Quality Improvement & Quality Assessment Performance Improvement Plan Annual Report, FY 2017-2018

Submitted by:

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The Children's Center
Quality Improvement and Quality Assessment Performance Improvement Plan
Fiscal Year 2017-2018
October 1, 2017 – September 30, 2018

Introduction

The Children's Center provides a comprehensive array of services for children and families in Wayne County. We lead the way in working with children who struggle with behavioral, emotional, educational, intellectual and developmental challenges or may have been exposed to trauma or experienced trauma. We treat the whole child, looking at more than a single issue so we can provide the best, most comprehensive integrated care. We examine barriers in the home, school and community, working with the family who raises them and the organizations that support them. Our mission is to help children and families shape their own futures. In order to achieve this, we focus on preventative treatment, therapeutic interventions, the fostering and provision of safe home environments, and linking families to other community resources. We provide best practice and evidence-based care to guide diagnosis and treatment, and help families overcome their struggles. While a wide variety of services is offered, quality is a critical component and common underpinning amongst them all. This concept and philosophy is supported through the structure of the Quality & Compliance Department, the Quality Improvement Plan (QIP), and the Quality Assessment Performance Improvement Plan (QAPIP).

The purpose of the Quality Improvement Plan is to design the quality monitoring system for all of The Children's Center programs and services. The plan primarily consists of indicators designed to measure key performance areas, both at the individual program level as well as the organization as a whole. Current data and historical trends are utilized to inform which indicators to use relative to the logic of program models, qualitative and contractual mandates, and Strategic Plan initiatives. However, above all else, indicators have been chosen based on their ability to accurately measure program areas while assisting program leadership in identifying opportunities for improvement.

The purpose of the QAPIP is to provide Assessment that The Children's Center achieves alignment with healthcare reform and demonstrates to clients, advocates, community organizations, health care providers, and Local and State policy makers that it has a distinct competency as a client-focused provider of behavioral health services. The QAPIP is the vehicle for improving the quality of care to clients and families and improving methods of service delivery to ensure desired client health status and client satisfaction.

The development and implementation of the quality improvement initiatives is a collaborative effort that includes Quality & Compliance staff along with Program staff. This process transpires in a planned, systematic fashion. At the point of implementation, the data is continuously reviewed and collected over time to determine if these initiatives have had the hypothesized positive impact in the applicable area(s) of focus. If the data indicates that adjustments to the initiatives or development and implementation of additional initiatives are necessary, then such changes will be made with subsequent indicators developed for ongoing measurement. Throughout the entire quality improvement process, sound data will be used to make informed decisions.

Access to valid data is crucial in the development of reliable quality indicators. However, data by itself is not enough to ensure that we measure what we need to measure; the data must be useful enough to answer important questions regarding specific areas of service delivery, and then utilize that data to drive decisions when needed. For the purposes of ensuring comprehensive analysis of services, the indicators generally fall in one of four areas: effectiveness, efficiency, satisfaction, and contractual compliance. This annual report provides an update on the quality improvement initiatives identified in the Fiscal Year 2017 QIP & QAPIP.

<u>Glossary Guide</u>

ABA: Applied Behavioral Analysis

ASD: Autism Spectrum Disorder

CBP: Community Based Partnerships

CCC: Crisis Care Center

CMH: Community Mental Health

CPS: Child Protective Services

CW: Child Welfare

DDS: Development Disability Services

DWMHA: Detroit Wayne Mental Health Authority

ECBH: Early Childhood Behavioral Health

FAIS: Family Assessment Integration Services

FCBH: Family Court Behavioral Health

FROP: Formal Review of Progress

FY: Fiscal Year

GBH: General Behavioral Health (Teams 1, 2, 4 &5)

HB: Home Based

HURT: High Utilization Review Team

IMH: Infant Mental Health

ISEP: Implementation, Sustainability and Exit Plan

MDHHS: Michigan Department of Health and Human Services

MHWIN: Mental Health Wellness Information Network

MiSACWIS: Michigan Statewide Automated Child Welfare Information System

MISTICC: Management Information System of the Incredible Children's Center (TCC's Electronic Health Record)

QI: Quality Improvement

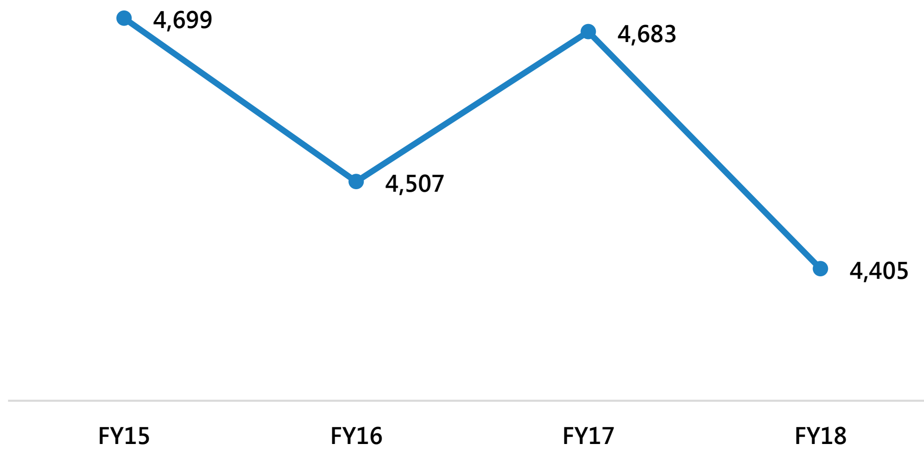
SED: Serious Emotional Disturbance

SCS: Supports Coordinator Specialist

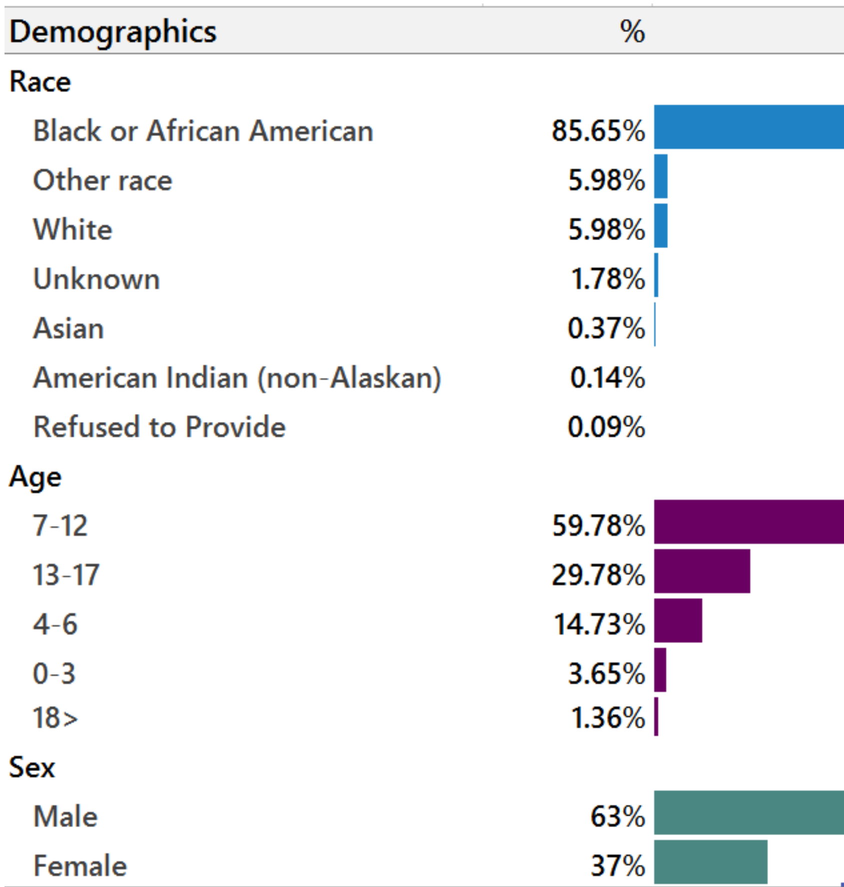
YASS: Young Adult Self Sufficiency

Population Served

The Children's Center provided behavioral health services to an unduplicated count of 4,405 clients during FY18, a decrease from 4,683 clients in FY17.



The Children's Center served a diverse population of clients with serious emotional disturbance and intellectual/developmental disabilities during FY18.



Demographics	%
Race	
Black or African American	85.65%
Other race	5.98%
White	5.98%
Unknown	1.78%
Asian	0.37%
American Indian (non-Alaskan)	0.14%
Refused to Provide	0.09%
Age	
7-12	59.78%
13-17	29.78%
4-6	14.73%
0-3	3.65%
18>	1.36%
Sex	
Male	63%
Female	37%

Effectiveness

Effectiveness indicators measure the impact that services have on the quality of life of the clients and families we serve. Primarily, these indicators look at clinical improvement as evidenced by validated measurement tools and completion of family-centered treatment goals. In summary, effectiveness indicators ensure that the primary qualitative output and outcomes for our programs are being met.

Efficiency

Efficiency indicators measure the timeliness of service delivery, ensuring that quality services are delivered using only the resources necessary to facilitate such delivery. While effectiveness is viewed as a qualitative measure of service, efficiency indicators are necessary to ensure maximum impact of services. For example, identification of appropriate clinical services at Intake is a crucial effectiveness indicator, yet such identification is severely limited if initial delivery of services is delayed in a significant way.

Satisfaction

Satisfaction indicators assess a client and family's satisfaction with service delivery. The Children's Center prides itself on supporting clients and families in achieving their goals and objectives based on the voice and choice of the client and family. Effective services delivered in an efficient manner are hampered if the clients and families we serve are not satisfied with the services they receive. Satisfaction surveys are a typical measure of client satisfaction. Measurements of client satisfaction are also obtained conversely via client complaints.

Contractual Compliance

Contractual Compliance indicators are directly tied to contractual and legal requirements. Many of these requirements correlate to effectiveness, efficiency, and satisfaction; for the purposes of clarity, such indicators are included in the applicable sections of this plan. However, many contractual compliance indicators measure areas that are not directly related to the other three indicator types but are meant to facilitate and/or support achievement of indicators in these three areas. Examples of these processes or structure-focused indicators include quality improvement chart reviews and corporate compliance reviews of service activity logs to ensure appropriate coding and billing of services delivered.

Within each of these indicator sets, organizational indicators were identified that affect multiple programs or are tied to the overall mission and values of The Children's Center. Additionally, Program-specific indicators were developed to measure critical items that only can be found in one or a small set of programs. It should be noted that, in general, most indicators found in the clinical programs are organizational. While these programs may use different interventions and serve clients with differing diagnoses, they share the overarching task of assisting clients to achieve their goals via family-centered and youth driven planning processes.

Effectiveness

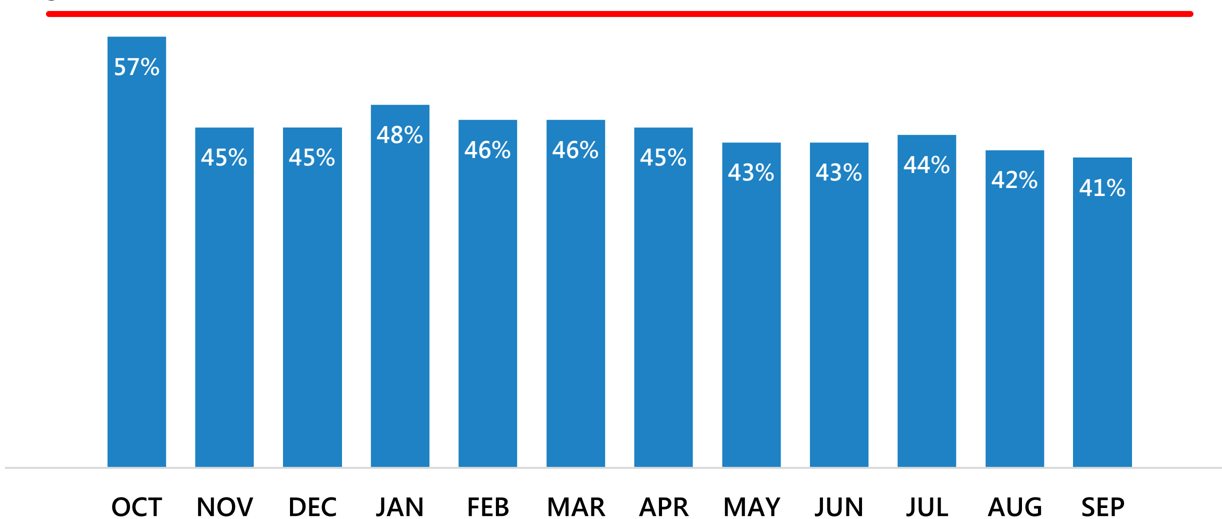
Performance Improvement Goal #1: CAFAS/PECFAS Progress

60% of clients discharged each month will exhibit a 20-point decrease in total score as a measure of clinical progress.

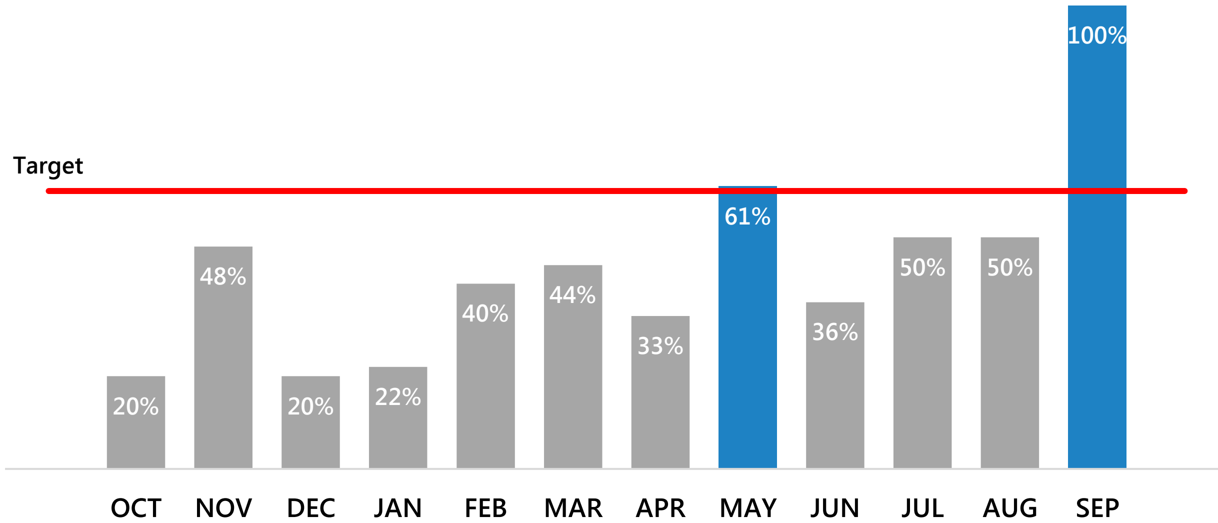
Throughout our SED (Serious Emotional Disturbance) clinical programs, the Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) are standardized, valid and reliable assessments used to measure clinical progress. CAFAS and PECFAS data is obtained through initial and ongoing standardized assessments of the child or adolescent's functioning in different areas of their life (domains). Clinical progress is defined by a 20-point decrease in total score. The lower the score, the better, and the monitoring of these assessments is a requirement throughout all Community Mental Health agencies in the State of Michigan and the data is entered in the Functional Assessment Systems (FAS).

Throughout the Detroit Wayne Mental Health Authority (DWMHA) system, the benchmark has been set to observe a 20-point decrease in total CAFAS score for 60% of clients discharged each month, reported as year-to-date. The monthly agency-wide results for decreased CAFAS/PECFAS score are reported below:

20-point CAFAS score decrease was not met in FY18.
Target is 60%

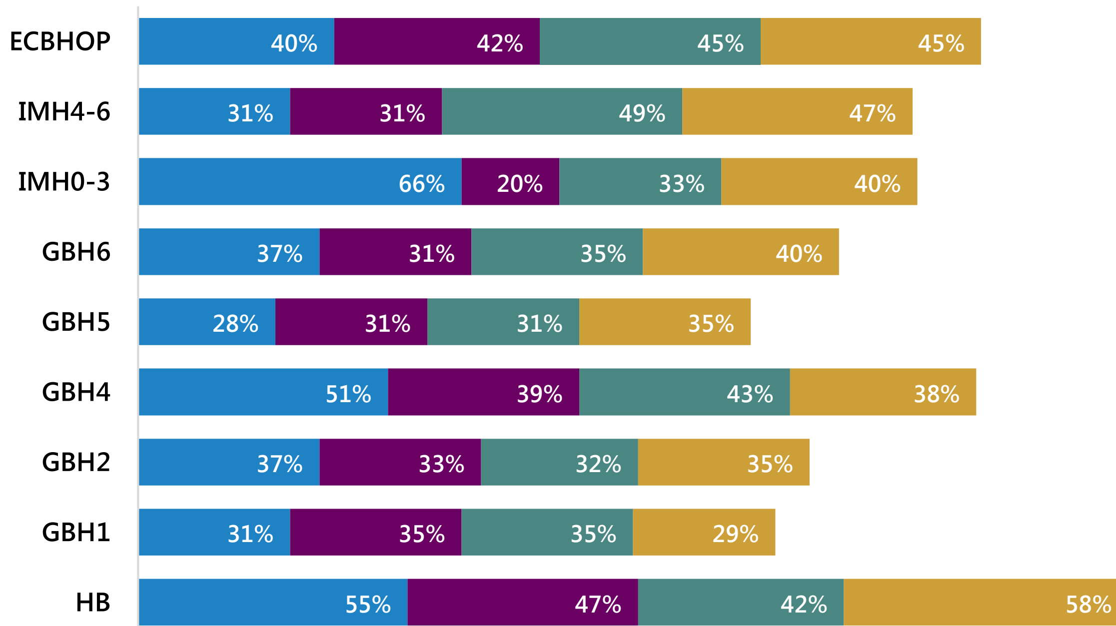


20-point PECFAS score decrease was not met throughout FY18, except May and September.
Target is 60%



Overall, the data shows that we only met target for two months in the last fiscal year. We exceeded the target in September and May for PECFAS, but a deeper dive into the data illustrated that this was a result of one client discharged in the month of September and 13 in May. As a result of not consistently meeting target, this demonstrates the need for continuous monitoring to occur during the monthly Quality Improvement meetings to assess how we can better address the clinical needs of the clients and families we serve.

In order to pinpoint possible drivers, the specific program areas are reviewed:



This graph that contains the program breakdown, shows that quarter 1 had the highest overall percentage of FAS score improvement. An overall downward trend occurred from Q1 to Q2 and Q3, and then an increase in Q4. A significant increase transpired in Home Based in the last quarter, which is theorized to be closely tied to a large number of Home Based clients stepping down to GBH. This graph includes a comparison of initial to most recent assessment of both active and closed clients. The data for FY18 is similar to FY17 with no program hitting target. However, Home Based trended the closest by averaging above 50%, and almost hitting target at 58%.

Performance Improvement Goal #2: Hospital Utilization

The Children's Center will decrease hospital recidivism for SED clients and monitor the hospitalization of DDS clients.

The services funded by Detroit Wayne Mental Health Authority and provided by The Children's Center are to help clients remain in their community setting and avoid psychiatric hospitalizations or institutional settings. The psychiatric hospitalization rate measures the effectiveness of this goal. Further, The Michigan Department of Health and Human Services (MDHHS) mandates that less than 15% of clients discharged from psychiatric inpatient settings are readmitted to a psychiatric hospital setting within 30 days of the discharge date. This pattern of readmission is known as "recidivism." Since recidivism focuses on SED clients, The Children's Center added an additional component to monitor the count of DDS (Development Disability Services) clients admitted to inpatient hospitals. Additionally, in FY18 we monitored ER data and how long our clients sat in the ER prior to admission.

In order to determine the interventions necessary to reduce hospitalizations and recidivistic admission, the High Utilization Review Team (HURT) meets on a monthly basis to review hospitalization-related statistics. Their purpose is to decrease the utilization of higher levels of care by identifying services and interventions that may decrease the crisis incidents of our clients. The applicable treatment team along with the Crisis Care Supervisor and members of the Quality & Compliance Department attend the monthly meeting to discuss the critical case(s) and identify possible interventions and additional services to support the client's stabilization.

Additionally, the Crisis Care Center (CCC) equips children and families with strengths and resources to assist them in recovering from a crisis situation. A family focused approach is practiced to assess and intervene during psychiatric crises with the hopes of supporting the family and having the child safely return home. When safety for all involved is not assured, the CCC team will work with the psychiatrist to determine the most appropriate and lowest level of care to stabilize the child in crisis.

For FY18, the statistics for hospital utilization, crisis care services, and ER data is as follows:

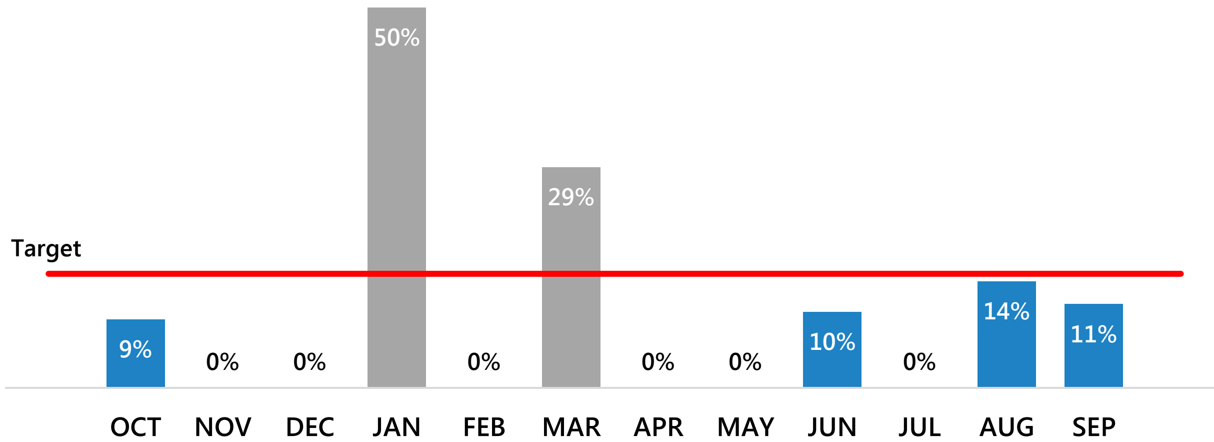
Objectives	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
Inpatient Data (from Hospital Liaison Log)												
1. CareLink Inpatient Admissions	11	9	9	2	11	7	8	6	10	7	7	9
2. Average length of stay	6	6	6	5.5	5	7	7	*M=6	8	10	8	6
3. CareLink Recidivistic Admissions	1	0	0	1	0	2	0	0	1	0	1	1
4. CareLink Percent Recidivism Target: <15%	9%	0%	0%	50%	0%	29%	0%	0%	10%	0%	14%	11%
5. CareLink Total Discharged (inp.)	9	9	10	4	9	5	10	7	8	6	9	7
6. ConsumerLink Inpatient Admissions	0	2	1	1	3	1	2	2	0	2	1	2
7. ConsumerLink Recidivistic Admissions	0	0	0	0	0	1	1	1	0	0	0	0
8. ConsumerLink Total Discharged (inp.)	0	1	1	1	1	3	2	2	0	1	2	1
9. All MCPN Aftercare Appointments (7 days)	5	4	6	2	2	6	7	4	5	4	7	5
Crisis Center Data (from CC Monthly Log)												
10. Crisis Center Contacts (face to face)	71	78	67	60	60	103	72	92	43	25	35	46
10a. Screening Location: Crisis Care (CareLink)	58	56	56	53	52	84	60	75	29	17	30	43
10b. Screening Location: Children's Hospital (CareLink)	13	22	11	7	8	19	12	17	14	8	5	3
11. Crisis Center to Psych. Hosp.	15	12	14	10	10	22	17	16	12	12	11	10
12. CC Diversion Rate Target=65%	79%	85%	79%	83%	83%	79%	83%	83%	72%	52%	69%	78%
Overall Crisis Data (from MISTICC SALs)												
13. Psychiatrist Interventions (829 codes)	109	99	97	79	91	162	125	128	56	39	63	74

14. H2011 codes billed	84	94	79	71	79	144	116	122	48	35	67	60
ER Data												
15. Count of children in ER	4	5	4	2	10	11	12	8	2	1	4	1
16. Children in ER, no bed available	2	4	2	0	9	4	8	7	0	1	1	1
17. Children in ER, denied	2	1	2	1	1	7	4	1	2	1	4	1
18. Average length of stay in ER in days	3	2	2	1	2.5	3.5	3.5	3	4.5	18	9.5	4
19. Children in ER – disp. changed to PHP or OP	1	0	0	0	1	3	3	6	0	0	1	0
20. Number of Rescreens	10	5	8	2	20	26	27	15	4	13	28	6

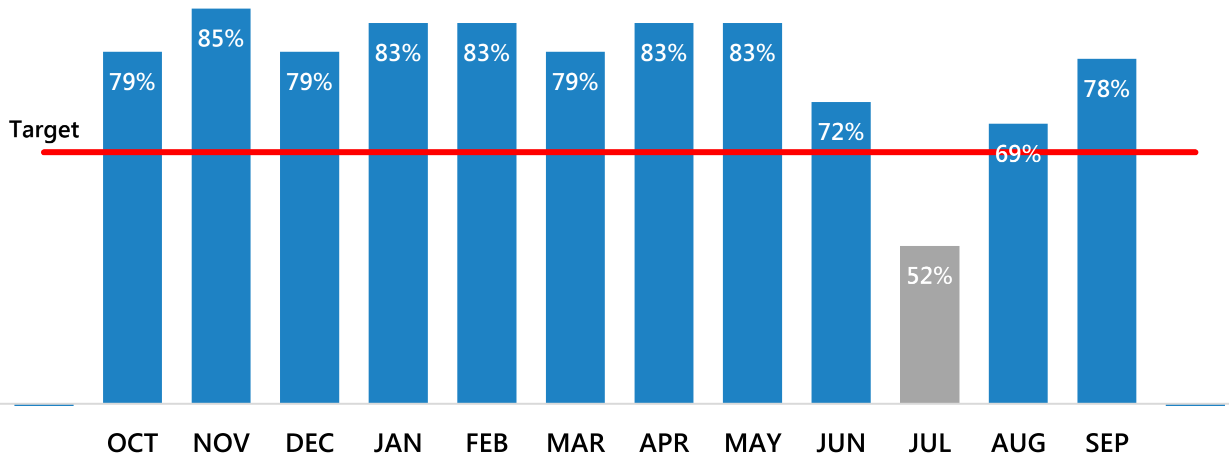
Objectives	Q1	Q2	Q3	Q4
1. CareLink Inpatient Admissions	29	20	24	23
2. Average length of stay	6	6	7	8
3. CareLink Recidivistic Admissions	1	3	1	2
4. CareLink Percent Recidivism	3%	26%	3%	8%
5. CareLink Total Discharged (inp.)	28	18	24	22
6. ConsumerLink Inpatient Admissions	3	5	5	5
7. ConsumerLink Total Discharged (inp.)	2	5	5	4
8. Crisis Center Contacts (face to face)	216	223	207	106
9. Crisis Center to Psyc. Hosp.	41	42	45	33
10. CC Diversion Rate	81%	82%	79%	66%
11. Psychiatrist Interventions (829)	311	335	306	176
12. H2011 codes billed	258	295	287	162
13. Count of children in ER	13	22	22	6
14 Children in ER, no bed available	12	20	15	3
15. Children in ER, denied	0	1	7	6

16. Average length of stay in ER	2.5 Days	2.5 Days	3.5 days	10.5 days

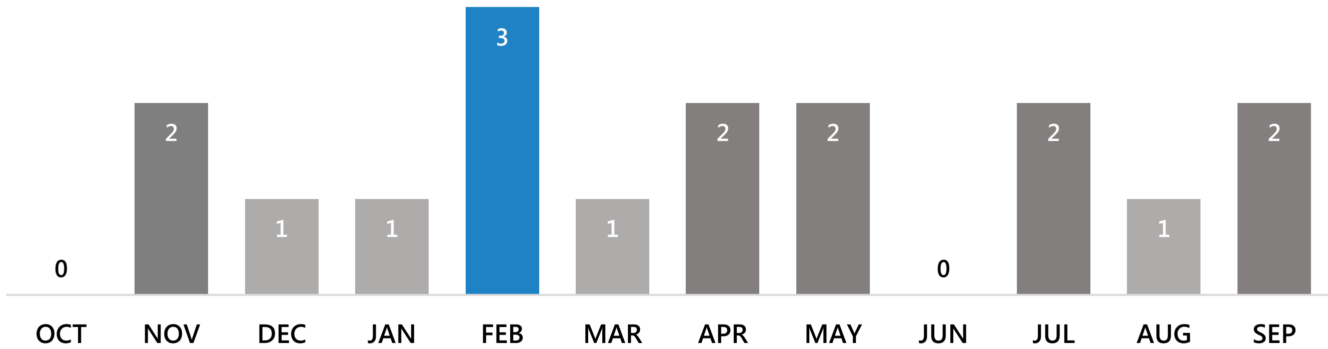
Recidivism target was met each month except January and March during FY18.
Target is <15%



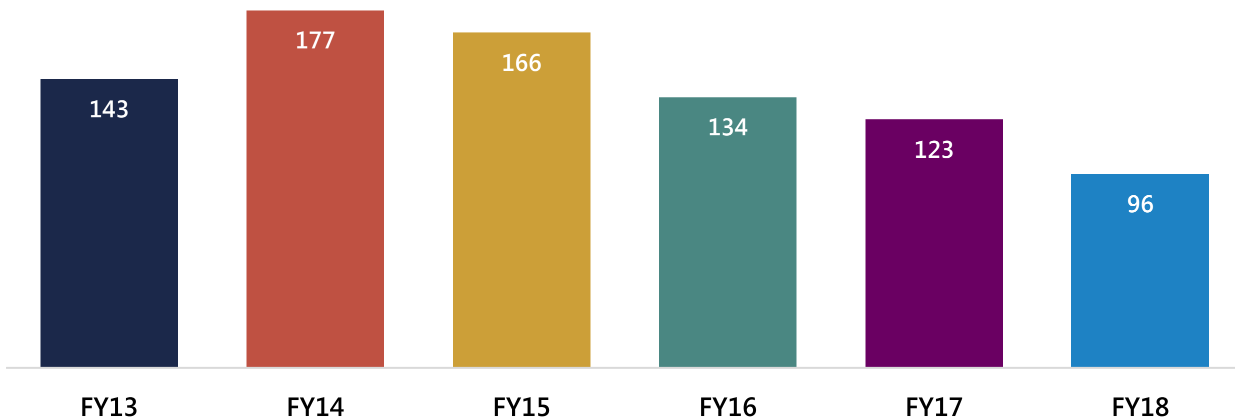
CCC Diversion Rate was met each month except July during FY18.
Target is >65%



The highest number of DDS hospitalizations was in February.



FY18 saw the fewest inpatient CareLink hospitalizations in 6 fiscal years.



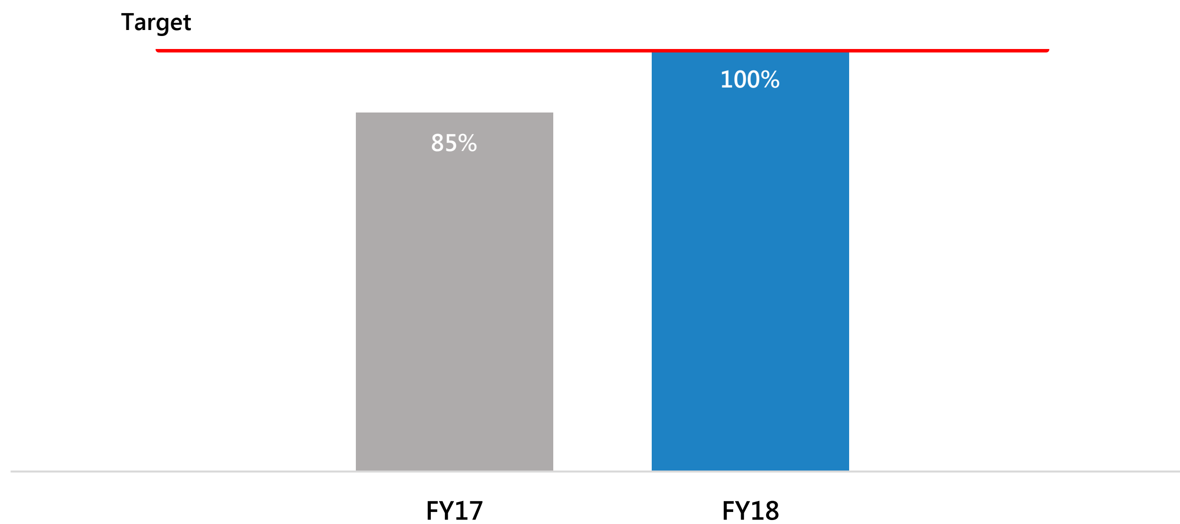
Overall, trends in admissions continually decrease from prior years. Additionally, the recidivism rate was on par in FY18 with FY17. Meaning, we were able divert about the same number of children from re-entering the hospital within 30 days of their discharge. The average recidivism rate for FY18 was 10% as opposed to an average of 9% in FY17. The target of 15% or less was met each month except January and March. The Crisis Care Center continues to have a significant impact on admissions when compared to the other available interventions with an average diversion rate of 77%.

Performance Improvement Goal #3: Child Welfare YASS Graduation %

95% of YASS clients will graduate high school. YASS (Young Adult Self-Sufficiency)

Our Young Adult Self-Sufficiency Program (YASS) gives young people aging out of the foster care program a chance to find success. We empower these young adults with the life skills they need to become contributing members of society, and graduating from high school is a strong predictor of better health.

YASS clients graduation rate was met in FY18 and increased from FY17.
Target is 95%



This data point monitors our effectiveness in impacting a social determinant of health. The social determinants of health are social, economic, and environmental factors that contribute to the overall health of individuals and communities. These are the conditions in the environment in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of health foods, local emergency/health services, and environments free of life-threatening toxins.

The staff in this department provided education monitoring and tutorial services to support the YASS students in graduating high school. We will continue to monitor annual trends and assess our continual impact.

Efficiency

Performance Improvement Goal #1: MDHHS – Access to Services (Performance Indicator 2)

The Children's Center will increase and maintain the standard of providing clients with an Intake within 14 calendar days of non-emergent requests 95% of the time.

MDHHS requires that 95% of clients will receive a face-to-face assessment with a professional within 14 days of a non-emergent request for service. The exception to this is when a client requests an appointment outside of the 14-day timeframe. The Intake Department captures this data in the MHWIN system and it is monitored by the Quality & Compliance Department.

The monthly trend for timely assessments is reported below:

Indicator 2 compliance decreased from FY16 to FY17, but increased from FY17 to FY18.

Target is 95%

	FY16	FY17	FY18
SEP	100%	83.87%	99.11%
AUG	100%	84.71%	100%
JUL	96.36%	50.79%	97%
JUN	98.18%	64.41%	100%
MAY	95.88%	54.17%	98.10%
APR	96.61%	65.08%	100%
MAR	99.17%	84.16%	100%
FEB	100%	79.57%	97.53%
JAN	100%	98.61%	92.11%
DEC	94.87%	100%	
NOV	100%	100%	57.50%
OCT	98.20%	98.55%	78.95%

Historically, The Children's Center has met or exceeded the 95% target for this indicator on a consistent basis until FY17. In FY17, target was only met in Q1 and part of Q2. A major contributing factor was the realization through training that the definition of "exception" had to be standardized and consistent. Additionally, we experienced capacity challenges with not having enough appointments to offer within 14 days. This trend changed significantly, meeting target every month since February during FY18. Strategic focus on the contributing factors and reducing barriers facilitated meeting target. Because of systemic limitations in MHWIN, we did not have data to analyze in December.

Performance Improvement Goal #2: MDHHS – Access to Services (Performance Indicator 3)

The Children's Center will maintain the standard of providing clients with an ongoing appointment following Intake within 14 calendar days 95% of the time.

In addition to measuring the time between first request and initial assessment, MDHHS requires that 95% of clients will receive a needed on-going service within 14 days of a non-emergent assessment with a professional. The exception to this is when client requests an appointment outside of the 14-day timeframe. As with the previous indicator, the data is captured in MHWIN and monitored by the Quality & Compliance Department.

The monthly trend for timely ongoing appointments is reported below:

Indicator 3 compliance in FY18 decreased from FY16 and FY17.
Target is 95%

	FY16	FY17	FY18
SEP	100%	97.73%	94.12%
AUG	98.55%	97.44%	96.97%
JUL	97.62%	93.94%	94%
JUN	94.30%	96%	67%
MAY	97.70%	100%	100%
APR	100%	97.65%	100%
MAR	98.85%	99.22%	94.50%
FEB	100%	99.08%	95.18%
JAN	96.72%	98.61%	97.26%
DEC	100%	96.88%	
NOV	98.75%	97.89%	97.67%
OCT	100%	96.70%	97.50%

The Children's Center met or exceeded the 95% target for each month in FY17 except July 2017. During FY18 target was not met in March, June, July and September. Because of systemic limitations in MHWIN, we did not have data to analyze in December.

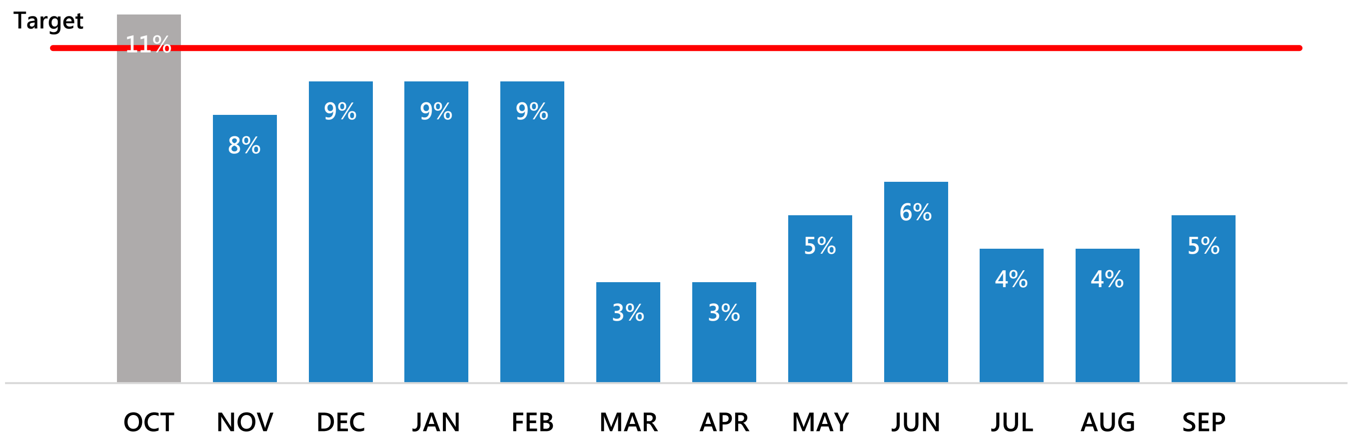
Performance Improvement Goal #3: CAFAS/PECFAS completion and FAS entry.

The Children's Center will provide timely CAFAS and PECFAS assessments and not exceed an overdue rate of 10% as well as enter clients into the FAS system 100% of the time.

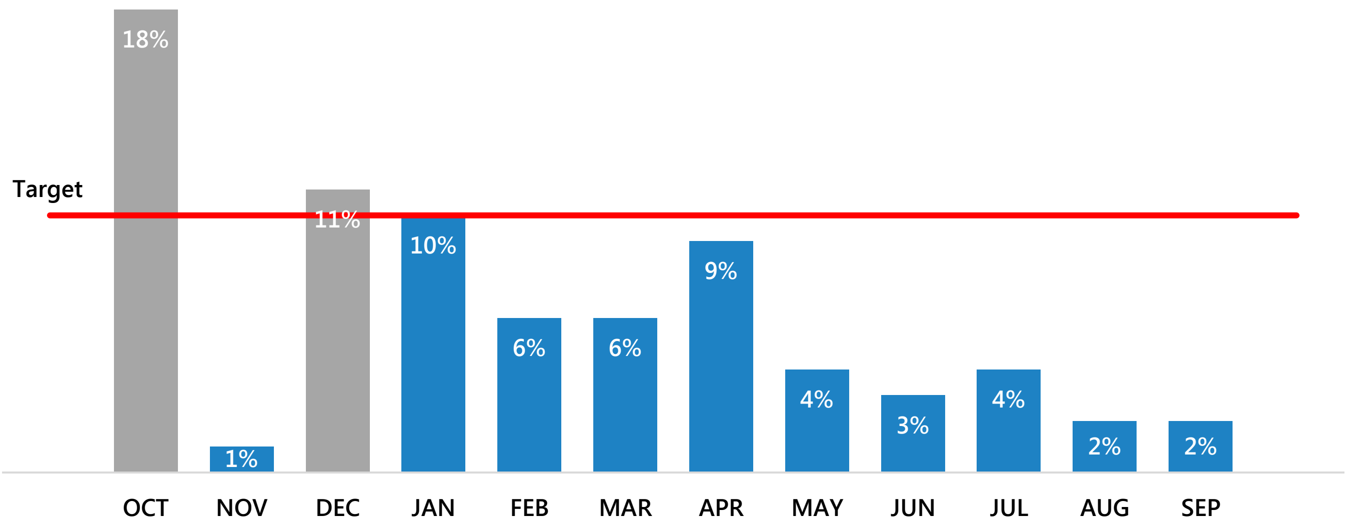
Per our former contract with CareLink, The Children's Center is responsible for monitoring overdue CAFAS/PECFAS rates. Monitoring the number of overdue CAFAS/PECFAS assessments is necessary to help create and sustain ongoing and timely evaluations of clients, which is critical when monitoring clinical outcomes. The threshold is that no more than 10% of expected assessments are overdue system-wide. Additionally, it is required to have 100% of our clients entered into the FAS system.

The monthly agency-wide results for overdue FAS assessments is reported below:

Overdue CAFAS rate was met throughout FY18, except October.
Target is <10%



Overdue PECFAS was met throughout FY18, except October and December.
Target is <10%



In FY17, the program manager implemented an improvement action plan to achieve a higher compliance rate and provide more timely assessments. As a result, we met target each month for CAFAS and PECFAS except three.

The monthly agency-wide results for FAS entry compliance is as follows:

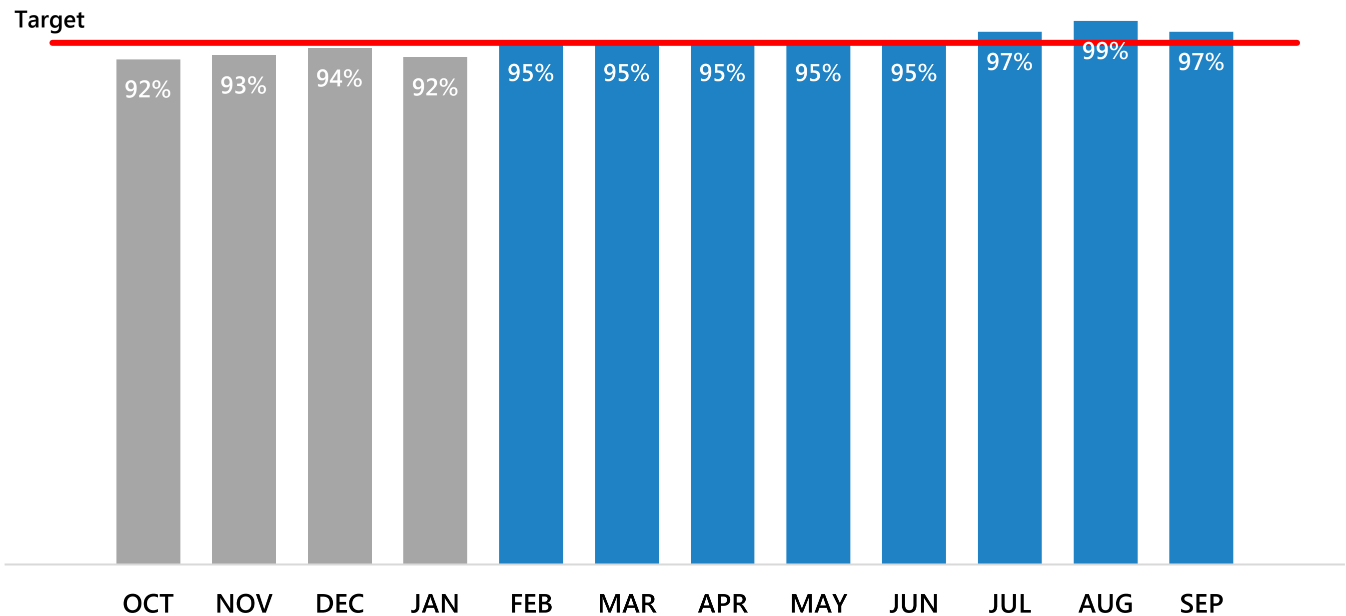
We met 100% compliance in Q3 and Q4 in FY18.

During the monthly QI meeting, Program and Quality staff review the aggregated data that is continuously worked on by staff throughout the month.

Performance Improvement Goal #4: Treatment Plan Completion

All current clients at The Children's Center will have their treatment plan completed within 30 days of Intake and annually, 95% of the time.

Timely completion of the treatment plan is essential to help identify treatment needs, initiate ongoing services, and authorize appropriate services. For new clients entering treatment, the treatment plan completion occurs within 30 days of Intake and then annually thereafter. In FY17 we met target of 92% which resulted in increasing the target from 92% to 95%.



We achieved the target of 95% for two-thirds of the year. This data point is monitored closely as a result of recent mandates from our funders where they implemented sanctions system-wide if compliance falls below 90%. Because we understand and value the importance of the treatment plan and how it assists in steering services, our internal target remains at 95%.

Satisfaction

Performance Improvement Goal #1: Maintain Statistically Significant Response Rate of 20% or Higher

Every year, The Children's Center administers a satisfaction survey to all clients and families to determine how pleased they are with the services they receive as well as what areas can be improved. For FY18, we assessed satisfaction using a revised survey from FY17. The parents or guardians of children receiving services provided answers to the survey using a five-point Likert scale: "Strongly Agree," "Agree," "Neutral," "Disagree," and "Strongly Disagree". A positive response is defined as a "strongly agree" or "agree" response. The content for the survey is as follows:

Survey

- "I receive services/assistance in a timely manner"
- "Appointments are available at convenient times"
- "Front desk staff are warm, welcoming, and helpful"
- "Customer Service staff are helpful and my concerns are addressed"
- "Staff are respectful of my confidentiality and privacy"
- "I feel that I can talk with my case worker/therapist about anything"
- "TCC staff works well together to meet my family's needs"
- "The case worker/therapist is easily accessible"
- "The Psychiatrist/(Doctor) helps me and is available"
- "Staff listens to me, I feel my voice is heard"
- "The Boutique has helped my family meet their basic needs"
- "The enrichment activities (Birthday Parties, Game Night, Art Adventures, Homework Help, etc.) are beneficial for my family"
- "Since coming to TCC, there have been positive improvements"
- "I am satisfied with the cleanliness of The Children's Center campus"
- "I feel safe at The Children's Center"
- "Overall, I am satisfied with my services at The Children's Center"

The intent of the client satisfaction survey is to reach a vast sample of TCC clients and families. With a goal of a statistically significant response rate of 20%, a total of 34% (N=859) of active clients or their caregiver (N=2,512) completed the survey. A total of 49% (N=62) of Child Welfare active clients or their caregiver (N=126) completed the survey. This is a significant improvement from the overall response rate of 24% in 2017, and 11% in 2016.

The results of the survey showed a majority agreement on all questions and the majority of the open-ended comments expressed overall satisfaction with the lowest scoring areas as the Boutique and Enrichment

Activities. One individual wrote *"I love the help that The Children's Center provides for my family"* and *"Thank you Children's Center for helping my family".* Another family simply wrote, "*I think you guys are doing great things*". There were some negative comments that related to appointment times, appointment frequency, beginning services and wanting to know more about what services are available. There were 109 total comments and 72 (66.05%) were positive.

Of the 16 total questions, there were 5 questions that had over an 80% strongly agree response with three rated questions having over an 84% strongly agree response. The highest response of 86.94% who answered strongly agree was when asked if staff are respectful of their confidentiality and privacy. The second highest strongly agree was 85.37% of participants that felt safe at The Children's Center. The third highest strongly agree was at 84.81% of participants answered that the front desk staff are warm, welcoming and helpful.

Participants overwhelmingly agreed that staff at TCC work well together and they feel they can talk to their worker/clinician about anything. Of the 921 participants surveyed, 836 agreed or strongly agreed that they feel their voice is heard. Participants overwhelmingly felt that they received services/assistance in a timely manner. Customer Service staff were reported by participants to be helpful if needing to express a complaint and felt that their case worker/clinician was easily accessible.

A total of 860 (94.30%) participants answered agree or strongly agree that they were satisfied with their services at The Children's Center. A total of 864 (94.52%) of participants agreed or strongly agreed that they were satisfied with the cleanliness of TCC's campus. Additionally, participants felt that appointment times are convenient and the psychiatrists are helpful and available. Overall, the overwhelming majority of participants felt that because of receiving services at TCC there have been positive improvements with families.

Performance Improvement Goal #2: Monitor parent satisfaction in Child Welfare.

The Children's Center will survey new foster parents and birth parents to garner their feedback on foster parent training and the overall process.

The Children's Center strives to provide safe and nurturing foster homes for abused and neglected children. We also strive to achieve permanency in an adoptive home. To reach these goals, The Children's Center provides potential foster parents with orientation, PRIDE training, and support during the licensing process. Potential foster parents are thoroughly informed on what it means to care for a foster child. Further, we pride ourselves on our welcoming staff and quality services.

The goal of the "New Foster Parent Survey" and "Birth Parent Survey" in FY18 was to garner a 50% response rate and give new foster parents the opportunity to provide feedback on the new foster parent orientation, PRIDE training, interactions with staff, support for the licensing process, and additional services. Further, new foster parents communicated if they would recommend TCC to others, the motivation behind becoming a new foster parent, and any additional comments.

Most birth parents "strongly agree" to staff treating them with courtesy and respect. Further, most "strongly agree" in knowing what steps must be done to be reunited with their children and feel included in setting their goals. Similarly, "most strongly" birth parents feel included in decisions regarding their child(ren). When

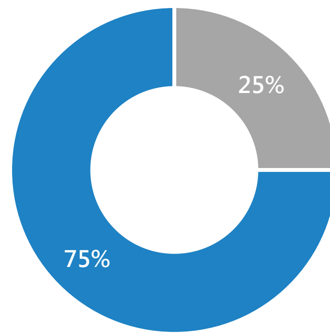
responding to the statement "My family receives the help they need from The Children's Center," most birth parents "strongly agree". Most birth parents "strongly agree" with the statement, "the case manager answers my questions in a polite and timely manner." Most birth parents "strongly agree" or "agree" to their family feeling welcomed at The Children's Center. The Children's Center's hours and location are convenient for most birth parents. Overall, most birth parents (71.43%) are pleased with the services their families receive from The Children's Center.

When responding to "What I like best about The Children's Center," birth parents appreciated being helped and seeing their child(ren.) Additionally, one unique response indicated they like "the respect and common courtesy". When asked "What are three things you would like to improve about The Children's Center," birth parents indicated "the dinners", "people's attitude", and "parking and transportation". One additional comment includes positive feedback, stating that staff "are very good at what they do and I appreciate them very much."

A total of 7 birth parents completed the "Birth Parent Survey" for both FY17 and FY18. Providing a response rate less than 8% for each year. Therefore, a statistically significant number of respondents were not garnered. Greater strategies will be developed to increase the response rate for next year. This will allow for a valid representation of services being provided, which will help The Children's Center identify high and/or low performing areas, as well as provide an opportunity for open communication from our birth parents.

In relation to new foster parents, the survey data is representative due to a 40% response rate. The majority of new foster parents were contacted within 7 days after initial inquiry about fostering with TCC. The majority of new foster parents "strongly agree" and "agree" that "the foster parent orientation provided adequate information about fostering a child." All new foster parents attended PRIDE training through TCC. Of these individuals the majority of new foster parents "strongly agree" or "agree" to being "warmly welcomed and [feeling] comfortable at their first PRIDE training." All new foster parents "strongly agree" or "agree" that the training session was scheduled at convenient times. These individuals also "strongly agree" or "agree" that PRIDE training "offered the information needed to understand how to care for a foster child." Most new foster parents felt the staff "treated [them] with courtesy and respect during the licensing process." More than half "strongly agree" or "agree" to the licensing worker being "willing to assist [them] in working through the licensing steps." Overall, half of new foster parents "agree" to being satisfied "with the services TCC provided to [them] during the initial process." Conversely, the data demonstrated that the majority of new foster parents "strongly disagree" and "disagree" that the licensing process "went smoothly." When asked about recommending TCC, 75% of new foster parents "would not recommend TCC to an individual who is interested in becoming a foster parent." On the contrary, of these individuals who would not recommend TCC, one new foster parent indicated the following: "becoming licensed in Wayne County takes too long, but I had no issues with TCC staff."

Most foster parents would not recommend TCC to someone who is interested in becoming a foster parent.



When asked "what factors motivated you to become a foster parent?" respondents answered because of family relations, inability to have biological children, and/or saw the need for foster parenting as reasons. These themes are encapsulating of all survey responses to this question.

When asked "why did you choose TCC" half of the respondents indicated that TCC is located close to their place of employment. It was also indicated that marketing through billboards and positive feedback from clients persuaded them to choose TCC. The last question of the survey prompted respondents to provide additional comments. Two out of 4 respondents answered. Responses demonstrated trends of negative feedback. The negative feedback included themes of the licensing process taking too long and feeling that the agency was "working against me."

Last year, a possible limitation was conducting the survey over the phone versus on the Survey Monkey website. As a result, New Foster Parents were offered the opportunity to complete the survey over the phone or electronically. It was hypothesized that New Foster Parents responding to the survey questions over the phone may have skewed some of their survey answers. This is known as response bias, which is when respondents are not as truthful as they would have been given the circumstances of how the survey was conducted. Despite being offered the chance to complete the survey electronically, each of the four respondents chose to complete the survey over the phone rather than electronically.

The information from both the foster parent and birth parent survey will be taken into account when improving and sustaining the quality of services provided to them. Strategies will be implemented to improve the survey response rate. Thus, The Children's Center will be able to reach our mission of helping children and families shape their own futures.

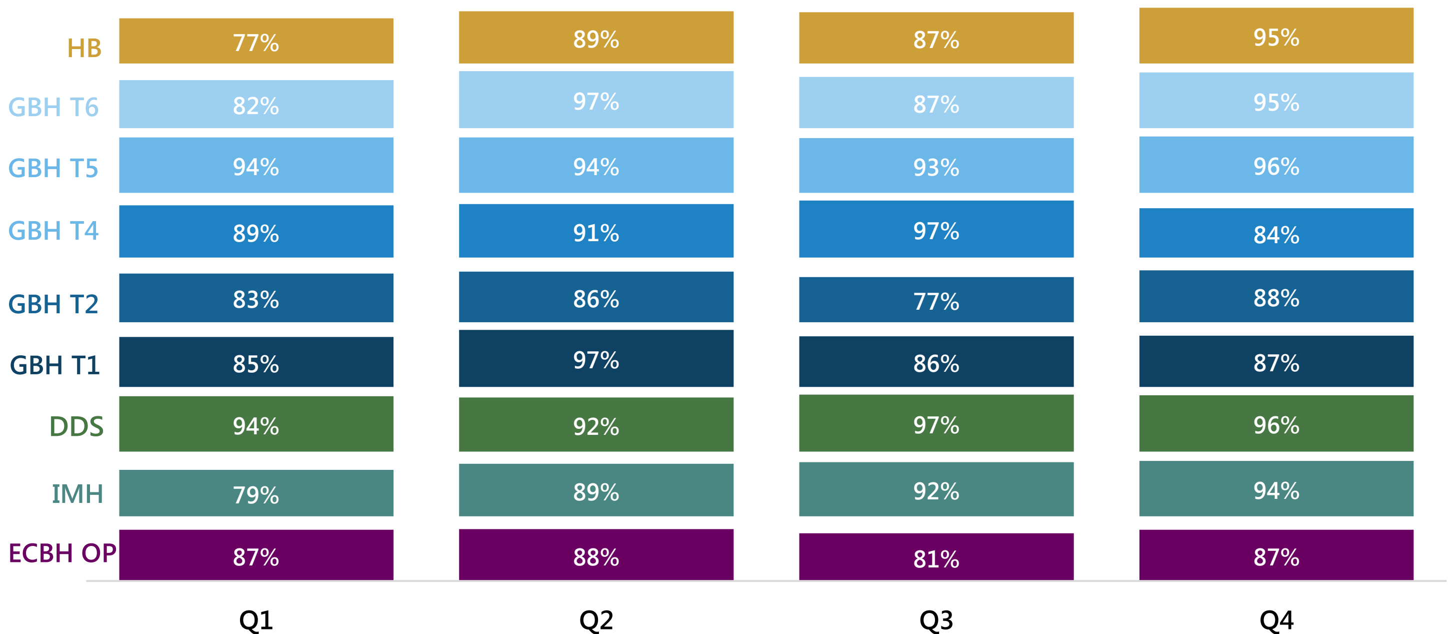
Contractual Compliance

Performance Improvement Goal #1: Maintain and increase chart compliance to 95% for all quarters.

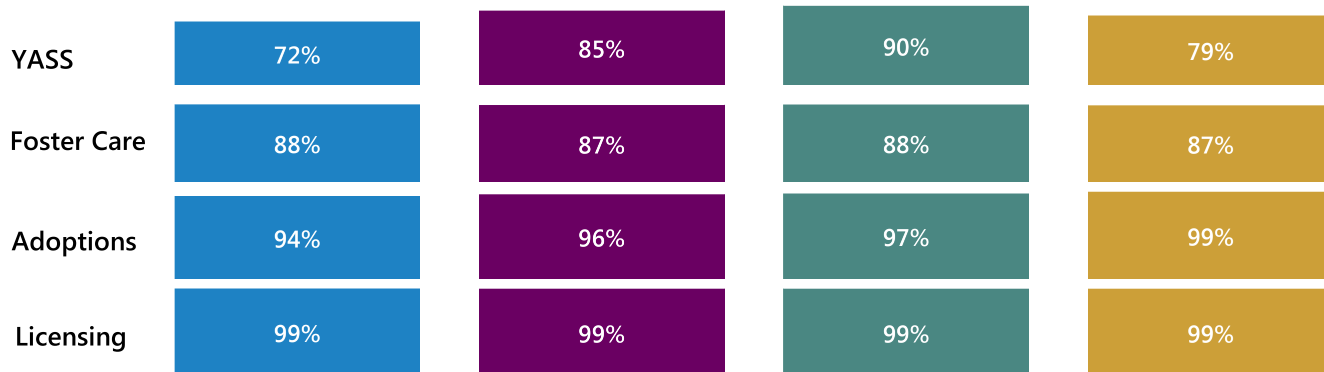
The Children's Center will increase and maintain chart compliance to 95% for all four quarters for all programs.

As established in FY12, all programs at The Children's Center go through a quarterly Quality Improvement chart review process. The Quality and Compliance Department provides aggregate reports to the Director, Manager and Supervisor overseeing the program, while individual chart feedback is sent to specific supervisors, allowing for routine review of their documentation and providing them more opportunities to capitalize on this feedback to improve their overall services. The programs that have an overall score below 95% compliance require a corrective action plan that highlights measurable tasks that assist in meeting compliance by the subsequent review. Audits for the Community Mental Health (CMH) funded programs are completed using a standardized audit tool developed by DWMHA. The Child Welfare programs: Foster Care, YASS, Adoptions, and Licensing utilize their respective chart audit tools as developed by MDHHS during their external reviews.

The aggregate results for the FY18 internal quality chart review for the CMH-funded and Child Welfare programs are reported below:



Licensing met chart compliance in Q1, Q2, Q3 and Q4.
Target is 95%



Overall, the clinical chart reviews for FY18 exceeded compliance rates from previous fiscal years. The most significant improvement transpired in Q4, where 4 programs met or exceeded target. The main contributing factor to this increase is the implementation of the "internal chart review team". This team consists of about 8 staff, who focus on standardizing the process and the ratings.

In Child Welfare, Licensing continues to meet or exceed target. One difference in the Child Welfare programs from FY16 to FY18 is that Adoptions did not meet target each quarter as they have in previous years. A possible driver may be that the audit tool changed from FY16 to FY18. The tool for FY18 is a condensed version that focuses on high risk areas. Additionally, a change in supervisor transpired and the supervisor overseeing the FY18 tool is more stringent with the review process. This change from FY16 to FY18 warrants continuous monitoring during the monthly Quality Improvement meetings.

Review of Incidents and Root Cause Analysis of Critical Incidents

Whenever an incident of an atypical nature involving a client occurs, staff are to complete an Incident Report (IR) documenting the details of the incident, forward to their supervisor, and then to Quality & Compliance within twenty-four hours for review, coding, and aggregation. The Quality & Compliance Specialist works collaboratively with the department and the applicable program staff to identify the incidents that require further follow-up and communicate those needs to the necessary parties. This monitoring ensures that any necessary treatment and/or procedural changes occur in order to prevent reoccurrence of the incident. With regards to establishing a benchmark for this indicator, a quantitative measurement is insufficient as an increase or decrease in the number of IR's completed in and of itself is neither a positive or negative trend. However, aggregate reporting of incidents by program and type occurs on a quarterly basis to determine if trends requiring action exist. If such trends are noted, then global interventions are developed and implemented.

Below is a comparison, by category and volume, of the documented incident reports completed in FY17 to FY18:

	CW		ECBH		GBH DDS		GBH SED		Other		Total		% Change
	FY17	FY18	FY17	FY18	FY17	FY18	FY17	FY18	FY17	FY18	FY17	FY18	
Arrest	4	1			4	6	13	15			21	22	5%
AWOL	5	4			1	11	43	31		1	49	47	-4%
Behavioral Problem	7	6	11	10	127	128	156	158	12	6	313	308	-2%
CPS Referral	26	39	30	47	59	55	160	222	60	17	335	380	13%
Exposure		4		1		33		4		6	0	48	
Homicidal/ Suicidal Threat	4	4		2	8	11	29	68	6	2	47	87	85%
Medical Emergency	8	18	1	1	32	60	23	34	3	3	67	116	73%
Medication Error						1			2		2	1	-50%
Non-serious Injury	23	9	3	4	167	141	22	28	6	10	221	192	-13%
Other	5	11	3	13	125	67	25	23	10	14	168	128	-24%
Safety	17	6	9	10	54	34	54	24	14	5	148	79	-47%
Death/Serious Injury				1		1	1				1	2	100%
Substance Use/Abuse	1						4				5	0	-100%
Theft	1	2				4	4	4	2	4	7	14	100%
Physical Management		1				2		1	2		2	4	100%
Property Damage				1	1	1		3			1	5	400%
Grand Total	101	105	57	90	578	555	534	615	117	68	1387	1433	3%

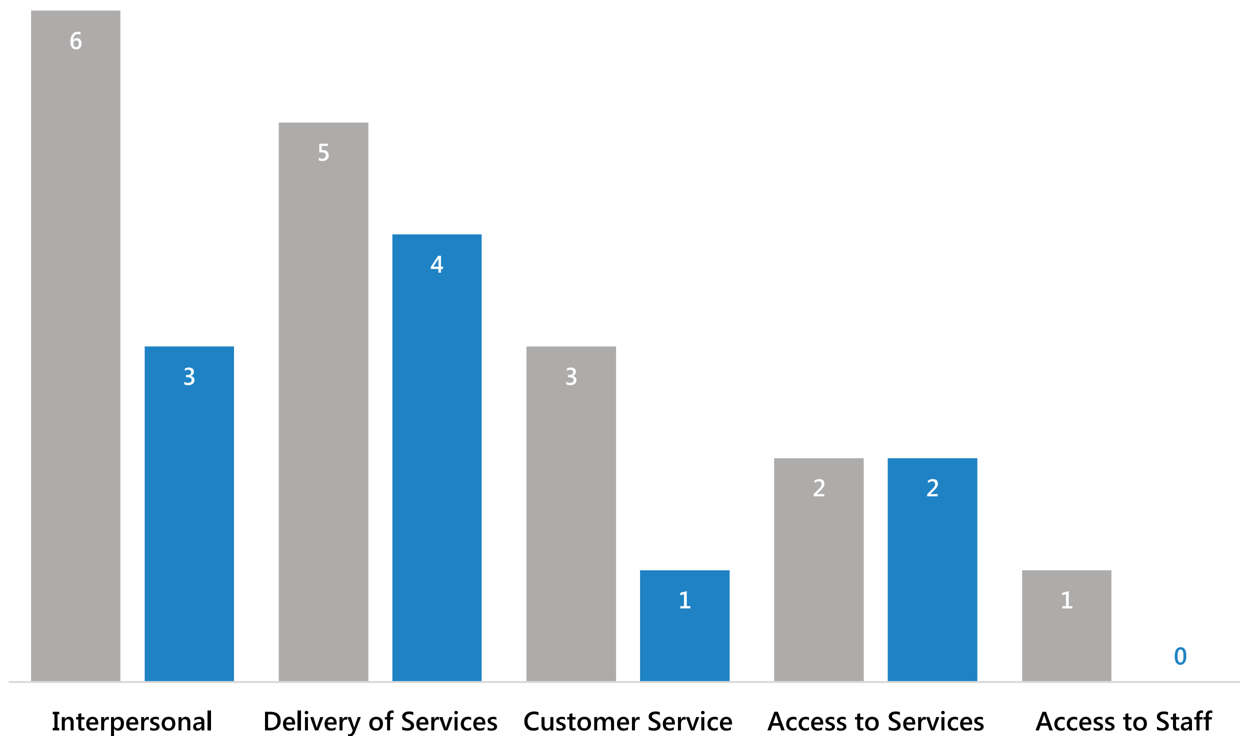
In total, the number of IR's completed in FY18 increased 3% compared to FY17. A contributing factor derives from the direction given by The State requiring an IR for inpatient hospitalizations. We also added additional categories to highlight specific risk categories. The largest shifts at 400% and -100% is "property damage" and "substance use/abuse" respectively.

Review of Grievances and Recipient Rights Complaints

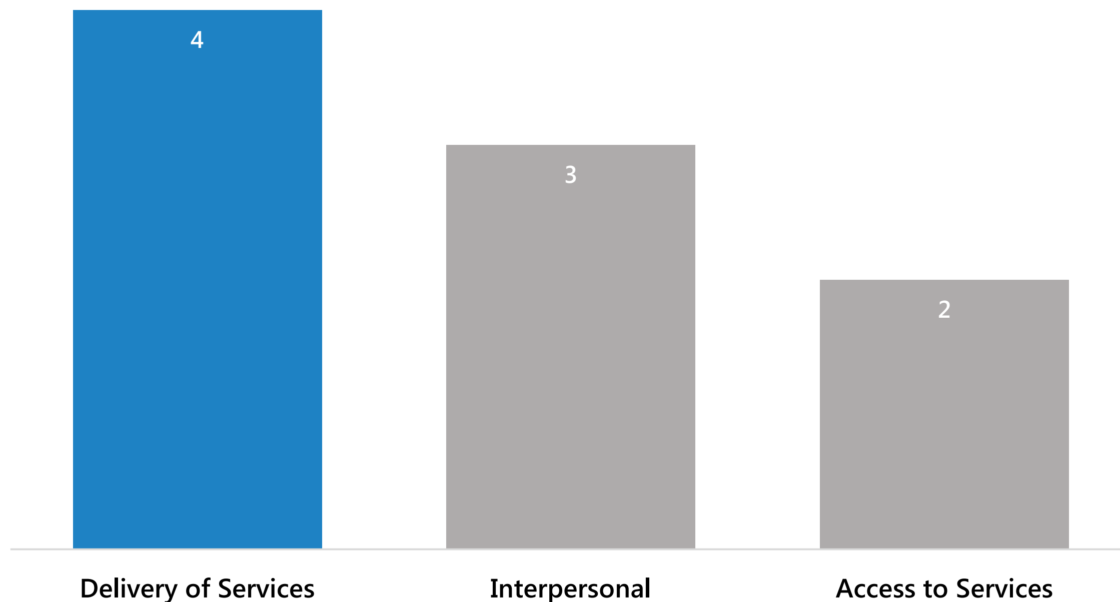
The inverse indicator to the satisfaction rate is the number of service-related complaints received during the year. Complaints can take one of two forms: Grievances and/or Recipient Rights complaints. While we encourage clients and families to first try to resolve any grievances they may have with their treatment team and the supervisor of that team, occasionally this does not lead to an outcome they are satisfied with. In these instances, clients are sometimes referred to the Quality & Compliance Department (Customer Service) for assistance in resolution or they actively seek out this department to have their complaints investigated thoroughly.

Of the two types of complaints listed above, most are categorized as grievances. Grievances usually involve clients or families having concerns with the behavioral health services they are receiving. The Quality & Compliance department investigates the grievances by speaking with the client/family to obtain a full understanding of their concerns; reviewing the documentation at hand; interviewing the staff involved, their supervisors, HR staff (if necessary), and any other staff or leadership as applicable; and developing a plan of action that best meets the client/family's needs within reason. We enter all grievances and their follow-up notes into the DWMHA MHWIN system, with resolution expected within 60 days of receipt of initial complaint.

FY18 saw a large decrease in the number of grievances compared to FY17.



Most of the grievances processed in FY18 were in the Delivery of Services category.



The second category of complaints is a Recipient Rights complaint. These complaints are specific to perceived Recipient Rights violations, and may be submitted by the client/family directly or by someone assisting the client/family with the submission. When we are aware of a complaint, the process for investigation would proceed as described above for grievances, except the complaint form would also be forwarded directly to the DWMHA Office of Recipient Rights for their review, during which they may decide to open their own investigation, and we will fully assist DWMHA with their investigation and implementation of any requested corrective action plans.

In FY18, The Children's Center received eight Recipient Rights complaints, which is the same number reported in FY17. Of the eight complaints investigated, none of the complaints were substantiated.

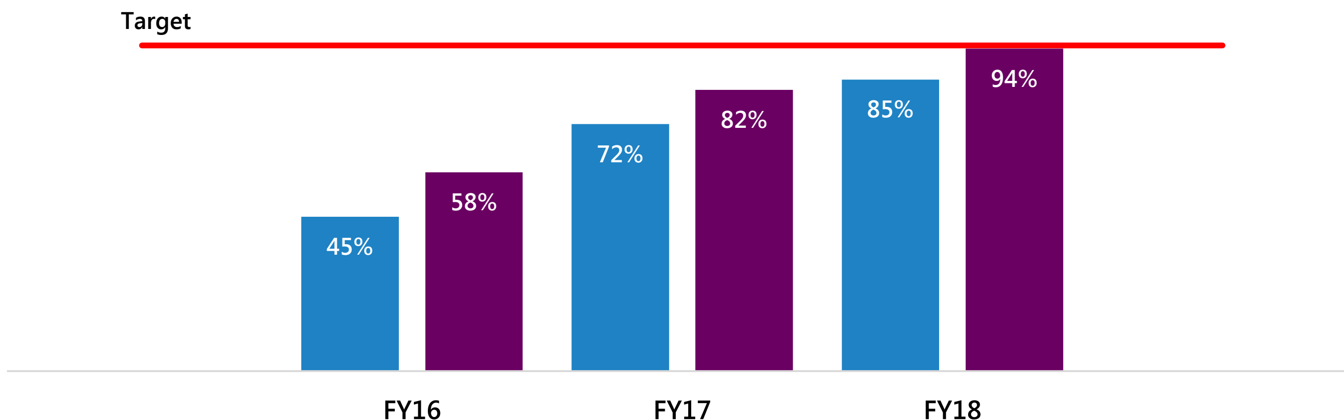
Performance Improvement Goal #2: Child Welfare Social Work Contacts - 85-95%

The Children's Center will ensure that the children in foster care receive monthly social work contacts as outlined in the ISEP (Implementation, Sustainability and Exit Plan).

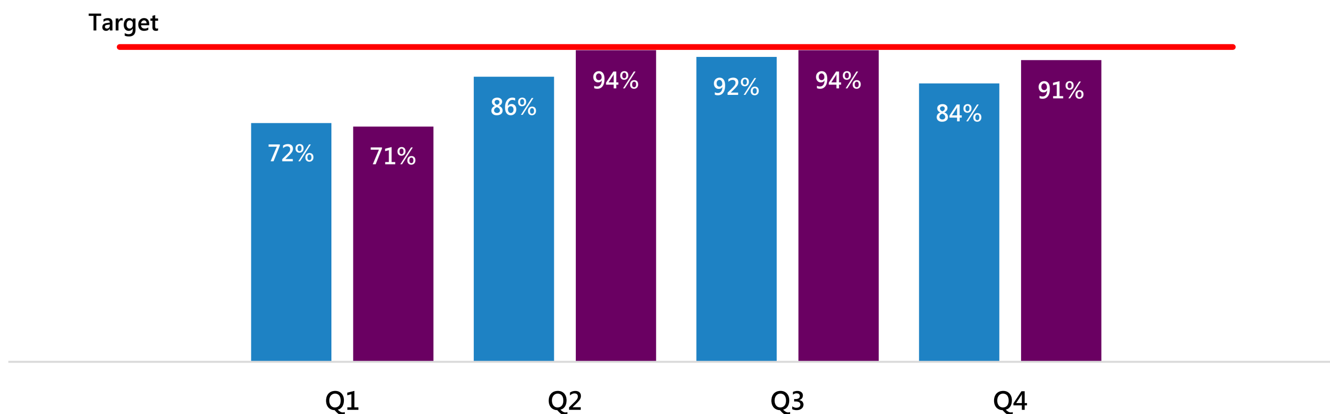
As part of the ISEP, children in foster care are to receive monthly social worker contacts with their worker 95% of the time and their birth parent 85% of the time. The worker and supervisor are required to have their monthly contacts 95% of the time and 85% of the time for the worker and birth parent.

Below are the comparisons for social work contacts from FY16 to FY18:

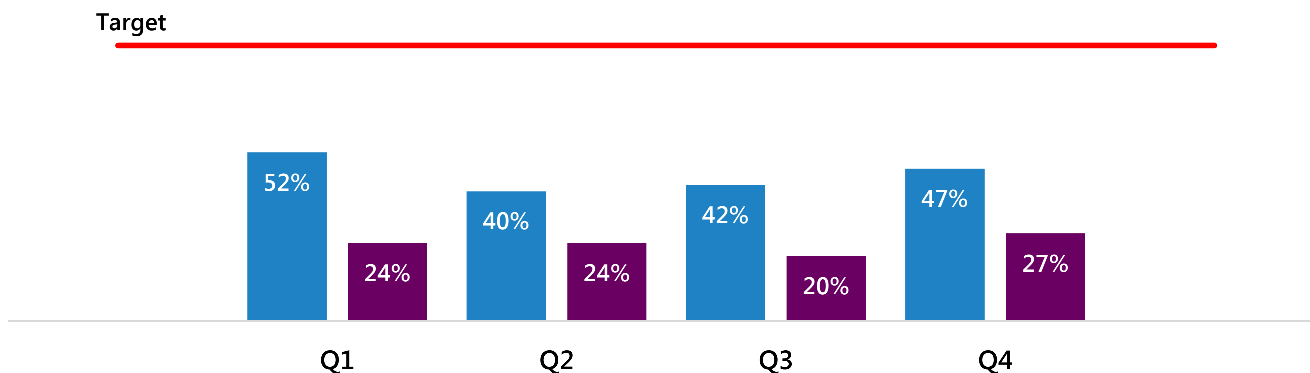
Monthly contacts between Child & Worker and Worker & Supervisor was not met during FY18, but have increased each year.
Target is 95%



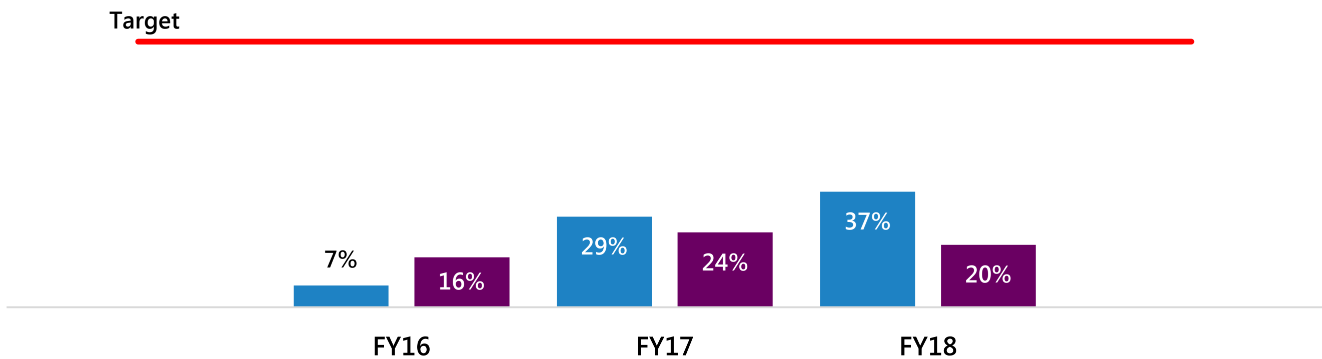
Monthly contacts between Child & Worker and Worker & Supervisor was not met during FY18.
Target is 95%



Monthly contacts between Worker & Parent and Parent & Child was not met during FY18.
Target is 85%



Monthly contacts between Worker & Parent and Parent & Child was not met for 3 years.
Target is 85%



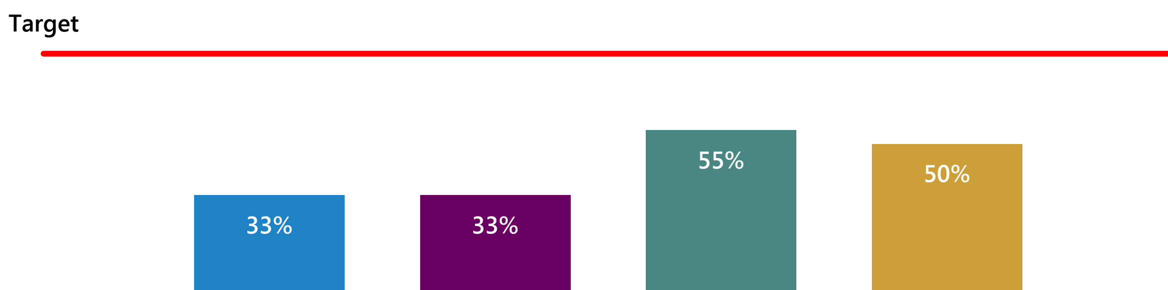
An increase has transpired from FY16 to FY18 with the worker and supervisor and child and worker monthly contacts. Contributing factors to not hitting target include a high turnover of staff in that department, learning curve and training of the system MiSACWIS, and accurately utilizing MiSACWIS to document each contact.

Performance Improvement Goal #3: Child Welfare Adoption Timeliness – 240 days

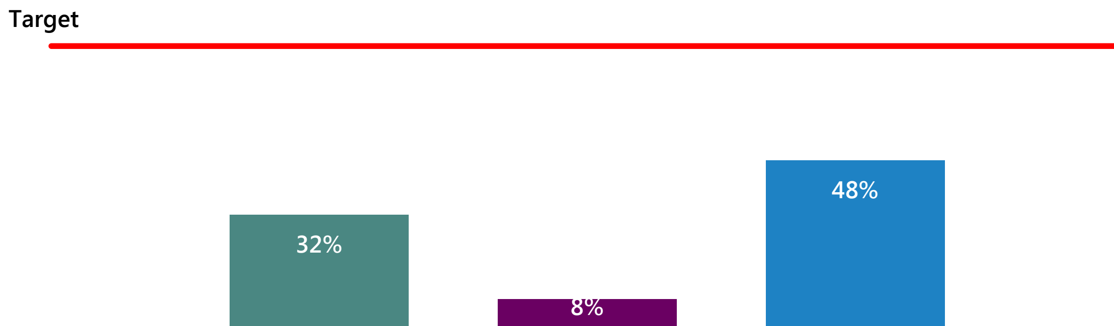
The Children's Center will strive to have 80% of children who have a goal of adoption to have their adoption finalized within 240 days. The measurement of this indicator shifted for FY18, measuring the petition filing date from the 3600 date.

Below is the quarterly results for FY18 and year over year trends:

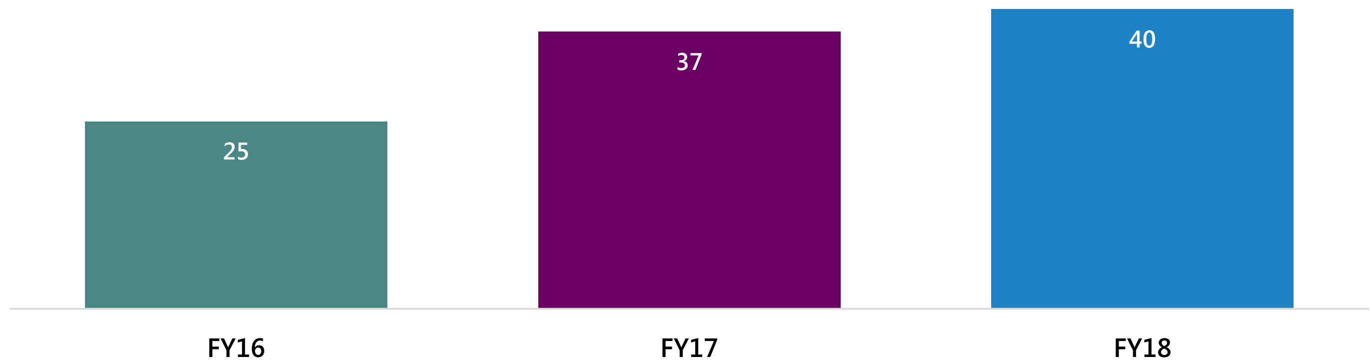
Adoption petitions filed within 240 days were not met in Q1, Q2, Q3 and Q4 during FY18.
Target is no less than 80%



Adoption petitions filed within 240 days were not met for FY16, FY17 and FY18.
Target is no less than 80%



The highest count of adoption petition filings were during FY18.



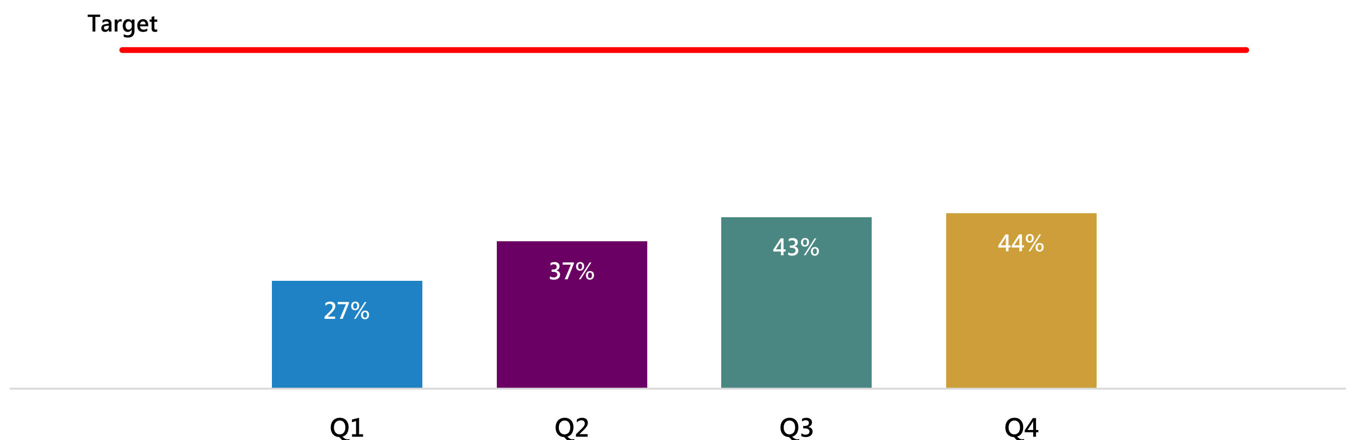
This trend has significantly increased from FY17 to FY18 due to this indicator measuring the petition filing date from the 3600 date, rather than the child's MCI date from the adoption finalization date.

Performance Improvement Goal #4: Child Welfare Sibling Visits

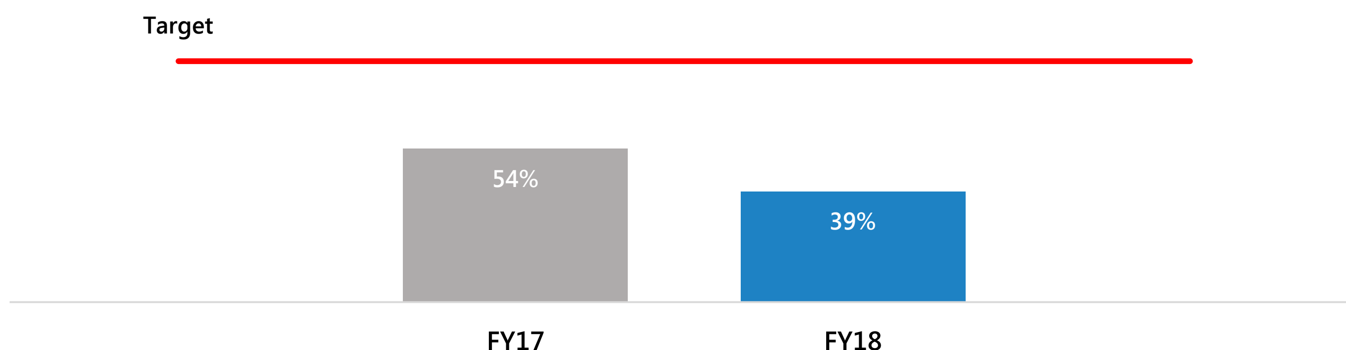
The Children's Center will ensure that children in foster care who are separated from their siblings will visit each other once a month, 85% of the time.

The percentage of children who received a monthly visit with their sibling(s) every month is reported below:

Monthly sibling visits were not met in Q1, Q2, Q3 or Q4.
Target is 85%



Monthly sibling visits were not met in FY17 or FY18.
Target is 85%



The results are based on reports pulled from the data warehouse portal within MiSACWIS. Overall, a decrease transpired from FY17 to FY18. It is recommended that concentrated attention and action plans take place to ensure that the occurrence of consistent sibling visits continue to improve and address the external barriers of coordination with other agencies that sometimes affect this outcome. These two areas require continuous monitoring by Quality & Compliance to ensure the source documentation accurately reflects the data reported.

Performance Improvement Goal #5, #6 & #7: Child Welfare YASS (Young Adult Self-Sufficiency) – Productive Activity Involvement, Connected to a Mentor & and Living in a Safe Environment

The Children's Center will ensure that clients in the YASS program will be involved in productive activities and connected to a mentor, and living in a safe environment 100% of the time.

Meeting the needs of young adults aging out of the foster care system who have experienced their parents' rights terminated by the court, but not experienced an adoption, poses a unique challenge. Young adults who are transitioning out of the Child Welfare system often do not have family members or friends to help them adapt to societal expectations once they leave the foster care system. The Foster youth do not have access to familial resources and upon reaching a legal age, are often left to fend for themselves. To accommodate this

subpopulation, the Child Welfare program developed the Young Adult Self Sufficiency (YASS) program to help the young adult learn how to be self-sufficient. This includes teaching them essential life skills so they are able to interact successfully in society, make a living, manage a budget and perform all other expected functions of independent adults. However, typically in our society, young adults usually have family and/or friends help them learn these tasks.

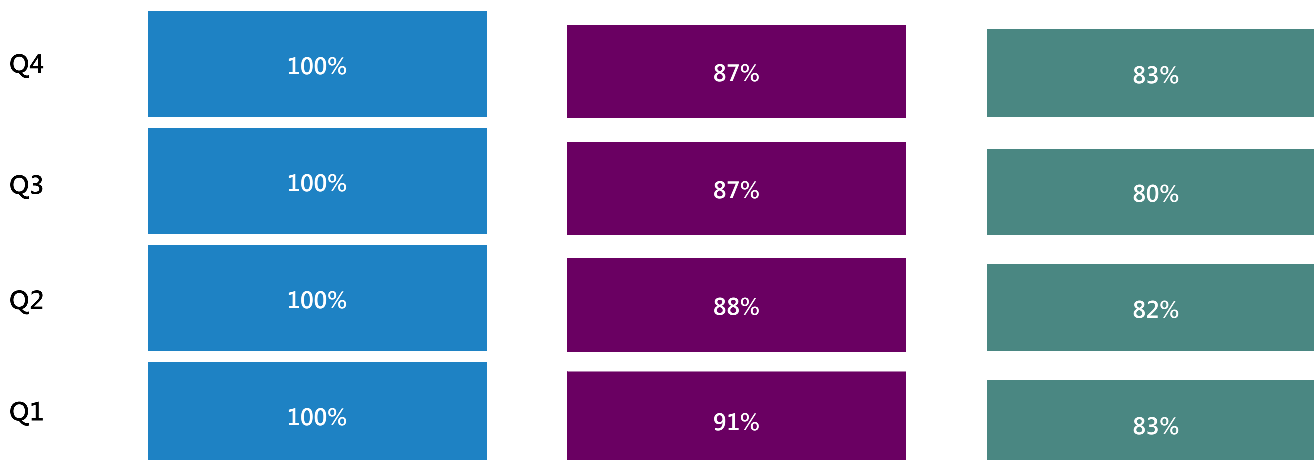
One of the expectations for the youth served in the YASS program is to either be involved in obtaining an education, obtaining a vocational training, or be employed; thus, engaged in “productive” activities. YASS staff work closely with the clients in the program to develop the skills necessary to achieve these markers of independent living. The target for the program is 100%. This data is reported by the YASS staff to the Quality & Compliance department on a monthly basis and aggregated to demonstrate trends over time.

Additionally, the YASS staff are tasked with working with the clients to ensure that they are in a safe living environment. Without acquisition of stable housing, any gains made by the youth are in jeopardy. For the purposes of measurement, “free from abuse and neglect and having basic safety and utility needs met” is defined as an absence of incident reports and substantiated special evaluations for all YASS staff specific to abuse, neglect, and health and safety.

The goals is for all young adults in the YASS program to be connected with a community support person who can be of assistance to them, provide a mentoring relationship and help the youth adjust to societal expectations outside the procedures of a formal DHHS-funded program. Therefore, the program seeks to connect the young adult with a community support person to help facilitate this process. The target for this indicator is 100% and is consistently achieved. Data is manually tabulated by the YASS staff and reported to the Quality & Compliance Department monthly.

Below is the quarterly results for FY18 and year over year trends:

Safe Living Environment met target each quarter during FY18.
Productive Activities and Mentors did not meet target of 100%



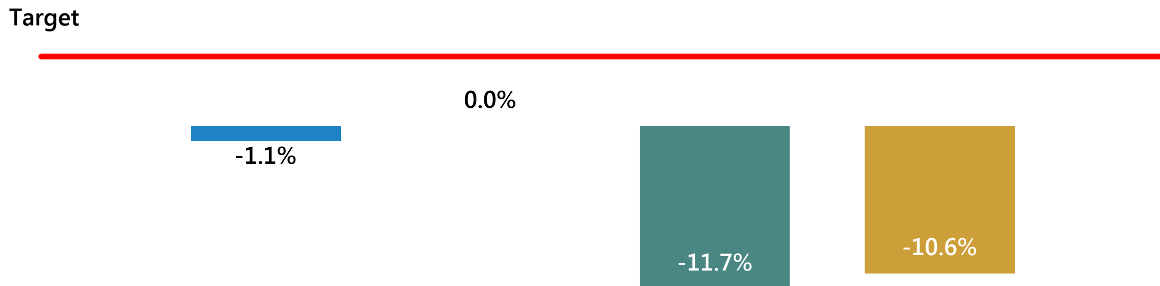
Performance Improvement Goal #8: Child Welfare Licensing Target

The Children's Center will increase the number of licensed homes by 5%.

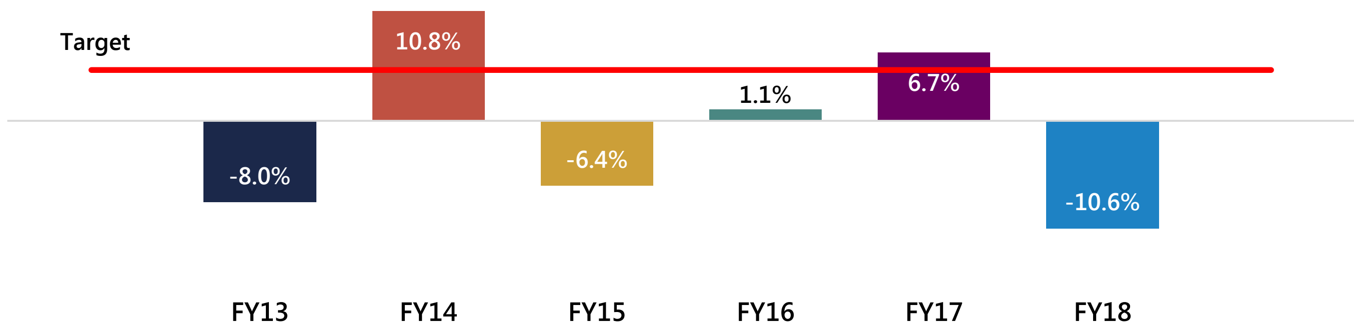
The requirements of the Licensing Department of the Child Welfare programs includes licensing and monitoring of new foster parent homes and responding accordingly to any findings. As part of this process, the Licensing Department monitors the number of licensed foster settings and sent an internal target to increase the number of licensed homes by 5%. Economic challenges within the community continue to have an impact on the ability of the program to license new foster parents and also result in the loss of licenses, as foster parents must be employed as a condition of their license.

Data is manually recorded and aggregated quarterly:

Foster Home Licensure did not meet target Q1, Q2, Q3 and Q4 during FY18.
Target is 5% increase



Foster Home Licensure did not meet target during FY18.
Target is 5% increase

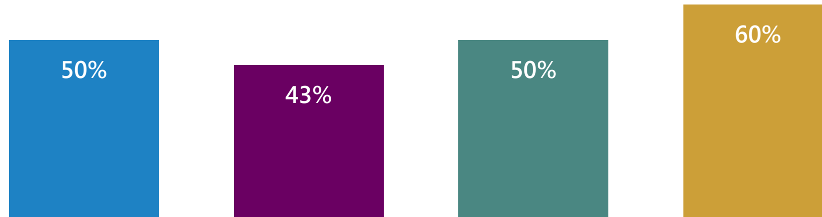


As illustrated above, the Licensing department did not meet target. The program will to continue to work to maintain participation in orientation and Pride trainings in order to maximize the number of new licensed homes available for safe and appropriate placement.

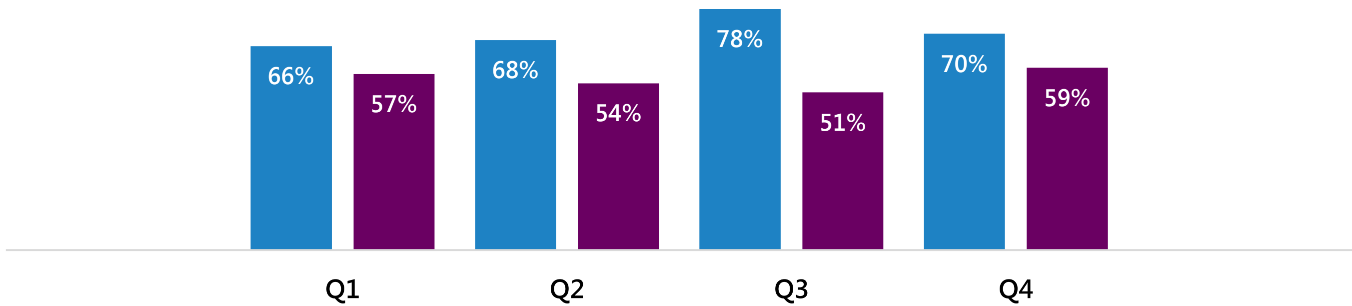
Performance Improvement Goal #9: Child Welfare Medical & Dental Timeliness

The Children's Center will increase the number of children in foster care who receive timely medical and dental assessments by 20%. The contractual target is 95% and TCC averaged 73% in FY18.

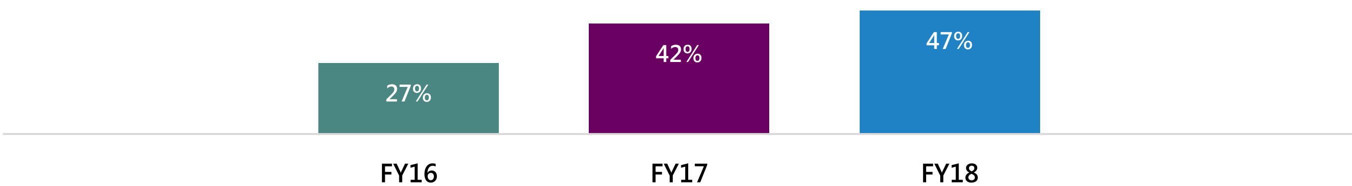
Timely initial medicals were not met Q1, Q2, Q3 and Q4 during FY18.
Target is 85%



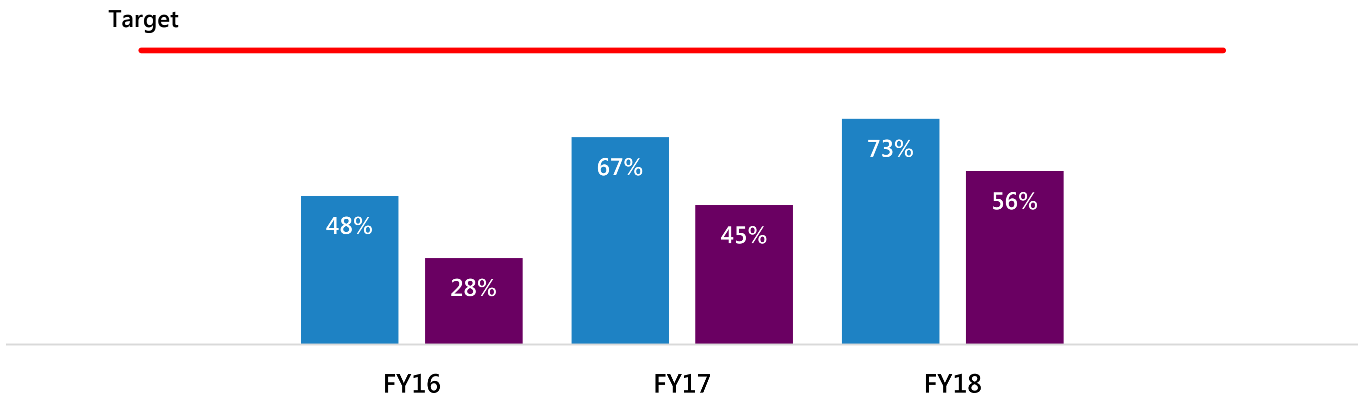
Timely annual medicals and dentals were not met during FY18.
Target is 95%



Timely initials medicals were not met for 3 years but were highest in FY18.
Target is 85%



Timely annual medicals and dentals were not met for 3 years but increased each fiscal year.
Target is 95%

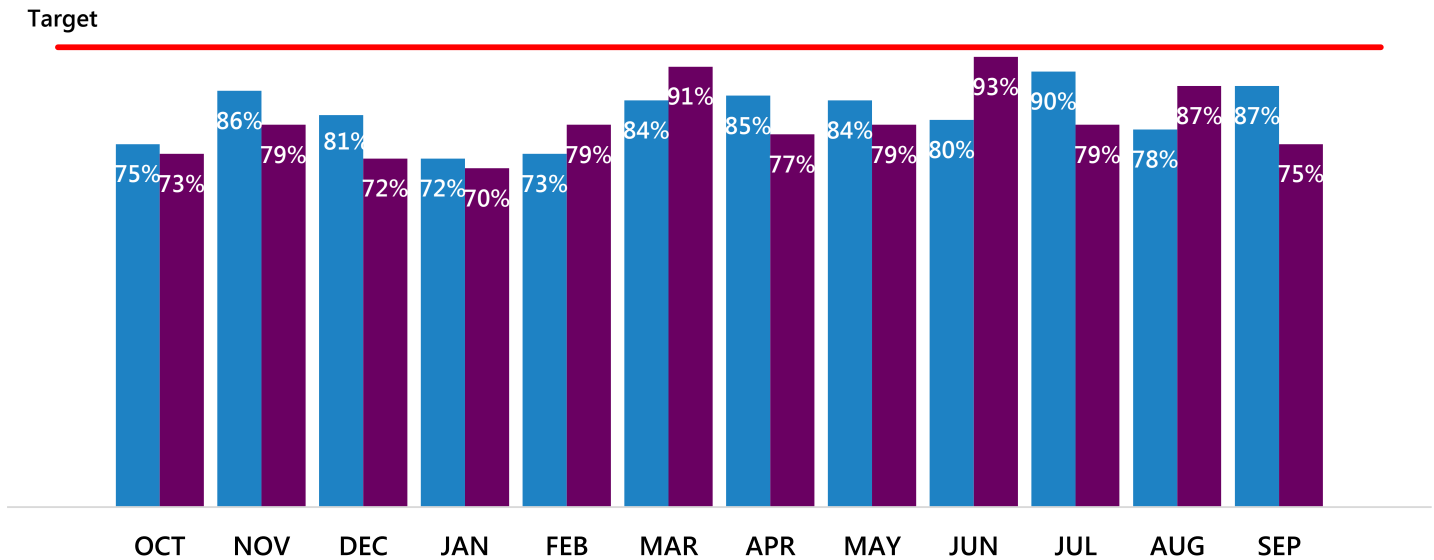


Although the 95% timeliness target was not met for FY18, nor the increase target, FY18 had the highest compliance rate compared to prior fiscal years. This increase is attributed to a lower vacancy rate in open positions and with increased efforts to assist foster children in receiving these assessments.

Performance Improvement Goal #10: Child Welfare Documentation Timeliness

The Children's Center will increase the timeliness of document in the Child Welfare Department by 10%. The target is 95% and TCC averaged around 80% in FY18.

Timely Service Plan Completion and Supervisory Approval were not met during FY18.
Target is 95%



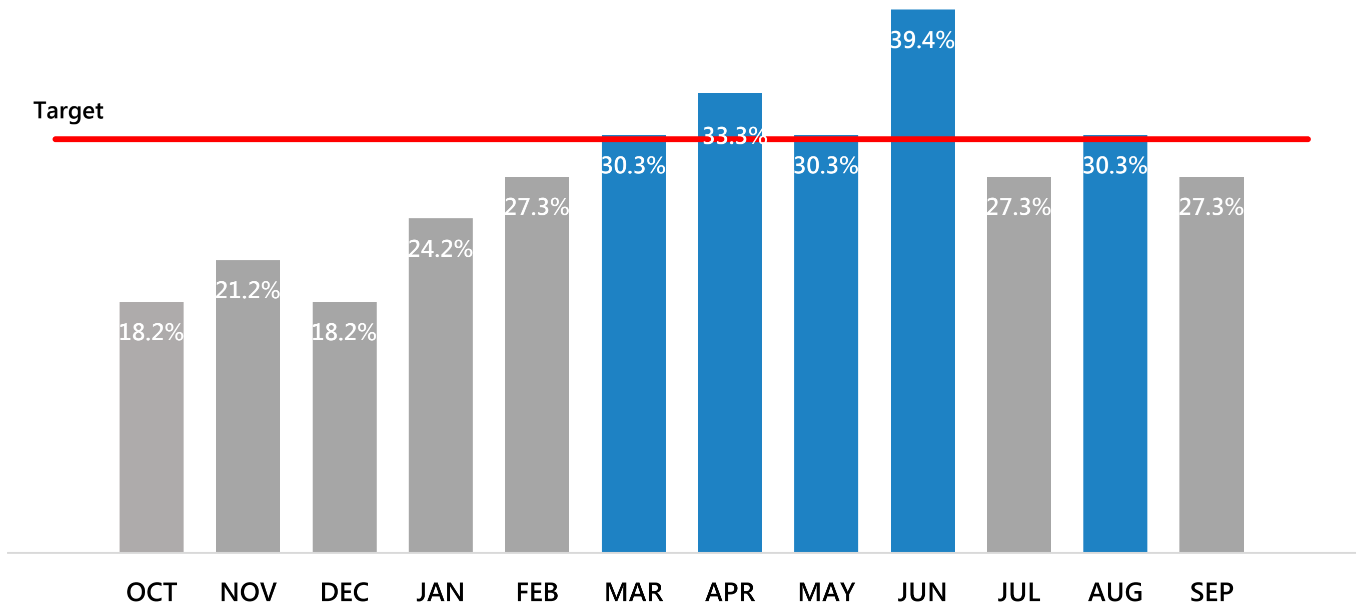
Although the 95% timeliness target was not met for FY18, nor the increase target, FY18 had a slight overall increase compared to the prior year.

Additional Indicators

At the Child Welfare Quality Improvement meeting, the group decided to focus on a few additional quality improvement initiatives that will positively impact the staff as well as clients.

Performance Improvement Goal #1: Child Welfare Host Provider Increase

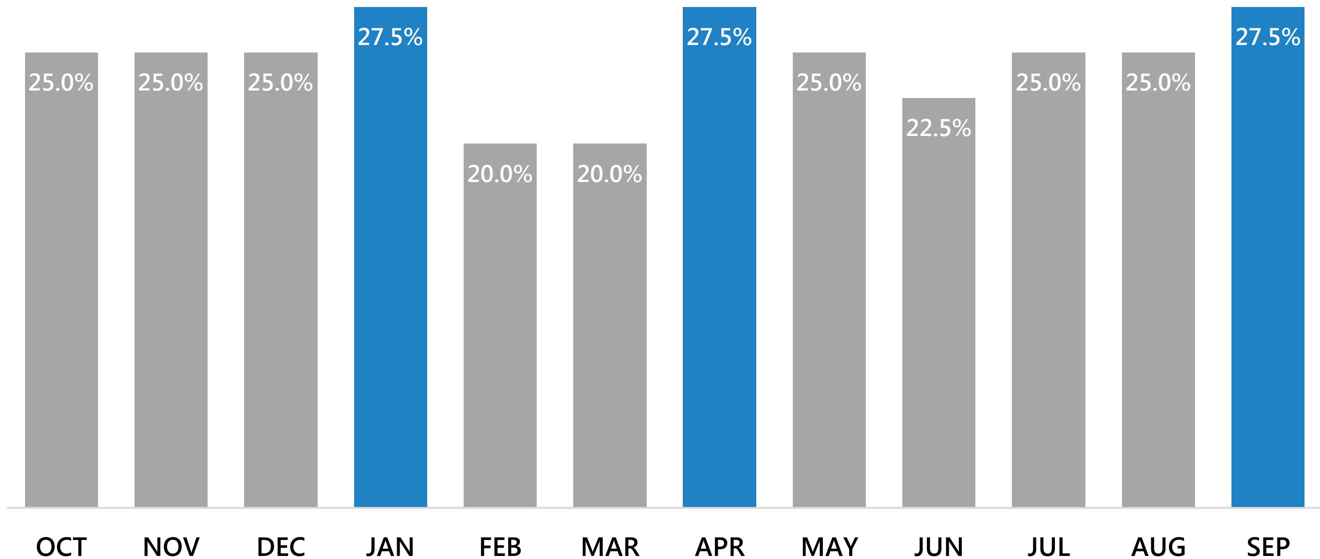
The goal for FY18 was to increase the number of host providers by 30%.



Performance Improvement Goal #2: Child Welfare Staff Retention

The goal for FY18 was to positively affect the staff retention rate. A specific target was not set, as the key to this initiative was to review staff turnover and identify and implement initiatives.

Child Welfare Staff Turnover was highest in January, April and September during FY18.

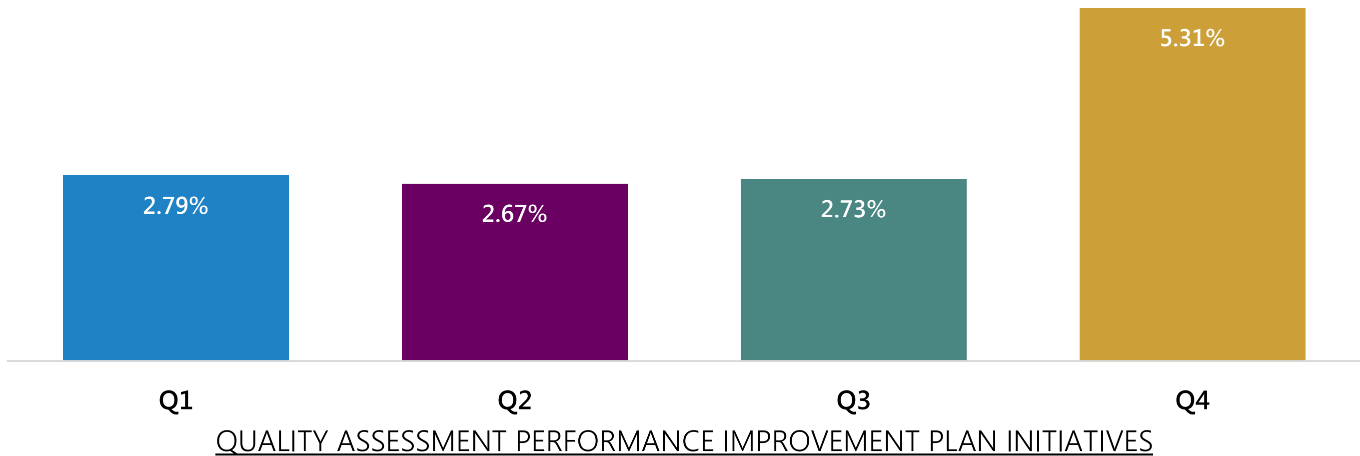


Performance Improvement Goal #3: Child Welfare Achieve Permanency

When children are placed in out-of-home care (also called foster care), it is imperative that TCC find safe, permanent homes for them as quickly as possible. In most circumstances, children can be reunited with their families, but in some cases children find homes with relatives or adoptive families.

TCC did not set a specific target, but identified the need to monitor reunification, guardianship/adoption, and transition timelines.

The highest rate of permanency was achieved in Q4 during FY18.



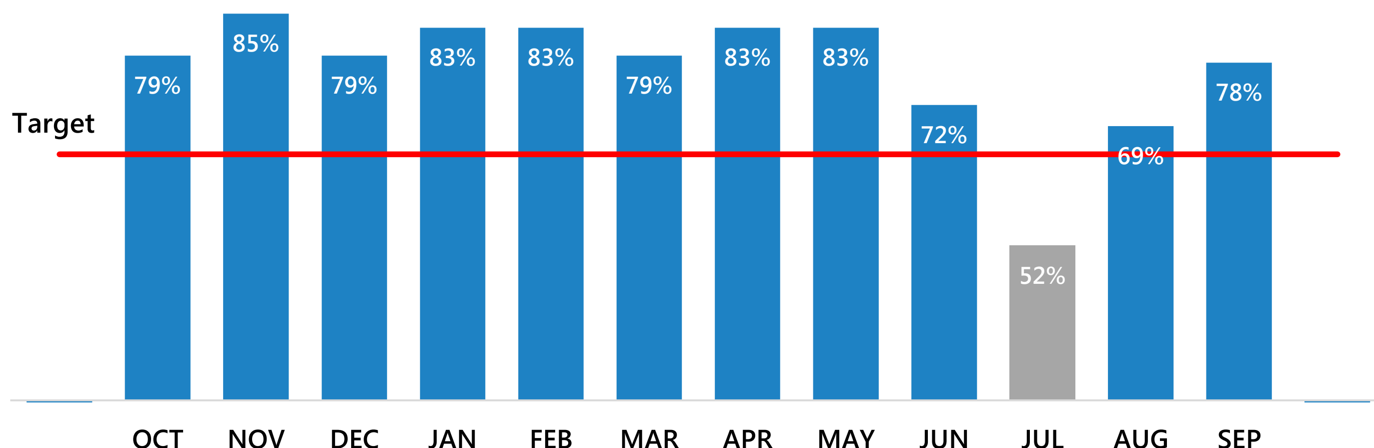
QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN INITIATIVES

Effectiveness:

The Crisis Care Center's purpose is to provide Wayne County families with a walk in alternative to the local emergency room when experiencing a psychiatric crisis. When families present at an emergency room, they are required to be screened and medically cleared by a physician before a staff social worker meets with the family to discuss the reason that the family has presented. This process requires that families presenting for psychiatric emergencies endure longer waits and procedures that are unnecessary for their immediate needs. Our Crisis Care Center is intended to reduce the wait time of families' immediate needs being met. Additionally, because local emergency rooms do not have psychiatric or behavioral health staff, the medical social worker and physicians are more likely to recommend hospitalization for these children. Our staff works with the family to identify stressors contributing to their crisis as well as utilizing natural supports to reduce any risk factors in hopes of stabilizing the crisis, maintaining the family unit, and helping the family increase their skills in coping with future crises.

Performance Improvement Goal #1: Crisis Care Center Diversion

The goal is for FY18 was to maintain a diversion rate of 65% and that was met each month except for one.



Performance Improvement Goal #2: Behavior Health Equity

The Children's Center implemented the Behavioral Health Equity (BHE) for Children and Families training during FY18. This fiscal year, three general staff trainings were facilitated focusing on clinical and administrative line staff. A training was facilitated at the We are Leaders Luncheon to members of ELT (Executive Leadership Team), LT (Leadership Team), and MT (Management Team). Additionally, the training was provided to all Child Welfare staff in their general staff meeting. A pre and post survey was developed to assess the effectiveness of the training.
In addition, The Children's Center hosted two Building Safety with Diverse SOGIE (Sexual Orientation, Gender Identity and Expression) Youth and Their Caregivers Trainings facilitated by the Ruth Ellis Center. Before the training took the place, TCC's Executive Leadership Team and Leadership Team met with the Executive Director of the Ruth Ellis Center to discuss SOGIE at TCC.

Through the BHE and SOGIE initiatives, an Equity, Diversity and Inclusion Committee (EDI) was developed in order to continue intentional conversations around these topics. It is the goal of this committee to create initiatives that support the agency in promoting a culture of equity, diversity and inclusion for all staff, clients, board members, donors, vendors, contractors and visitors to The Children's Center.

Performance Improvement Goal #3: IPOS Progress and Treatment

The goal of The Children's Center is to Increase the overall % of goal improvement.

Within our clinical programs, children and their families are involved in the development of their treatment goals and objectives in order to formulate an individualized, strength-based family-centered plan. Upon completion of the treatment plan, the clinician or supports coordinator monitors the client's progress on the treatment plan on a regular basis through the completion of a Formal Review of Progress (FROP). As part of this review, the case holder (clinician or supports coordinator) documents whether or not, in their clinical

judgment, the client has exhibited progress with a particular treatment plan goal or needs additional assistance and/or interventions to complete. For each goal listed in the treatment plan the case holder provides a narrative and marks the goal progress using one of five descriptors: "no progress," "little progress," "average progress," "significant progress," and "goal completed." In turn, these reviews can be monitored on an aggregated basis via reports generated from MISTICC to determine both within a particular program and across the agency to measure our success in assisting clients and their families in completing their treatment goals.

Progress	Total Count	% of Grand Total
Average Progress	4259	62.12%
Little Progress	1656	24.15%
No Progress	515	7.51%
Significant Progress	180	2.63%
Other	79	1.15%
Goal Completed	69	1.01%
Goal No Longer Applicable	64	0.93%
Not Addressed	34	0.50%
Grand Total	6856	100.00%

Performance Improvement Goal #4: Successful Discharge

The Quality Improvement group identified successful discharge as the following: Successful Discharge: Client satisfaction with treatment progress as evidenced by 1) client satisfaction and 2) progress towards treatment goals or 3) improvement in outcome measures.

As illustrated above, the monitoring of progress towards treatment goals transpires at the time of the formal review of progress. We made progress by monitoring this data at QI, and will continue to work on the other aspects of the definition in FY19.

Performance Improvement Goal #5: Client Engagement

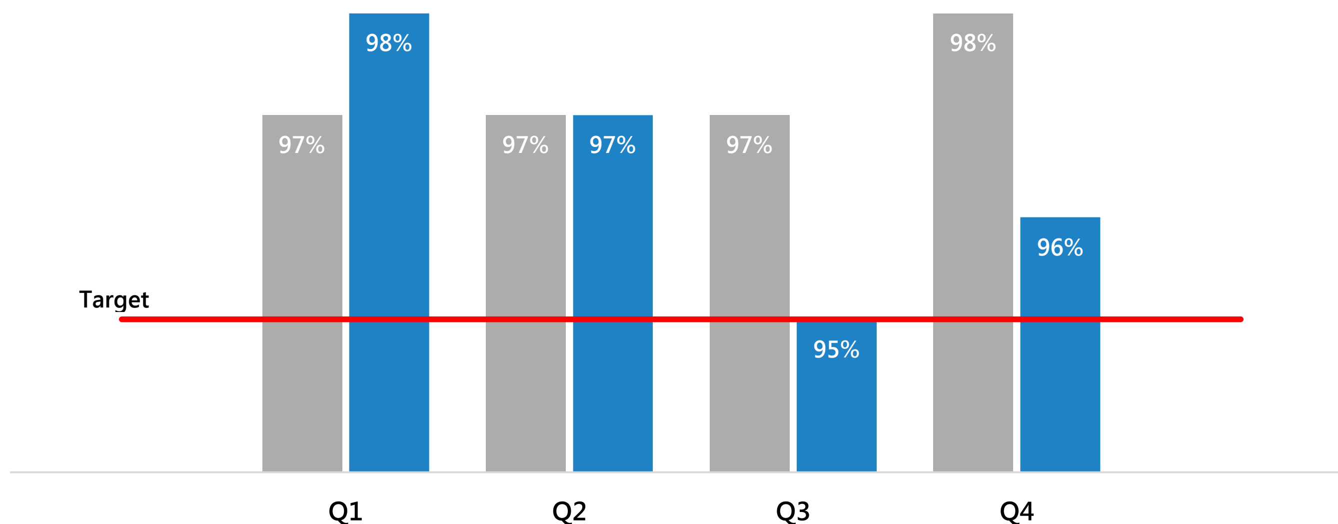
A vital part of successful treatment is engaging the client and family in the treatment process. Several factors can indicate if the client is engaged and some are easier to measure than others. As part of the continuous quality improvement process, the group at the Quality Improvement meeting decided to focus on monitoring 30 day and 60 day time intervals of no service utilization. The quantitative aspect is monitored through the caseload statistics report. Since this is more of a qualitative measure, communication will transpire between Quality & Compliance and clinical staff when concerning trends materialize.

Performance Improvement Goal #6: Utilization Management

Unlike the current Quality Improvement chart review process, the items reviewed will be of a qualitative, clinical nature. Utilization Management is the process of evaluating the medical necessity, appropriateness and

efficiency of health care services against established guidelines and criteria. The goal for FY18 was to maintain a 95% compliance rate.

Utilization Management Review was met each quarter in both FY17 and FY18.
Target is 95%

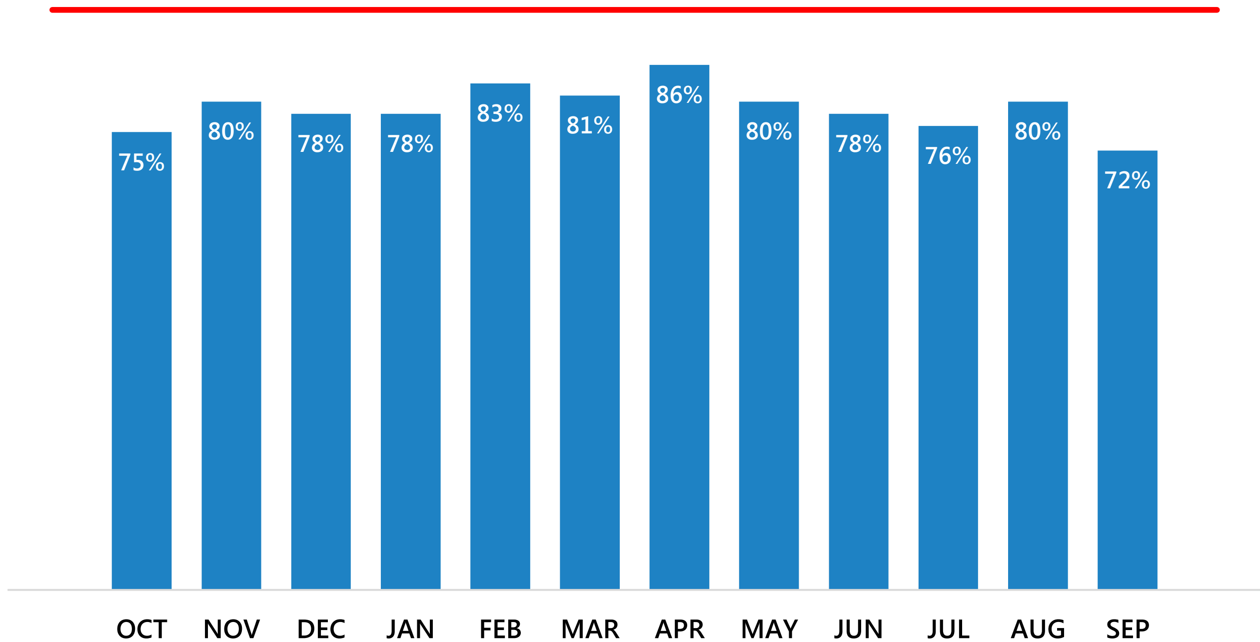


Although target was met each quarter, the problems areas include services not provided in the amount/scope/duration according to the treatment plan, documentation not uploaded into the chart, and limited coordination with other agencies. Feedback is provided to the supervisors of each area and discussed quarterly at the Quality Improvement meeting.

Efficiency

Performance Improvement Goal #1: Formal Review of Progress Completion

All CMH funded clients require a periodic and timely review of their progress towards completion of treatment plan goals and objectives. This is facilitated via completion of our Formal Review of Progress (FROP) document. The target is for all CMH funded clients to have this completed with the appropriate timeframes, 95% of the time.

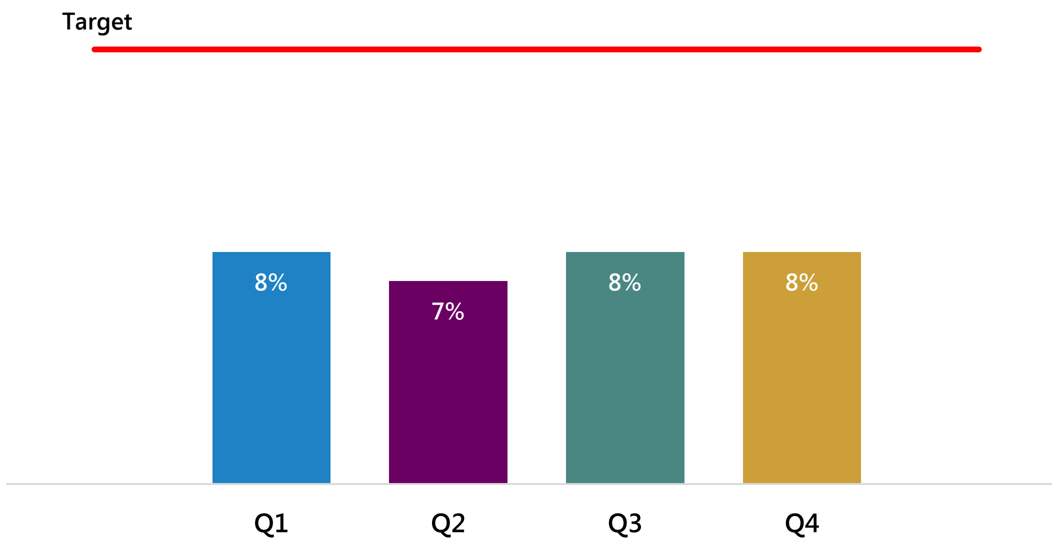


Satisfaction

Performance Improvement Goal #1 & #2: Follow Up Survey

The Children's Center obtains feedback via our client satisfaction survey process as well as the follow-up survey. The main purpose of the follow-up survey is to determine if our interventions were successful and/or if the client was linked to the appropriate aftercare services. Completion of the follow-up surveys is facilitated by the Client Services Department. We wanted to increase our response rate to 15% and receive positive responses, 80% of the time. We devoted significant efforts to revamping the collection methodology and questionnaire and will focus more on the positive response indicator in FY19.

Follow-up survey response rate did not meet target during FY18.
Target is 15%



We did not hit target for the response rate, but it was higher in FY18 and FY17.

Contractual Compliance

Performance Improvement Goal #1: Credential Committee

100% of clinical staff is credentialed within 60 days of hire date.

52%

Compliance

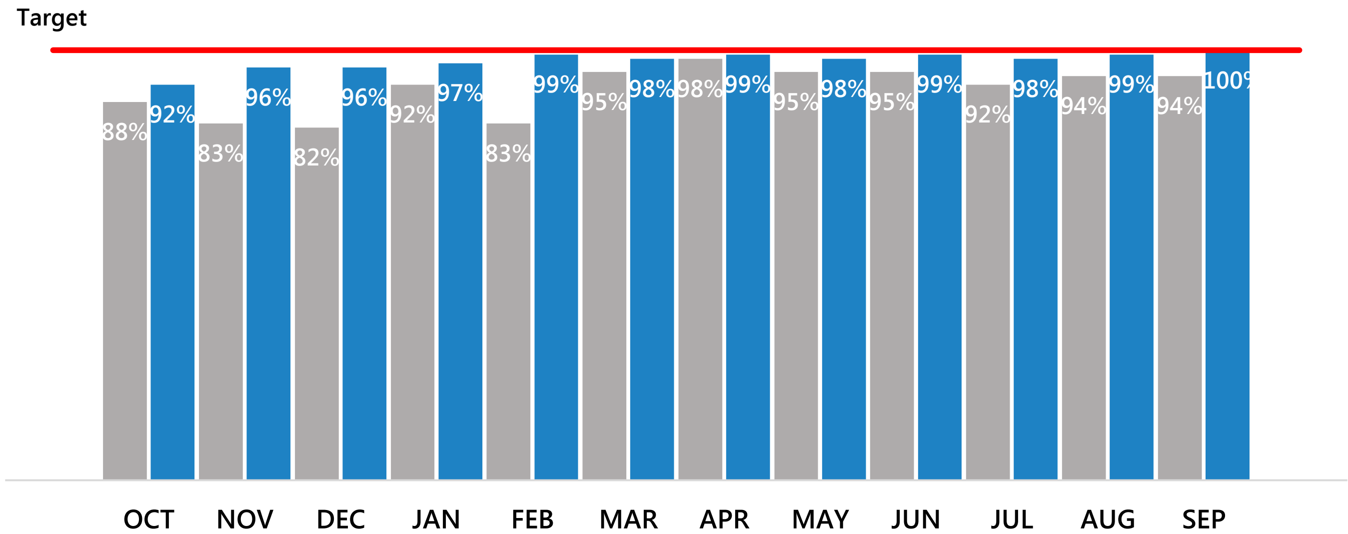
The Children's Center is its own CVO (Credential Verification Organization), and has a Credential Committee that meets monthly to develop and review credentialing criteria, make recommendations for approval of clinical responsibilities, and have oversight of the approval process. FY16 was a benchmark year to establish the baseline for how long it took to credential a new employee in accordance with MDHHS Provider Qualification Guidelines. Adherence to this standard is critical as it has funding implications in connection to the community behavioral health services we provide.

The average number of days it took to credential a staff in FY18 was 73 days. When removing a couple extreme outliers, the average drops to 63 days.

In FY17, the range shortened from 10 days to 165 days, averaging 66 days, and a decrease of 27%. This monitoring will continue in FY19 with the professional development department implementing ideas that continue the upward trend.

Performance Improvement Goal #2: Action Notice

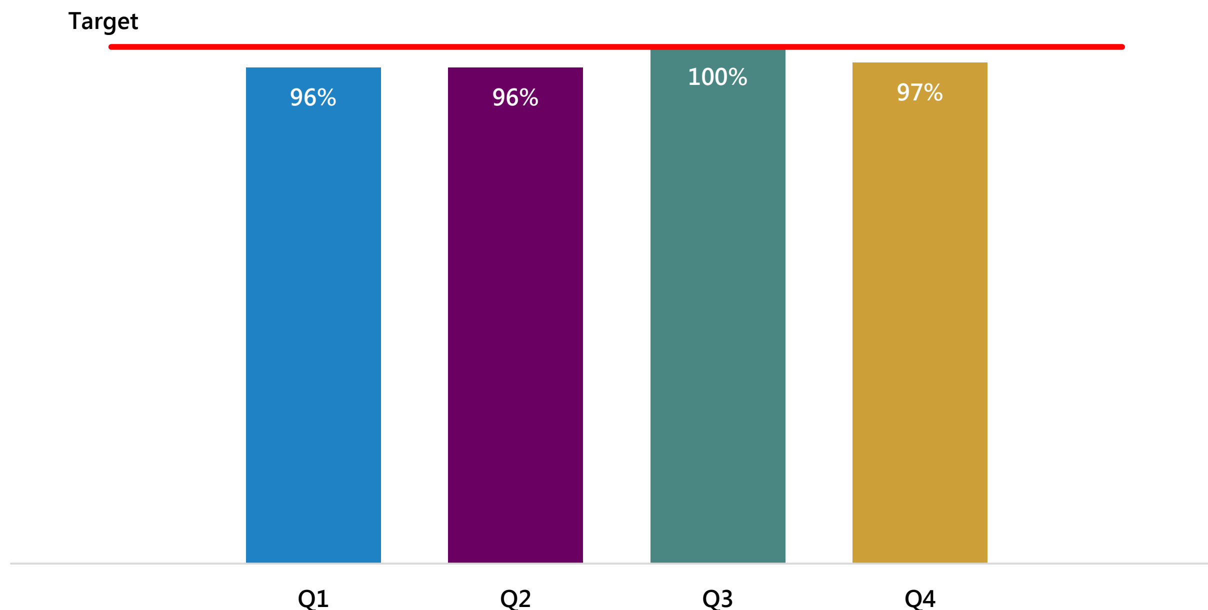
The goal is to increase compliance to 100%.



The Children's Center hit target one time over the past two fiscal years with an overall increase from FY17 to FY18. A few key contributing factors to this increase is the implantation of the Action Notice Training, Action Notice FAQs, and monthly monitoring.

Performance Improvement Goal #4: Internal Claims Audit

Increase and maintain compliance of 100%



As a result of the PIHP (Pre-paid Inpatient Health Plan) requiring the providers to more closely monitor the alignment of service delivery and claims, we implemented an internal claims audit. The internal claims audit assesses factors such as:

- Valid Treatment Plan
- Credentials of staff providing the service
- CPT code matching the service provided

We continue to make strides towards 100%. Providing ongoing feedback to the program areas allows for correction to take place.

Conclusion

Overall, some improvement concerning client output and outcomes was noted in the Behavioral Health programs, as evidenced by moderately decreased FAS scores. The Home Based program came the closest to meeting target. Within these programs, additional focus on developing comprehensive, measureable, family-centered treatment plans will likely result in increased success with goal completion, as well as family-reported satisfaction with outcomes. With respect to efficiency indicators, we noted significant improvement with treatment plan completion and FAS entry compliance, but further work must be done in order to consistently achieve targets for timely CAFAS and PECFAS completion. Another note-worthy accomplishment is that the diversion rate was met for most of the year and the fewest SED inpatient hospitalizations took place. As noted in previous annual reports, all of the efficiency targets listed above correlate and interconnect to agency-wide factors such as client no-shows/cancellations, utilization of collaborative documentation, management of caseloads, and change in mandates from funders, amongst other factors.

The Quality & Compliance department will work closely with Child Welfare programs in monitoring the targets for Foster Care by meeting monthly to review key performance indicators. Specific focus will transpire on the timeliness of medical & dentals and any contributing nuances that can positively affect this outcome. Another focus will be monitoring the initiatives created for FY19 to achieve permanency and increase the number of foster homes and host providers. A huge success transpired when the 100% of YASS clients graduated and about 80% of YASS clients worked with a mentor.

Agency-wide, collaborative work will continue to occur between Quality & Compliance and Program service areas to ensure effective and efficient service delivery takes place. Within the Quality & Compliance department, consistent reviews using large sample sizes are an essential aspect of obtaining valuable data in order to inform data driven decision making. This practice will support continuous quality improvement resulting in the development of initiatives that will positively impact the lives of the children and families we serve.