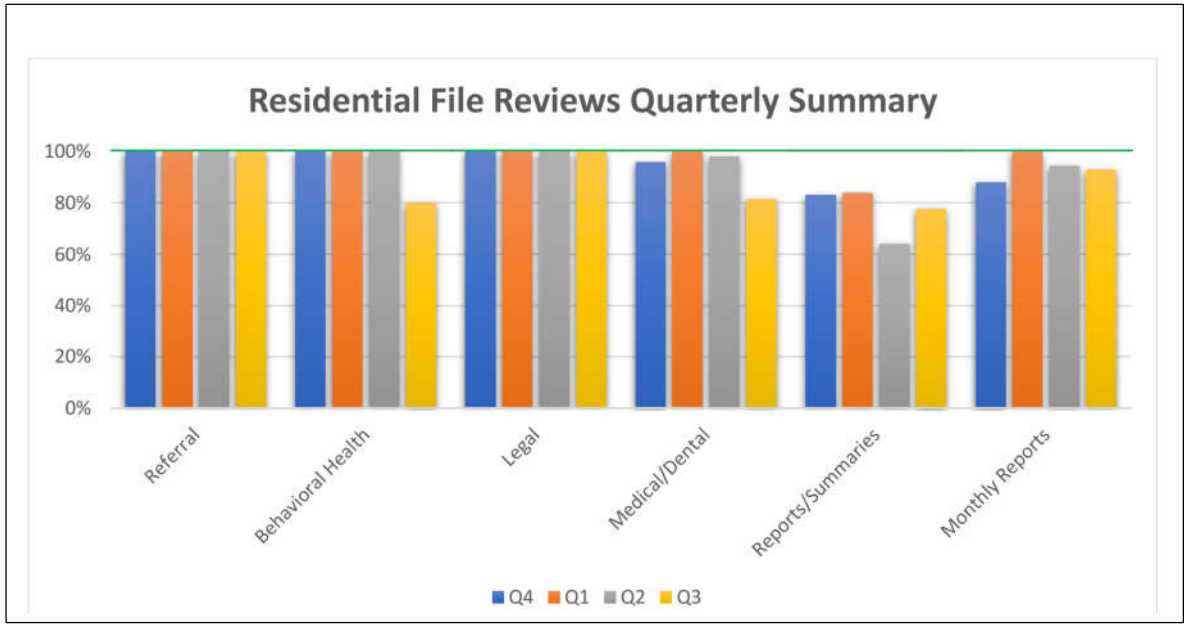
File Audits & Inspections

CONCERN conducts internal reviews to minimize the risks associated with poorly maintained client files, to document the quality of the service being delivered and to identify barriers and opportunities for improving services. Uniform collection tools are used to ensure consistency and allow comparison of data across programs. Quarterly reviews of client files evaluate the presence, clarity, continuity, and completeness of required documents.

External entities (state and county government, other regulators, and funding sources) conduct external file audits and regular licensing inspections.

Inspection/Audit Type	Running Totals	Jan-Mar 2023	Oct-Dec 2022	July-Sept 2022	Apr-June 2022
Internal File Audits	965	216	244	261	244
External File Audits	10	5	2	1	2
Licensing Inspections/Full Licensure	20	8	3	5	4

Residential Program Quarterly Totals



Q4 (Apr-June 2022)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 94%.

Q1 (July-Sept 2022)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 97%.

Q2 (Oct-Dec 2022)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 87%.

Q3 (Jan-Mar 2023)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 87%.

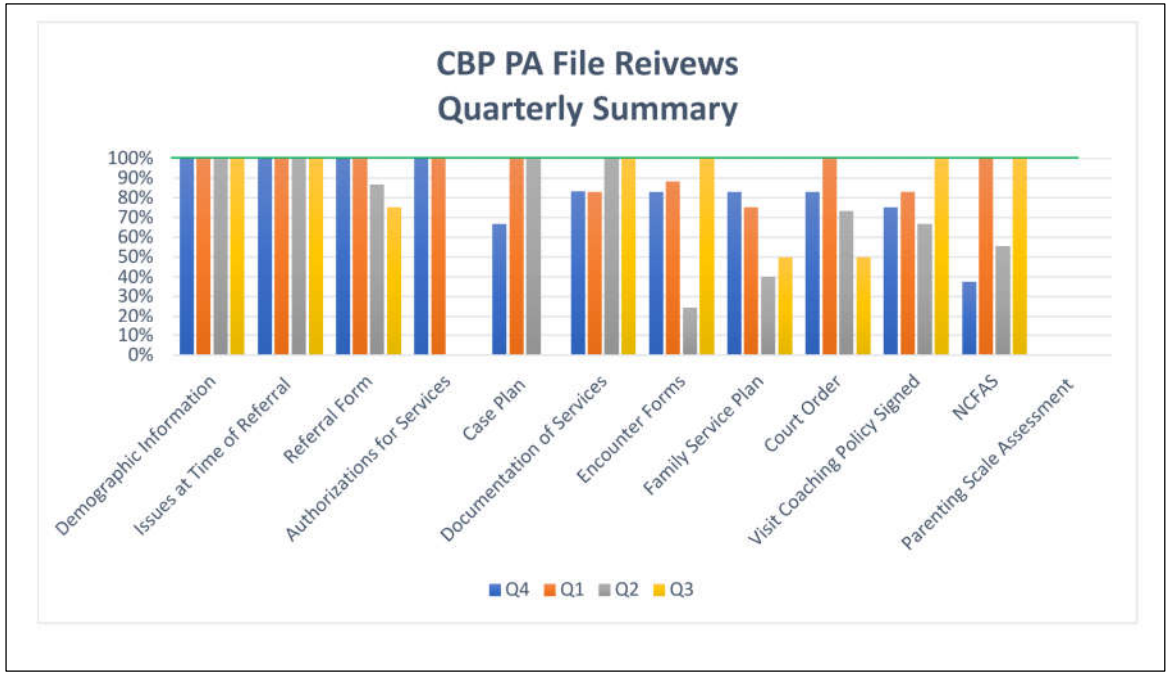
The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicators (QI)	Q4	Q1	Q2	Q3
Behavioral Health				
Treatment Plan (Initial) (QI)	100%	100%	100%	100%
Treatment Plan (Review) (QI)	n/a	100%	n/a	100%
Reports/Summaries				
ISP- Initial (QI)	100%	100%	100%	100%
ISP 6 month (QI)	n/a	100%	100%	n/a
ISP 12 month (QI)	n/a	100%	n/a	n/a
ISP other (QI)	n/a	100%	n/a	n/a
Monthly Reports				
Monthly Reports (QI)	100%	100%	100%	100%

Quality Indicator Results Detail

For Q4, overall compliance for these items was 100%.
For Q1, overall compliance for these items was 100%.
For Q2, overall compliance for these items was 100%.
For Q3, overall compliance for these items was 100%.

Pennsylvania Community Based Programs Quarterly Totals



Q4 (Apr-June 2022)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 9 files.
Overall compliance was 83%.

Q1 (July-Sept 2022)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 8 files.
Overall compliance was 91%.

Q2 (Oct-Dec 2022)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 13 files.
Overall compliance was 79%.

Q3 (Jan-Mar 2023)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 4 files.
Overall compliance was 86%

The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicators	Q4	Q1	Q2	Q3
Case Plan (QI)	67%	100%	100%	n/a
Documentation of Services				
Progress Notes (QI)	100%	100%	100%	100%
Quaterly Reports (QI)	50%	50%	100%	n/a
Discharge Summaries (QI)	100%	100%	100%	100%

Quality Indicator Results Detail

For Q4, overall compliance for these items was 79%.
For Q1, overall compliance for these items was 88%.
For Q2, overall compliance for these items was 100%.
For Q3, overall compliance for these items was 100%.

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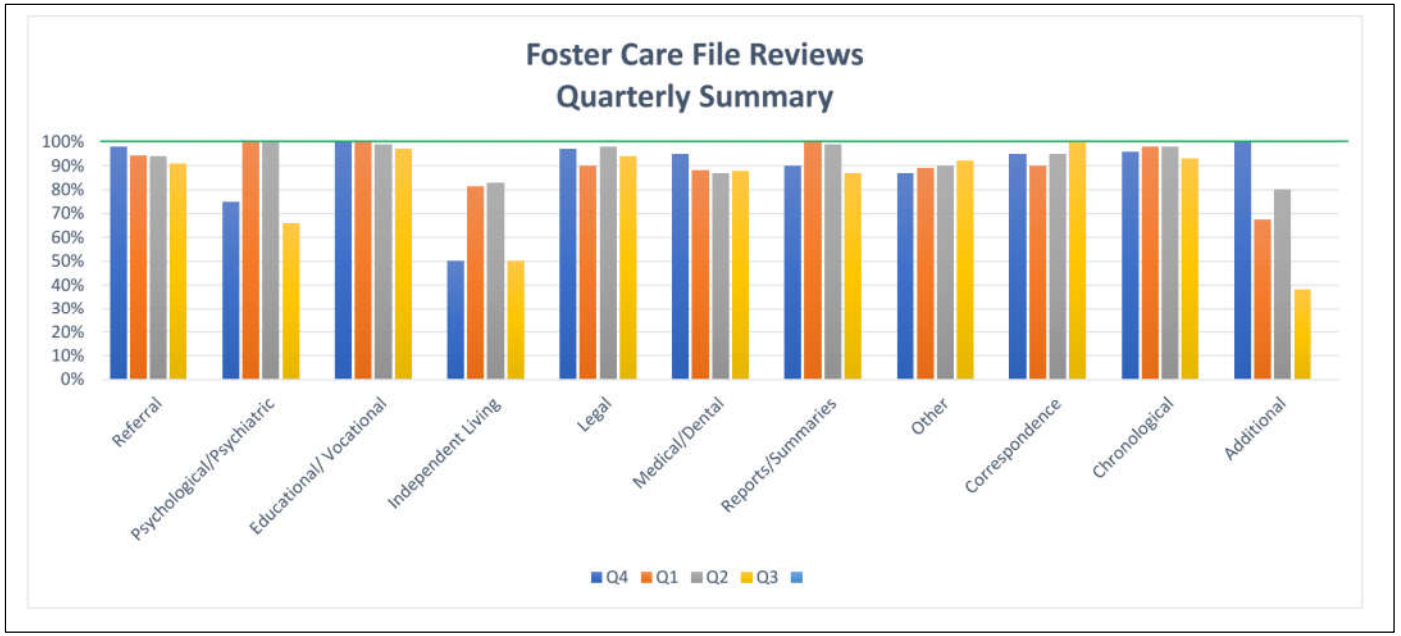
Foster Care Quarterly Totals



Q4 (Apr-June 2022)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 27 files.
Overall compliance was 90%.

Q1 (July-Sept 2022)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 30 files.
Overall compliance was 91%.

Q2 (Oct-Dec 2022)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 29 files.
Overall compliance was 93%.

Q3 (Jan-Mar 2023)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 27 files.
Overall compliance was 88%.

The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

The CRR Program audited 4 files for Q3 with an overall compliance of 100%.

Quality Indicators (QI)	**Q4**	**Q1**	**Q2**	**Q3**
Reports/Summaries				
Discharge Summaries (QI)	100%	100%	100%	90%
Initial Individual Service Plan (QI)	100%	100%	97%	94%
Quarterly Review/ Updated Service Plan (QI)	100%	100%	100%	100%
Six Month Review/Updated Service Plan (QI)	92%	100%	100%	75%
Chronological				
Client Chronological Report of Case Activity (QI)	96%	100%	100%	90%
Assessment of Safety (QI)	96%	96%	96%	96%

Quality Indicator Results Detail

For Q4, overall compliance for these items was 97%.
For Q1, overall compliance for these items was 99%.
For Q2, overall compliance for these items was 99%.
For Q3, overall compliance for these items was 91%.

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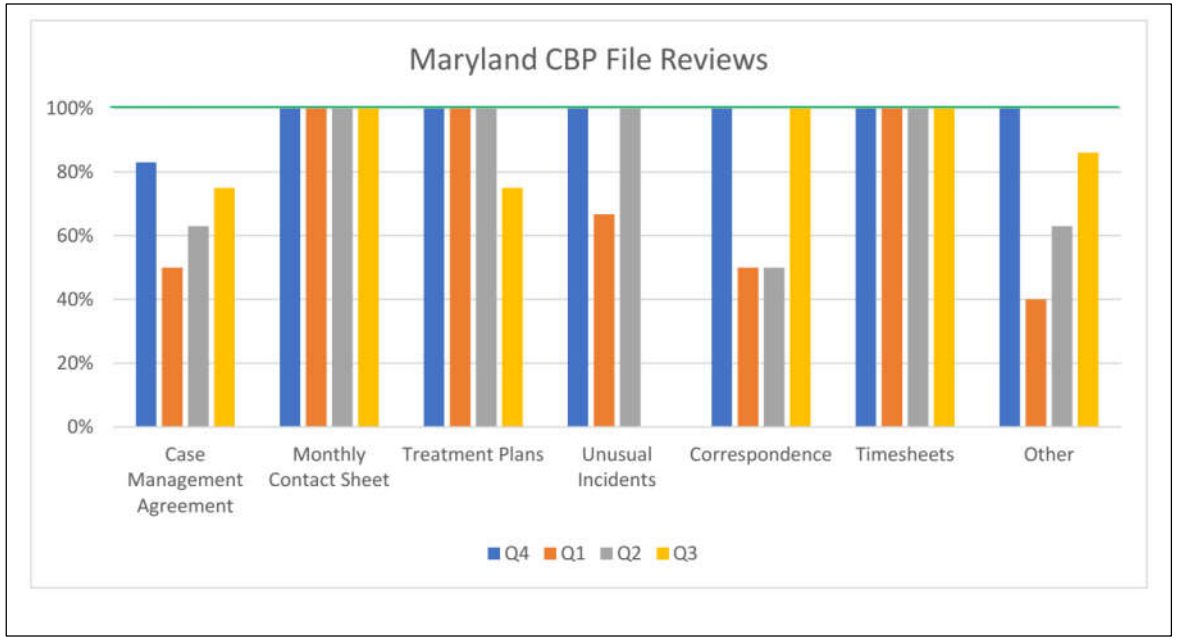
Maryland Community Based Programs Quarterly Totals



Q4 (Apr-June 2022)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 4 files.
Overall compliance was 98%.

Q1 (July-Sept 2022)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 5 files.
Overall compliance was 72%.

Q2 (Oct-Dec 2022)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 4 files.
Overall compliance was 75%.

Q3 (Jan-Mar 2023)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 4 files.
Overall compliance was 88%.

The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicator Results Detail

For Q4, overall compliance for this item was 100%.
For Q1, overall compliance for this item was 100%.
For Q2, overall compliance for this item was 100%.
For Q3, overall compliance for this item was 75%.

Quality Indicators (QI)	Q4	Q1	Q2	Q3
Treatment Plans (QI)	100%	100%	100%	75%

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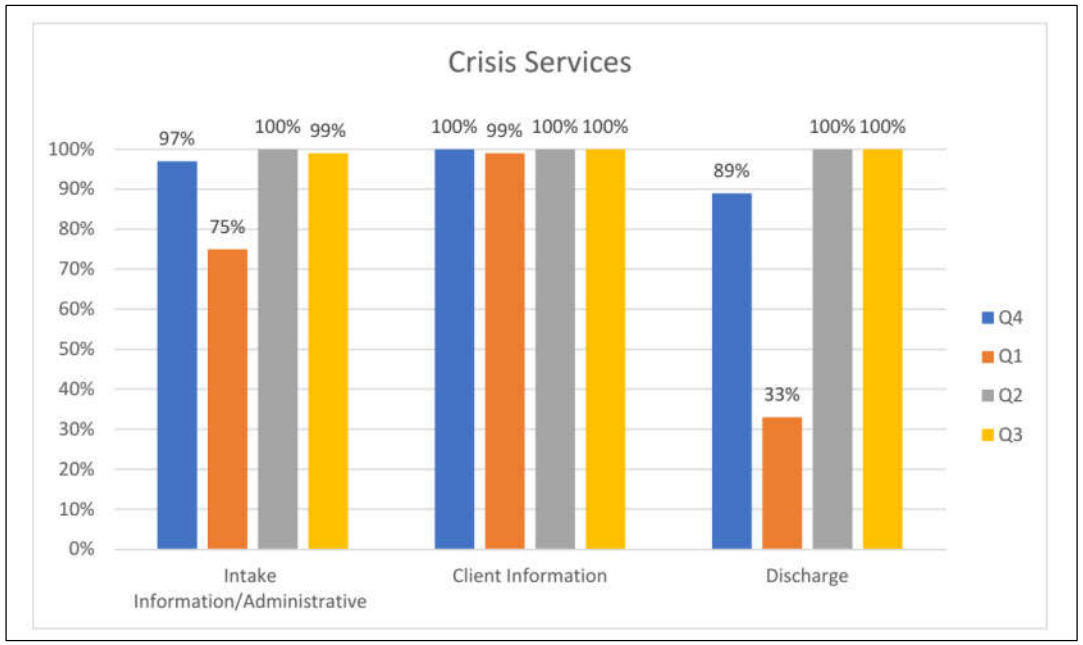
Crisis Services Quarterly Totals



Q4 (Apr-June 2022)
Crisis Programs conducted file reviews on a total of 42 files.
Overall compliance was 95%.

Q1 (July-Sept 2022)
Crisis Programs conducted file reviews on a total of 37 files.
Overall compliance was 69%.

Q2 (Oct-Dec 2022)
Crisis Programs conducted file reviews on a total of 45 files.
Overall compliance was 100%.

Q2 (Jan-Mar 2023)
Crisis Programs conducted file reviews on a total of 37 files.
Overall compliance was 99%.

Quality Indicator Results Detail

For Q4, overall compliance for these items was 100%.
For Q1, overall compliance for these items was 99%.
For Q2, overall compliance for these items was 100%.
For Q3, overall compliance for these items was 100%.

Quality Indicators	**Q4**	**Q1**	**Q2**	**Q3**
Client Information				
"D" section of progress note active intervention occurring during the session (QI)	100%	98%	100%	100%
"D" section addressed natural and community supports (QI)	100%	98%	98%	100%
"A" section of the note includes assessment of SI/HI risk (QI)	100%	100%	100%	100%
"A" section of the note includes assessment of D&A needs (QI)	100%	100%	100%	100%

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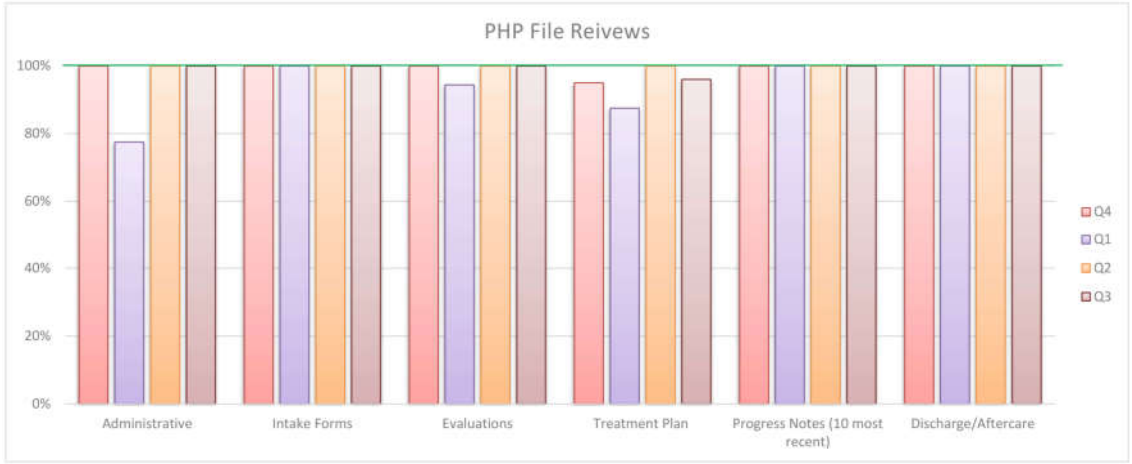
Partial Hospitalization Services Quarterly Totals



Q4 (Apr-June 2022)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files.
Overall compliance was 99%.

Q1 (July-Sept 2022)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files.
Overall compliance was 93%.

Q2 (Oct-Dec 2022)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files.
Overall compliance was 100%.

Q3 (Jan-Mar 2023)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files.
Overall compliance was 99%.
The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicator Results Detail

For Q4, overall compliance for these items was 96%.
For Q1, overall compliance for these items was 95%.
For Q2, overall compliance for these items was 100%.
For Q3, overall compliance for these items was 98%.

Quality Indicators (QI)	Q4	Q1	Q2	Q3
Treatment Plan				
Treatment Plan contains the strengths of the client (QI)	100%	100%	100%	100%
Treatment Plan has goals clinically consistent with problems/needs/diagnoses identified in the psychiatric evaluation (QI)	100%	100%	100%	100%
Treatment Plan has specific, behaviorally defined objectives or steps to meet goals (QI)	100%	100%	100%	100%
Does Treatment plan indicate goals/objectives for trauma for the client and/or family? (QI)	80%	50%	100%	100%
Transition/discharge plan contains strengths, supports, and is clearly defined (QI)	100%	100%	100%	83%
Progress towards goals documented appropriately on treatment plan (QI)	83%	100%	100%	100%
Progress Notes (10 most recent)				
"D" section clearly states an active intervention occuring during sessions (QI)	100%	100%	100%	100%
"P" section states the focus for the next session, any homework given to the client, and any follow-up the therapist will be doing. (QI)	100%	100%	100%	100%
Written in DAP format (including goal to be addressed). Content of the note is consistent with goal/objective/intervention in Tx. (QI)	100%	100%	100%	100%
Discharge/Aftercare				
Discharge summary addresses all Tx Plan goals and is clearly defined (QI)	100%	100%	100%	100%

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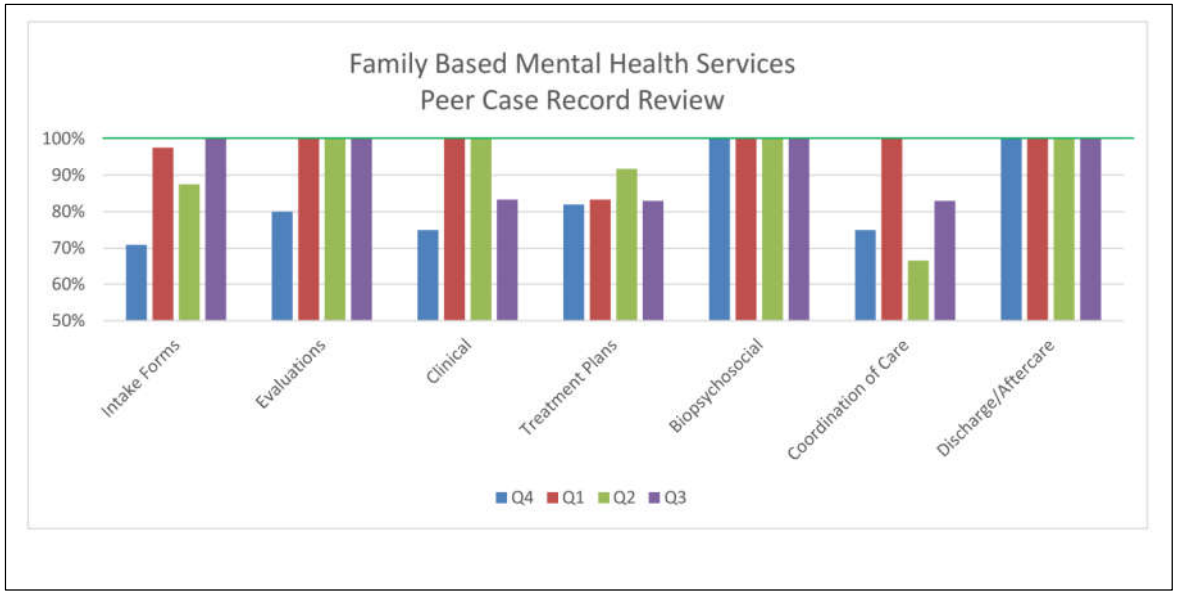
Family Based Mental Health Services Quarterly Totals



Q4 (Apr-June 2022)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 6 files.
Overall compliance was 83%.

Q1 (July-Sept 2022)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 8 files.
Overall compliance was 97%.

Q2 (Oct-Dec 2022)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 6 files.
Overall compliance was 92%.

Q3 (Jan-Mar 2023)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 6 files.
Overall compliance was 93%.

The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicator Results Detail

For Q4, overall compliance for these items was 76%.
For Q1, overall compliance for these items was 100%.
For Q2, overall compliance for these items was 88%.
For Q3, overall compliance for these items was 87%.

Quality Indicators (QI) **Clinical**	**Q4**	**Q1**	**Q2**	**Q3**
Documentation supporting that Client seen by Team within 24 hours of client returning home from hospitalization? (QI)	50%	100%	100%	67%
Progress Notes include client response to intervention (QI)	100%	100%	100%	100%
Does Treatment plan indicate goals/objectives for trauma for the client and/or family?(QI)	80%	100%	83%	83%
Coordination of Care - Initial and most recent 2-months				
Evidence of coordination of care with other formal/informal supports a minimum of monthly? (QI)	50%	100%	67%	83%
Evidence that the prescribing physician was informed within 48 hours of medication issue or in instances in which refusal of taking medication? (QI)	100%	100%	n/a	100%

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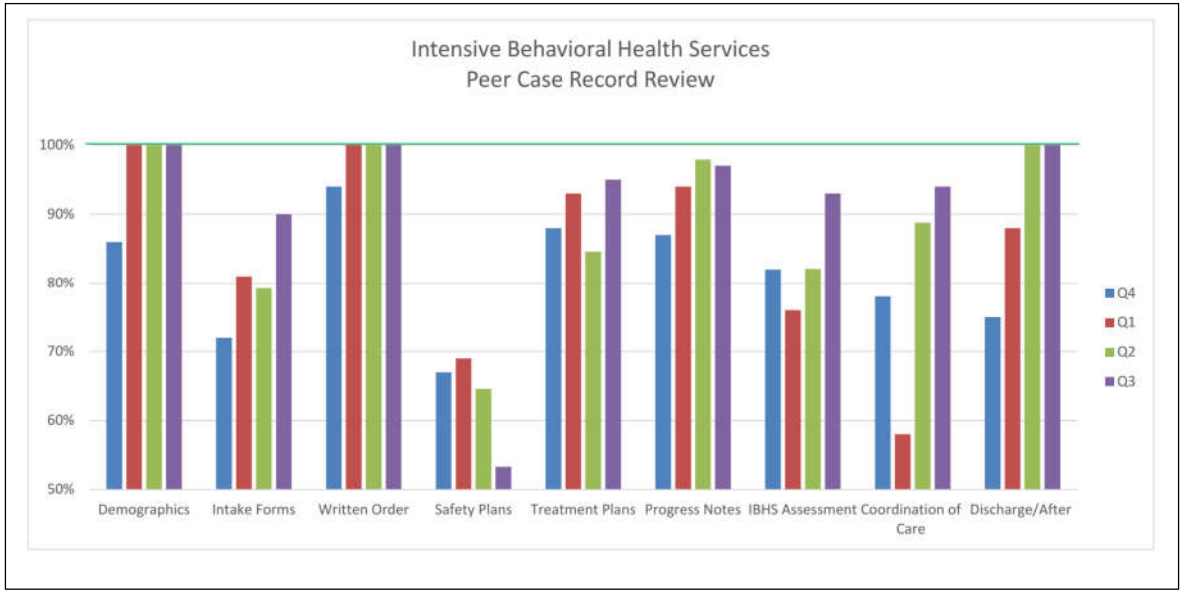
Intensive Behavioral Health Services Quarterly Totals



Q4 (Apr-June 2022)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 40 files.
Overall compliance was 81%.

Q1 (July-Sept 2022)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 32 files.
Overall compliance was 84%.

Q2 (Oct-Dec 2022)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 25 files.
Overall compliance was 89%.

Q3 (Jan-Mar 2023)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 26 files.
Overall compliance was 91%.

The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicator Results Detail

For Q4, overall compliance for these items was 82%.
For Q1, overall compliance for these items was 81%.
For Q2, overall compliance for these items was 87%.
For Q3, overall compliance for these items was 90%.

Quality Indicators (QI)	Q4	Q1	Q2	Q3
Safety Plans				
Safety/Crisis plans identify specific steps for all settings? (QI)	65%	73%	63%	41%
Safety/Crisis plans identify natural and communirty supports and their role in the plan? (QI)	68%	65%	67%	66%
Treatment Plans				
Treatment plan documents the client, family, and cultural strengths? (QI)	94%	94%	72%	100%
Treatment plan has goals clinically consistent with problems/needs/diagnoses identified in IBHS assessment (QI)	98%	98%	100%	99%
Treatment plan has operationally defined, measurable, objectives to meet goals (QI)	78%	95%	92%	99%
Progress summary includes measurable data for each goal objective (if continued stay/amendment) (QI)	80%	85%	75%	83%
Progress Notes				
"D" section clearly states an active intervention occurring during session (must come directly from Tx plan) (QI)	96%	89%	100%	99%
"D" client's response to the intervention (QI)	96%	98%	96%	99%
"A" section Clinician's interpretation of clients symptoms, level of participation, prognosis, concerns, & interpretation of data comparison (QI)	86%	94%	100%	98%
"P" section states Tx goal/objective focus/setting for next session, any HW given, and any follow-up the therapist will be doing (QI)	70%	94%	96%	92%
IBHS Assessment				
Was a referral made **OR** does treatment plan identify how trauma/MISA is being addressed? (QI)	64%	54%	71%	88%
Recommendations reflect the needs of the client and family (QI)	100%	97%	93%	99%
Coordination of Care				
Evidence of coordination of care with educational and/or vocational systems a minimum of monthly? (QI)	68%	69%	86%	96%
Evidence of coordination of care with other child-serving systems a minimum of monthly? (QI)	66%	71%	86%	88%
Evidence of coordination of care with other behavioral health specialists minimum of monthly? (QI)	100%	33%	94%	100%
Discharge/Aftercare				
Discharge summary addresses al Tx plan goals and is clearly defined (QI)	75%	88%	100%	100%

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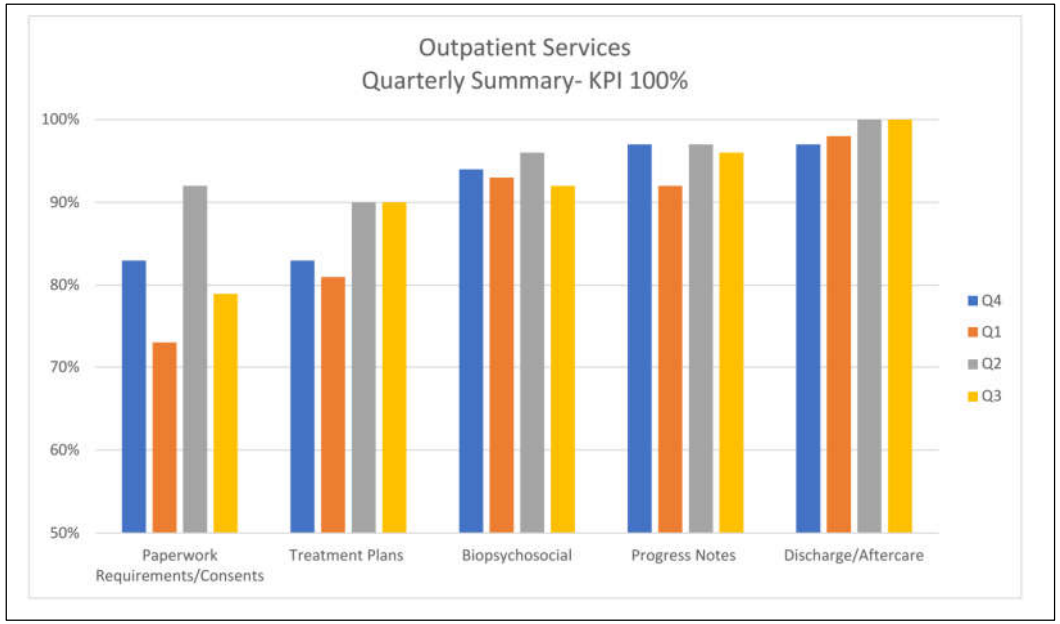
Outpatient Services Quarterly Totals



Quality Indicators	Q4	Q1	Q2	Q3	KPI's
Treatment Plans					
Transition plan described (supports/resources for client) (QI)	84%	82%	94%	94%	80%
Discharge criteria clearly defined/measurable (QI)	86%	83%	86%	94%	80%
Interventions incorporate client strengths (QI)	68%	69%	82%	73%	80%
Client friendly language used (QI)	96%	100%	98%	100%	80%
Client's strengths listed (QI)	100%	98%	100%	98%	80%
Goals consistent with diagnosis/needs of client (QI)	99%	94%	98%	91%	80%
In updated treatment plans, progress is documented (QI)	86%	86%	95%	95%	100%
Safety Plan: individualized (QI)	94%	88%	91%	99%	80%
Biopsychosocial					
Assessment of client's strengths/needs is made (QI)	97%	95%	98%	95%	100%
Diagnoses are consistent with present features (QI)	92%	91%	95%	89%	80%
Progress Notes					
D section lists intervention listed in Tx plan (QI)	94%	86%	94%	93%	100%
A section lists clinical features, mood, affect, level of cooperation (QI)	98%	93%	99%	100%	100%
Treatment modalities used in session are listed (QI)	99%	98%	95%	96%	100%
P section lists date of next session and goals to work on (QI)	97%	90%	99%	95%	100%

Q4 (Apr-June 2022)
Outpatient Programs (OPT) conducted file reviews on a total of 101 files.
Overall compliance was 91%.

Q1 (July-Sept 2022)
Outpatient Programs (OPT) conducted file reviews on a total of 101 files.
Overall compliance was 87%.

Q2 (Oct-Dec 2022)
Outpatient Programs (OPT) conducted file reviews on a total of 99 files.
Overall compliance was 93%.

Q3 (Jan-Mar 2023)
Outpatient Programs (OPT) conducted file reviews on a total of 100 files.
Overall compliance was 90%.

The Key Performance Indicator (KPI) thresholds for this line of service are either 80% or 100%.
The items requiring a KPI of 80% had an average score of 87%.
The items requiring a KPI of 100% had an average score of 92%.

Quality Indicator Results Detail

For Q4, overall compliance for these items was 92%.
For Q1, overall compliance for these items was 89%.
For Q2, overall compliance for these items was 95%.
For Q3, overall compliance for these items was 94%

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Strategic Planning

The strategic planning encompasses the Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis data we collected from the Board and staff surveys in March. After compiling the data, the Senior Leadership Team, Regional Leadership Team, and some invited guests reviewed the data on March 28th and then met in person on April 11th for a full day of brainstorming and planning. On April 19th we then began a rough draft of objectives, strategies, and actions. We then reconvened on May 5th to get a Strategic Plan draft ready for the Board. On May 11th, the Board reviewed the plan and provided feedback input into the plan. More specifically for PQI we focused on quality assurance and what specifically the PQI committee will be focusing on. We will now meet again one last time as a group to finalize the strategic plan to be ready for July 1st, 2023! This plan will guide our actions/strategies for the next 3 years!

Plan Updates

The PQI Committee has been involved in creating several Improvement Plans for a variety of areas within CONCERN. Data is reviewed and then evaluated for the use of an Improvement Plan. Members of the PQI Committee are involved with the implementation and monitoring of the Improvement Plans and progress and data is reported to the committee regularly.

- CTUB Training Improvement Plan was initiated in January 2021 related to our compliance with staff training requirements and is still being worked on with improvements noted. The improvement plan activities during the first year of implementation allowed for significant improvement in all areas of training completion. Training completion for **New Hire** is listed at 96% for the past 6 months and the previous 6 months were listed at100% completion, which is an overall improvement from Q2. **CPSL** is currently at 100% with the previous 6 months being at 75% completion. Notable improvements have been made in this area. **SCM** is currently at 87% compliance rate with the previous 6 months being at 73%, which again has made notable improvements. **All training completion** is currently at a 64% compliance rate and improved since August of 2022 when completion was only 44%. Procedures have been put into place to help with compliance, including adding it as a goal to all staff evaluations for follow up each month during supervisions, setting advance scheduling notices so supplemental staff and FT time have plenty of notice to attend, and bringing in an outside agency to ensure the quality of the training is not compromised. In conclusion, CTUB is on an upward trend.

- The Behavioral Health and Social Services Training Improvement Plan was initiated in January 2021. We initially reported updates separately for Behavioral Health and Social Services and have recently determined that updating the plans would be better if reported on by region. The focus is on compliance for all trainings for all staff being 90% or higher and 100% for both Safe Crisis Management (SCM) and for Child Protective Services Law (CPSL) training. For the **Northern Tier Region**, the overall compliance changed from 93% to 89%. **Eastern Region BHS** achieved 100% compliance for new hire training and CPSL. However, the ongoing training

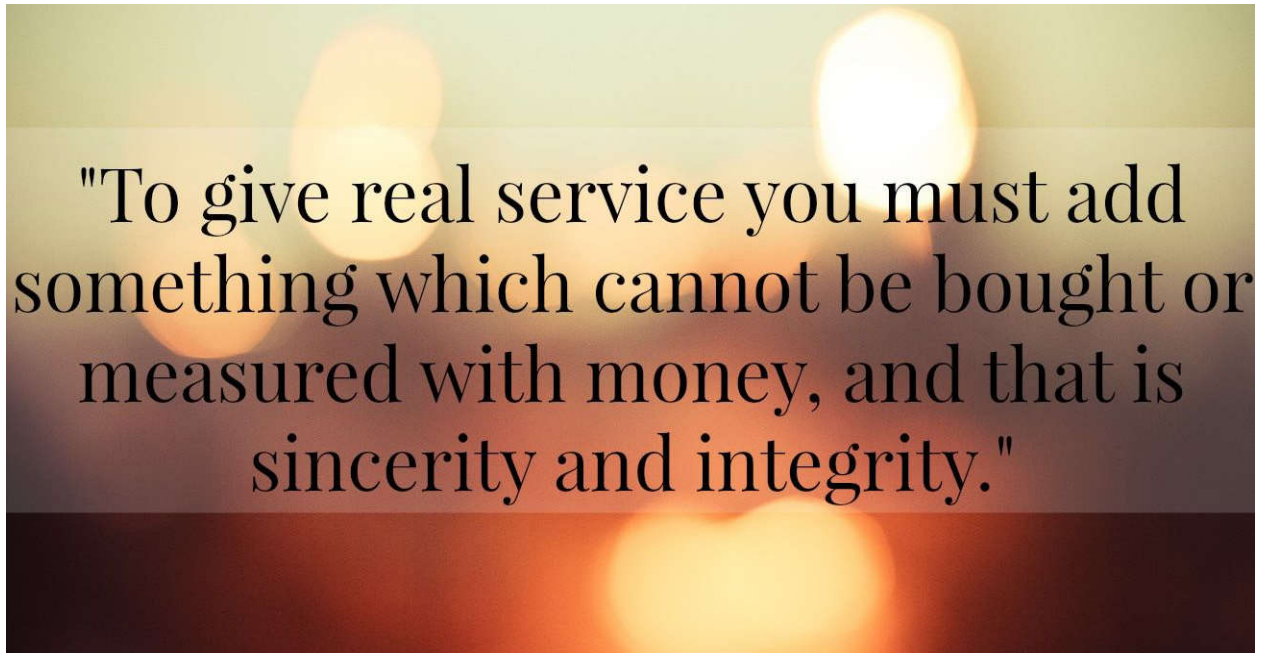
percentage is 86%, with some programs performing better than others. Some training courses are delayed due to monthly IT sessions, staff absences, or as per staff reported they would prefer to complete trainings when they have no shows and this does not always fall within a week when IT trainings are due. The supervisors continuously remind everyone about the importance of meeting the 90% compliance goal at staff meetings. The **Maryland** training completion and compliance for Quarter 3 (1/1/23-3/31/23) was 100% Total Completion and 100% Total Compliance- we have met our goal and will continue doing what we have been to maintain our goal!

- Outpatient Program Improvement Plan -A treatment plan report was generated for January 17-31, 2023. 10 treatment plans were reviewed and 10/10 were completed on time. Met with Region Directors on 4/18/23 to review our current process and changes that need to occur to align with the regulations. Our next treatment plan review and discussion will occur on 5/30/23.

- Partial Hospitalization Program Improvement Plan- In our February 2023 supervision, 12 treatment plans were reviewed and 12/12 (100%) were completed on time. In our March 2023 supervision 6 treatment plans were reviewed and 6/6 (100%) were completed on time. In our April 2023 supervision 21 treatment plans were reviewed and 21/21 (100%) were completed on time.

- Training Evaluations Improvement Plan- Introduction to Trauma Informed Care training was removed from staff training plans due to poor evaluation scores and after further investigation, not being useful for non-clinical staff. This training was replaced with "What Does Becoming Trauma-Informed Mean for Non-Clinical staff" and is included as an annual training for all agency non-clinical staff. Further evaluation of this new training will occur in the near future to assess its effectiveness/usefulness.

- Collaborative Documentation- An improvement plan is being developed for use with Collaborative Documentation which is used in all behavioral health programs. Baseline data has been collected and improvement plans will be developed for those program under 90%. Because there is fluctuation in the data due to new staff being hired and trained, we will closely monitor the changes and subsequent actions.



Thank you to all the PQI Committee members who not only meet monthly to review and analyze data but also attend sub-committee meetings and spread the culture of quality improvement through the agency.

This report includes data from Q-3 (January 2023 to March 2023) for Fiscal Year 2022-23 and is a testament to the focus, and commitment of staff especially as it relates to their daily work with clients and their attention to detail when working with the data.

If you have any feedback about this report, please contact us at creeling@concern4kids.org or 484-578-9600.