Quality Improvement &
Quality Assessment Performance Improvement Plan
Annual Report, FY 2019-2020

Submitted by:
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The Children's Center
Quality Improvement and Quality Assessment Performance Improvement Plan
Fiscal Year 2019-2020
October 1, 2019 – September 30, 2020

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 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, continuous quality improvement 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 performance, both at the individual program level as well as the organization. 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, we chose indicators based on their ability to accurately measure program areas while assisting program leadership in identifying opportunities for improvement as well as celebrating successes.

The purpose of the QAPIP is to demonstrate 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 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 continuous 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.

Two major events transpired in Fiscal Year 2020 that will result in unprecedented reporting results. As a result of fiscal challenges, the Autism program closed in July 2020. Additionally, The Children's Center experienced unprecedented activities because of the World Pandemic caused by COVID-19. As a result, the graphs will highlight the results "Pre-COVID" and "During COVID" to illustrate the shift in reported information. This annual report provides an update on the quality improvement initiatives identified in the Fiscal Year 2020 QIP & QAPIP.

Glossary Guide

ABA: Applied Behavioral Analysis

ASD: Autism Spectrum Disorder

CBP: Community Based Partnerships

CCC: Crisis Care Center

CMH: Community Mental Health

CPS: Child Protective Services

CQI: Continuous Quality Improvement

CW: Child Welfare

DDS: Developmental Disability Services

DWIHN: Detroit Wayne Integrated Health Network

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, 3 & 4)

HB: Home Based

I/DD: Intellectual or Developmental Disorder

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)

PRIDE: Parent Resources for Information, Development and Education

QI: Quality Improvement

SED: Serious Emotional Disturbance

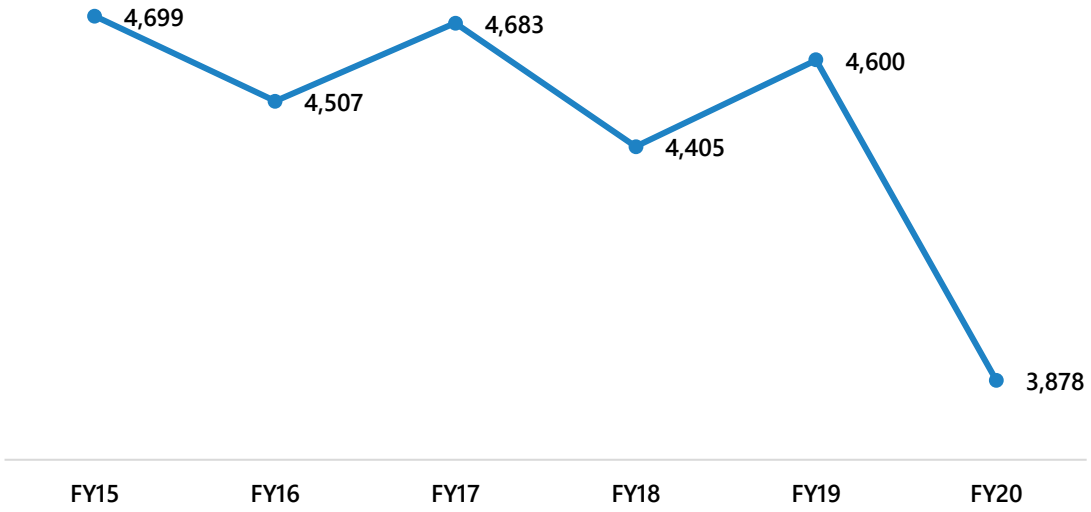
SCS: Supports Coordinator Specialist

SSI: School Success Initiative

YASS: Young Adult Self Sufficiency

Population Served

The Children's Center provided behavioral health services to an unduplicated count of 3,878 clients during FY20, a decrease from 4,600 clients in FY19.



The Children's Center served a diverse population of clients with serious emotional disturbance and intellectual/developmental disabilities during FY20.

Demographics	%
Race	
Black or African American	81.58%
Other race	7.83%
White	6.51%
Unknown	3.40%
Asian	0.44%
American Indian (non-Alaskan)	0.19%
Native Hawaiin or other Pacific	0.05%
Age	
7-12	47.11%
13-17	32.52%
4-6	13.90%
0-3	3.84%
18>	2.63%
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.

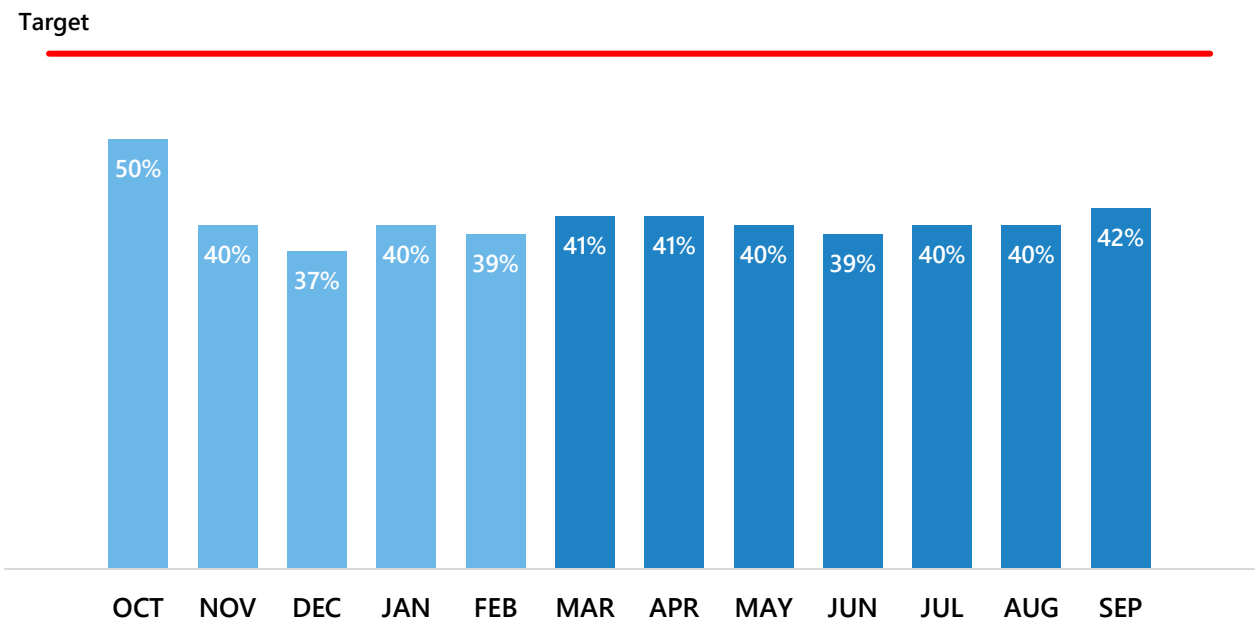
Effectiveness

Performance Improvement Goal #1: CAFAS/PECFAS Progress

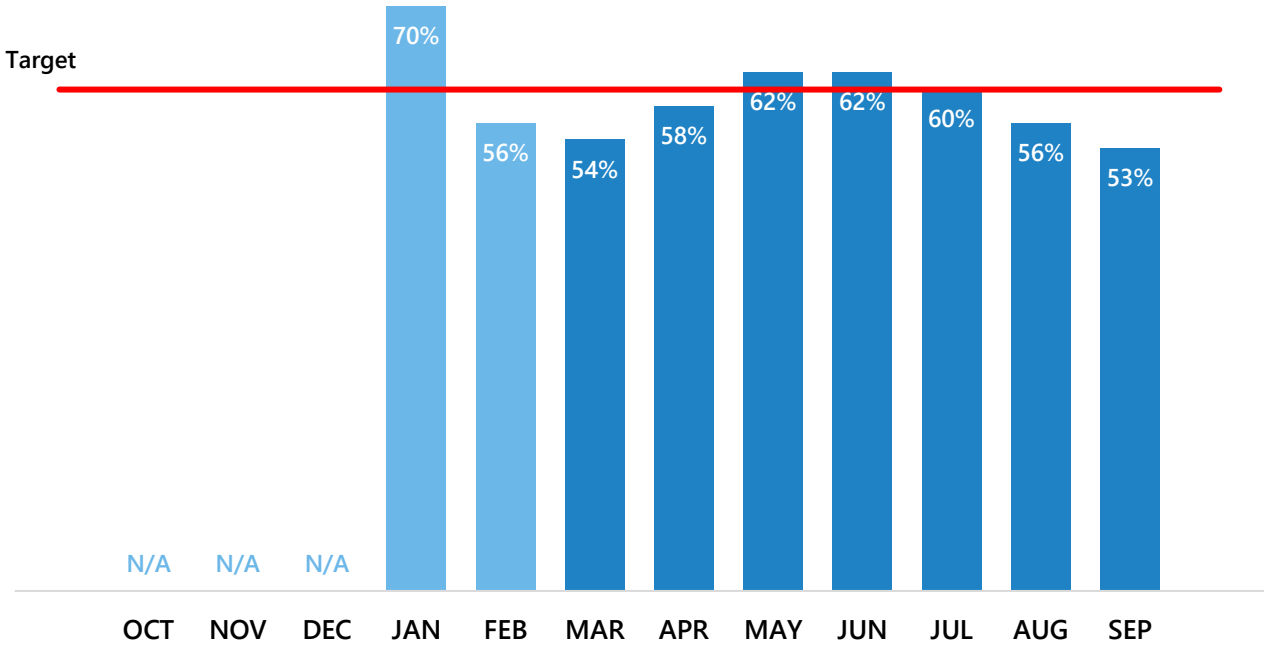
60% of clients discharged each month will exhibit a 20-point decrease in total score as a measure of clinical progress.

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 Integrated Health Network (DWIHN) 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:



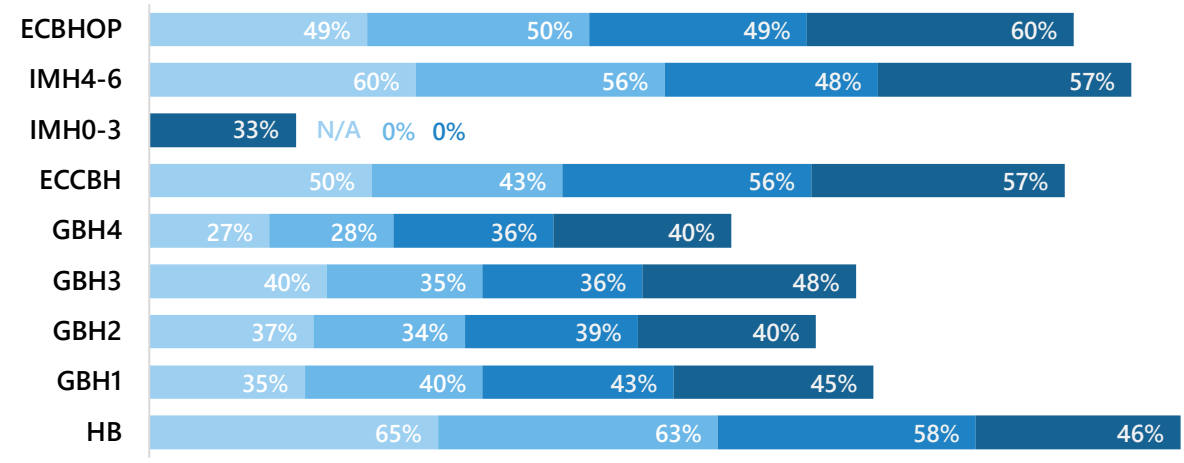
20-point PECFAS score pre-COVID and during COVID.
Target is 60%



Overall, the CAFAS data shows that we did not meet target in the last fiscal year. Some of the contributing factors include the measurement of the assessment interval and clients dropping out of treatment. The PECFAS data shows that we met target 33% of the year. This demonstrates tremendous progress from previous fiscal years.

To pinpoint possible drivers, the specific program areas are reviewed as well:

FAS overall 20+ point score improvement for Q1, Q2, Q3 and Q4.



The graph that contains the program breakdown shows that Home Based reached target 2 of the 4 quarters. Additionally, it illustrates that the General Behavioral Health (GBH) department averages around 35%. 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.

Performance Improvement Goal #2: Hospital Utilization

The Children's Center will decrease hospital recidivism for SED clients and monitor the hospitalization of I/DD (Intellectual/Developmental Disability) clients.

The services funded by Detroit Wayne Integrated Health Network 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 I/DD clients admitted to inpatient hospitals. Additionally, in FY20 we continued to monitor ER data reviewing how long our clients sat in the ER prior to admission but will discontinue this monitoring in FY21.

In order to determine the interventions necessary to reduce hospitalizations and recidivistic admission, an internal workgroup meets on a routine 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.

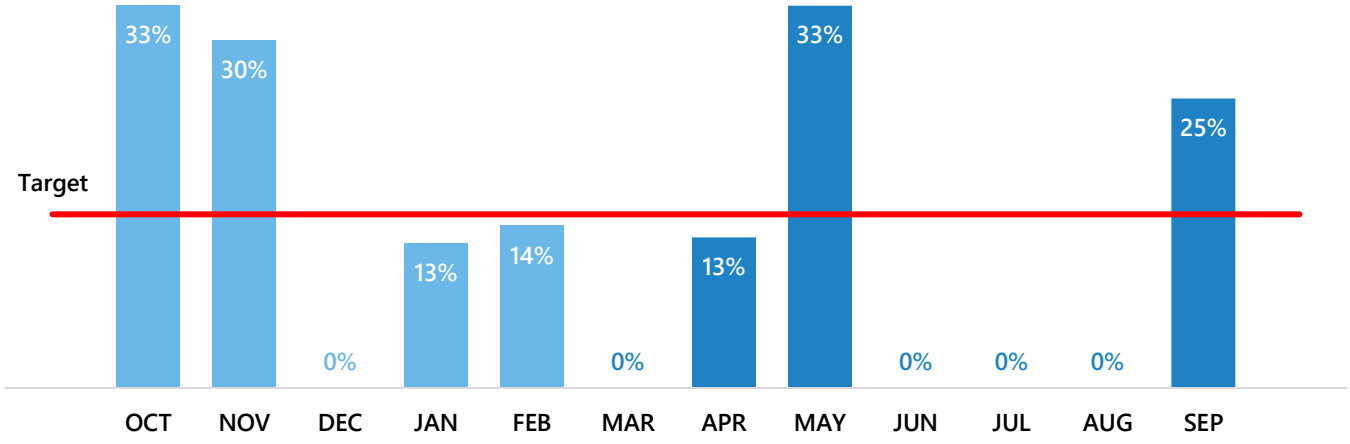
Additionally, the Crisis Care Center (CCC) equips children and families with strengths and resources to assist them in recovering from a crisis. A family focused approach is practiced to assess and intervene during psychiatric crisis with the hopes of supporting the family and having the child safely 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 FY20, the statistics for hospital utilization, crisis care services, and ER data is as follows:

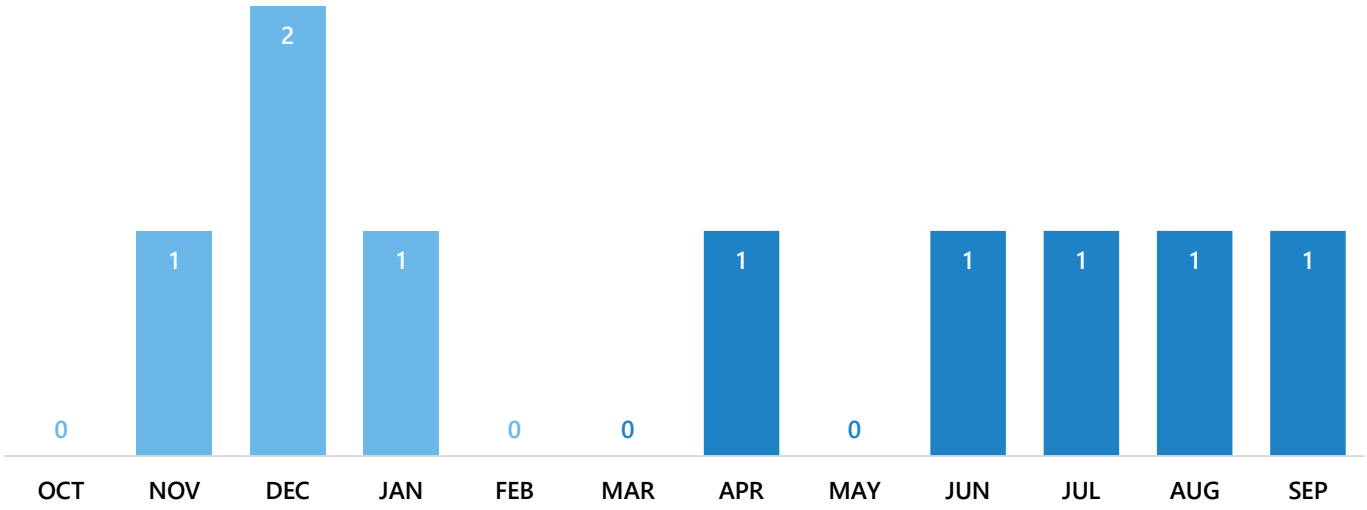
Objectives	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
Inpatient Data (from Hospital Liaison Log)												
1. SED Inpatient Admissions	6	10	6	8	7	10	8	3	5	4	6	4
2. Average length of stay	9.2	11	9.4	9.3	9.1	7.3	9.3	7	8.5	8	9.2	14.3
3. SED Recidivistic Admissions	2	3	0	1	1	0	1	1	0	0	0	1
4. SED Percent Recidivism Target: <15%	33%	30%	0%	13%	14%	0%	13%	33%	0%	0%	0%	25%
5. SED Total Discharged	5	10	7	7	6	12	6	5	5	3	8	3
6. I/DD Inpatient Admissions	0	1	2	1	0	0	1	0	1	1	1	1
7. I/DD Recidivistic Admissions	0	0	0	0	0	0	0	0	0	0	0	0
8. I/DD Total Discharged	1	1	1	2	0	0	1	0	1	1	0	2
9. SED and I/DD Aftercare Appts. (7 days)	6	5	4	7	3	4	5	5	5	2	2	3
Crisis Center Data (from CC SED Monthly Log)												
10. Crisis Center Contacts (face to face)	63	53	41	42	49	37	7	6	7	4	15	10
11. Crisis Center to Psych. Hosp.	9	10	12	7	9	5	1	1	2	1	4	2
12. CC Diversion Rate Target>75%	86%	81%	71%	83%	82%	86%	86%	83%	71%	75%	73%	80%
Overall Crisis Data (from MISTICC SALs)												
13. Psychiatrist Interventions (829 codes)	81	66	58	51	67	51	8	7	8	7	16	13
14. H2011 codes billed	71	54	42	48	52	49	13	13	9	10	15	12
15. 90839 codes billed	18	9	13	7	10	10	0	1	1	3	0	1
ER Data – Clients in ER Awaiting Inpatient Admission												

Objectives	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
16. Clients in ER awaiting inpatient admission	3	2	8	4	5	2	1	0	4	2	5	3
17. Clients in ER, denied admission due to no bed	3	2	6	4	5	2	1	0	4	2	5	3
18. Clients in ER, denied admission due to acuity	2	1	3	2	3	1	1	0	3	0	2	2
19. Average length of stay in ER in days	4.6	2.5	4.75	12	9.4	4	2	0	3.5	1.5	5.6	4
20. Clients in ER – disp. changed to PHP or OP	1	1	3	0	3	0	1	0	3	0	3	1
21. Total # of Rescreens	9	3	22	27	22	3	3	0	12	1	13	11

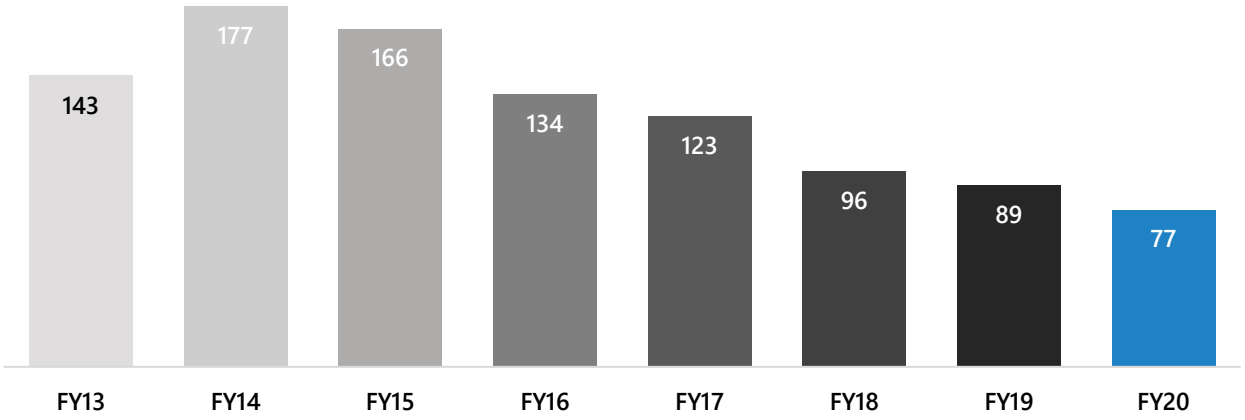
SED inpatient hospitalization recidivism rates pre-COVID and during COVID in FY20.
Target is <15%



The highest number of DDS hospitalizations was in December of FY20.



FY20 saw the fewest inpatient SED hospitalizations in 8 fiscal years.



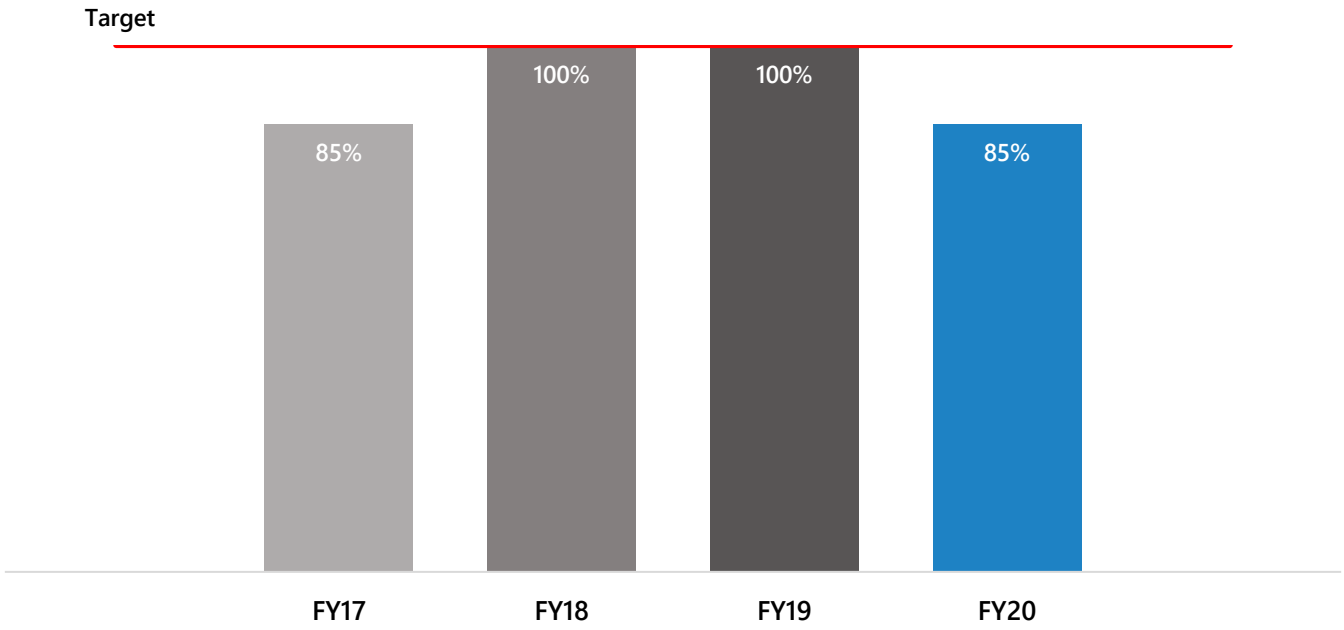
Overall, trends in admissions continually decrease from prior years. Additionally, the recidivism rate was not on par in FY20 with FY19 due to a smaller sample and a larger number of clients re-entering the hospital. The average recidivism rate for FY20 was 13% compared to 10% in FY19 and an average of 9% in FY18. The target of 15% or less was met each month except October, November, May, and September. 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 80% in FY20, 84% in FY19, and 77% in FY18.

Performance Improvement Goal #3: Child Welfare YASS Graduation %

95% of YASS clients will graduate high school.

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 not met in FY20.
Target is 100%



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.

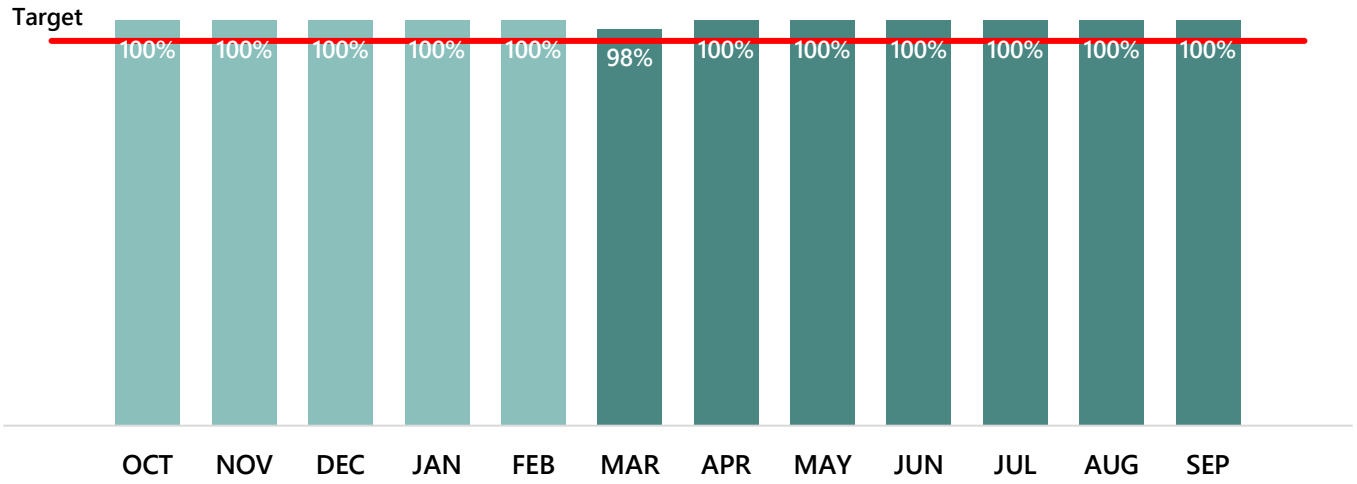
The most recent graduation data available for the state of Michigan for the school year 2018-2019 was 81.41%. The graduation rate for Detroit for the same time was 75.84%. The staff in this department provided education monitoring and tutorial services to support the YASS students in graduating high school. We will continue to monitor annual trends and assess our continual impact.

Efficiency

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

The Children's Center will ensure that children will receive a pre-admission screening for psychiatric inpatient care within 3 hours, 95% of the time.

% of dispositions completed within 3 hour time standard for emergency screening request was met pre-COVID and during COVID.
Target >95%



Performance Improvement Goal #2: 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:

Performance Indicator 2 compliance increased in FY20 compared to FY17, FY18 and FY19.
Target is 95%

OCT	98.55%	78.95%	99.25%	98.01%
NOV	100.00%	57.50%	90.79%	97.96%
DEC	100.00%		90.91%	95.83%
JAN	98.61%	92.11%	90.63%	96.83%
FEB	79.57%	97.53%	100.00%	99.12%
MAR	84.16%	100.00%	98.68%	97.78%
APR	65.08%	100.00%	96.62%	100.00%
MAY	54.17%	98.10%	100.00%	100.00%
JUN	64.41%	100.00%	98.75%	88.64%
JUL	50.79%	97.00%	100.00%	100.00%
AUG	84.71%	100.00%	97.12%	100.00%
SEP	83.87%	99.11%	99.22%	100.00%

In prior years, 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. Significant improvement transpired from FY18 to FY19. 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 FY18.

Performance Improvement Goal #3: 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.

This standard changed during FY20 to the percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. Because of this change, The Children Center will meet target unless a client leaves Intake prior to completing the biopsychosocial. 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:

Performance Indicator 3 compliance increased overall in FY20 comared to FY17, FY18, and FY19. Target is 95%

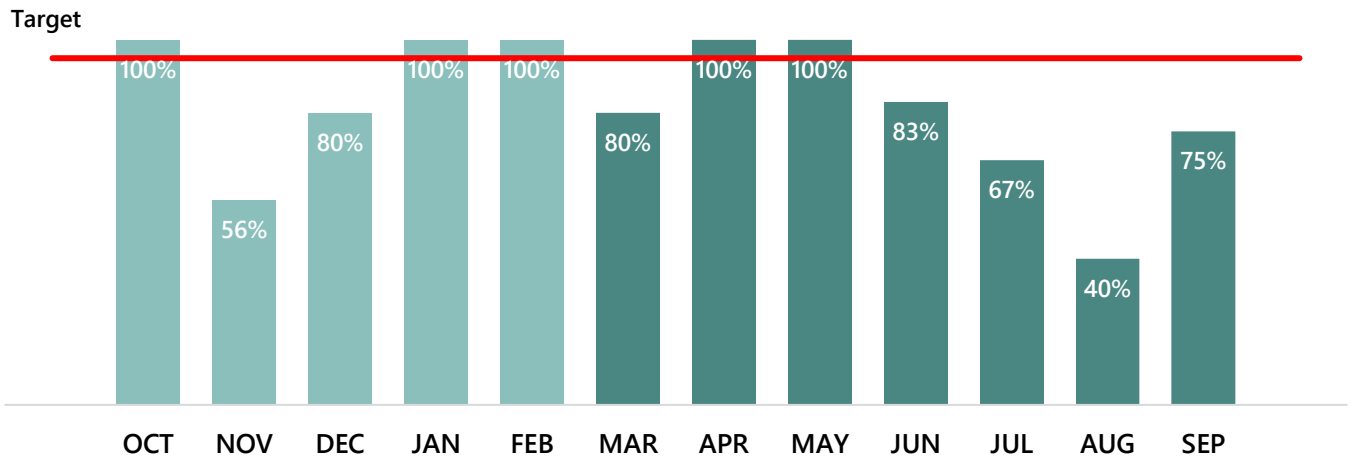
OCT	96.70%	97.50%	95.79%	65.08%
NOV	97.89%	97.67%	93.18%	100.00%
DEC	96.88%		94.03%	100.00%
JAN	98.61%	97.26%	76.47%	100.00%
FEB	99.08%	95.18%	95.45%	100.00%
MAR	99.22%	94.50%	90.68%	100.00%
APR	97.65%	100.00%	96.67%	100.00%
MAY	100.00%	100.00%	96.75%	100.00%
JUN	96.00%	66.67%	93.67%	100.00%
JUL	93.94%	94.00%	93.67%	100.00%
AUG	97.44%	96.97%	94.12%	100.00%
SEP	97.73%	94.12%	79.05%	100.00%

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. In FY19, we struggled to consistently meet target. Contributing factors include system issues, staff turnover and department capacity. We are currently monitoring a corrective action plan that will assist in increasing this compliance. In FY20, we met target each month except for October. As a result of the standard changing, we manually monitor client attendance between Intake and the first ongoing appointment.

Performance Improvement Goal #4: MDHHS – Access to Services (Performance Indicator 4a)

The Children's Center will ensure that children who are discharged from a psychiatric inpatient unit will be seen for follow-up care within 7 days, 95% of the time.

% of discharges seen within 7 days of discharge pre-COVID and during COVID.



We met target 42% of the year and will continue to monitor this at the Quality Improvement meetings.

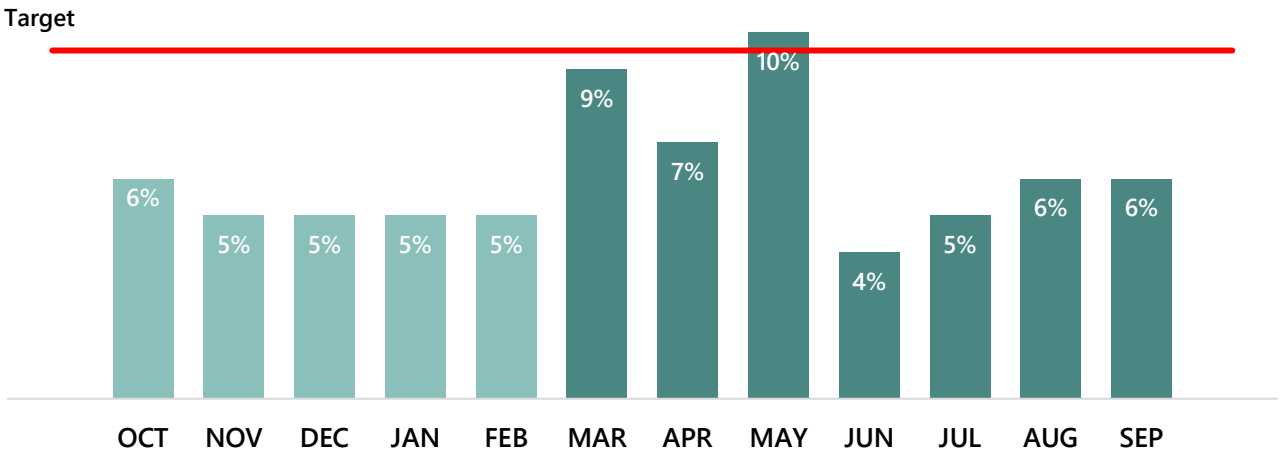
Performance Improvement Goal #5 and #6: CAFAS/PECFAS completion and FAS entry

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.

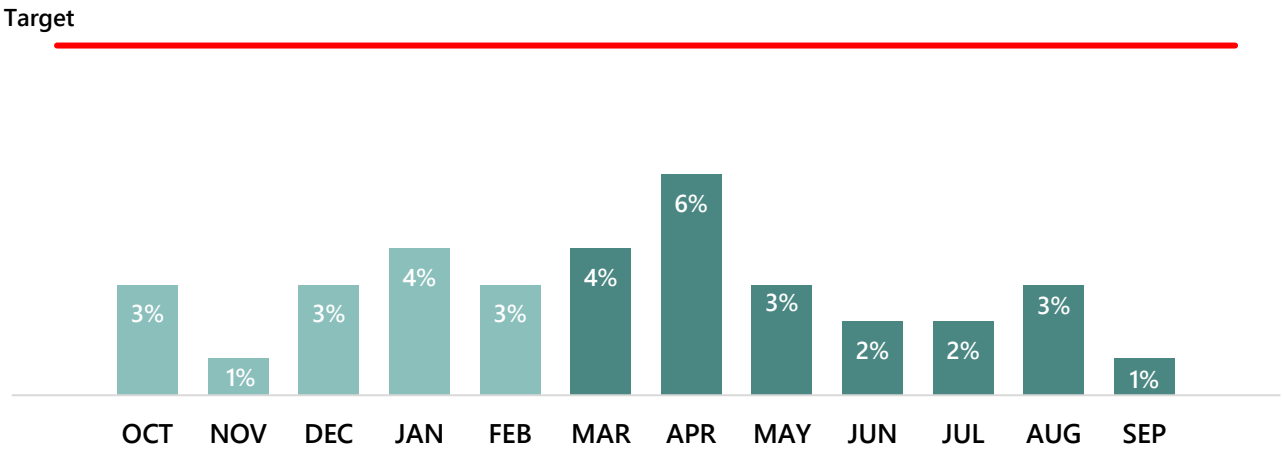
Per our contract with DWIHN, The Children's Center is responsible for monitoring overdue CAFAS/PECFAS rates. Monitoring the number of overdue CAFAS/PECFAS assessments is necessary to help create and maintain ongoing and timely evaluations of clients, which is critical when monitoring clinical outcomes. 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 identified in the FAS system.

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

Overdue CAFAS pre-COVID and during COVID.
Target<10%



Overdue PECFAS pre-COVID and during COVID.
Target<10%



In prior fiscal years we struggled to consistently meet target, but in FY19, the continuous monitoring and reporting by Program and Quality & Compliance proved to be effective. As a result, we met target each month for CAFAS and PECFAS except during the month of May for the CAFAS requirement.

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

We met 100% compliance in each quarter during FY20.

Q1	Q2	Q3	Q4
0.0%	0.0%	0.0%	0.0%

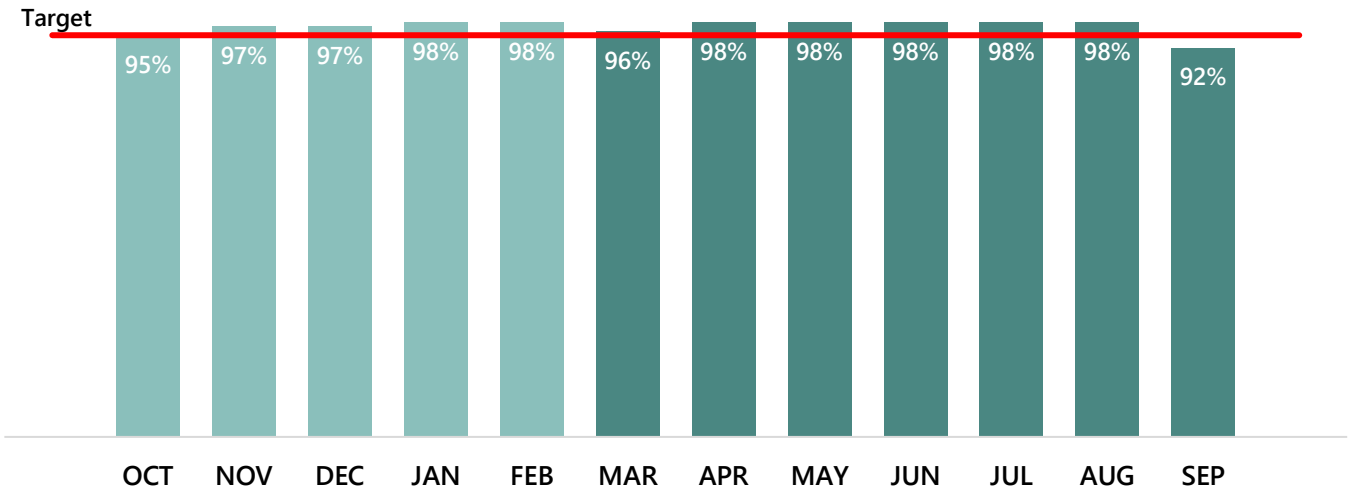
During the monthly QI meeting, Program and Quality staff review the aggregated data that is continuously worked on by staff throughout the month.

Performance Improvement Goal #7: Treatment Plan Completion

All active 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. We achieved the target of 95% for eleven months of the year.

Treatment Plan completion during FY20 pre-COVID and during COVID.
Target is 95%



We met target each month in FY20. We know that the system changes to our Electronic Health Record on September 10th contributed to the decline in compliance.

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 FY20, we assessed satisfaction using a revised survey from FY19. 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"
- "If your services at The Children's Center (TCC) began within the last year, I was satisfied with the intake process"
- "Front desk staff are warm, welcoming, and helpful"
- "If I need to express a complaint, Customer Service staff are helpful"
- "I feel that I can talk with my case worker/clinical staff about anything"
- "The Psychiatrist/(Doctor) is helpful and available"
- "Staff listen to me, I feel my voice is heard"
- "If I used Telemedicine/Telehealth services, I was satisfied with the experience"
- "Since coming to TCC, there have been positive improvements"
- "I feel well informed about what's happening at TCC"
- "TCC is welcoming to people of all cultures and backgrounds"
- "TCC staff works well together to meet my family's needs"
- "The enrichment activities (Game Time, Art Adventures, Homework Help, etc.) are beneficial for my family"
- "I feel safe returning to The Children's Center campus"
- "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 number of unique active clients (N=2,208) as of the writing of this report gave a total number of responses at 19% (N=429) completed the survey.

The survey results showed an overwhelming majority of positive responses. Positive response rates for the purposes of this report are participants that either gave a Strongly Agree or Agree rating on the initial 14 close ended questions. The survey results showed on 10 of the 14 initial questions having an over 80% positive response rate.

Of the 14 closed ended questions, there were 7 that had an over 90% positive response rate. The highest positive response was 96.5% (N=410) clients answered that TCC is welcoming to people of all cultures and backgrounds. The second highest positive response was 94.8% (N=404) that clients overall were satisfied with services at TCC. The third and fourth highest positive response had the same rate at 94.4% (N=403) of participants answered that they receive services/assistance in a timely manner, and they feel they can talk with

their caseworker/clinical staff about anything. Participants overwhelmingly agreed that TCC staff work well together to meet their families' needs 93.6% (N=397), that staff listen to them and they feel their voice is heard 92.0% (N=392) and front desk staff are warm, welcoming, and helpful 90.9% (N=390).

In addition, there were 3 questions that had an over 80% positive response rate. Participants responded positively 82.8% (N=355) that they felt satisfied with the use of Telemedicine/Telehealth. Participants felt that since coming to TCC there was positive improvements in their child 82.2% (N=350) and a total of 81.0% (N=345) participants felt well informed about what was happening at TCC.

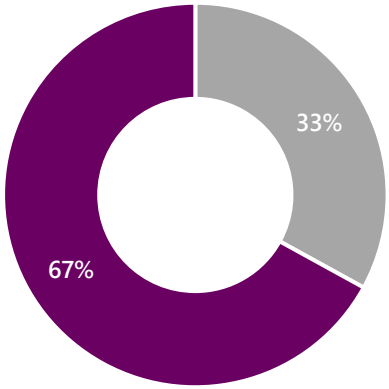
There were 4 questions that received a less than 70% positive response rate. Participants responded 69.9% (N=312) that the Psychiatrist/doctor was helpful and available. Participants felt the enrichment activities were beneficial to their family 63.3% (N=271), if services began within the last year participants were satisfied with the intake process 60.3% (N=258) and lastly if returning to campus participants felt safe 57.9% (N=247) rated the lowest.

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

The goal of the "New Foster Parent Survey" in FY20 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.

There were 16 new foster parents for the fiscal year, and there were 3 surveys completed for a response rate of 19%. Of the 3 respondents, 66.67% "strongly agree" to the following: "staff treated them with courtesy and respect during the licensing process" and "the licensing worker was willing to assist them in working through the licensing steps". Additionally, 33.33% of new foster parents "strongly agree" that "they are satisfied with the preparation and teaching provided through PRIDE training", 66.67% "…felt welcomed and comfortable at PRIDE training", and "PRIDE training was held at convenient times". When asked if they are pleased with the services their family receives from The Children's Center, 33.33% of new foster parents "strongly agree". 100% of new foster parents "strongly agree" that "PRIDE training offered the necessary information needed to understand how to care for a foster child" 33.33% of new foster parents "are satisfied with the services the licensing worker provided during the initial process". When asked about recommending The Children's Center, 66.67% of new foster parents provided a rating of 7 out of 10, and 33.33% provided the rating 10 out of 10 when asked "Based on your experience today, how likely are you to recommend TCC to someone who is interested in being a foster parent on a scale between 0 and 10?"

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



Performance Improvement Goal #3: Monitor customer service satisfaction for foster parents

The Client Services staff administered the distribution of the "Foster Parent/Host Provider Customer Service Survey," and the Quality and Compliance staff handled the data collection and analysis of the survey. Survey Monkey was used by the Quality and Compliance team when analyzing the data. At the end of FY20, TCC has 80 foster homes and 55 host providers. A total of 27 surveys were completed at a 20% response rate.

The results of this survey show that while most respondents are satisfied with the services, there are still some improvements that they would like to see. Some of their suggested improvements include clothing allowances and difficulty of care payments are in place, better access to information electronically, counseling, and more communication. This feedback will be considered when working to improve the services that the Foster Care/YASS program at The Children's Center provides.

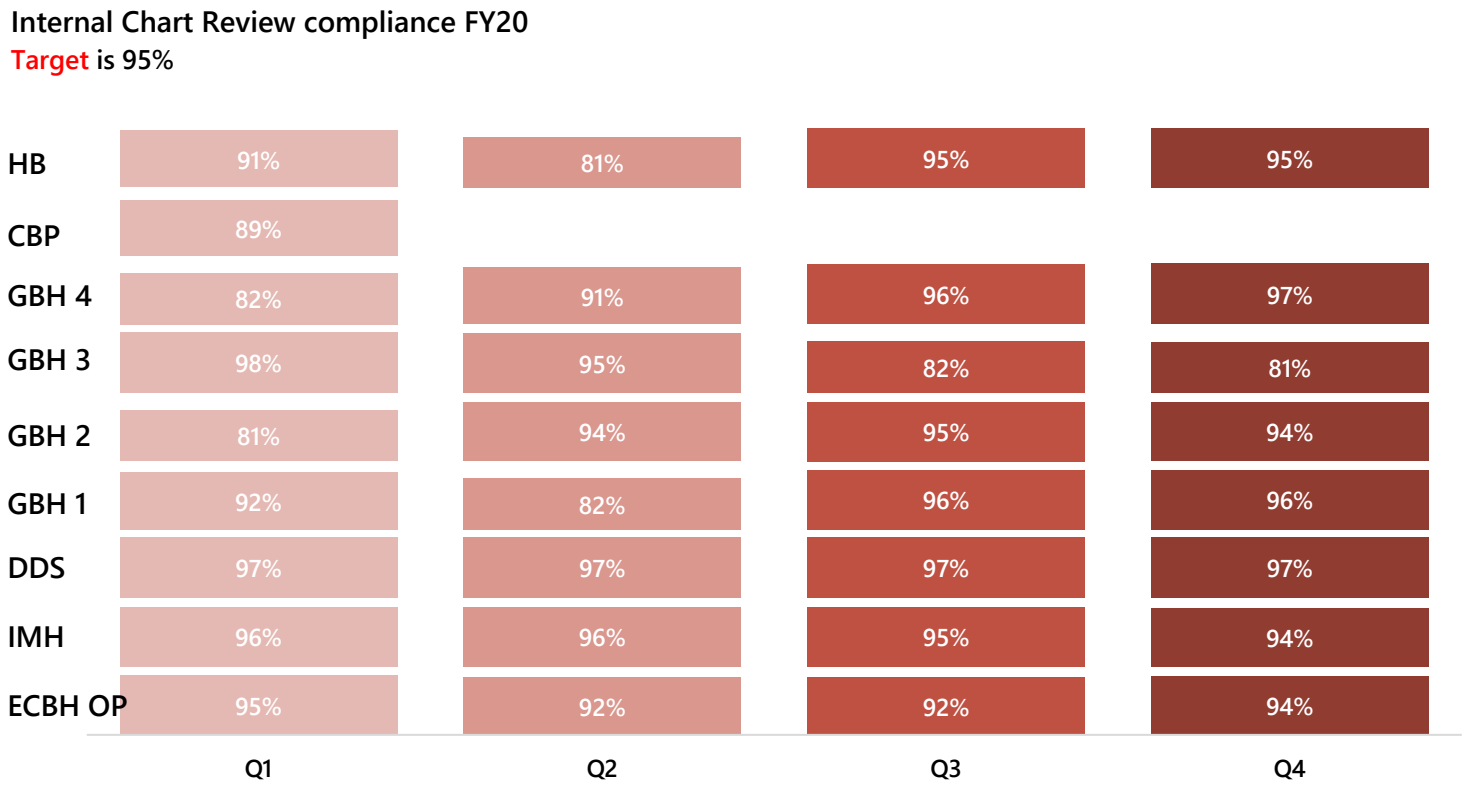
Contractual Compliance

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

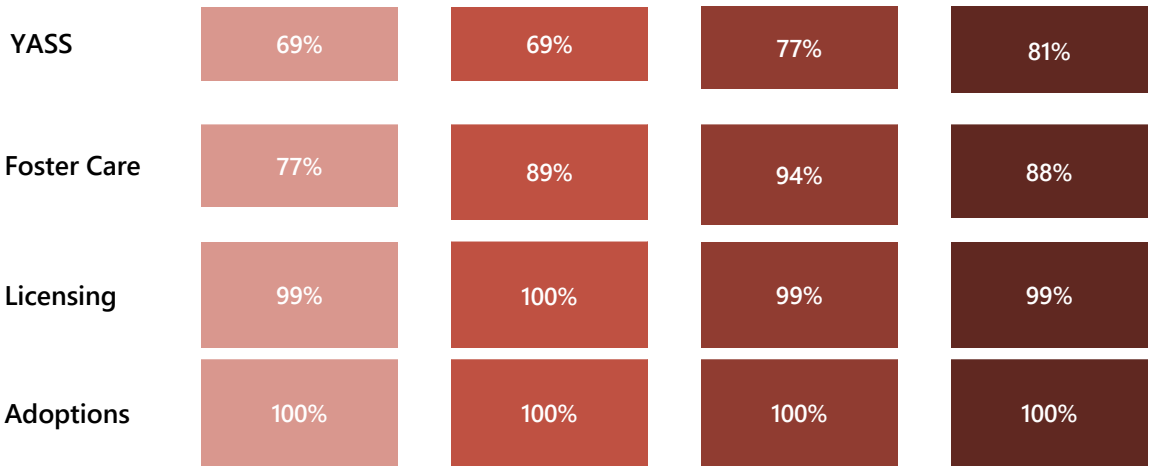
The Children's Center will increase and maintain chart compliance to 95% for all four quarters for all programs.

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 DWIHN. 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 FY20 internal quality chart review for the CMH-funded and Child Welfare programs are reported below:



YASS, Foster Care, Licensing, and Adoption chart compliance in Q1, Q2, Q3, and Q4 in FY20.
Target is 95%



Overall, the clinical chart reviews for FY20 exceeded compliance rates from previous fiscal years. At least 50% of the programs met or exceeded target each quarter. After Q1, the CBP chart reviews were incorporated into various teams of GBH. A continued contributing factor of this success 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 and Adoptions continues to exceed target each quarter. YASS trended up each quarter while Foster Care trended up and then saw a decline in quarter four. A contributing factor to this is ratio of caseloads and supervisors and managers having to carry cases. This dynamic will be explored in the month quality improvement meetings to identify strategies to assist in increasing compliance.

Review of 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 nor 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 FY19 to FY20:

	CW		ECBH		BHS - DDS		BHS - SED		Other		Total		Change%
	FY19	FY20	FY19	FY20	FY19	FY20	FY19	FY20	FY19	FY20	FY19	FY20	Change %
Arrest	4	0	0	0	6	3	19	21	0	1	29	25	-14%
AWOL	6	5	1	1	10	5	45	67	0	2	62	80	29%
Behavioral Problem	10	14	31	19	150	76	298	272	13	10	502	391	-22%
Code Blue	0	0	0	0	1	0	4	1	7	2	12	3	-75%
Code Gray	0	0	0	0	0	3	5	6	4	3	9	12	33%
Code Green	1	0	0	0	1	1	3	2	2	1	7	4	-43%
Code Red	0	0	0	0	0	0	1	0	1	0	2	0	-100%
COVID-19	0	1	0	10	0	29	0	65	0	4	0	109	N/A
CPS Referral	39	25	50	34	71	32	220	205	11	7	391	303	-23%
Death/Serious Injury	0	2	0	0	0	0	1	0	0	1	1	3	200%
Exposure	1	0	8	1	18	8	12	4	10	1	49	14	-71%
Homicidal/ Suicidal Threat	2	2	0	1	4	5	23	26	1	0	30	34	13%
Medical Emergency	19	17	2	9	44	53	28	48	1	0	94	127	35%
Medication Error	1	0	1	0	0	0	2	2	0	0	4	2	-50%
Non-serious Injury	8	6	11	10	116	26	50	36	14	3	199	81	-59%
Other	2	4	11	11	30	13	18	29	19	12	80	69	-14%
Physical Management	1	1	2	0	3	0	1	4	1	0	8	5	-38%
Property Damage	0	0	0	0	4	1	1	2	2	0	7	3	-57%
Safety	10	8	25	26	21	27	42	45	10	3	108	109	1%
Theft	0	1	0	0	1	1	0	6	4	1	5	9	80%
Grand Total	**104**	**86**	**142**	**122**	**480**	**283**	**773**	**841**	**100**	**51**	**1599**	**1383**	**-14%**

In total, the number of IR's completed in FY20 decreased 14% compared to FY19. A contributing factor is a direct correlation of the reduction in clients served in FY20 compared to FY19. A new category, COVID-19 was added to assist leadership in tracking potential exposure cases. The largest shifts at 200% and -100% is "death/serious injury" and "code red" respectively. A 80% increase in thefts transpired from FY19 to FY20.

Additionally, CPS referrals decreased 23%. 3 major contributing factors include the decrease in clients, the closure of the ASD program, and the COVID-19 Pandemic.

Review of Root Cause Analysis

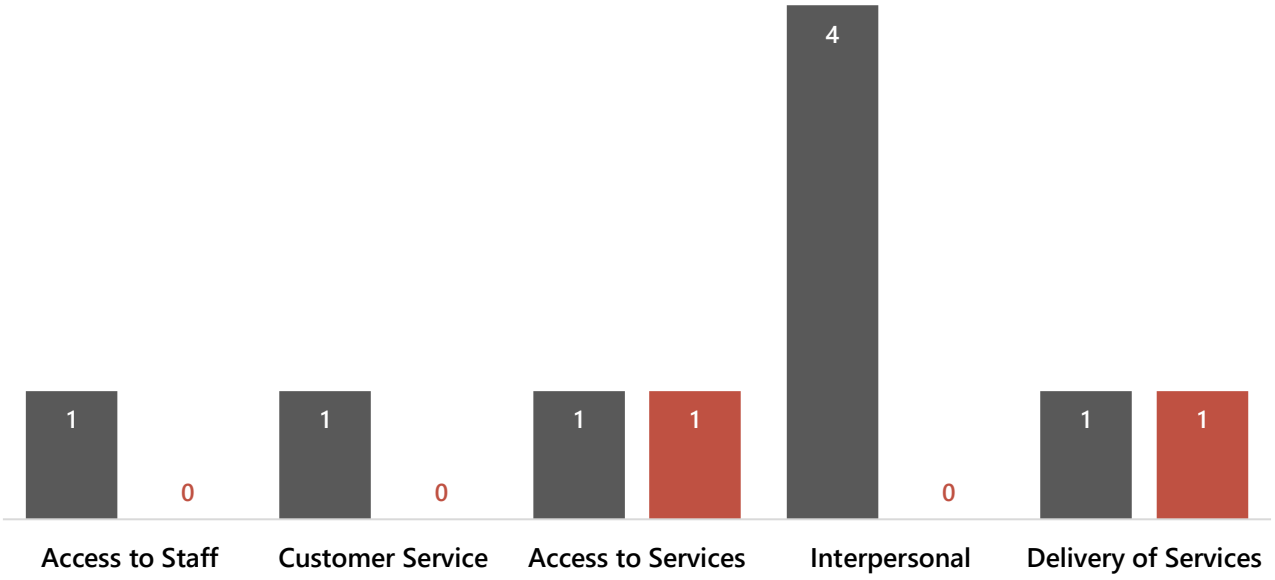
When injuries and behavioral concerns are reported and cross the threshold of a Critical Incident, it is entered into MHWIN. DWIHN notifies us if the Critical Incident is a Sentinel Event. Also, these events are reviewed through our Root Cause Analysis process when necessary. The Compliance Officer or designee leads the process and incorporates the appropriate parties to participate. Any areas of improvement are noted during the review, even those determined as to not have contributed to the occurrence of the incident, result in a formal Process Improvement Plan, identifying the areas requiring improvement, the necessary action steps to improve, the staff responsible, and the timeframe for completion. If FY20, the Compliance Officer led 5 RCAs.

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 grievances 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.

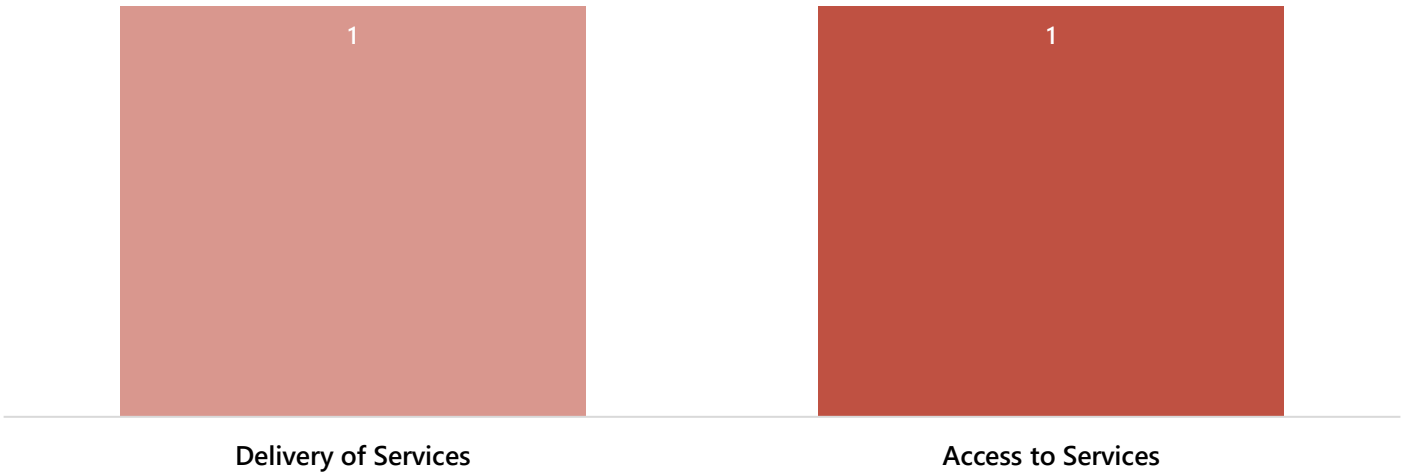
Of the two types of complaints listed above, most are categorized as grievances. Grievances usually involve clients or families having concerns with the behavioral health services they are receiving. The Quality & Compliance department investigates the grievances by speaking with the client/family to 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 DWIHN MHWIN system, with resolution expected within 60 days of receipt of initial complaint.

FY20 saw a major decrease in the number of grievances compared to FY19.



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 DWIHN Office of Recipient Rights for their review, during which they may decide to open their own investigation, and we will fully assist DWIHN with their investigation and implementation of any requested corrective action plans.

Grievances processed in FY20 were split between Delivery of Services and Access to Services.



In FY20, The Children's Center received five Recipient Rights complaints, and four of the five were substantiated. In FY19, The Children's Center received six Recipient Rights complaints, which is lower than the number reported in FY18.

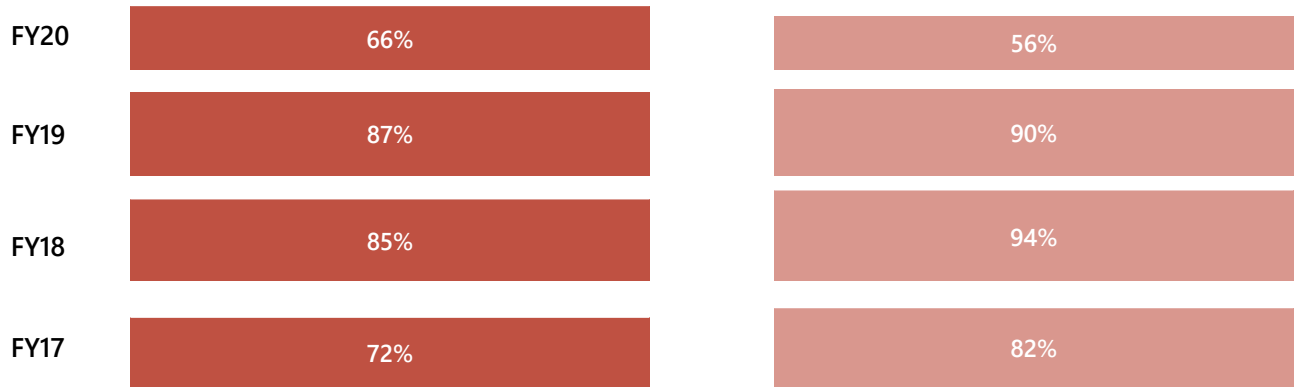
Performance Improvement Goal #2: Child Welfare Social Work Contacts - 85-95%

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 FY17 to FY20:

Monthly contacts between Child & Worker and Worker & Supervisor were not met each fiscal year and decreased in FY20 from previous fiscal years.
Target is 95%



Monthly contacts between Worker & Parent and Parent & Child were not met each year

Monthly contacts between Worker & Parent and Parent & Child were not met during FY20.
Target is 85%

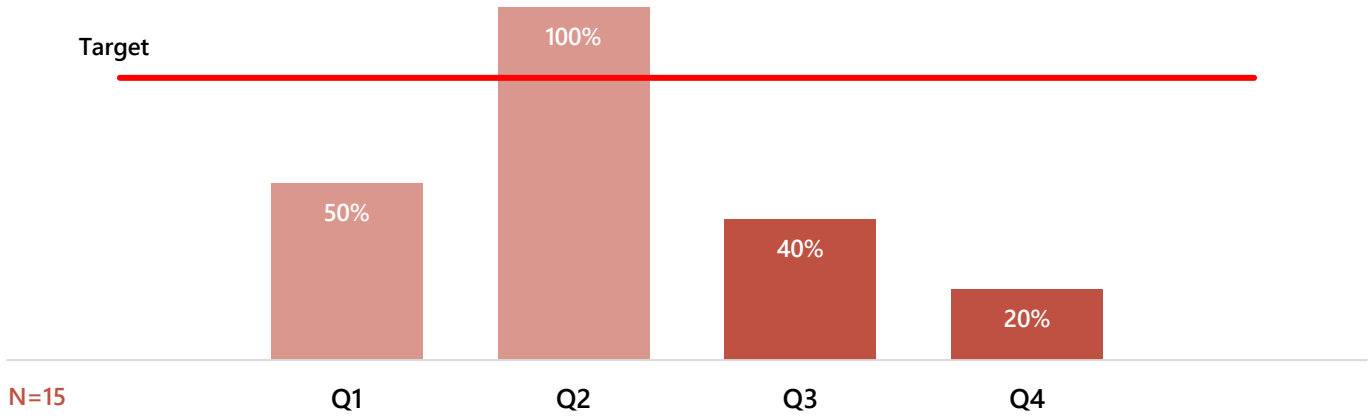
Contributing factors to not hitting target include a high turnover of staff in that department, learning curve and training of the system MiSACWIS, and accurately utilizing MiSACWIS to document each contact as well as the barrier with documentation due to the Pandemic.

Performance Improvement Goal #3: Child Welfare Adoption Timeliness – 365 days

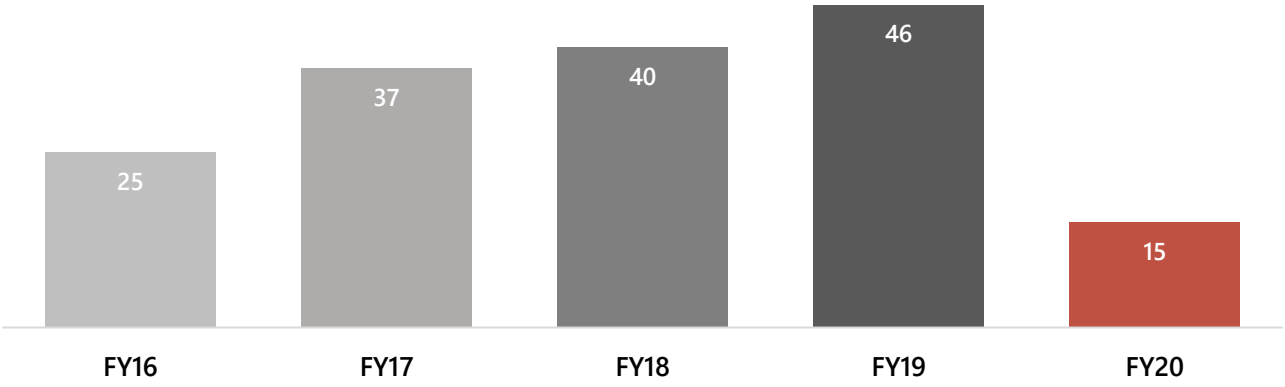
The Children's Center will strive to have 80% of children who have a goal of adoption to have their adoption finalized within 365 days. The measurement of this indicator shifted during FY18, measuring the petition filing date from the 3600 date.

Below are the quarterly results for FY20 and year over year trends:

Adoption petitions filed within 365 days pre-COVID and during COVID.
Target is 80%



The highest count of adoption petition filings occured in FY19.



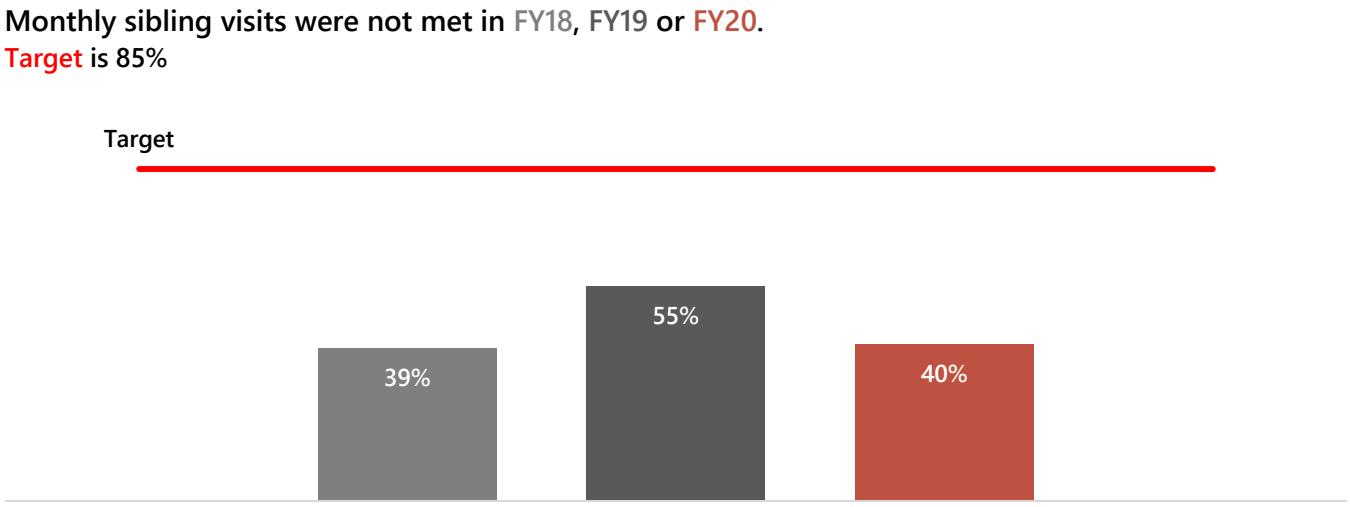
This trend had significantly increased from FY16 to FY19 due to this indicator measuring the petition filing date from the 3600 date, rather than the child's Michigan Children's Institute (MCI) date from the adoption

finalization date as well as specific plans of action implemented by leadership. FY20 saw a decline in adoption filings due to court closures during the COVID-19 pandemic.

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



The results are based on reports pulled from the data warehouse portal within MiSACWIS. An increase transpired from FY18 to FY19. Concentrated attention will continue to take place to ensure that the occurrence of consistent sibling visits continue to improve and that we 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 YASS program to help the young adult learn how to be self-sufficient. This includes teaching them essential life skills, so they can 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.

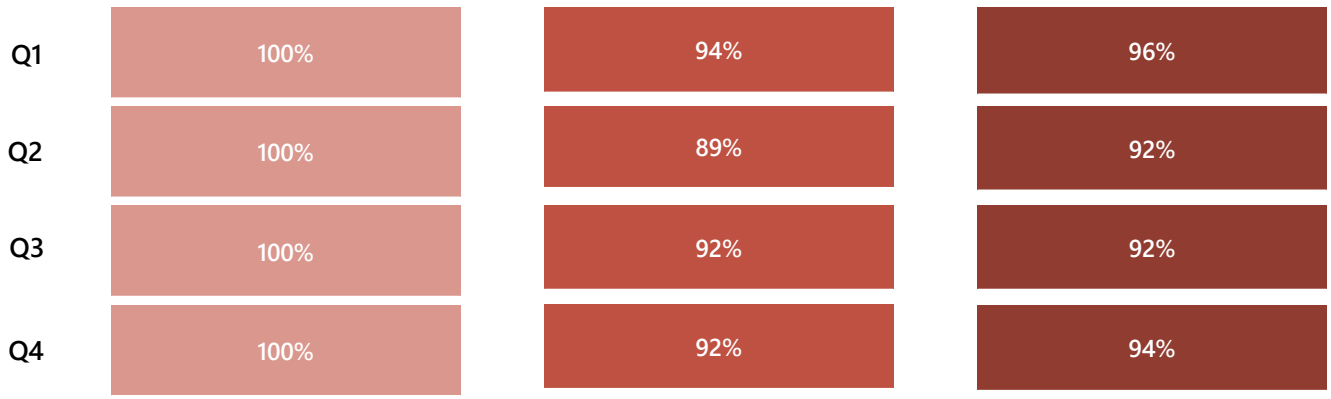
One of the expectations for the youth served in the YASS program is to either be involved in obtaining an education, obtaining a vocational training, or be employed; thus, engaged in "productive" activities. YASS staff work closely with the clients in the program to develop the skills necessary to achieve 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 monthly 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.

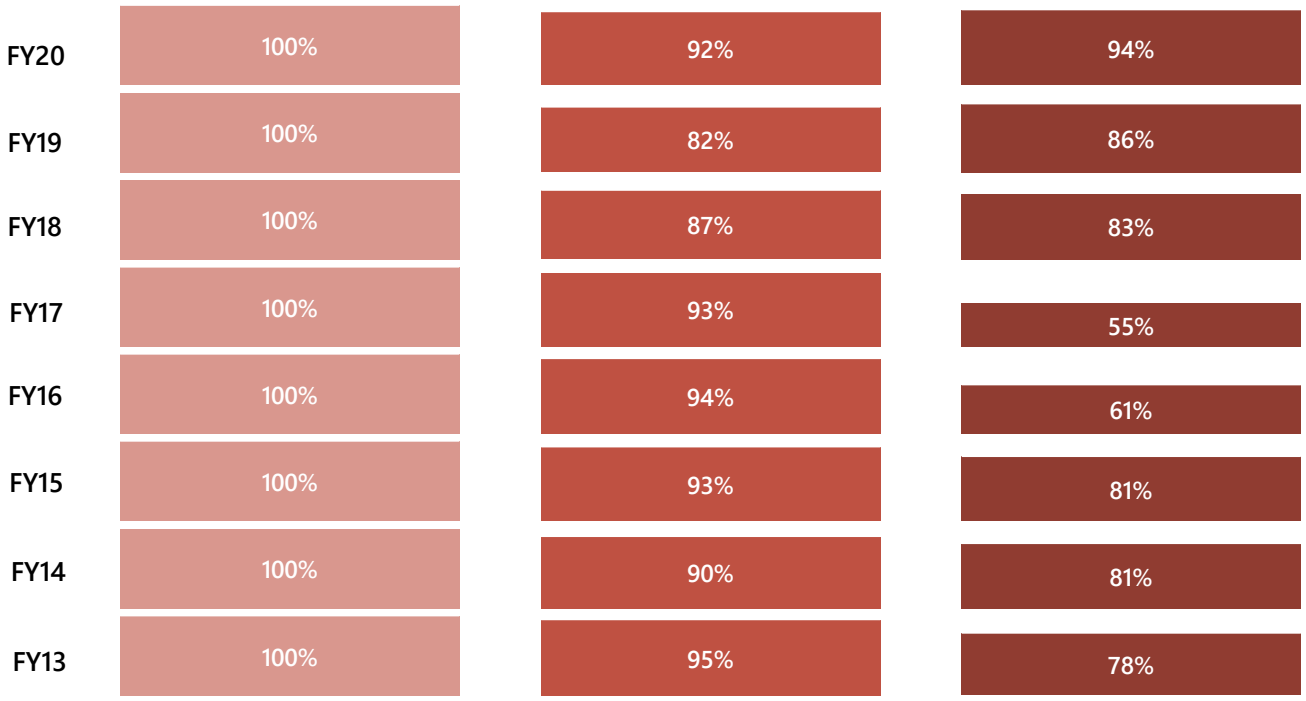
The goals are for all young adults in the YASS program to be connected with a community support person who can be of assistance to them, provide a mentoring relationship and help the youth adjust to societal expectations outside the procedures of a formal DHHS-funded program. Therefore, the program seeks 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 are the quarterly results for FY20 and year over year trends:

Safe Living Environment met target during FY20.
Productive Activities and Mentors did not meet target of 100%.



Safe Living Environment met target for 8 consecutive fiscal years.
Productive Activities and Mentors did not meet target of 100%.



Although target was not met for Mentors, it achieved its highest target year-to-date.

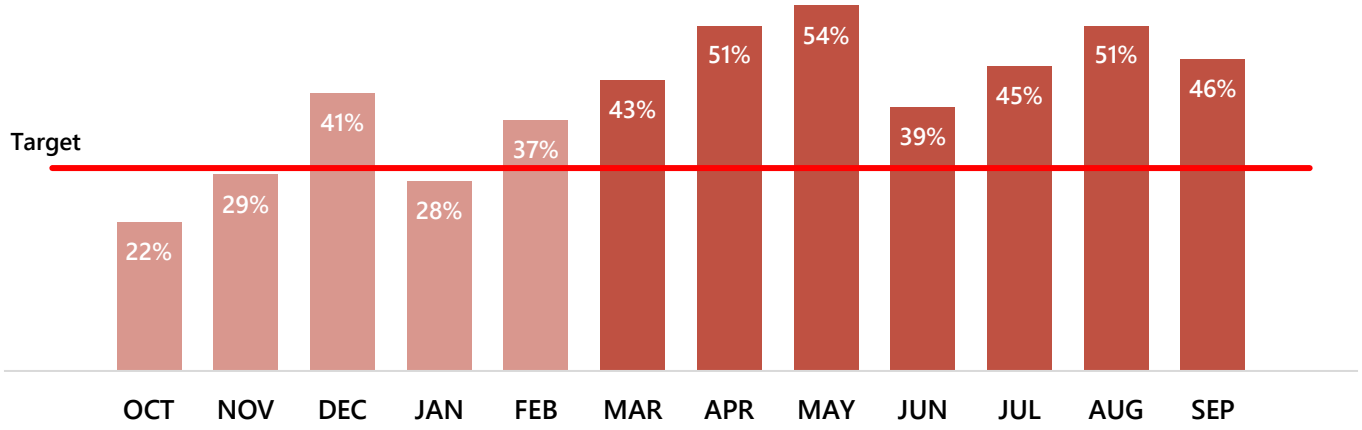
Performance Improvement Goal #8: Child Welfare Licensing Target

The Children's Center will maintain a 30% net gain of viable beds.

The requirements of the Licensing Department of the Child Welfare programs include 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 10%. Economic challenges within the community continue to have an impact on the ability of the program to license new foster parents and 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:

Viable beds for foster homes pre-COVID and during COVID for FY20.
Target is 30% net gain of viable beds by the end of the fiscal year.

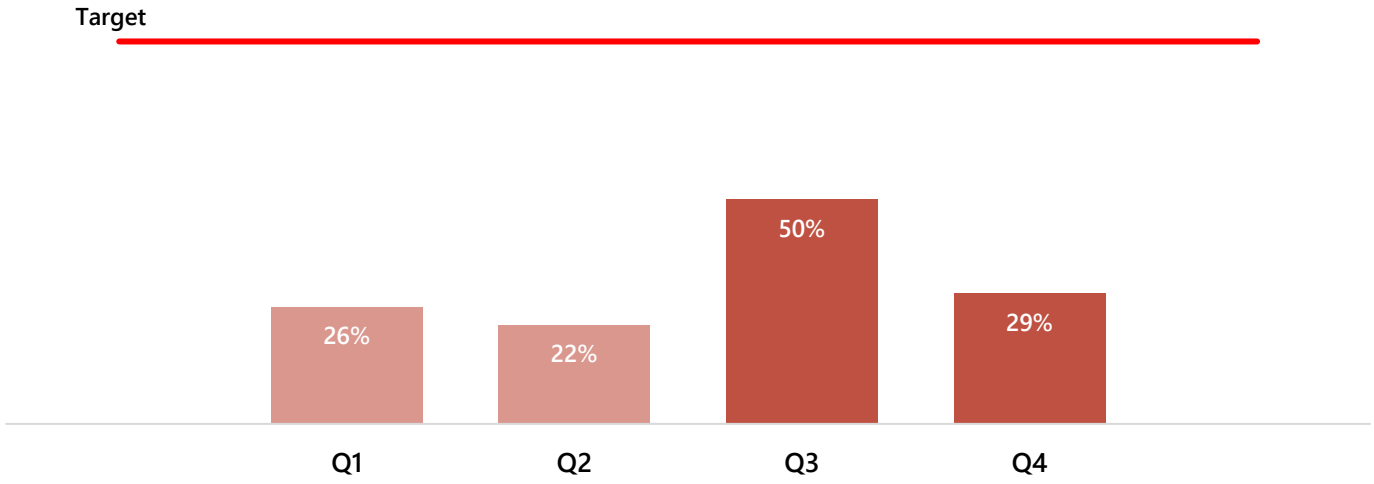


During the monthly Quality Improvement meeting it was determined to shift the focus from homes to viable beds, because one home can have multiple beds open. Also, recruiting efforts have shifted to include smaller engagement activities. The program will continue to work to maintain participation in orientation and PRIDE trainings to maximize the number of new licensed homes available for safe and appropriate placement.

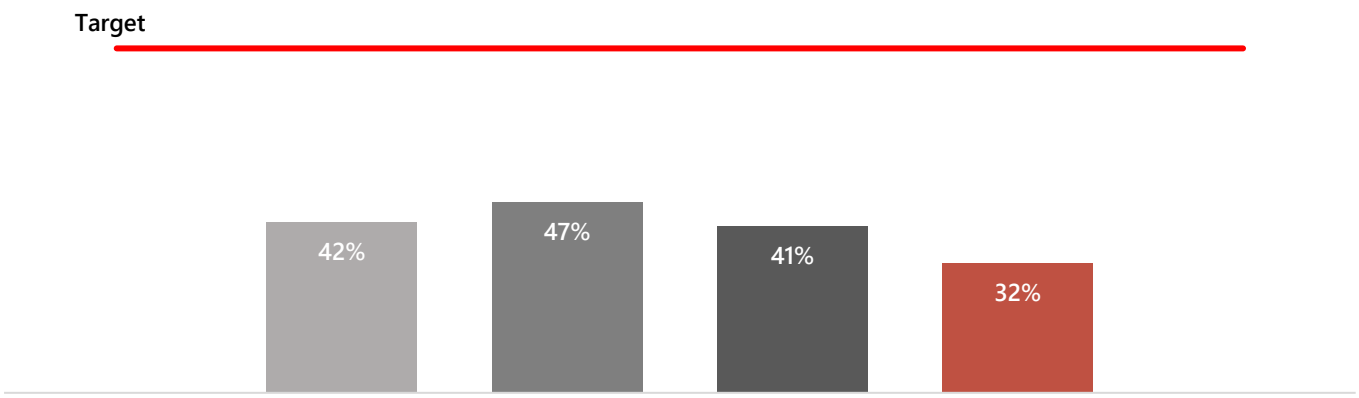
Performance Improvement Goal #9: Child Welfare Medical & Dental Timeliness

The Children's Center will increase the number of children in foster care who receive timely medical and dental assessments by 10%. The contractual target is 85% for initials and 95% for annuals.

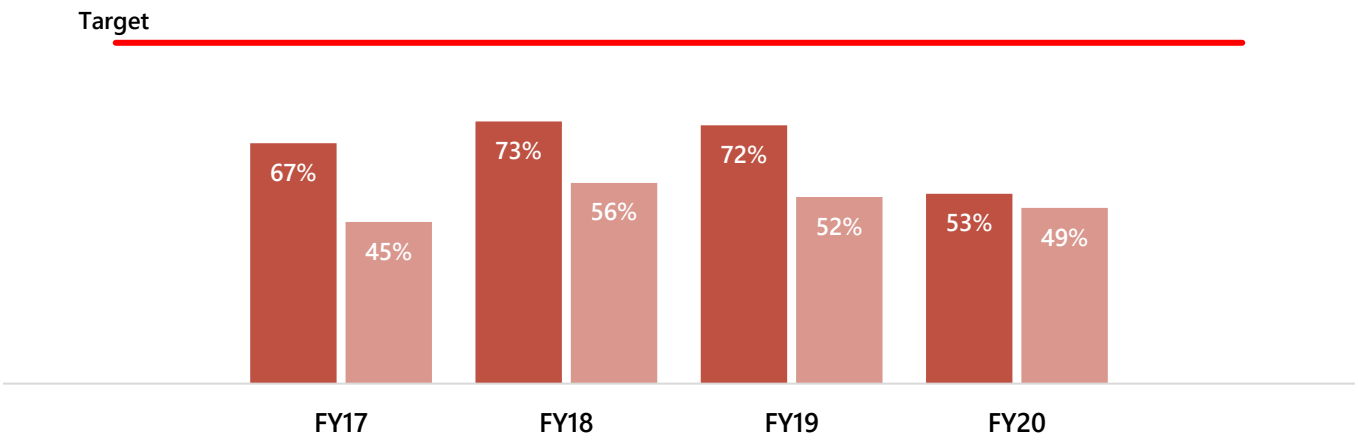
Timely initial medicals were not met during FY20 pre-COVID and during COVID.
Target is 85%



Timely initial medicals were not met each fiscal year and decreased in FY20 from FY19, FY18, and FY17. Target is 85%



Timely annual medicals and dentals were not met each fiscal year. Target is 95%

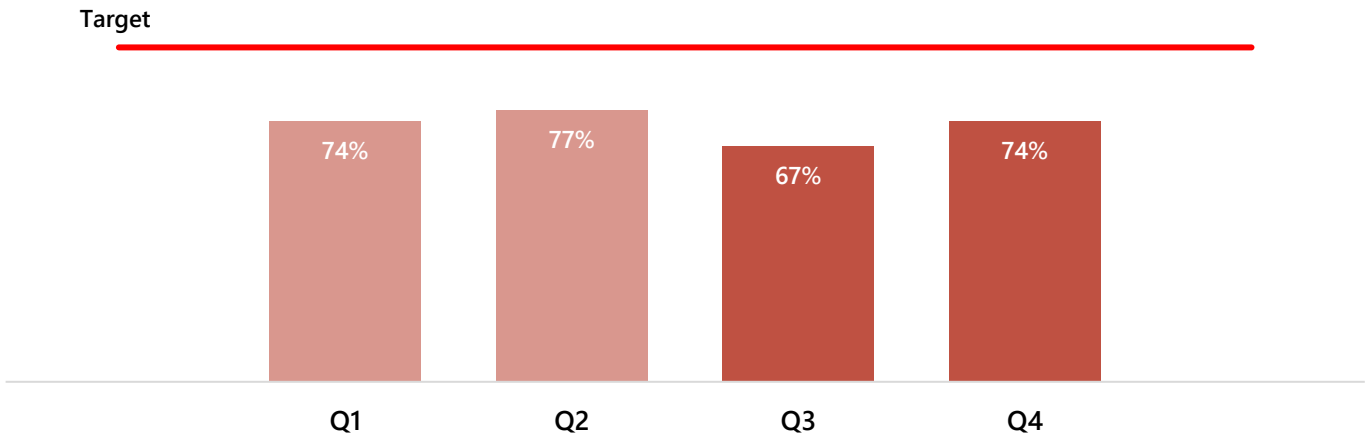


Due to the pandemic, medicals and dentals could not be provided in person for several months resulting in a decrease in compliance from FY19 to FY20.

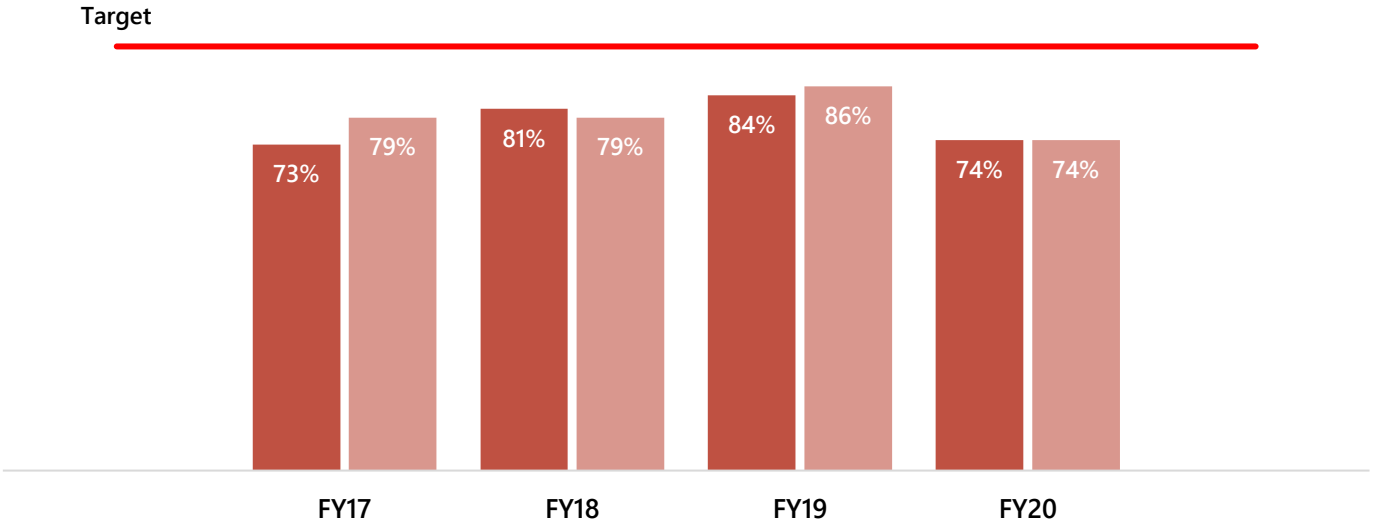
Performance Improvement Goal #10: Child Welfare Documentation Timeliness

The Children's Center will increase the timeliness of documents in the Child Welfare Department by 10%. The target is 95% and TCC averaged around 80% in FY18 and 84% in FY19.

Timely service plan completion was not met during FY20 pre-COVID and during COVID.
Target is 95%



Timely Service Plan Completion and Supervisory Approval were not met in the last four fiscal years.
Target is 95%



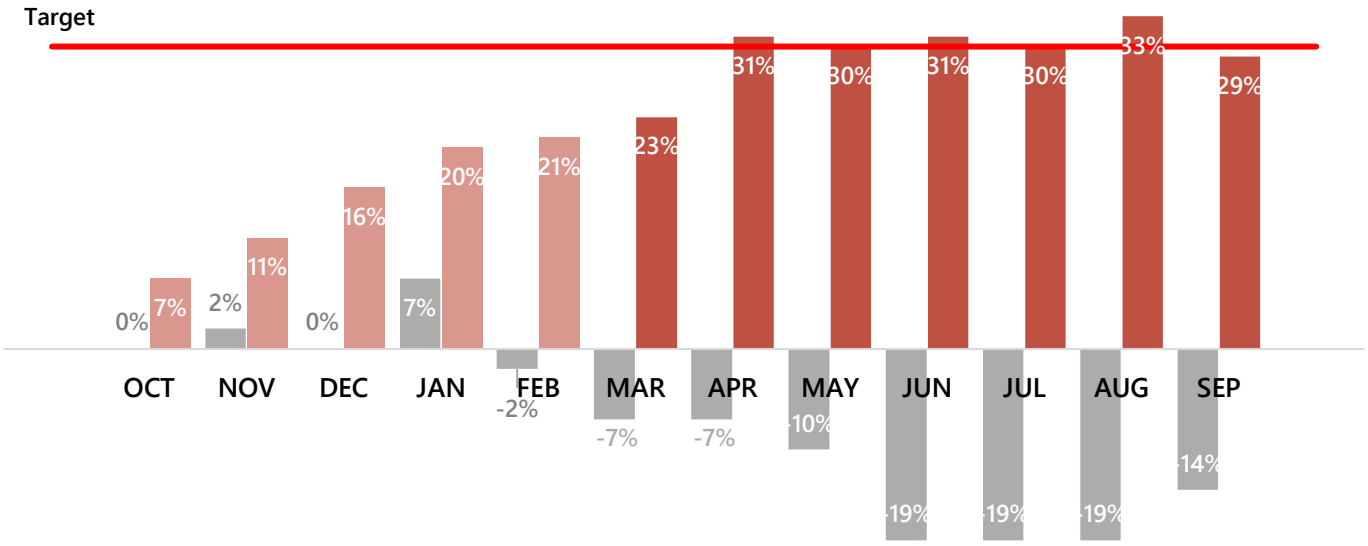
Additional Indicators

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 Viable Beds Increase

The goal for FY20 was to increase the number of viable beds by 30%.

Viable beds for YASS clients increased in FY20 pre-COVID and during COVID from FY19.
Target is 30% net gain of viable beds by the end of the fiscal year.



Performance Improvement Goal #2: Child Welfare Staff Retention

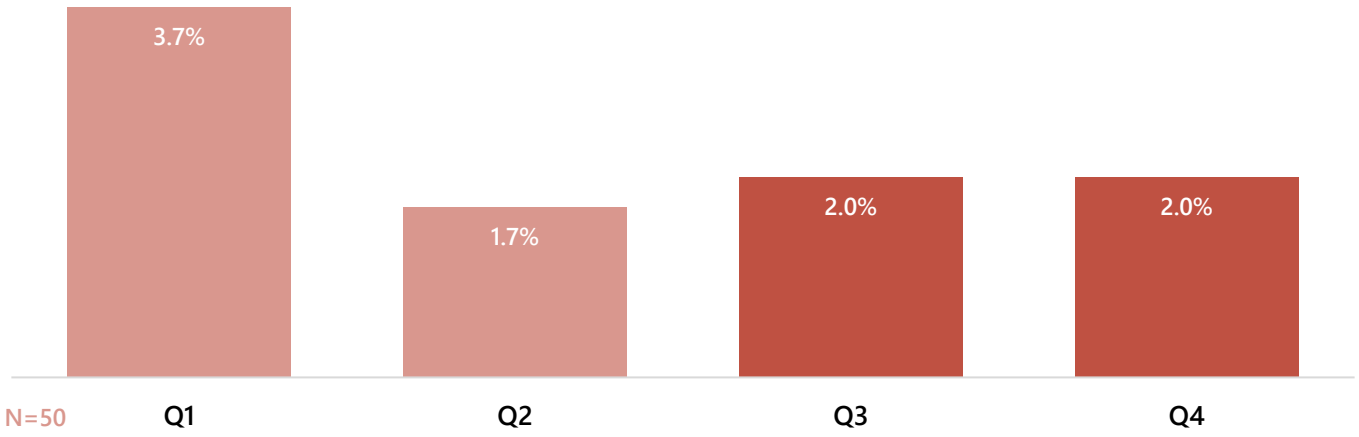
The goal for FY19 was to positively affect the staff retention rate. A specific target was not set, as the key to this initiative was to review staff turnover and identify and implement initiatives. In FY20, staff decided to focus on qualitative ways to increase staff morale and not include in the Quality Improvement process.

Performance Improvement Goal #3: Child Welfare Achieve Permanency

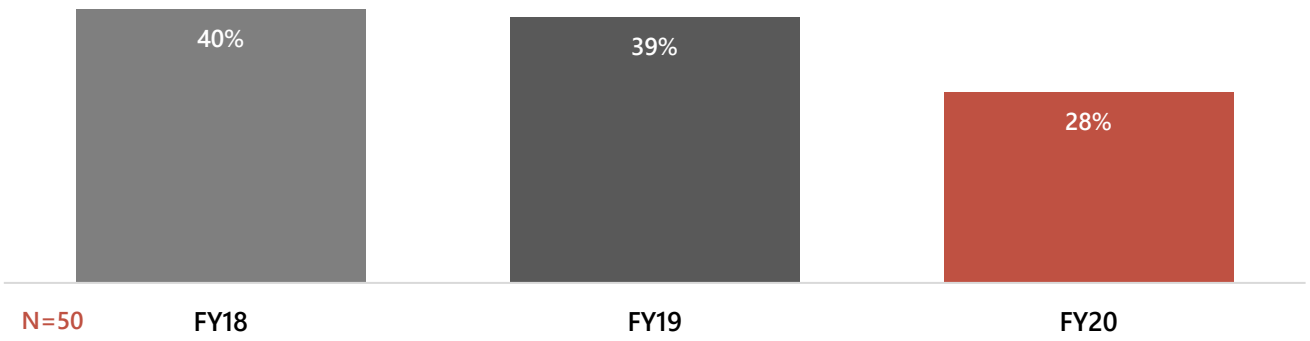
When children are placed in out-of-home care (also called foster care), it is imperative that TCC find safe, permanent homes for them as quickly as possible. In most circumstances, children can be reunited with their families, but in some cases children find homes with relatives or adoptive families.

TCC did not set a specific target as this was a baseline year for tracking this data, but identified the need to monitor reunification, guardianship/adoption, and transition timelines.

Permanency pre-COVID and during COVID.



Permanency decreased in FY20 from FY18 and FY19.

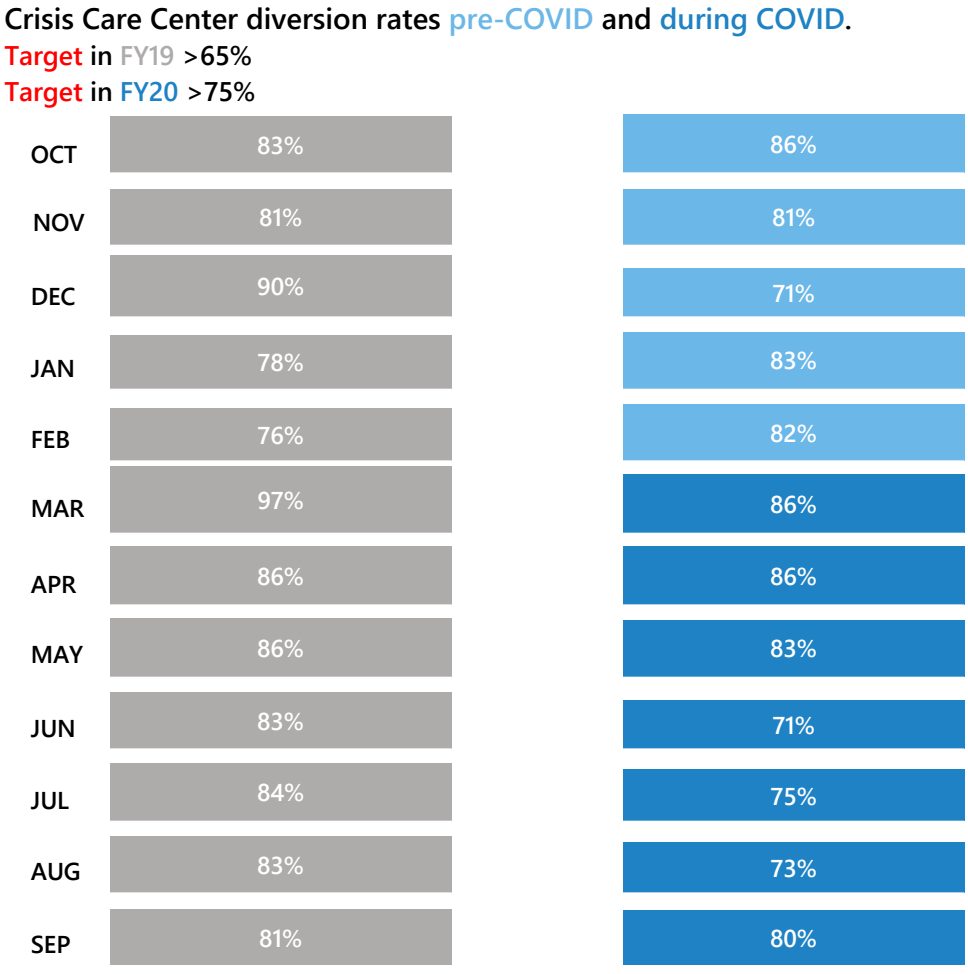


QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN INITIATIVES

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 crisis. The goal in FY20 was to maintain a diversion rate of 75%, an increase from 65% in FY19.

Performance Improvement Goal #1: Crisis Care Center Diversion



Performance Improvement Goal #2: Behavioral Health Equity

The Children's Center continued the Behavioral Health Equity (BHE) for Children and Families training during FY20. This fiscal year, two staff trainings took place with a total of 37 attendees.

A pre- and post-survey was administered to staff only to monitor the effectiveness of the training by assessing attendee's competency before and after the training. Based on baseline data and the background of the target audience, the target is 10%.
The results are as follows:

13

Average point increase from pre-survey to post-survey

19%

Average percentage increase from pre-survey to post-survey

Performance Improvement Goal #3: Treatment Plan Effectiveness

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 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.

Row Labels	Total Count	% of Grant Total
Average Progress	4103	57.14%
Little Progress	2097	29.21%
No Progress	532	7.41%
Significant Progress	242	3.37%
Goal No Longer Applicable	80	1.11%
Goal Completed	66	0.92%
Not Addressed	34	0.47%
Other	26	0.36%
Grand Total	7180	100.00%

Performance Improvement Goal #4: 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-, 60-, and 90-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. After reviewing the data for several months at the Quality Improvement meeting, the Clinical Management Team began reviewing all individual cases monthly that were not seen withing the 30-, 60-, and 90-day intervals. Since the implementation of this oversight, the total number of clients that have not been seen by anyone within these intervals has trended down.

Performance Improvement Goal #5: 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 FY20 was to maintain a 95% compliance rate. The process to gather the information was changed through a collaborative process to include information that would be valuable to the program areas and meaningful for our clients.

1) The Internal Utilization Management Review sample size has increased to 50 cases reviewed per quarter.

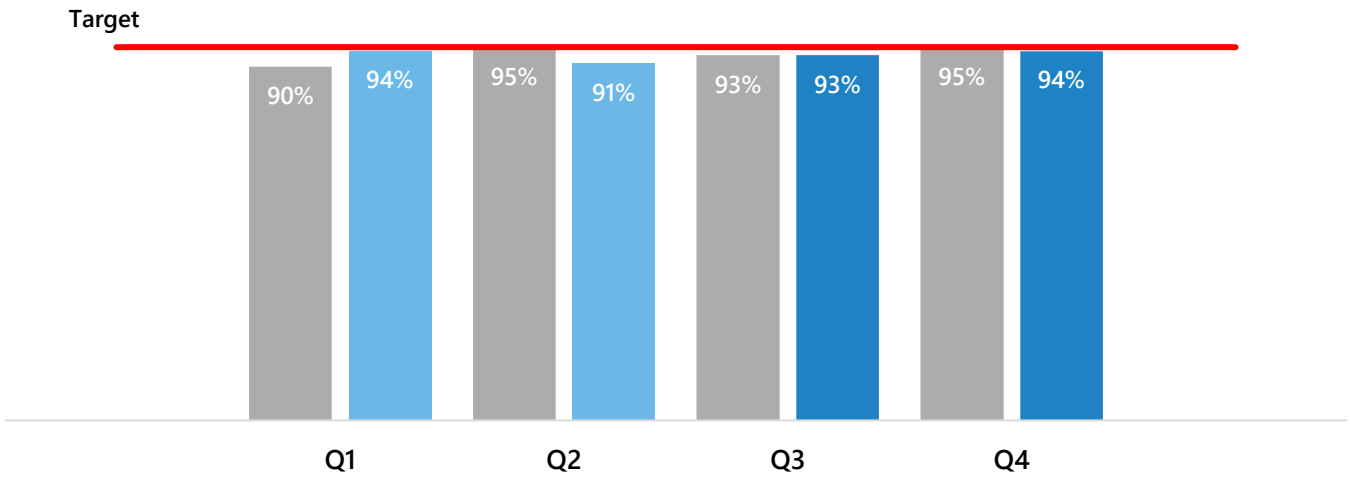
2) 75% of the sample will be pulled from a pre-determined program. The remaining 25% of the sample will be made up of other programs.

3) Results for the larger sample will be disseminated to program leadership in a face-to-face meeting. Results for the smaller sample will be disseminated to program leadership via email.

4) The UM Specialist will check in with program leadership one month after results and recommendations have been disseminated to review the actions taken.

5) Criteria in the Internal Utilization Management Review tool have been updated to ensure a more accurate and meaningful UM review.

Utilization Management Review results in FY19 and pre-COVID/during COVID FY20.
Target is 95%



Although target was not met each quarter, here are the biggest contributing factors:

1. Missing documentation (i.e., no evidence referrals for ancillary services were completed, no evidence supervisor recommendations on IRs were completed)
2. Inappropriate authorization of services
3. Objectives not written in a measurable manner
4. Underutilization of services authorized in the Treatment Plan

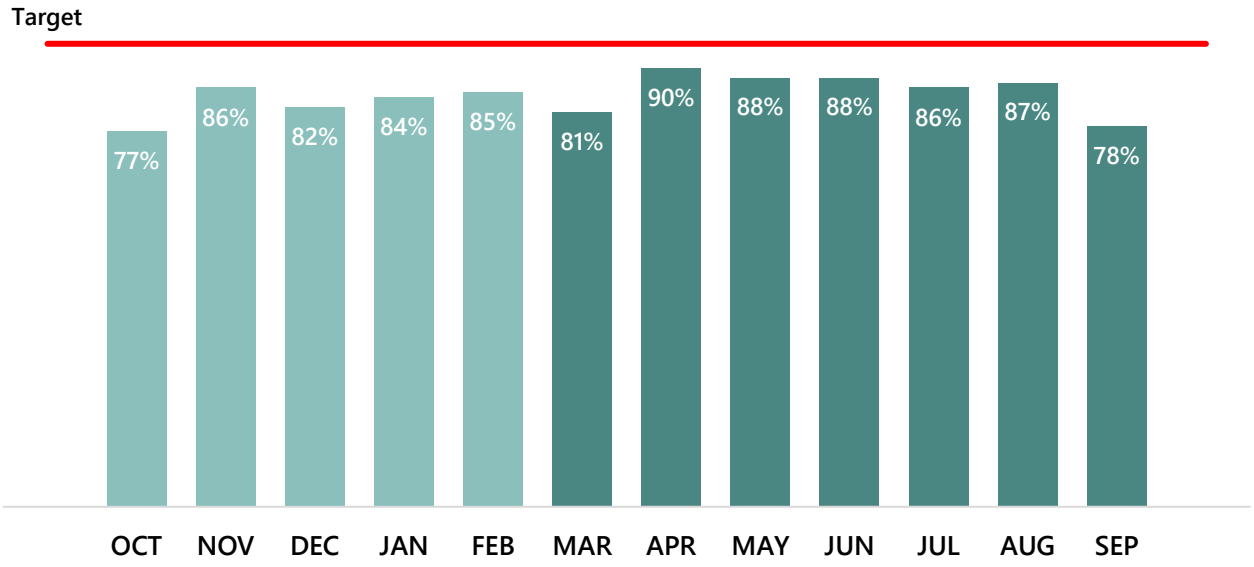
One thing to note is that being fully remote in the beginning of the pandemic was a barrier to getting documentation uploaded into the chart. However, this was a theme across all quarters so, regardless of the pandemic, it is still an area for growth and feedback is provided to the supervisors of each 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.

Formal Reviews of Progress did not meet compliance pre-COVID and during COVID in FY20.
Target is 95%

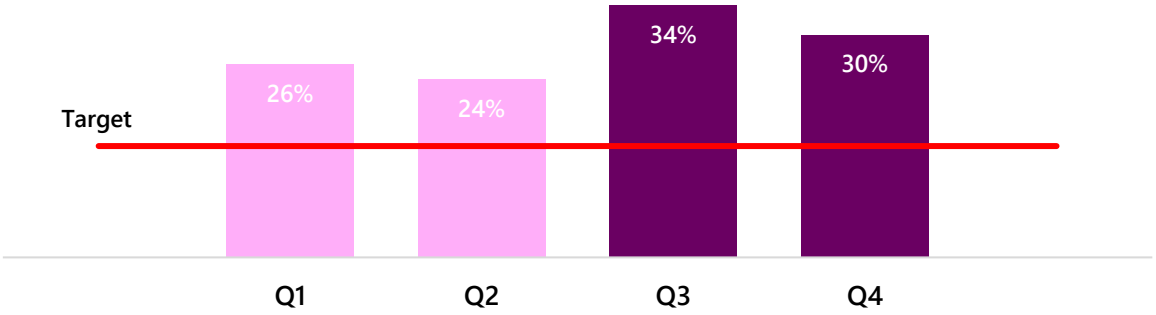


Satisfaction

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. Our goal was to maintain a response rate of 15% and receive positive responses, 80% of the time. We devoted significant efforts to revamping the collection methodology and questionnaire and implemented the NPS (Net Promotor Score) to utilize as a positive response indicator.

FY20 Follow Up Survey Response Trend pre-COVID and during COVID.
Target is 15%

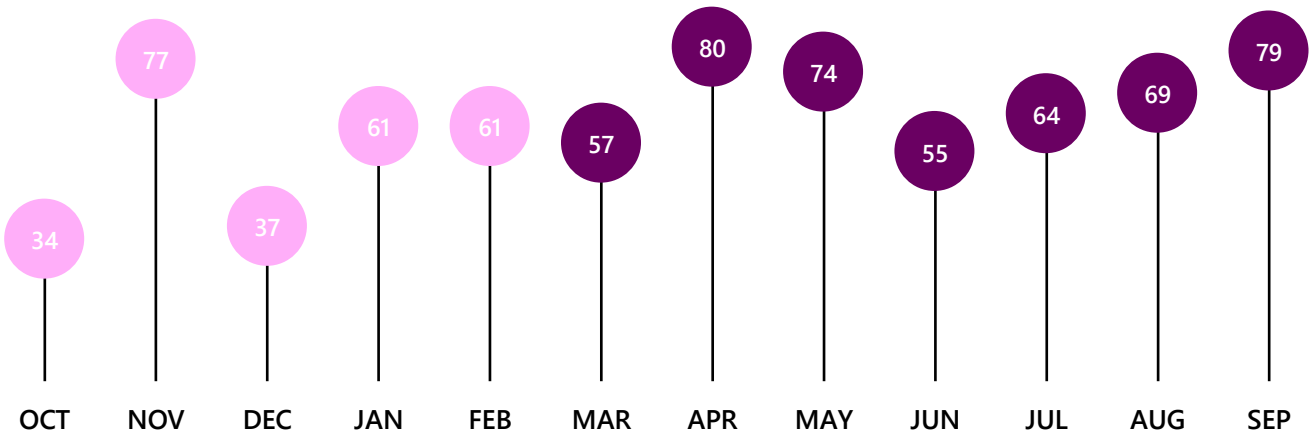


The Children's Center's Big Hairy Audacious Goal (BHAG) is to be recognized as The Best Children's Service Provider in the Nation. One of the recognition measurements includes achieving an overall Net Promoter Score (NPS) of 75 with clients, donors, volunteers, and other partners. NPS is focused on a single ultimate question: "How likely is it that you would recommend this company to a friend or colleague?"

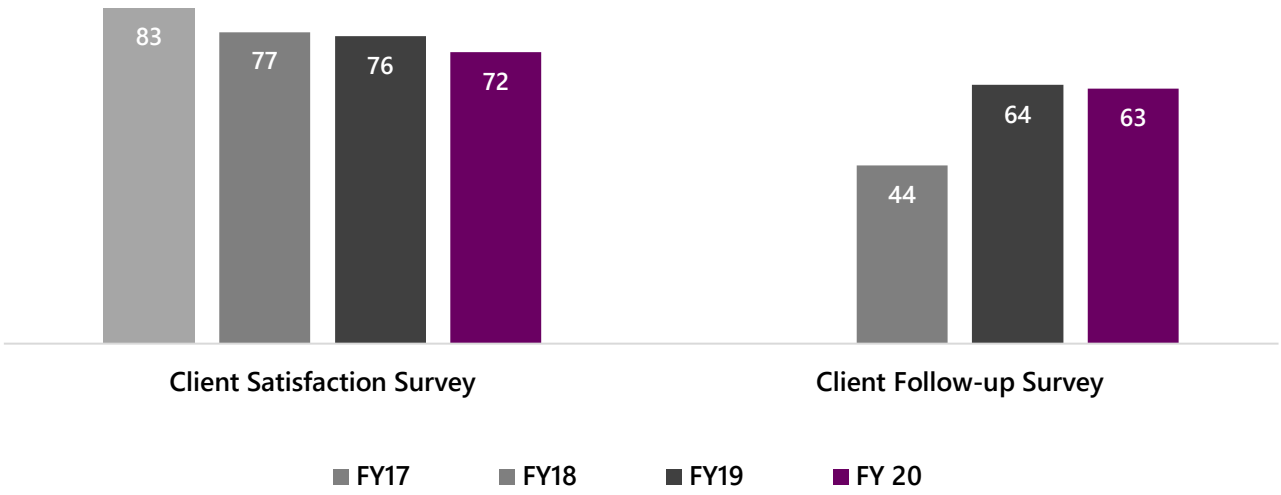
In order to gear this question towards other audiences aside from our clients, we tweaked the "ultimate" question for the audience being surveyed and increased the target for the follow-up survey to 80.

NPS FY20 Score is 63.

FY20 NPS score pre-COVID and during COVID.
Target is 80%



Overall Client Satisfaction is on the decline while closed client satisfaction trended up or is remaining steady.



Contractual Compliance

Performance Improvement Goal #1: Credential Committee

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

70%

Compliance

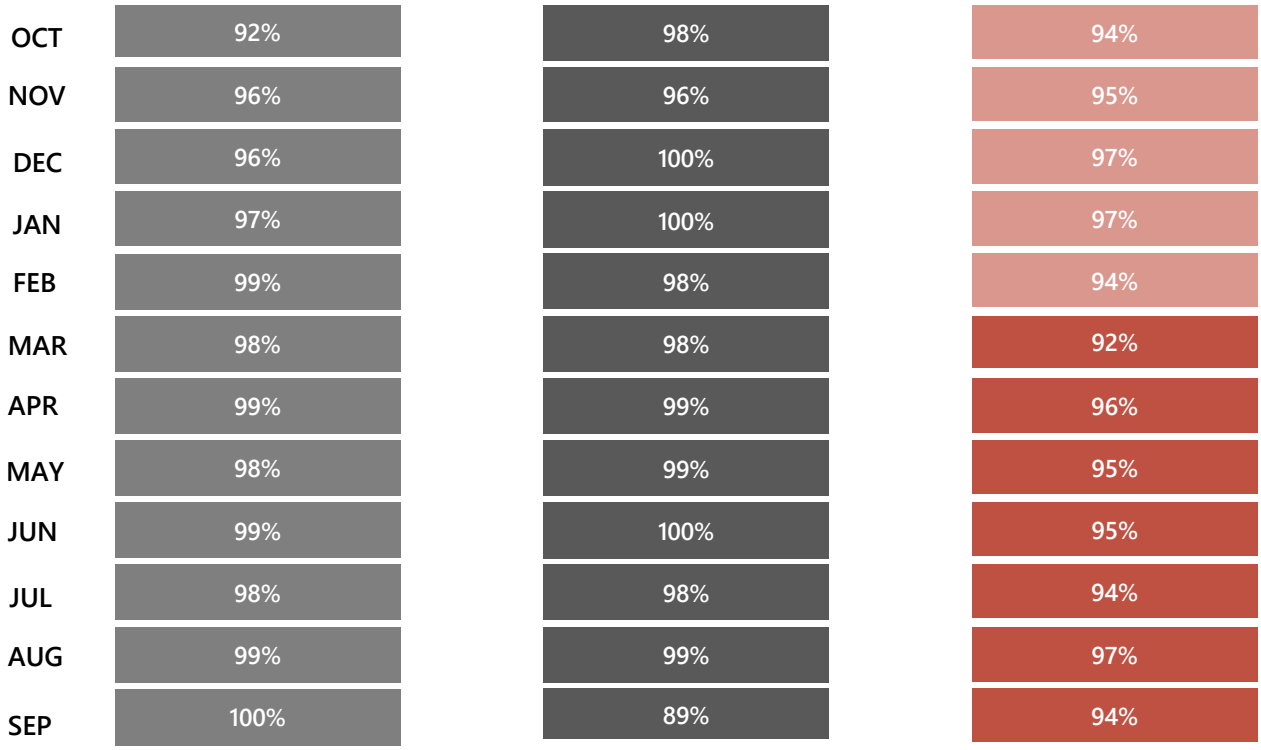
The Children's Center is its own CVO (Credential Verification Organization) and has a Credential Committee that meets monthly to develop and review credentialing criteria, make recommendations for approval of clinical responsibilities, and have oversight of the approval process. FY16 was a benchmark 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 compliance rate increased from 52% in FY18 to 70% in FY20. Some notable barriers to credentialing staff timely were delays in trainings during the COVID-19 pandemic. There were also less staff being credentialed during FY20 due to less staff being hired. This monitoring will continue in FY21 with the professional development department implementing strategies that will continue the upward trend.

Performance Improvement Goal #2: Action Notice

The goal is to increase compliance to 100%.

Action Notice Audit compliance pre-COVID and during COVID in FY20 compared to FY18 and FY19.
Target is 100%

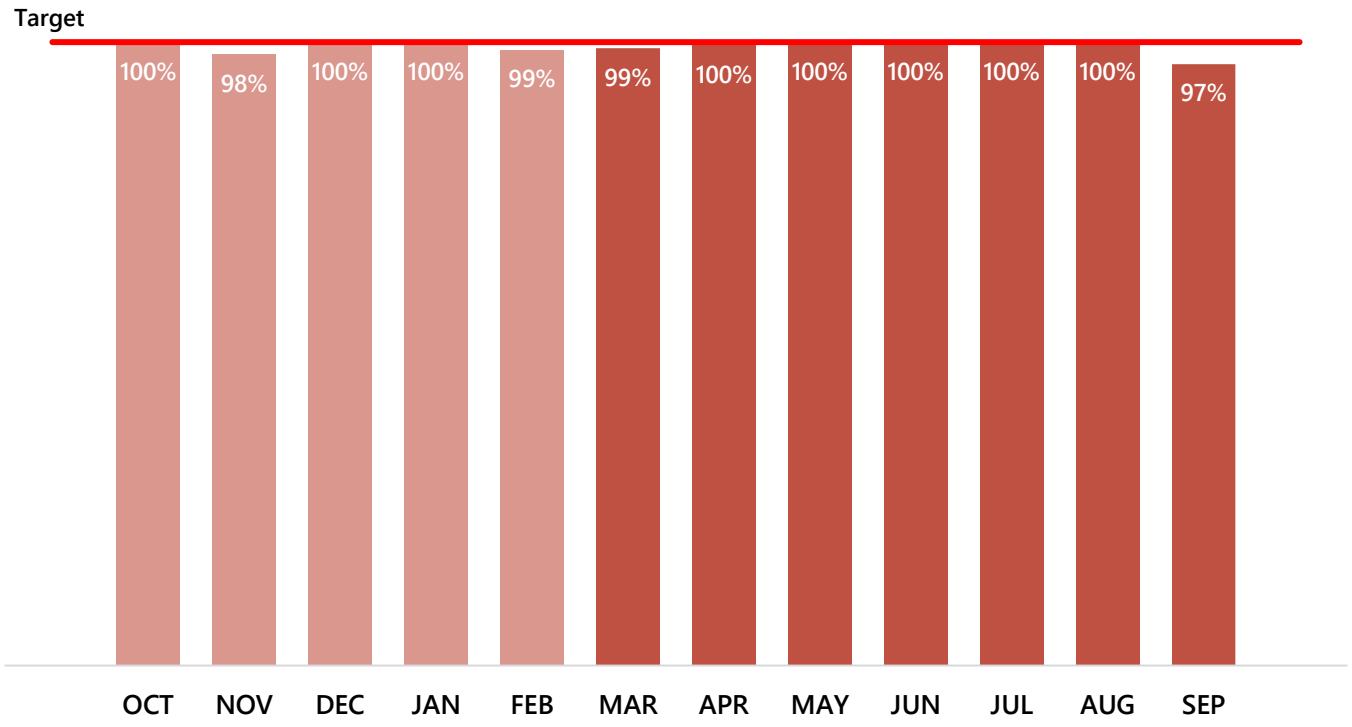


Because of the changes with the regulatory requirements, the trend decreased in FY20. In addition to the monthly monitoring, over-communication to program staff will need to continue highlighting the requirements as well as implementing additional measures to improve compliance.

Performance Improvement Goal #3: Internal Claims Audit

Increase and maintain compliance of 100%

Internal Claims Audit compliance in FY20 pre-COVID and during COVID.
Target 100%



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

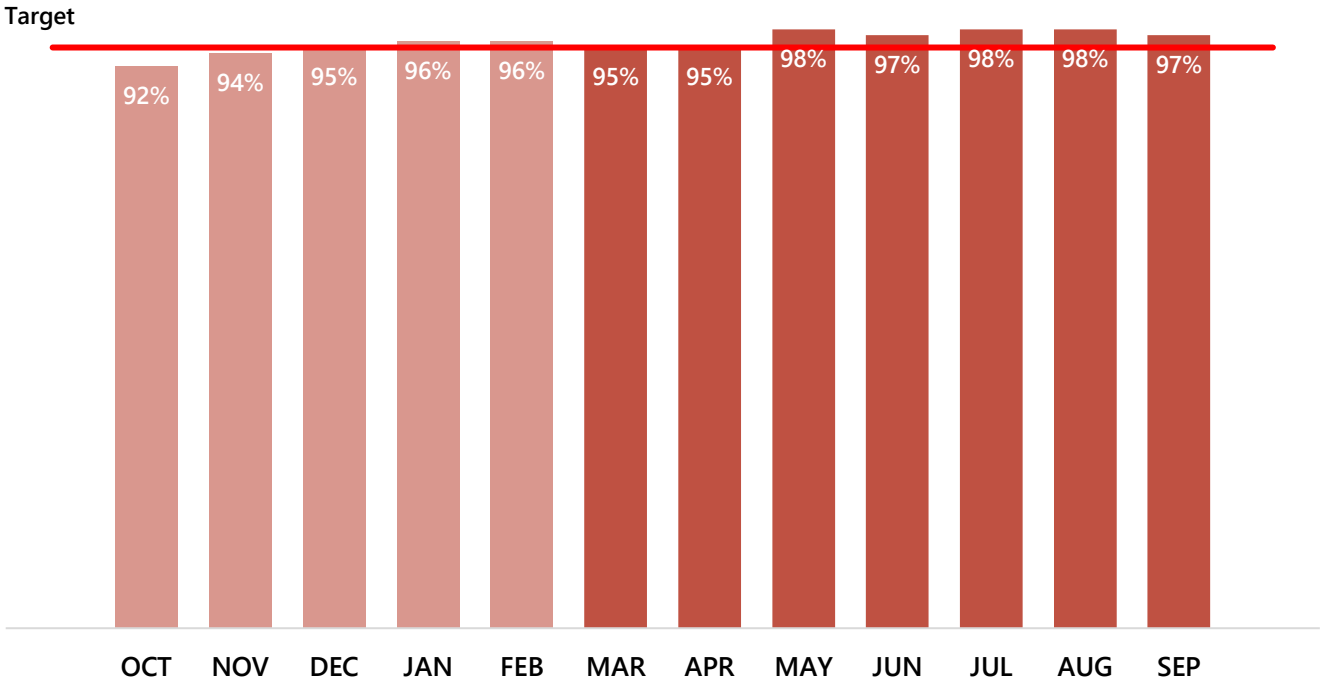
- Valid Treatment Plan
- Lack of assessment codes in the Treatment Plan
- Missing signature on the Treatment Plan
- Incorrect use of the indirect codes

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

Performance Improvement Goal #4: PHQ-9/A

The PHQ-9/A is a questionnaire to measure the severity of depression in children and adolescents ages 11 – 17, 18-21 SED youth will complete the adult PHQ-9. If a client scores 10 or higher, a reassessment is due every 90 days. The Children's Center will increase compliance to 95%.

PHQ-9 compliance pre-COVID and during COVID in FY20.
Target is 95%



With continuous review at the Quality Improvement meetings, we were able to increase and maintain target starting in December 2019 through September 2020.

Conclusion

Overall, improvement in the realm of client output and outcomes was noted in the Behavioral Health programs, as evidenced by decreased FAS scores. The Early Childhood Behavioral Health program demonstrated tremendous progress in this area. Also, The Home Based program met target for two quarters. 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 consistently achieving target for timely CAFAS and PECFAS completion.

Another note-worthy accomplishment is that the diversion rate was met for most of the year, even with an increased target. Also, in FY20, the fewest inpatient hospitalizations took place. We had the highest response rate for the follow-up survey and a statistically significant client satisfaction survey response rate. Both behavioral health surveys along with the foster parent surveys provide quantitative and qualitative feedback on how we can better serve our children and families. As noted in previous annual reports, all 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 FY21 to achieve permanency and increase the number of viable beds in foster homes and host homes. Although the YASS graduation rate declined, it exceeds the State and City of Detroit graduation rate, which is a tremendous success. YASS clients with a mentor reached the highest percentage in FY20 and the Child Welfare chart reviews increased from FY19 to FY20.

Agency-wide, collaborative work will continue to take place between Quality & Compliance and Program service areas to ensure effective and efficient service delivery happens. Within the Quality & Compliance department, consistent reviews using large sample sizes are an essential aspect of obtaining valuable data to foster 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.