Youth Focus, Inc.

Quality Improvement Reports

Fiscal Year 2014-2015

Available for Public Review

At Youth Focus we welcome feedback on ways to improve our services. The program reports included in this document describe some of our efforts to do that. We also welcome any suggestions you might have on additional services that we need to offer. Please use the feedback form located at the end of these reports to provide suggestions on ways to improve our services.

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Thank you.

Youth Focus Staff

Residential Treatment Center

Introduction:

The following report summarizes incidents and issues addressed at Youth Focus Residential Treatment Center related to Quality Assurance in the provision of care at the facility. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Eastside Campus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by Report:

This report covers the period of the time from July 1, 2014 through the close of the 2014 - 2015 Fiscal Year on June 30, 2015.

Sentinel events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events in the 2014 – 2015 Fiscal Year.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee and Youth Focus Eastside Campus Continuous Quality Improvement Committee each met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety at the RTC program. In the course of the four occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety at the facility were monitored, and are summarized as follows:

Fire & Disaster Drills: Both live and simulated fire drills and disaster drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Quality Assurance Director. No significant deficiencies or problems were noted.

Incident Reports: During the period of time covered by this report, seventy-eight (78) incidents involving potential safety concerns were tracked by means of Incident Reports completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety / Risk Management Committee. The following represents summary data for the period in question:

1. Physical Restraints of Residents – 46
2. Locked Seclusion - 0
3. Client, staff or visitor requiring more than minor medical care - 0
4. Client minor accident or injury, not requiring medical care – 0

5. Client aggressive or destructive act – 0
6. Client aggressive or destructive act, police involved - 14
7. Reaction to medication requiring medical care - 0
8. Adverse medication event – 18
9. Self-injury or suicidal – 0
10. AWOL – 0
11. Inappropriate Sexual Behavior – 0
12. Abuse allegation - 0

Incident Reports were reviewed throughout the year during the quarterly committee meetings.

Quarterly Facility Inspections: Quarterly inspections were conducted at the facility throughout the period. Utilities systems and equipment were monitored and reported upon regularly, including the facility emergency generator, the fire alarm and sprinkler system, fire extinguishers, kitchen stove hood, security system, electrical systems, and heating and air conditioning equipment. Aside from routine maintenance issues, no significant facility deficiencies were reported during the period of time covered by this report. The facility emergency generator was replaced early in the fiscal year with a new model to improve consistency of operation.

Public Complaints: No complaints by members of the public about the program were noted throughout the course of the year.

Employee Complaints: No complaints by employees about the program were noted throughout the course of the year.

Client Grievances: Grievance Forms were available to residents and their families throughout the course of the year. A total of twenty-six (26) Grievance Forms were completed, all addressing concerns about various staff members, peers and program procedures.

Senior staff members and/or an individual therapist reviewed the above grievances with the resident in question and reported their findings. The Youth Focus Eastside Campus Continuous Quality Improvement Committee tracked and reviewed all Complaint Forms during its quarterly meetings. The Youth Focus Client Rights Committee also reviewed all Compliant Forms during its monthly meetings. The present trend reflects a slight decrease in complaints by RTC residents relative to last year's total. The incidents noted above were addressed as indicated in the minutes of the RTC Continuous Quality Improvement Committee.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Eastside Campus Continuous Quality Improvement Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted the Residential Treatment Center program. During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted.

Performance Reviews:

Annual and probationary employee performance reviews were monitored by the Youth Focus Eastside Campus Continuous Quality Improvement Committee on a quarterly basis. During the period of time addressed in this report, 14 full-time and 16 part-time reviews were conducted and approved.

Utilization Reviews:

Total Admissions:	28
Total Re-Admissions:	1
Total Discharges:	29
Average Length of Stay:	157 days
Total Resident Days:	4265 days
Average Daily Census:	11.75 residents per day
Average Daily Census (Billable Days)	11.68 residents per day

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	9	5	14
Black	10	4	14
Native Amer.	0	0	0
Hispanic	0	1	1
Other	0	0	0
TOTAL	19	10	29

Services Provided:

Psychiatric Residential Treatment Facility (PRTF)

Services Needed but Unavailable:

None noted

Applicants Not Accepted for Service Who Were Eligible:

Total Referrals:	112
Referred Applicants Accepted:	69 (62%)
Referred Applicants Admitted:	29 (26%)

Reasons for Non-Admission:

Clinically Inappropriate / Referred elsewhere	43 (38%)
Found other Placement prior to bed being free	35 (31%)
Currently on Waiting List	5

Premature Termination of Services By Gender and Race:

Pattern or Relationship between variables of gender and racial identity, respectively, and services, resources and case dispositions: None noted.

Quarterly Record Reviews

Quality Assurance reviews of open and recently closed RTC case records were conducted on quarterly basis. Records were reviewed as dictated by Youth Focus policy #410.

No high-risk interventions were noted in any of the reviewed charts. All relevant forms were present in the case records, and all ratings of assessment, treatment plan, and discharge plan content were Average or above. The quality of billable notes and their prompt completion have been identified as areas for improvement in the coming year. No other suggestions for improvement were noted.

Annual Consumer Satisfaction Summary:

Resident satisfaction surveys were implemented during the course of the present fiscal year as a means of assessing resident satisfaction with various aspects of their experience of the RTC program. A survey of resident satisfaction was administered monthly during the course of the year. Response trends identified in the results of the resident survey served to identify potential areas for quality improvement in the program.

During this fiscal year, the highest rated items indicated that residents feel that staff encourages them to be responsible, that they have opportunities to talk to staff when they are feeling angry, scared, lonely, embarrassed or anxious. The lowest rated items asked if residents got along with their peers during the month, and whether they were provided with nutritious meals.

Summary of Continuous Quality Improvement Monitor

A. Monitor: Medication Errors

B. Outcome: Data was collected throughout the course of the fiscal year regarding the number of medication errors reported at the Residential Treatment Center over the course of the year. Monthly summary data on incidents were presented during each quarterly meeting of the Eastside Campus Continuous Quality Improvement Committee. The evidence suggests that medication error reports have decreased since corrective measures were put into place following the baseline period of data collection. Given the successful outcome in this monitor in reducing the number of medication errors occurring at the facility, the Eastside Campus Continuous Quality Improvement Committee recommended concluding this monitor at this time during its meeting on July 15, 2015.

Comparative Program Study

Ongoing data collection continued for clients on admission and at discharge using the Child Behavior Check List, with the focus being on the following clinical subscales: Anxious/Depressed, Withdrawn/Depressed, Social Problems, Attention Problems, Rule Breaking Behavior, and Aggressive Behavior. Data available from a comparable program (Millcreek of Magee PRTF in Mississippi) was used for comparison data. The tables below summarize the results to date:

Benchmark - Millcreek of Magee, Mississippi PRTF (1st quarter 2010)

	Pre	Post	Diff
Anxious / Depressed	66	56	10
Withdrawn / Depressed	69	59	10
Social Problems	70	60	10
Attention Problems	73	61	12
Rule Breaking Behavior	72	61	11
Aggressive Behavior	82	64	18

Youth Focus RTC – through FY 2010/2015 n=44

	Pre	Post	Diff
Anxious / Depressed	76.3	61.5	15.8
Withdrawn / Depressed	72.7	59.2	13.5
Social Problems	72.6	58.89	13.8
Attention Problems	72.1	57.9	14.2
Rule Breaking Behavior	76.7	57.7	19.0
Aggressive Behavior	82.0	58.0	24.0

As can be seen, clinical improvement of the clients discharged from the program are comparable to the benchmark data.

Program Improvements Made as a Result of the CQI Program

The CQI monitor tracking medication errors showed a significant decrease in medication errors following the targeted intervention. Based upon this successful outcome, this CQI monitor has been concluded.

Recommendations for Program Improvements in the Upcoming Year

A. Residential Record Documentation Compliance
Errors requiring staff correction in Medicaid documentation in the RTC residents' records will continue to be identified as an area to be targeted for quality improvement efforts during the upcoming fiscal year.

B. Medication Errors
Medication errors will continue to be monitored as a means of ensuring that progress made during the recent CQI monitor will be maintained.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

Monitor: Pharmacy Errors

It has been identified that medications received by the facility from the pharmacy have contained errors in relation to the written orders of the doctor. A tracking method for catching pharmacy errors was implemented a year ago and will provide baseline data for comparing results as interventions between the facility and the pharmacy are presently implemented. Monthly summary data on incidents will be presented during each quarterly meeting of the Eastside Campus Continuous Quality Improvement Committee.

Summary:

During the period of time covered by this report, the Youth Focus Eastside Campus Safety / Risk Management Committee and the Youth Focus Eastside Campus Performance Improvement / Quality Assurance Committee monitored and addressed issues and events related to quality assurance during regular quarterly meetings. The present report is indicative of a uniformly high level of quality in all areas monitored, relevant to both to the level of clinical care provided to the residents in the RTC program and the level of safety at the facility. A new monitor has been identified as important for further examination in the upcoming fiscal year.

Mell-Burton School

Introduction:

The following report summarizes incidents and issues addressed at Youth Focus Mell-Burton School related to Quality Assurance in the provision of care at the facility. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Eastside Campus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by the Report:

This report covers the period of the time from July 1, 2014 through June 30, 2015

Sentinel Events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. No sentinel events were noted during the period of time covered by this report.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee and Youth Focus Eastside Campus Continuous Quality Improvement Committee each met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety at the Mell-Burton School program. In the course of the four occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety at the facility were monitored, and are summarized as follows:

Fire and Disaster Drills: Both live and simulated fire drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Safety and Executive Director. Simulated disaster drills were also conducted on the prescribed schedule throughout the period and filed in a timely manner to Safety and Executive Director. No significant deficiencies or problems were noted.

Facility Inspections: Quarterly inspections were conducted at the facility throughout the period. Utilities systems and equipment were monitored and reported upon regularly; including the facility emergency generator, the fire alarm and sprinkler system, fire extinguishers, security system, electrical systems, and heating and air conditioning equipment. Aside from routine maintenance issues, no significant facility deficiencies were reported during the period of time covered by this report.

Incident Reports: During the period of time covered by this report, incidents involving potential safety concerns were tracked by means of Incident Reports completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety / Risk Management Committee. The following represents summary data for the period in question:

1. Physical Restraints of Clients – 10

2. Client AWOL – 22
3. Client emergency evaluations for suicidality-2
4. Client medication error-36
5. Client property destruction-2
6. Abuse Allegation-2
7. Client AWOL from another program-1
8. Client destructive behaviors-1

Incident Reports were reviewed throughout the year during the quarterly committee meetings.

Client Grievances: were available to clients and their families throughout the course of the year. There were no complaints filed by a student or the student's family throughout the year.

Public Complaints: There were no public complaints made this year.

Employee Complaints: There were no employee complaints this year.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Eastside Campus Continuous Quality Improvement Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted the Mell-Burton School. During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted.

Performance Reviews:

Annual and probationary employee performance reviews were monitored by the Youth Focus Eastside Campus Continuous Quality Improvement Committee on a quarterly basis. During the period of time addressed in this report, 5 full-time reviews were conducted and approved.

Utilization Review:

Total Admissions: 26

Total Discharges: 25

Total Students Served: 42

Average Daily Census: 14.27

Students Served (New Admissions):

Race	*Males*	*Females*	*TOTAL*
White	7	7	14
African-Am	6	2	8
Native Amer.	0	0	0
Hispanic	3	1	4
Other	0	0	0
TOTAL	16	10	26

Applicants Not Accepted Who Were Eligible

There were no applicants or clients who were not accepted for services during this fiscal year who were eligible for services.

Premature Termination of Services by Gender and Race

There was no early termination of services for clients in the Mell-Burton Program.

Quarterly Record Review

Quality Assurance reviews of open and recently closed Mell-Burton School case records were conducted on a quarterly basis. Records were reviewed as dictated by Youth Focus policy #410. No high-risk interventions were noted in any of the reviewed charts. All relevant forms were present in the case records, and all ratings of assessment, treatment plan, and discharge plan content were Average or above. There were no significant areas for improvement that were noted.

Consumer Satisfaction Summary:

The parent/guardian surveys returned contained the following eight questions and were rated in the same manner as the client surveys. (5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree)

1. Staff is responsive to inquires about program and students. **4.60**
2. Staff is appropriate in their interactions with children. **4.79**
3. Staff uses appropriate interventions with children. **4.79**
4. My child's progress towards IEP goals has improved since admission into MBS. **4.29**
5. My child's ability to engage in appropriate problem solving has improved since admission. **4.14**
6. My child's ability to interact with others has improved since admission. **4.07**
7. My child's ability to function in public school after attending MBS has increased. **3.77**

8. There is adequate communication between myself and staff regarding my child's progress in the program. **4.64**

Significantly high scores were obtained from parents/guardians in all areas of the program. Results indicate positive opinions towards staff interventions with clients, staff responsiveness and overall communication with program staff. Scores also represent high ratings towards clients' progress towards IEP goals and interactions with others. An above average score was obtained in the area of clients' ability to function in public school after discharge.

Below are some of the additional comments were made by parents/guardians:

"You were wonderful to him"

"I picked up some pointers on interventions from you guys"

"Our transition is still going great"

"The program really helped shape her to where she is at"

"Overall, Mell-Burton helped my son despite some unorthodox interventions. Some additional training for staff to help them learn about different diagnosis would be good"

"Great job! Thanks for all your help"

"A great program/school. Guilford County is lucky to have such a facility"

Results of Continuous Quality Improvement Monitor:

CQI Monitor: Medication Error Reduction by Administering Medication as Prescribed

Reason for Selection of this Quality Improvement Project: There continued to be a large number of medication errors this fiscal year as well. There appeared to be a challenge in ensuring that medication was administered properly in part due to missing medications and staff error.

Steps Taken To Support Improvement:

- Staff continued to utilize the procedures put into place for the last fiscal year to address medication errors (involving phone calls to group homes and parents, etc).
- To address the staff errors, one staff member was assigned to administer the medications and keep up with the MARs, etc.
- Program manager completed weekly checks of the MARs and the prescriptions provided by client guardians to ensure that all medication was being administered correctly and at the right times.

Project Barriers:

As always, one of the barriers to medication administration is ensuring that the medication prescribed is actually present at the school. Unfortunately, despite the numerous attempts made by staff to notify parent/guardians in a timely manner there were still incidents in which the medication was not present. The largest error came prior to the above steps being put into place when a client returned to the program and the prior person assigned to medication administration failed to check MARs again and there was a month time period in which the client was not given his correct medication at the correct time.

Baseline Data Time Period: July 1, 2014 – September 30, 2014 (1st quarter)

Baseline Data Results: Medication was administered as prescribed 100% of the time.

*please note that this is not an accurate number as 27 medication errors reflected in the 2nd quarter period were actually errors from the baseline period (this errors were not recognized until October)

Improvement Goal: Medication will be administered as prescribed 100% of the time.

Project Outcome:

- 73% in the 2nd quarter
- 95% in the 3rd quarter
- 96% in the 4th quarter

The quality improvement goal was not met within the specified timeframe but is trending toward achievement of the goal if steps to support improvement continue. As a result, this CQI monitor will be continued into FY 2015-2016.

Final Analysis / Recommendations:

In addition to not having the medication needed to administer to client and client refusal the biggest challenge came from staff errors. According to the data there was a 1 month time frame in which the assigned staff administering medications failed to follow procedure and check MARs with medication prescriptions at the time of re-admission. Therefore, the client was not administered his PM medication until discovered after one month. Since that time a new procedure has been put into place and a separate staff member has been assigned to administer medication to clients and monitor client prescriptions. The program manger completes weekly checks of MARs against prescriptions to ensure medication is being done correctly. Despite that new procedure there have been two medication errors in 3rd and 4th quarter that resulted from staff error. To address those errors a second person will also be assigned to medication administration to ensure no errors when the original staff person is absent. There will also be medication reminders posted in the staff area as a reminder.

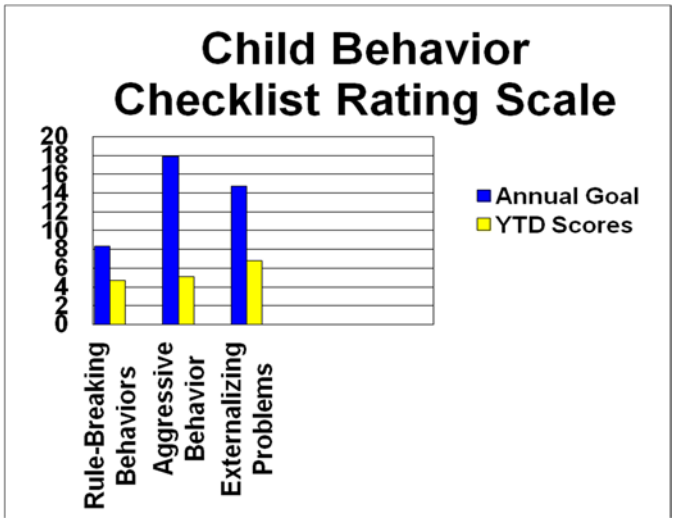
Comparing Outcomes with Other Programs:

Research was conducted to look at outcome data from other day treatment programs. Studies were identified that examined day treatment programs similar to the Mell-Burton program. The two studies reviewed indicated that a behavior management system was in place and that the clients in the programs were experiencing severe emotional disabilities and behavior disorders. The children in the studies had

been identified as having been unsuccessful in the traditional school setting similar to those in the Mell-Burton program. Results from the studies indicated that the clients experienced an improvement in behavioral symptoms and some improvement in academic performance. These improvements were measured through the use of the Connors Teacher Questionnaire, Child Behavior Checklist and Youth Outcome Questionnaire. As a result, the Mell-Burton program will begin utilizing the Child Behavior Checklist at admission and discharge to measure for improvements in behavior symptoms.

The Mell-Burton School utilized the Child Behavior Checklist for pre and post testing this fiscal year to examine improvements in both behavior and academic performance. The results indicated that there was an improvement in all areas looked at. The two studies found indicated that there was an improvement in the aggressive, rule-breaking and externalizing behaviors of the clients who participated in the day treatment programs. During the 2014-2015 fiscal year the Mell-Burton School looked specifically at these three subcategories to monitor the progress of the clients being served. The following scores show and improvement in those three subcategories looked at: Rule-Breaking Behavior –4.7 ; Aggressive Behavior – 5.1; Externalizing Behavior – 6.8).

The chart below indicates the improvements made in all areas of the Child Behavior Checklist that were monitored this year.



Program Improvements Made as a Result of the CQI Program

During the 2014-2015 fiscal year we saw a number of high acuity clients which presented challenges to program delivery at times. The needs and illnesses of the clients served have created certain dynamics within the program that have created resistance to treatment provided. In addition, this fiscal year we had two staff members out at the same time for maternity leave which created a shortness in staff and challenges in being able to effectively address client concerns/behaviors. Despite that staff have continued to improve the delivery of the 'Goal/Intervention Groups' with their clients to address this increase in behavior. Staff have implemented new procedures for monitoring clients while they are taking 'breaks' or 'cool down' periods. They have made a stronger effort in recognizing de-escalation techniques that clients have identified and encouraging to use them when agitated. In response to the medication errors a new policy (see above) has been implemented to help address the number of staff related medication errors.

Recommendations for Program Improvements in the Upcoming Year

Mell-Burton continues to grow in the number of clients served throughout the year and the services that we offer in conjunction with the Guilford County School System. This has presented numerous challenges for us in several different areas. Some of them are as basic as not having enough space to allow clients the needed safe place to deescalate when they are agitated to the complexity of working with the schools in transitioning clients back to their home schools. We are frequently presented with the challenge of clients who have been here for a number of months or even years and are clinically ready to return but the clients' home school is resistant to this transition and will extend it for a long period of time. We would like to find a way to work with the schools in ensuring needs of the client, their home school and the Mell-Burton program.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year

Due to the continued struggle with medication administration and the errors after the implementation of the new policy and procedure we will continue to monitor and document all medication errors throughout the year. Our quality improvement goal for this monitor will be to administer medication as prescribed 100% of the time. In addition, there were a high number of AWOLs this year (again due to the high acuity of the clients served) and we will also monitor that area as well. Our goal to address this area will be that we have no more than 20 AWOLS during the 2015-2016 fiscal year. Steps will be taken by staff to prevent AWOLs and provide clients with more appropriate coping skills.

Summary:

During the period of time covered by this report, the Eastside Campus Continuous Quality Improvement Committee monitored and addressed issues and events related to quality assurance during regular bimonthly meetings. The present report is indicative of a uniformly high level of quality in areas monitored, relevant to both the quality of services provided to the community and the level of safety at the facility. The identified monitor for 2015/2016 has been recognized as an important area for ongoing examination in the upcoming fiscal year.

Structured Day Program

Introduction:

The following report summarizes incidents and issues addressed at Youth Focus Structured Day Program related to Quality Assurance in the provision of care at the facility. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Eastside Campus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by the Report:

This report covers the period of the time from July 1, 2014 through June 30, 2015.

Sentinel Events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events this review period.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee and Youth Focus Southside Campus Continuous Quality Improvement Committee each met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety at the Structured Day program. In the course of the four occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety at the facility were monitored, and are summarized as follows:

Fire Drills: Both live and simulated fire drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Executive Director. No significant deficiencies or problems were noted.

Disaster Drills: Simulated disaster drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Executive Director. No significant deficiencies or problems were noted.

Facility Inspections: Quarterly inspections were conducted at the facility throughout the period. Utilities systems and equipment were monitored and reported upon regularly, including the security system, electrical systems, and heating and air conditioning equipment. Aside from routine maintenance issues, no significant facility deficiencies were reported during the period of time covered by this report.

Incident Reports: During the period of time covered by this report, twenty-one (21) incidents involving potential safety concerns were tracked by means of Incident Reports completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety / Risk Management Committee. The following represents summary data for the period in question:

1. Physical Restraints of Residents – 1
2. Client, staff or visitor requiring more than minor medical care - 3
3. Client minor accident or injury, not requiring medical care – 0
4. Client aggressive or destructive act; resulting in suspension – 10
5. Client aggressive or destructive act, police involved - 3
6. Client AWOL- 4
7. Medication error - 0
8. Allegation of abuse of client - 0

Incident Reports were reviewed throughout the year during the quarterly committee meetings.

Public Complaints: No complaints by members of the public about the program were noted throughout the course of the year.

Employee Complaints: No complaints by employees about the program were noted throughout the course of the year.

Client Grievances: Grievance Forms were available to clients and their families throughout the course of the year. There were no grievances filed during the 2014-2015 review period.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Eastside Campus Continuous Quality Improvement Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted the Structured Day School. During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted.

Performance Reviews:

Annual and probationary employee performance reviews were monitored by the Youth Focus Eastside Campus Continuous Quality Improvement Committee on a quarterly basis. During the period of time addressed in this report, 11 full-time reviews were conducted and approved.

Utilization Review:

Total Admissions: 60

Total Discharges: 43

Total Students Served: 89

Average Daily Census: 28.80 students per day

Students Served (New Admissions):

Race	*Males*	*Females*	*TOTAL*
White	5	2	7
African-Am	33	10	43
Native Amer.	0	0	0
Hispanic	1	2	3
Other	4	3	7
TOTAL	43	17	60

Applicants Not Accepted for Service:

Total Referrals: 149

Referred Applicants Admitted: 60 (40.3%)

Early Termination of Service:

Total: 3 clients

Quarterly Record Reviews:

Quality Assurance reviews of open and recently closed Structured Day Program case records were conducted on a quarterly basis. Records were reviewed as dictated by Youth Focus policy #410. No high-risk interventions were noted in any of the reviewed charts. All relevant forms were present in the case records, and all ratings of assessment, treatment plan, and discharge plan content were Average or above. There were no significant areas for improvement that were noted.

Consumer Satisfaction Summary:

A favorable response will be obtained from the parent/guardian satisfaction surveys with an overall survey satisfaction score average above 4.1.

A parent/guardian survey was attempted with 50 former parents. Of the 50 attempted, 24 were completed and scored. The survey contained eight questions and the parent/guardian rated these as follows: 5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree.

The results of the survey are averaged as follows:

1. Staff is responsive to inquiries about the program and students. 4.92
2. Staff is appropriate in their interactions with children. 4.92
3. Staff utilizes appropriate interventions with children. 4.75
4. My child's progress towards IEP goals has improved since admission into Structured Day. 4.5
5. My child's ability to engage in appropriate problem solving has improved since admission. 4.13
6. My child's ability to interact with others has improved since admission. 4.38
7. My child's ability to function in public school after attending Structured Day has increased. 4.42
8. There is adequate communication between myself and staff regarding my child's progress in the program. 4.75

Favorable responses were given most often in the categories stating that the parents feel like staff are responsive to inquiries about the program and students, staff is appropriate in their interactions with students, staff utilizes appropriate interventions with students, and that there is adequate communication between parents and staff. No areas of concern were indicated on the surveys. Averages in this survey period were consistently higher than the last survey period. The amount of parents surveyed decreased from last year as many of the parents' contact information had changed.

25 students at the Structured Day Program were also surveyed with results as follows:

1. I get enough to eat. 2.2
2. I think the food is good. 2.0
3. School staff responds when I need help or support. 3.5
4. I feel that I am getting a good education. 3.8
5. I feel like the program has good recreational activities. 3.8
6. The therapist (Ms. Sarah, Ms. Megan) is available if I need her. 3.6
7. (Ms. Shawn/Ms. Michelle) is available if I need her. 3.8
8. The building is clean and looks nice. 3.6
9. Staff likes me. 3.8
10. I am able to do better here than I did at my old school. 3.6
11. I understand the point and level system. 4.2
12. I am learning how to get along with other people. 3.8

Overall the students seemed to have a good understanding of the point and level system; they also feel like the therapists and staff are readily available to them. The students were also favorable in thinking that they are getting a good education while at the Structured Day Program. They also feel they are able to do better here than at their traditional school. The major area of concern for the students is that they feel as though they do not get enough to eat and that they don't think the food is good. The majority of lower scores in these areas came from the high school classrooms who receive a different lunch each day than the middle schoolers.

Possible ways to Improve Services Based on Survey Findings:

The lowest score relates to the food being "good" and having enough to eat. Feedback has been given to the restaurant regarding client comments repeatedly with little success. As a result of this, we have decided to change the lunch service for our high school service. We will now be using the cafeteria at the Eastside campus. We will re-evaluate student feedback to these new lunches once they have started. We have also increased the portions of food that we offer the students for breakfast and will measure the satisfaction rate after the change has been implemented for a few more months.

Summary of Continuous Quality Improvement Monitor:

Increase approval rate of client authorizations. The referral to approval process is taking too long for client services to be considered given in a timely manner. MCOs are requiring more paperwork for approval and this paperwork has been taking much too long to gather from home schools and other sources. At the end of this year, we were able to decrease the turnaround time to an average of less than 3 weeks 61% of the time. This was an increase from 50% but still fell short of our overall goal of 85% of the time. We have created a checklist for schools to use so they know exactly what documentation is needed from us. Most of the schools have this. We have utilized the support of various positions in the school system as well as support from DJJ. Program Manager also physically went to retrieve records on a number of occasions. We conclude that this is an ongoing battle that is slowly improving but continues to be held as a priority this upcoming school year as the MCOs increase documentation needed for client approval.

Comparing Outcomes with other Programs:

Two studies utilized the Child Behavior Checklist (CBCL) as a tool to track progress at similar day treatment programs who served clients with disruptive behaviors. In order to track progress on the clients' behaviors, a pre and post CBCL was completed by a mental health professional on new and discharged clients. The first study, *A clinical and academic outcome study of children attending a day treatment program* (Kotsopoulos, Walker, Beggs, & Jones, 1996), showed a significant decrease in the externalizing behaviors scale. In the second study, *Three-year outcome of disruptive Adolescents treated in a day program* (Rey, Denshire, Wever, Apollonov, 1998), there was a reduction in many of the scales but most significantly in the aggressive and attention problem scales. During the 2014 - 2015 school year, the Structured Day Program saw similar significant decreases in the aggressive, attention problems and externalizing problems scales. The Structured Day Program will continue to track changes in the client's referral behaviors by administering the CBCL at intake and discharge.

Program Improvements Made as a Result of the CQI Program:

- Documentation checklist is now an official part of the referral form so referral sources know on the front end what is required of them
- School staff are more aware of the requirements and we work with them to assist in getting these documents together
- Client services are accessed more quickly than before and we have a higher approval rate this year.

Recommendations for Program Improvement In the Upcoming Year:

Addressing the Quality Assurance Monitors noted below should result in continued improvements and insurance of the quality of the services being provided through the Structured Day Program. These monitors will help to ensure that the services provided by the program continue to satisfy the needs of the clients.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

1. Study 1: Increase staff knowledge around trauma and trauma-informed care to decrease incidents and increase success rate of our clients in the program. Assist staff in developing more creative interventions to address the problems these kids present with.
2. Change the point and level system to be more conducive to the ability levels of the kids to understand where they are in the program.

Summary:

During the period of time covered by this report, the Eastside Campus Continuous Quality Improvement Committee monitored and addressed issues and events related to quality assurance during regular quarterly meetings. The present report is indicative of a uniformly high level of quality in all areas monitored, relevant to both the quality of services provided to the community and the level of safety at the facility. The identified monitors for 2015-16 have been recognized as an important area for ongoing examination in the upcoming fiscal year.

Therapeutic Family Services

Introduction:

The following report summarizes incidents and issues addressed within the Therapeutic Family Services program related to Quality Assurance in the provision of care by the program. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by Report:

This report covers the period of the time from July 1, 2014 through June 30, 2015.

Sentinel Events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events this review period.

Safety and Risk Management Activities:

The Youth Focus Southside Campus CQI Committee met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety in the TFS program. In the course of the four occasions on which the committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety in the program were monitored and are summarized as follows:

A. Fire and Disaster Drills:

Both live and simulated fire and disaster drills were conducted on the prescribed quarterly schedule throughout the period by the therapeutic foster parents. No significant issues or problems were noted. In addition, the TFS office conducted an annual fire drill for office staff.

B. Facility Inspections:

Quarterly inspections were conducted on TFS homes throughout the period. Items addressed include the presence of a fire evacuation plan, current fire inspection, overall condition of the facility, presence of smoke detectors, and potentially hazardous conditions. Aside from routine maintenance issues, no significant facility problems were otherwise reported during the period covered by this report.

Facility inspections of the TFS office were also conducted monthly during this fiscal year. As a part of these inspections, the fire extinguisher was serviced and the fire alarm system was tested. There were no significant issues reported.

C. Incident Reports:

During the period of time covered by this report, incidents involving potential safety concerns were tracked by means of Variance Reports completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety/Risk Management Committee. The following represents summary data for the period in question.

(1) Physical Assaults/episodes of client aggression: 0

(2) Minor Injury of Clients: 3

(3) Staff Injury: 0

(4) Property Destruction: 0

(5) Contraband/Weapons: 0

(6) Medication Administration Errors: 0

(7) Runaway: 2

(8) Psychiatric Hospitalizations: 1

(9) Medical Hospitalizations: 0

(10) Client Arrest: 0

(8) Allegations against foster parents: 0

Variance Reports were reviewed throughout the year during the quarterly committee meetings.

D. Public Complaints:

One complaint was received on 6/15/15 from the neighbor of a client alleging verbally harsh treatment of the client by her foster mother as well as problems related to client home visits. The foster parent was not found to have dealt inappropriately with the client, however it was determined that in the future, TFS will focus on ensuring that decisions regarding client home visits will be made as part of the Child and Family Team meeting, rather than be made by individuals.

E. Employee Complaints: There were no employee complaints this year.

F. Client Grievances: There were no client grievances filed this year.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Eastside Campus Continuous Quality Improvement (CQI) Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted the TFS.

Performance Reviews:

Three performance reviews were conducted by the Program Director in June 2015: full time case manager and two contract case managers.

Utilization Review:

Utilization rates were as follows for this reporting period:

Total admission: 22

Total discharges: 21

Total resident days: 2306

Average daily census: 6.32

Clients served breakdown: race/gender

Female: Caucasian: 16, AA: 3, Native Am: 3, Other: 2 (Asian, multi-racial)

Male: Caucasian: 3

Premature Termination of Services by Gender and Race:

The was no premature termination of services based on gender and race.

Quarterly Record Reviews:

Significant findings were that quarterly inspections were not in foster parent charts.

Annual Consumer Satisfaction Summary:

Six surveys were returned this past fiscal year, 4 from guardians/referral sources, 2 from clients.

The client satisfaction survey offered six possible response choices which were assigned the following values:

5 Yes - I strongly agree.

4 Yes - I agree.

3 Maybe – I don't agree or disagree.

2 No - I disagree.

1 No - I strongly disagree.

N/A This statement doesn't apply to me. (No numerical value assigned.)

Responses were positive on the six surveys that were returned, particularly from the guardians/referral sources, however the sample size of six surveys is small. Please see below for survey items and average scores.

SATISFACTION SURVEY ITEMS:

Client Survey: 2 were completed.

1.) I am comfortable sharing personal information about my life with the Youth Focus TFS staff and case manager.

2.) I believe that the TFS staff and case manager listen to me and my opinions.

3.) I am comfortable talking to my foster parents about my problems.

4.) I can tell my foster parents when my feelings are hurt.

5.) I enjoy living in the TFS home.

6.) I like the school I am attending.

7.) I feel safe in my foster home.

8.) My basic needs (care, clothing, regular meals, a place to sleep & bathe) are taken care of in my foster home.

9.) I am in better control of my behavior and feelings since I've been living with my foster family.

10.) I know I can ask an adult on my team if I need help.

Average response score: 4.2

Referral Sources

Legal Guardians: 4 surveys were completed.

1.) The TFS staff is available to answer questions and/or address any concerns.

2.) The TFS staff and foster family treat the child with respect and dignity.

3.) The TFS staff & foster family are available and ready to help with the child when necessary.

4.) I feel involved in the child's service planning process.

5.) I feel the child's designated problem areas are addressed in the services received.

6.) I am satisfied with the overall referral process for admission.

7.) I am satisfied with the communication and feedback given to me by the TFS staff and foster family.

8.) I am satisfied with the information I receive on the child's progress by TFS staff.

9.) I am satisfied with the level of professionalism displayed by the TFS staff.

10.) I am satisfied with the overall quality of the services provided by the TFS staff.

11.) I would recommend this service to a friend or co-worker who is looking for a foster care placement.

Average response score: 4.91

Summary of Continuous Quality Improvement Monitor:

In efforts to increase the percentages of quarterly inspections complete within a timely manner, data was collected in the final two quarters of the fiscal year. During the 3rd quarter, 50% of licensed homes received a quarterly inspection. During the 4th quarter, 58% of the homes received their quarterly inspection. Timely completion of quarterly inspections continues to be an ongoing issue that needs correction. In light of this, TFS will continue with this monitor in the 2015-2016 fiscal year. A TFS data base is now being utilized which will assist in tracking needed activities, such as quarterly inspections, for the program and helping the program improve compliance with these requirements.

Program Improvements Made as a Result of the CQI Program:

Due to a low utilization rate, which has not been adequate to sustain the TFS program, a decision was made to implement a new staffing model for the program. In recent years, TFS has operated with one program director, who oversaw both clients and foster homes, with the assistance of contract case managers. The new model will utilize a half time program director and two full time bachelor level staff members. One staff member will focus on clients and case management while the second will focus on recruitment, licensing, and management of foster homes. Contract case managers will continue to be utilized as needed.

Recommendations for Program Improvements in the Upcoming Year:

TFS will be focusing on several areas of improvement for FY 2015-2016. One is more regular use of the TFS database to ensure that required activities related to both clients and foster homes are completed on time. A second is to focus on better use of child and family team meetings to make decisions related to treatment issues and visitation. A third is to fill the new recruiter position in order to improve both in managing current foster homes and recruiting new homes.

Continuous Quality Improvement Monitor to be addressed in the Upcoming Year:

TFS will continue to monitor timely completion of quarterly foster home inspections for the upcoming FY 2015-2016 with a goal of completing 100% of the inspections on time. In addition, TFS will monitor the use of the TFS database as a means to improve completion of multiple tasks/documents needed on an ongoing basis for foster care.

Summary:

With the significant change in staffing, it is hoped that the TFS program can focus both on providing quality foster care services to the youth in our care and on recruiting, licensing, and supporting additional homes so that the program is sustainable. Referrals to the program are quite strong, as the demand for therapeutic foster care services appears to be high. The TFS program has a strong base of existing foster homes to build on and our belief is that adding new, well trained and supported homes will improve our ability to both serve youth needing this program, particularly in Guilford County, and to maintain a sustainable program.

Family Preservation Services

Introduction:

The following report summarizes incidents and issues addressed within the Family Preservation Services program related to Quality Assurance in the provision of services. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by Report:

This report covers the period of the time from July 1, 2014 through June 30, 2015.

Sentinel Events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events this review period.

Safety and Risk Management Activities:

The Youth Focus CQI Committee met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety in the FPS program. In the course of the four occasions on which the committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety in the program were monitored and are summarized as follows:

A. Fire Drills:

An annual fire drill was held. No concerns were noted.

B. Facility Inspections:

Facility inspections were completed quarterly. Aside from routine maintenance issues, no significant facility problems were otherwise reported during the period covered by this report.

C. Incident Reports:

There were two incident reports made by FPS this past year, related to incidents that occurred on 10/2/14 and 6/29/15. Both incidents were related to clients who expressed thoughts of harm to self and/or others. Both clients were taken for psychiatric evaluation and then admitted to inpatient psychiatric care. Each incident was handled appropriately by FPS staff.

D. Public Complaints: There were no public complaints this reporting period.

E. Employee Complaints: There were no employee complaints this reporting period.

F. Client Grievances: Grievance Forms were available to clients and their families throughout the course of the year. There were no grievance forms received by this office during this reporting period.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Continuous Quality Improvement (CQI) Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted the Family Preservation Services program.

Performance Reviews:

The FPS program director completed performance reviews on six FPS full time and contract staff in June 2015. One FPS staff member was out on short term disability during the 4th quarter and her performance review has not been completed.

Utilization Reviews:

FPS served 31 new families during this past fiscal year. 17 cases were open at the beginning of the fiscal year, for a total of 48 families served. The goal for the year was to serve 60 families.

Break down by gender and race:

Caucasian male: 8

AA male: 9

Hispanic male: 1

Caucasian female: 7

AA female: 4

Other female: 2

Breakdown by age:

Under 7: 2

7-9: 5

10-13:10

14-17: 14

Applicants Not Accepted for Services Who Were Eligible:

FPS therapists did not decline any eligible families. On a number of occasions, families who requested services were declined authorization by the MCO and referred to different levels of care. On several of those occasions, FPS was able to serve families despite lack of authorization due to grant funding.

Premature Termination of Services by Gender and Race:

Pattern or relationship between variables of gender and racial identity, respectively, and services resources and case dispositions: None noted.

Quarterly Record Reviews:

Quarterly record reviews were completed. A total of 36 records were reviewed this year. Most deficiencies were related to incomplete documentation. There were several instances of missing NC Topps interviews and incomplete checklists. Quarterly supervisory reviews were not done with consistency.

Annual Consumer Satisfaction Summary:

The family preservation services program of Youth Focus, Inc. conducts an ongoing survey of consumer satisfaction with services as a means of monitoring the quality of the services we provide and as a vehicle for identifying and assessing areas needing improvement. Due to a change in program directors during FY 2014-2015, data from the Client Services Assessment Form was only available from seven families who were served in the 3rd and 4rth quarter of the year.

The third section of the Client Service Assessment Form contains seven items concerning satisfaction with the services we provided to the family. These items are rated on a five-point scale with five representing “very satisfied” and one representing “very dissatisfied”.

The following are the results for the responses to each of the seven items:

1. Services you received helped you effectively deal with needs and issues with your child(ren)?

(100% of the responses to this item are “very satisfied” or “satisfied”)

2. Amount of time the Family Preservation Counselor spent with you and your family was adequate?

(100% of the responses to this item are “very satisfied” or “satisfied”)

3. Working relationship the Family Preservation Counselor developed with your family was helpful?

(100% of the responses to this item are “very satisfied” or “satisfied”)

4. Services you received helped you and your family communicate better?

(100% of the responses to this item are “very satisfied” or “satisfied”)

5. Services you received helped you and your family set goals that you and your family are able to achieve?

(86% of the responses to this item are “very satisfied” or “satisfied”)

6. Services you received helped you and your family make changes so that your family can remain together?

(86% of the responses to this item are “very satisfied” or “satisfied”)

7. Services you received helped you make changes that benefited you and your family?

(100% of the responses to this item are “very satisfied” or “satisfied”)

In summary, 96% of the total number of responses was “very satisfied” or “satisfied”.

Summary of Continuous Quality Improvement Monitor

CQI Monitor: Timely Submission of NC-TOPPS without director file review.

Reason for Selection of this Quality Improvement Project:

Family Preservation Therapists were late on NC-TOPPS submissions leading to MCO plan of correction and a CQI monitor. In fiscal year 2013-2014 FPS therapists completed 100% of NC Topps submissions on time with significant attention paid to the issue by the FPS director, who completed regular record reviews to ensure timely completion. For FY 2014-2015, FPS continued to monitor timely NC Topps completion, only without director file reviews.

Steps Taken to Support Improvement:

Staff received email reminders of pending NC Topps interviews that were due.

Project Barriers: Due to illness, the FPS director position was vacant for much of the first half of the fiscal year.

Baseline Data Time Period: July 1, 2013 – June 31, 2014

Baseline Data Results: 21 of 21 NC Topps interviews, 100%, were submitted on time.

Improvement Goal: NCTOPPS will be submitted within the required timeframe 100% of the time, without director file review.

Project Outcome:

Percentage of NC-TOPPS submitted within required timeframe.

- Individual data from 1st and 2nd quarter is not available, however cumulative data was collected at the end of the 3rd quarter. Data from the 4th quarter was collected separately, along with a yearly total.

- End of 3rd quarter: 55%. (28 of 53 interviews)
- 4th quarter: 66%. (12 of 18)
- Entire year: 58% (40 of 69)

The quality improvement goal was not met. Timely submission of required NC-TOPPS interviews decreased substantially without the regular intervention of the director.

Final Analysis / Recommendations: FPS clinicians struggled particularly with timely completion of the initial NC Topps interview submitted by the second treatment session. Including NC Topps in the initial assessment interview process would help to ensure that it was completed on a timely basis. Email reminders continue and the program director will continue regular monitoring of timely submissions.

Comparative Program Study

Outcome for youth receiving intensive in-home therapy or residential care: a comparison using propensity scores (2007).

This study compares outcomes for behaviorally troubled children receiving intensive in-home therapy (IIHT) and those receiving residential care (RC). Propensity score matching is used to identify matched pairs of youth (n = 786) with equivalent propensity for IIHT. The majority of pretreatment differences between the IIHT and RC groups are eliminated following matching Logistic regression is then conducted on outcome differences at 1 year post-discharge. Results show that IIHT recipients had a greater tendency (.615) towards living with family, making progress in school, not experiencing trouble with the law, and placement stability compared with RC youth (.558: $p < .10$). This suggests that IIHT is at least as effective for achieving positive outcomes. Given IIHT's reduced restrictiveness and cost, intensive in-home services should be the preferred treatment over RC in most cases.

Program Improvements Made as a Result of the CQI Program:

Increased emphasis on completion of the initial NC Topps interview. Increased emphasis on case closure procedure including providing copy of termination summary to family. Increased focus on decreasing the time between intake session and submission for authorization to the MCO.

Recommendations for Program Improvements in the Upcoming Year:

Program director would like to focus on two specific areas for quality assurance for FY 2015-2016:

One, decreasing the time period between the intake session with a FPS counselor and the submission of a request for intensive in home services to the MCO. Baseline data from the second half of FY 2014-2015 shows that currently this time period varies between two weeks and over a month. In addition, the MCO can take up to 14 days upon receiving the request to make a decision regarding authorization. After a delay of this magnitude between a referral for service and the actual start of that service, some families appear to lose motivation to actively participate. Program director would like to shorten the time from intake to submission to one week and is working with the FPS therapists to find ways to make this possible.

Two, pursuing an improved system of clinical training and clinical supervision of open cases. Youth Focus FPS evidenced based practice for two of our four therapists is the Homebuilders model, a solution focused approach to intensive in home services. Training for this model has been provided by Courtney Smith, formerly of Barium Springs. Program director has spoken with Ms. Smith regarding a possible system where FPS therapists would receive their ongoing Homebuilders refresher training but would also take part in monthly clinical supervision with Ms. Smith with a focus on improving our fidelity to the Homebuilder's model by discussing therapist's clinical work with current open cases. Alternatively, the FPS program could pursue a similar arrangement with Youth Focus clinical director, Dr. Van Catterall.

Continuous Quality Improvement Monitor to be addressed in the Upcoming Year:

Program director would like to continue to monitor NC Topps compliance during the upcoming fiscal year. In addition, program director would like to monitor the efforts to decrease the time frame from intake submission to submission for authorization for services to the MCO described above.

Summary:

This has been a year of transition for the Family Preservation program, with the change of program director and a change of assistant director as well. In addition, one FPS therapist resigned, one FPS therapist went out on medical leave in the 4th quarter, and one FPS qualified professional accepted a new position within the agency. The number of FPS intensive in home teams decreased from three to two, based on the loss of Juvenile Crime Prevention Counsel (JCPC) grant funding and the resultant loss of the Department of Juvenile Justice as a referral source. Utilization goals for the program this past year were not met. Despite this, referrals towards the end of the last quarter from other sources (Cone Health System, Guilford County DSS) improved, leading to the potential for increased utilization of the program in fiscal year 2015-2016.

Outpatient Counseling

Introduction:

The following report summarizes incidents and issues addressed in the Outpatient Counseling Program with Youth Focus Inc. Since 1971 Youth Focus, Inc. has provided outpatient counseling for troubled young people. During most of the year under study there were eight masters trained and licensed therapists from different disciplines providing mental health counseling some percentage of their time. Due to turnover and funding loss, our staff has been reduced to five therapists; four are full-time and one is part-time. Services are provided from two office sites in Guilford County – one in High Point and one in Greensboro, NC. Referrals are accepted from any source but come primarily from area schools, juvenile court, local law enforcement, parents and mental health. In addition to individual and family counseling, various services are provided in group format and include a Character Education curriculum, Anger Management – Violence Prevention curriculum, and a "Straight Talk" group for adolescent females. Also, there are two group components of the Counseling program funded by the Juvenile Crime Prevention Council (JCPC) added last year: a Parenting of Teens group and a skill building group.

Period of Time Covered by Report:

This report covers the period of the time from July 1, 2014 through June 30, 2015.

Sentinel events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events in the 2014 - 2015 Fiscal Year.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety in all of our programs. In the course of the four occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety in the outpatient program were monitored, and are summarized as follows:

Fire Drills: Staff in Outpatient Counseling office conducts monthly safety inspections, documents them and forwards this documentation to the safety director. Staff also participated in an annual fire drill. No issues were noted.

Incident Reports: There were no incident reports in the outpatient counseling program in the 2014-15 year.

Quarterly Facility Inspections: All Youth Focus office facilities were inspected on a rotating quarterly basis by the Program Manager, the Director of Training and Quality Management, Executive Director, or Director of Operations. Areas of concern centered largely on maintenance items, were noted and correction plans developed as part of the inspection reports. These reports also are reviewed during quarterly agency safety meetings. Additionally, OSHA came out and completed a courtesy inspection on

March 26th in the Greensboro office. They cited concerns with broken laminate flooring in the file room. The flooring was repaired shortly after the site visit.

Public Complaints: No complaints by members of the public about the program were noted throughout the course of the year.

Employee Complaints: No complaints by employees about the program were noted throughout the course of the year

Client Grievances: Grievance Forms were available to clients and their families throughout the course of the year. No grievances were filed by clients or their families throughout the course of the year.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted.

Performance Reviews:

Annual and probationary employee performance reviews were completed by supervisors and directors in the Outpatient Program for the 2014-15 year. During the period of time addressed in this report, 7 full-time and 1 part-time reviews were conducted and approved.

Utilization Reviews:
The Outpatient Counseling Program provided individual, family and group treatment services to 638 new clients during the reporting period. Along with the carry-over of clients from the previous fiscal year Counseling served a total of 823 clients.

There are three component programs that fall under Outpatient:

1) Psychological testing: 29 psychological evaluations were conducted this year.
2) Active Parenting of Teens: 32 parents participated in the parent groups this year.
3) Future Focus Social Skills: 87 clients were served in the social skills groups.

Applicants Not Accepted for Service Who Were Eligible:

After careful consideration in quarterly CQI meetings, it was determined that all clients referred out were referred because they were not eligible for our services.

Premature Termination of Services By Gender and Race:

Pattern or relationship between variables of gender and racial identity, respectively, and services, resources, and case dispositions: None noted.

Quarterly Record Reviews

Quality Assurance reviews of open and recently closed outpatient counseling case records were conducted on a quarterly basis. Records were reviewed as dictated by Youth Focus policy #410.

A. Internal Random Review of Records
1. Number of open files reviewed: 94
2. Number of closed files reviewed: 3
3. Name & Program of outside reviewer/s: Internal reviewers- all clinicians reviewed alternate therapists' charts

B. Significant Findings: Several treatment plans were missing in files at the time of review. Additionally, a few files showed no evidence in documentation of supervisory review. Timeliness in completing treatment plan and in documenting supervisory review was noted as an area in need of improvement. No other suggestions for improvement were noted.

Annual Consumer Satisfaction Summary:

Over the course of the 2014 year, consumer surveys were mailed to outpatient clients in the counseling program after their fourth session with a Youth Focus therapist. Of the surveys mailed, 74 were returned. The survey was structured so it targeted three major components of the counseling program: the intake process, counselor professionalism and client recidivism. The responses were reviewed in detail and determined to be overwhelmingly positive.

In summary, approximately 83 % of respondents expressed satisfaction with six components of the intake process. When asked of their overall satisfaction of Youth Focus services thus far, 96% of respondents rated services as above average. Regarding recidivism, of those responding with an opinion, 75% felt that their child showed improvement at the time of response. Finally, 97% of respondents said they were satisfied with the specific counselor assigned to them in therapy.

At the conclusion of the survey, respondents were asked to make recommendations to help improve services. Out of 24 comments, all were considered positive or constructive. Some of the comments and recommendations are as follows:

"*Thanks for the support and guidance.*"

"*Have more male counselors.*"

"*Don't see any way services could be better than what they are.*"

"*Sooner appointments.*"

"*I think it's a great service. More staff would be nice, so you don't have to wait so long.*"

"*We are pleased with our experience at Youth Focus.*"

"*He is verbalizing things more-that is a plus.*"

Summary of Continuous Quality Improvement Monitor

A. **CQI Monitor**: Primary care physician referrals
B. Quality Improvement Goal: Increase referrals by 75%
C. Reason for Selection of this Monitor: Medicaid and Health Choice require documentation in the client folder that a primary care physician referred or approved the referral for outpatient counseling services. Our office has not been very successful in obtaining these referrals from physicians after faxing a form signed by the legal guardian requesting support for the referral.
D. Baseline Time Period: July and August of 2014
E. Baseline Data Results: Our return rate for July through August 2014 was 58%.
F. Steps Taken this Quarter to Support Improvement: This quarter we continued to have our Medical Director review all new clients. After each client was reviewed, our clinical director signed the support for referral.
G. Barriers to Improvement Encountered this Quarter: We had two significant barriers this quarter: 1) Time restraints with our Medical Director limit information shared about referrals and, 2) When clients don't present with a Medicaid or Health Choice card, it is hard to determine what type of insurance they have.
H. Progress Towards Goal (include data): In the Greensboro Office we had 46 new clients seen this quarter who required the support for referral. In the High Point Office we had 21 new clients seen this quarter who required the support for referral. All 67 support for referrals were signed, therefore, our rate of return was 100%.
I. Project Outcome (include data): Our year to date data is not at 100% because of the struggles we had in the first two quarters. Our year to date data suggests that we got 73% of the support for referrals signed by physicians for client having Medicaid or Health Choice. The actual number of primary care physician referrals we had was 147 out of the total number 201.

J. Final Analysis & Recommendations: In summary, once our Medical Director agreed to sign the support for referrals, we were able to operate at 100% of the referrals being signed. We will continue to rely on this method since it is much simpler, saves time and is 100% effective.

Comparative Program Study

This year in the outpatient program we were able to get follow up data on court ordered clients through Department of Juvenile Justice (DJJ). We developed a list of clients referred only by DJJ who were terminated in the year 2013. We chose clients served in 2013 so we could "follow up" 12 months later. We also designated that each client followed must have been seen by a therapist at least 3 times in order to consider our time effective. We looked at how many of these clients had new offenses after their discharge dates. This gave us a recidivism rate of 30% when we look exclusively at our population referred by DJJ.

In comparison, we looked at the 2009 Statewide Juvenile Court report for Missouri. Juvenile Courts in Missouri were focused on reducing their recidivism rate so they were connecting their juvenile offenders with local evidence-based programs. They calculated a recidivism rate for identified offenders after 12 months and their rate was 26% or 4,106 recidivists of 11,804. This rate is very similar to our recidivism rate of 30%.

Program Improvements Made as a Result of the CQI Program:

As a result of the CQI Program, we have a new plan for obtaining support for the referral of Medicaid and Health Choice clients. Instead of obtaining these referrals from physicians after faxing a form signed by the legal guardian requesting support for the referral, we now have our medical director sign the support for referral. We will continue to rely on this method since it is much simpler, saves time and is 100% effective

Recommendations for Program Improvements in the Upcoming Year

We collect data for one of our annual outcomes measured through parent surveys. On this survey we ask parents if their child's behavior has improved as a result of their involvement with our outpatient counseling program. Our goal is that 80% of parents responding will say that their child's behavior has improved. We have recently noted a decrease in the return of our surveys. We suspect that parents are receiving our surveys in the mail too soon and have not been seen more than two times for counseling which would not be enough time to see significant changes. We are going to change the time frame in which the surveys are mailed out to try to improve our return of the surveys. Instead of mailing the surveys 4 weeks after intake, we will mail all surveys of children seen in one quarter at the end of the quarter. This should allow families more time to have follow- up appointments before they are asked if their child's behavior has improved.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

Monitor: Incomplete/inaccurate Data

Due to ongoing errors in reporting the number of clients seen per quarter as broken down by age, race and sex, a new CQI monitor will be started cleaning up data being put into the Echo data base. Data from the first quarter of year 2015-16 will serve as a baseline and our goal is to reduce the number of errors in data by 50%. Monthly summary data on incidents will be presented during each quarterly meeting of the Continuous Quality Improvement Committee.

Summary:

During the period of time covered by this report, the Youth Focus Continuous Quality Improvement Team monitored and addressed issues and events related to quality assurance during regular quarterly meetings. The present report is indicative of a uniformly high level of quality in all areas monitored, relevant to both to the level of clinical care provided to the clients in the Outpatient Counseling program and the level of safety at the facilities. Recommendations and monitors have been identified as important for ongoing examination in the upcoming fiscal year.

Substance Abuse Outpatient

Introduction:

The following report summarizes incidents and issues addressed within the Substance Abuse Outpatient program related to Quality Assurance in the provision of services. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by Report:

This report covers the period of the time from July 1, 2014 through the close of the 2014 - 2015 Fiscal Year on June 30, 2015.

Sentinel Events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events in the 2014 – 2015 Fiscal Year.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety in all of our programs. In the course of the four occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety in the outpatient program were monitored, and are summarized as follows:

Fire Drills: Staff in the Substance Abuse Outpatient office conducted monthly safety inspections, documents them and forwards this documentation to the safety director. Staff also participated in an annual fire drill. No issues were noted.

Incident Reports: There were no incident reports in the Substance Abuse Outpatient program in the 2014-15 fiscal year.

Quarterly Facility Inspections: All Youth Focus office facilities were inspected on a rotating quarterly basis by the Program Manager, the Director of Training and Quality Management, Executive Director, or Director of Operations. Areas of concern centered largely on maintenance items, were noted and correction plans developed as part of the inspection reports. These reports also are reviewed during quarterly agency safety meetings. Additionally, OSHA came out and completed a courtesy inspection on March 26th in the Greensboro office. They cited concerns with broken laminate flooring in the file room. The flooring was repaired shortly after the site visit.

Public Complaints: No complaints by members of the public about the program were noted throughout the course of the year.

Employee Complaints: No complaints by employees about the program were noted throughout the course of the year

Client Grievances: Grievance Forms were available to clients and their families throughout the course of the year. No grievances were filed by clients or their families throughout the course of the year.

Credentialing and Privileging Activities:

Consistent with agency policy, the annual privileging review of current staff that is a part of the annual employee update took place in May, 2015.

Performance Reviews:

The performance reviews have been completed for both full-time and part time employees as of June 2015. Each employee has reviewed and accepted individual goals for the next fiscal year. Each employee is encouraged to participate in continuing education opportunities. These evaluations were submitted to the Human Resources Director and are filed in the employee folder.

Utilization Reviews:

The therapists in the SAOP program served a total of 162 new clients this year.

Applicants Not Accepted for Services Who Were Eligible:

None

Premature Termination of Services by Gender and Race:

None

Quarterly Record Reviews:

Quarterly record reviews were conducted by the SAOP therapists. A total of 24 records were reviewed this fiscal year. No major deficiencies were noted during the review process. Therapists were reminded that client goals/treatment plans are to be updated every 90 days. Additionally, consents are to be updated each year.

Annual Consumer Satisfaction Summary:

See Outpatient Counseling Annual Consumer Satisfaction Summary for Survey Results

Summary of Continuous Quality Improvement Monitor:

As a result of Youth Focus' involvement with the Juvenile Justice, Substance Abuse, Mental Health Partnership (JJSAMHP) initiative in Guilford County, the Substance Abuse Outpatient (SAOP) program implemented the use of the GAIN, an evidence-based comprehensive assessment tool. The SAOP therapists were interested in how the GAIN would impact client engagement in therapy. It was found that only 67% of clients recommended for services after receiving an assessment returned for a follow up

session. This is down from the engagement rate of 86% last fiscal year. As a result, this upcoming year changes will be made in order to attempt to engage clients and their families in services.

Comparative Program Study:

Nguyen, Walters, Wyatt, and DeJong (2013) examined the impact of recent alcohol-related consequences on planned protective drinking strategies among college freshmen. They found that students who recently had higher levels of external harms associated with their drinking were more likely to plan to limit their drinking in the future. Additionally, those with recent impaired driving experiences also planned to limit their drinking more in the future. Therefore, the recent negative experiences were leading these students to consider their drinking patterns and plan for lower levels of use in the future.

As part of the Seven Challenges, the SAOP counselors assist clients in examining what they like about substance use in addition the to the harm that substances have caused them or the potential harm substances may cause. As a result of this process, the hope is that clients will choose not to use substances, or if they do choose to use substances, they will do so in a decreased and safer manner. As Nguyen, Walters, Wyatt, and DeJong (2013) found, examining the harm associated with substance use can lead adolescents to be more likely to limit their substance use in the future. For 2014-2015, ninety five percent of clients scored lower on the CAFAS substance abuse subscale at discharge from services. This means that even if clients are not completely abstinent from substances at discharge, they are at least using smaller amounts of substances and considering the negative impact substances have on their lives.

Program Improvements Made as a Result of the CQI Program:

In order to attempt to reduce the rate of missed appointments this year, administrative support staff members have been making reminder calls to clients. Additionally, in order to better serve clients and to reduce their amount of wait time for assessment and follow up services, an additional therapist was added this year. He spends time in both Greensboro and High Point offices.

Recommendations for Program Improvements in the Upcoming Year:

Therapists will continue to administer the GAIN to clients this upcoming year as required by the JJSAMHP initiative. However, therapists will be offering clients' incentives such as snacks for coming to services. It is hopeful that the incentives will allow the clients to be more comfortable with the assessment process and have an increased desire to return for services.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

SAOP clinicians will monitor the impact of providing incentives to clients on engagement in treatment.

Summary:

The SAOP program has undergone shifts in staffing and program requirements by stakeholders this year. However, the program has continued to meet the needs of its clients and provide quality services as evidenced by 81% of clients being abstinent from substances at discharge and 95% of clients at least reducing their substance use at the time of discharge.

Adolescence Substance Abuse Program

Introduction:

The following report summarizes incidents and issues addressed at Youth Focus Adolescence Substance Abuse Program (ASAP) related to Quality Assurance in the provision of care at the facility. These issues are monitored and address during quality meetings of the Youth Focus Safety/Risk Management Committee and the Youth Focus Outpatient Counseling and Substance Abuse Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by the Report:

This report covers the period of the time from July 1, 2015 through the close of the 2014—2015 Fiscal Year on June 30, 2014.

Sentinel Events:

The occurrence of sentinel event is monitored by the Youth Focus Safety/Risk Management Committee. Sentinel event refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events in the 2014-2015 Fiscal Year.

Safety and Risk Management Activities:

Youth Focus Safety/Risk Management Committee and Youth Focus Counseling and Substance Abuse Quality improvement Committee each met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues to risk management and safety at ASAP program. In the course of the four occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to the safety at the facility were monitored, and are summarized as follows:

A. Fire & Disaster Drill: Both live and simulated fired drills and disaster drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Executive Director. No Significant deficiencies or problem were noted.

B. Incident Reports: There were thirty seven (39) incidents involving potential safety concerns that were tracked by means of incident reporting completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety/Risk Management Committee. Below is the summary data for the period in question:
    1. Running away from the House----- 15
    2. Medication errors -18
    3. Hospitalization due to over dose on illegal drugs------ 2

4. Hospitalization due to co-morbid mental health problem----1
5. Clients' physical aggression no police involved----- 3

Incident Reports by Level:
Level I------- 19
Level II------- 20
Level III------- 0

C. Quality Facility Inspections: Quality inspections were conducted at the facility throughout the period. Utilities systems and equipment were monitored and reported upon regularly; including the fire alarm and sprinkler system, fire extinguishers, kitchen stove hood, security system, electric system, and heating and air condition equipment. Aside from routine maintenance issues, no significant facility deficiencies were reported during the period covered by this report. Additional window sensors were added due to client sneaking out of the house without staff knowing about it. The front pouch was renovated and new roof put on the house due to aging and to prevent minor leaks.

D. Public Complaints: Throughout the course of the year no complaints by members of the public about the program.

E. Employee Complaints: No complaints by employees about the program were noted throughout the course of the year.

F. Client Grievances: Clients and their families during admission and in the course of treatment were educated on the grievance process. No grievance was filed by clients to the clients' Right Committee. However, a complaint was made to DHSR by a client who was discharged unsuccessfully. The complaint was unsubstantiated.

Credentialing and Privileging Activities:

During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted. The process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee.

Performance Reviews:

Annual and probationary employee performance reviews were monitored by Youth Focus Counseling and Substance Abuse Continuous Quality Improvement Committee on monthly and/or quarterly basis. For the period of time addressed in this report, 7 full-time and 5 part-time reviews were conducted and approved.

Utilization Reviews:

Total Admission and Served: ---------- 21
Total Discharge: ---------- 18
Total Re-Admitted: ---------- 0

Total Resident Days: ---------- 2032

Clients Served:

Race	Males	Females	Total
Black	9	0	9
Hispanic	2	0	2
Native American	0	0	0
White	9	0	9
Total	20	0	20

Female client are not accepted because it an all male resident facility.

Applicants Not Accepted for Services Who Were Eligible:

Total referrals: 19
Referred Applicants accepted: 15
Referral Applicants Admitted: 15
Reason for non-admission:
Clinically inappropriate/Referred elsewhere: 2
Found other placement prior to bed being available: 1
Failed to follow up/ send requested information: 1

Premature Termination of Services by Gender and Race:

There was no premature Termination.

Quality Record Reviews:

Quality Assurance reviews of open and recent ASAP case records were conducted on a quarterly basis. Records were reviewed as directed by Youth Focus policy #410.

No high-risk interventions were noted in any of the reviewed charts. All relevant forms were present in the case records, and all ratings of assessment, treatment plan, and discharge plan content were Average or above. The quality of treatment plans; billable notes and their prompt completion have been identified as areas for improvement in the coming year.

Annual Consumer Satisfaction Summary:

Throughout the course of the fiscal year 2014-2015 resident satisfaction surveys were mailed to clients. The total of nine clients/ families responded to the survey. There were thirteen questions with the

fourteenth been a general question on their view on how to improve program. The surveys were developed targeting specific areas the program wanted to evaluate. Below are the questions and rating.

1. After you or your parent or guardian made application to come into a Youth Focus residential program did you have to wait a long time before you were admitted?

1	2	2.9	3	4	5
Yes, a long wait	Pretty long		Not Too Bad	Pretty Fast	Hardly Any Wait At All

2. Did you receive a copy (or was one made available for you to look at) of the Client Handbook?
100% yes

3. Did you get to participate in helping to develop goals on your treatment or case plan?
89% yes 11% no

4. How helpful has the program been so far in assisting you in making progress on your goals?

1	2	2.9	3	4	5
Not helpful at all	A little		Fairly helpful	Good	Very Helpful

5. Are you treated with dignity and respect by the staff? 89% yes 11% no
6. Has staff ever used physical discipline with you (spanking, hitting, etc.)? 100% no
7. Is the facility well maintained and clean? 100% yes
8. Are nutritious meals and snacks provided? 100% yes
9. Are your religious and cultural beliefs and practices respected? 100% yes
10. Are you allowed to visit or contact family members? 100% yes
11. Are recreational activities provided for you both at the facility and in the community? 100% yes
12. Do you have a general idea of when you will leave or be discharged from the facility? 100% yes
13. Do you know where you will be going when you leave? 100% yes

14. Thank you for completing this survey. Please use the space below to let us know any other ways that we could improve the program that you are in:
Comment shared include, *"More help with drug treatment"*, another said *"No it's just fine"*.
It is not exactly clear what both comments means but it seems that the latter is saying that the program is good as it is while the first is saying that he needed more substance abuse education and counseling.

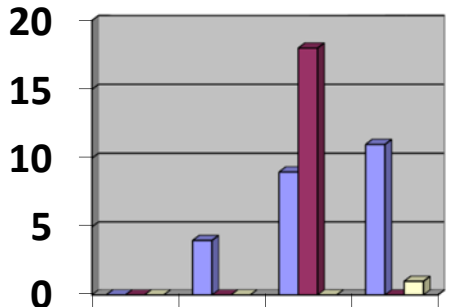
Over all ASAP made great improvement in the program. The time it took from the assessment day to admission improved from 2.5 averages in 2013-2014 to 2.9 in 2014-2015 fiscal year. Client's participation in developing treatment goals increased from 80% to 89%. Question number 4, How helpful the program has been in assisting client make progress on their goals drop from 3.5 to 2.9. "Are you treated with dignity and respect"? Improved from 67% to 89%. Clients' satisfaction with facility been maintain and clean went up from 67% to 100%; question 8 improved from 83% to 100%; question 9 from 87% to 100%; Number 12 from 83% to 100%.

Summary of Continuous Quality Improvement Monitoring:

CQI Monitoring: Incident Reports----- statistic from our incident reports indicated that ASAP had a high rate of med errors in the FY 2013--2014.
Improvement Goal: reduce med errors to 50%

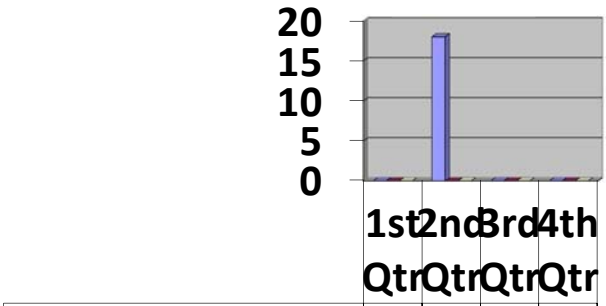
Reason for Selecting this Quality Improvement Project: Med errors have the potential of been fatal or becoming a level III incident. Client refusing to take his medication, staff allowing prescription to lapse might lead to potentially disastrous result.
Project Barriers: Most of our medication errors have been clients refusing to take their meds. It is their right. We cannot make them to take it. If our clinical intervention fails the number of med errors may remain high. We will work on educating parents, court counselors and all treatment team members the need for clients to comply with medications order by their doctors and psychiatrists.
Baseline Data Time Period: 2013-2014 fiscal year
Baseline Data Results: There were 43 medication errors in fiscal year 2013-14.
Projected Outcome: There was a total of 18 medication error in fiscal year 2014-2015, resulting in a 58% decrease in medication errors from the previous year.

2013-2014 (chart 1)

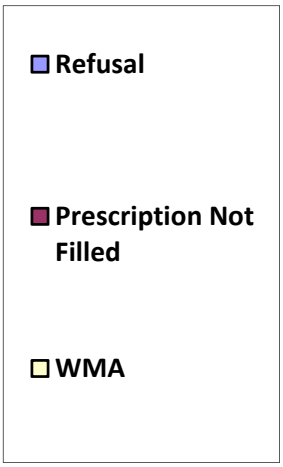


	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Refusal	0	4	9	11
Prescription Not Filled	0	0	18	0
WMA (wrong Medication Administered)	0	0	0	1

2014-2015 (chat 2)



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Refusal	0	18	0	0
Prescription Not Filled	0	0	0	0
WMA	0	0	0	0



Final Analysis/ Recommendations:

In the fiscal year 2013-2014 ASAP reported high med errors, 43. The program set as it goal to decrease the med errors to 50% in 2014-2015 fiscal year. This goal was met. The error was decreased to 58% in 2014-2015. The Med errors during this period were mostly level I incident reports, clients refusing to take their meds with no adverse effect. The plan put in place that led to the decrease in med error incidences will remain in effect for 2015—2016 fiscal year.

Comparative Program Study:

During the past year ASAP has set a goal for 75% of its successful graduates to significantly reduce or eliminate drug usage during one year follow-up period. For our comparative program study we chose a research done by Mary C. Acri, Leah Gogel, Michele Pollock and Jennifer P. Wisdon published online in 2012 by New York State psychiatric Institute, New York, NY, USA. The article was accessed from ww.ncbi.nih.gov/pmc/articles/PMC3979558. The research attempted to answer the question, "What Adolescents Need to Prevent Relapse after treatment for Substance Abuse: A Comparison of Youth, Parents, and Staff Perspectives". The study identified four major areas of interest from the respondents. They are: Aftercare-Related Needs, Relationship with Peers & Family, Non-Drug-Related Environments & Activities, and Internal Processes. The total of 87 people was involved in the study. Of the 87, 28 were adolescents, 30 parents and 20 treatment staffs. Below is the table:

	Adol-28	Parents – 30	Staff-- 29	Total---87	
Aftercare-related needs					
-Outpatient treatment	--- 21.43%	30.00%	65.52%	39.08%	
---AA/NA or Sponsor	--- 28.57%	13.33%	13.79%	18.39%	
Relationships with peers & family	--25.00%	30.00%	34.48%	29.89%	
---support	---25.00%	16.6%	6.9%	16.09%	
---Positive Peers	--10.71%	3.33%	0.00%	4.60%	
-- Family integration	---10.71%	0.00%	13.79%	8.09%	
--- someone to talk to					
No-drug-Related Environment & Activities	*---28.75*	*26.67%*	*13.79%*	*22.99%*	
--- In School or working	*---14.29%*	*20.00%*	*6.90%*	*13.79%*	
--- Hobbies/Structured Time	*---7.14%*	*13.33%*	*3.45%*	*8.05%*	
---New/Healthy Environment	*---3.57%*	*3.33%*	*0.00%*	*2.30%*	
--- Religion					
Internal Processes					
---Focus	--7.14%	6.67%	3.45%	5.75%	
--- Emotionally Stability	---0.00%	6.67%	0.00%	2.30%	
--- Commitment to program	--7.14%	0.00%	0.00%	2.30%	
--- Discipline	---3.35%	0.00%	0.00%	1.15%	
---Integrity	---3.35%	0.00%	0.00%	1.15%	
Others					
--- Parents Rules	---3.57%	0.00%	10.34%	4.60%	
---- Information	---0.00%	0.00%	6.90%	2.30%	
---Nothing	---3.57%	6.67%	0.00%	3.45%	

This study has revealed that the top relapse prevention services that adolescents see as help after residential treatment include: AA/NA meetings—28%, drug free school/work—28%, support—25%, positive peer support---25%, and outpatient treatment—21%. For parents, outpatient treatment---30%, Support---30%, drug-free school/work----26%, and Hobbies/structured----20%. Treatment staffs' top relapse prevention services after residential treatment were outpatient treatment –64% and Support---30%.

ASAP view will be in line with treatment staffs in the study. All of the clients that successfully graduate from the residential program are referred to outpatient treatment and parents are encouraged to provide a lot of support for consumer to succeed. The reason for this is that the local LMEs and State requires that clients be step down to a lower level of care after successful completion from an enhanced or high level of treatment. It is believed that outpatient treatment will provide both support and assist clients in working on relapse prevention plans.
However, this study has revealed the need to seriously listen and take into consideration the views of client when it comes to step down planning. Doing this will help the program, clients and the treatment team develop after treatment plans that will prevent clients from relapsing.

Program Improvements Made as a Result of the CQI Program:

As the above chart has shown ASAP made improvement on medication errors in 2014-2015 fiscal year. Training and intense supervision of staffs administering medication were implemented. Program manager directly double checked meds administered daily. Program director checks the records weekly.

Recommendations for Program Improvements in the Upcoming Year:

ASAP had an investigation for complaint clients made. The complaint was not substantiated. But during the investigation we were cited for not making the PCPS person-centered enough and limited record keeping regarding substance use by clients in our care. For the Upcoming Year ASAP staffs are determined to make our PCPS more person-centered and maintain and continue to improve record keeping regarding substance use by clients in our care.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

For the 2015—2016 monitoring, ASAP will continue with the previous year CQI monitoring since it was implemented during the third quarter of the fiscal year. This will give us one year to monitoring the plan.

Summary:
During the period of time covered by this report, the Counseling /Substance Abuse Continuous Quality improvement Committee monitored and addressed issues and events related to quality assurance during regular bimonthly meetings. The present report is indicative of a uniformly high level of quality in areas monitored, relevant to both quality of services provide to the community and the level of safety at the facility. For the upcoming fiscal year the above monitor for 2015/2016 has been identified as an important area for ongoing examination and improvement.

My Sister Susan's House

Introduction:

The following report summarizes incidents and issues addressed at My Sister Susan's House related to Quality Assurance in the provision of care at the facilities. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by Report:

This report covers the period of the time from July 1, 2014 through the close of the 2014 - 2015 Fiscal Year on June 30, 2015.

Sentinel events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events in the 2014 – 2015 Fiscal Year.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee and Youth Focus Continuous Quality Improvement Committee each met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety at MSSH. On the occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety at the facilities were monitored, and are summarized as follows:

Fire & Disaster Drills: Both live and simulated fire drills and disaster drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Executive Director. No significant deficiencies or problems were noted.

Incident Reports: During the period of time covered by this report, two incidents were tracked by means of Incident Reports completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety / Risk Management Committee. The following represents summary data for the period in question:

Client, staff or visitor requiring more than minor medical care – 2
(admission to the hospital for labor and delivery)
Client minor accident or injury, not requiring medical care – 0
Client aggressive or destructive act – 0
Client aggressive or destructive act, police involved - 0
Reaction to medication requiring medical care - 0
Adverse medication event – 0

Self-injury or suicidal – 0
AWOL – 0
Inappropriate Sexual Behavior – 0
Abuse allegation - 0

Incident Reports were reviewed throughout the year during the quarterly committee meetings.

Quarterly Facility Inspections: Quarterly inspections were conducted at the facility throughout the period. Utilities systems and equipment were monitored and reported upon regularly, the fire alarm and sprinkler system, fire extinguishers, kitchen stove hood, security system, electrical systems, and heating and air conditioning equipment. Aside from routine maintenance issues, no significant facility deficiencies were reported during the period of time covered by this report.

Public Complaints: No complaints by members of the public about the program were noted throughout the course of the year.

Employee Complaints: No complaints by employees about the program were noted throughout the course of the year

Client Grievances: Grievance Forms were available to residents and their families throughout the course of the year. No grievances were made this year.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Continuous Quality Improvement Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted My Sister Susan's House. During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted.

Performance Reviews:

Annual and probationary employee performance reviews were monitored by the Youth Focus Continuous Quality Improvement Committee on a quarterly basis. During the period of time addressed in this report six reviews of full and part-time employees were completed.

Utilization Reviews:

Total Admissions:	16
Total Discharges:	18
Total Re-Admissions:	1
Average Length of Stay:	161 days
Total Resident Days:	2899 days

Average Daily Census: 4.96 residents per day

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	0	2	2
Black	3	6	9
Native Amer.	0	0	0
Hispanic	1	1	2
Biracial	2	3	5
TOTAL	6	12	18

Services Provided:

Transitional Living Services

Services Needed but Unavailable:

None noted

Applicants Not Accepted for Service Who Were Eligible:

Total Referrals: 51

Referred Applicants Interviewed: 20 (39%)

Referred Applicants Admitted: 14 (83%)

Reasons for Non-Admission:

Inappropriate / Referred elsewhere 3

Failed to follow up / send requested info 2

Currently on Waiting List 14

Premature Termination of Services By Gender and Race:

Pattern or Relationship between variables of gender and racial identity, respectively, and services, resources, and case dispositions: None noted.

Quarterly Record Reviews

Quality Assurance reviews of open and recently closed MSSH case records were conducted on a quarterly basis. Records were reviewed as dictated by Youth Focus policy #410.

All relevant forms were present in the case records, and all ratings of assessment, treatment plan, and discharge plan content were Average or above. The prompt completion of obtaining clients' physicals have been identified as areas for improvement in the coming year. No other suggestions for improvement were noted.

Annual Consumer Satisfaction Summary:

Resident satisfaction surveys were implemented during the course of the present fiscal year as a means of assessing resident satisfaction with various aspects of their experience of the MSSH program. A survey of resident satisfaction was administered once during the course of the year. Response trends identified in the results of the resident survey served to identify potential areas for quality improvement in the program.

During this fiscal year, the highest rated items this quarter indicated that residents feel that staff treat them with respect, that they are provided with nutritious meals and snacks, and that the facility is well-maintained and clean. The lowest rated item asked if the girls were being helped to live independently.

Summary of Continuous Quality Improvement Monitor

Monitor: Client Volunteer Hours

Outcome: Data was collected throughout the course of the fiscal year regarding the number of volunteer hours completed by clients. 100% of our clients logged at least 2 hours or 25% of the required community service hours. In comparison to the baseline data we did not meet the goal of having 80% completion. The staff made an effort to support the clients in reaching this goal by researching volnteer opportunities and assisted clients in applying for volunteer positions. There was improvement in the amount of volunteer hours completed by clients because the baseline was 0. However, the goal for the clients was not close to being met this past fiscal year.

Comparative Program Study

Teen Living, a program in Chicago, is a similar program to MSSH and serves the toughest neighborhoods in Chicago. They reported that in 2014, 66% of the youth that were in the

Teen living Program successfully transitioned to permanent housing. This past fiscal year 83% of MSSH clients successfully transitioned to permanent housing.

These numbers were based on information found on Teen Living's website: http://www.tlpchicago.org/what-we-do/outcomes/

Program Improvements Made as a Result of the CQI Program:

New Requirements were put into place to make volunteering in the community a priority at MSSH. Although, we did not get the results we set out to achieve, volunteering and community involvement became a focus among the residents at MSSH. More of our clients set out to achieve the goal than in years prior.

Recommendations for Program Improvements in the Upcoming Year

Residential Record Documentation Compliance. Required client documentation for charts is not being obtained in a timely manner. All documentation needs to be collected before the client moves in or within the first two weeks of admittance.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

Monitor: Obtaining Client Physicals prior to Admittance

We must have documentation of a recent physical for clients within the first two weeks of admission to MSSH. Due to several delays in obtaining physicals for clients, we will be monitoring when physical results are obtained and when physicals are completed. We have set a goal to have clients obtain a physical before the client is admitted to MSSH.

Summary:

During the period of time covered by this report, the Youth Focus Safety/Risk Management Committee and the Youth Focus Performance Improvement / Quality Assurance Committee monitored and addressed issues and events related to quality assurance during regular quarterly meetings. The present report is indicative of a uniformly high level of quality in all areas monitored, relevant to both to the level of care provided to the residents in the MSSH program and the level of safety at the facility. A number of monitors have been identified as important for ongoing examination in the upcoming fiscal year.

Transitional Living Program

Introduction:

The following report summarizes incidents and issues addressed at The Transitional Living Program related to Quality Assurance in the provision of care at the facilities. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by Report:

This report covers the period of the time from July 1, 2014 through the close of the 2014 - 2015 Fiscal Year on June 30, 2015.

Sentinel Events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events in the 2014 – 2015 Fiscal Year.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee and Youth Focus Continuous Quality Improvement Committee each met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety at TLP. On the occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety at the facilities were monitored, and are summarized as follows:

Fire & Disaster Drills: Both live and simulated fire drills and disaster drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Executive Director. No significant deficiencies or problems were noted.

Incident Reports: During the period of time covered by this report, three incidents were tracked by means of Incident Reports completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety / Risk Management Committee. The following represents summary data for the period in question:

Client, staff or visitor requiring more than minor medical care – 1
(admission to the hospital for labor and delivery)
Client minor accident or injury, not requiring medical care – 0
Client aggressive or destructive act – 1

Client aggressive or destructive act, police involved - 0
Reaction to medication requiring medical care - 0
Adverse medication event – 0
Self-injury or suicidal – 0
AWOL – 1
Inappropriate Sexual Behavior – 0
Abuse allegation - 0

Incident Reports were reviewed throughout the year during the quarterly committee meetings.

Quarterly Facility Inspections: Quarterly inspections were conducted at the facility throughout the period. Utilities systems and equipment were monitored and reported upon regularly, the fire alarm and sprinkler system, fire extinguishers, kitchen stove hood, security system, electrical systems, and heating and air conditioning equipment. Aside from routine maintenance issues, no significant facility deficiencies were reported during the period of time covered by this report.

Public Complaints: No complaints by members of the public about the program were noted throughout the course of the year.

Employee Complaints: No complaints by employees about the program were noted throughout the course of the year

Client Grievances: Grievance Forms were available to residents and their families throughout the course of the year. No grievances were made this year.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Continuous Quality Improvement Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted The Transitional Living Program. During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted.

Performance Reviews:

Annual and probationary employee performance reviews were monitored by the Youth Focus Continuous Quality Improvement Committee on a quarterly basis. During the period of time addressed in this report five reviews of full and part-time employees were completed.

Utilization Reviews:

Total Admissions: 11

Total Discharges: 7
Total Re-Admissions: 0

Average Length of Stay: 142 days

Total Resident Days: 994 days
Average Daily Census: .87 residents per day

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	0	3	3
Black	0	4	4
Native Amer.	0	0	0
Hispanic	0	0	0
Biracial	1	3	4
TOTAL	1	11	11

Services Provided:

Transitional Living Services

Services Needed but Unavailable:

None noted

Applicants Not Accepted for Service Who Were Eligible:

Total Referrals: 67

Referred Applicants Interviewed: 12 (18 %)

Referred Applicants Admitted: 11 (92%)

Reasons for Non-Admission:

Inappropriate / Referred elsewhere	1
Failed to follow up / send requested info	0
Currently on Waiting List	8

Premature Termination of Services By Gender and Race:

Pattern or relationship between variables of gender and racial identity, respectively, and services, resources, and case dispositions: Note noted.

Quarterly Record Reviews

Quality Assurance reviews of open and recently closed TLP case records were conducted on a quarterly basis. Records were reviewed as dictated by Youth Focus policy #410.

All relevant forms were present in the case records, and all ratings of assessment, treatment plan, and discharge plan content were Average or above.

Annual Consumer Satisfaction Summary:

Resident satisfaction surveys were implemented during the course of the present fiscal year as a means of assessing resident satisfaction with various aspects of their experience of the TLP program. A survey of resident satisfaction was administered once during the course of the year. Response trends identified in the results of the resident survey served to identify potential areas for quality improvement in the program.

During this fiscal year, the highest rated items this quarter indicated that residents feel that staff treat them with respect, that they are provided with nutritious meals and snacks, and that the facility is well-maintained and clean. The lowest rated item asked if the girls were being helped to live independently.

Summary of Continuous Quality Improvement Monitor

Monitor: Follow-up Interviews

> Outcome: Data was collected throughout the course of the fiscal year regarding aftercare and the number of follow-ups at the appropriate intervals. Staff was able to complete follow-up interviews in 3, 6 and 12 month intervals at 100% when alternative methods such as Facebook, social workers, face to face contact and resource providers (with consents in place), to conduct follow-up interviews, were used. An alternative method of contact was put in place because a few of the former resident's phone numbers were no longer in service.

Comparative Program Study

> Teen Living is a similar program to TLP and serves the toughest neighborhoods in Chicago. They reported that in 2014, 66% of the youth that were in the Teen living Program successfully

transitioned to permanent housing. This past fiscal year 88% of TLP clients successfully transitioned to permanent housing.

These numbers were based on information found on Teen Living's website: http://www.tlpchicago.org/what-we-do/outcomes/

Program Improvements Made as a Result of the CQI Program:
Staying in contact with residents supported a continued relationship with clients. Checking in with client regularly gave the clients an opportunity to talk about their current needs and get referrals to services when necessary.

Recommendations for Program Improvements in the Upcoming Year

Residential Record Documentation
It is recommended to keep active client files (current and those receiving aftercare) at the TLP program for easier follow-up and documentation.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

Monitor: Follow-up Interviews

Follow-up Interviews will continue to be monitored this upcoming fiscal year to continue the high quality of care that aftercare provides to clients.

Summary:

During the period of time covered by this report, the Youth Focus Safety/Risk Management Committee and the Youth Focus Performance Improvement / Quality Assurance Committee monitored and addressed issues and events related to quality assurance during regular quarterly meetings. The present report is indicative of a uniformly high level of quality in all areas monitored, relevant to both to the level of care provided to the residents in the TLP program and the level of safety at the facility. A number of monitors have been identified as important for ongoing examination in the upcoming fiscal year.

Act Together Crisis Care

Introduction:

The following report summarizes incidents and issues addressed at Act Together Crisis Care related to Quality Assurance in the provision of care at the facility. These issues are monitored and addressed during quarterly meetings of the Youth Focus Safety / Risk Management Committee and the Youth Focus Eastside Campus Continuous Quality Improvement Committee. Further details regarding issues addressed in this report may be found in the minutes of the relevant committee meetings, which are available at Youth Focus Administrative Offices.

Period of Time Covered by the Report:

This report covers the period of the time from July 1, 2014 through the close of the 2014 - 2015 Fiscal Year on June 30, 2015.

Sentinel Events:

The occurrence of sentinel events is monitored by the Youth Focus Safety / Risk Management Committee. Sentinel events refer to any deaths, serious injuries, substantiated reports of abuse or neglect of residents by staff members, and any other incidents involving breaches of resident safety at a similar magnitude of severity. There were no sentinel events in the 2014 - 2015 Fiscal Year.

Safety and Risk Management Activities:

The Youth Focus Safety / Risk Management Committee and Youth Focus Eastside Campus Continuous Quality Improvement Committee each met on a quarterly basis throughout this period as a means of actively monitoring and addressing issues related to risk management and safety at Act Together Crisis Care. In the course of the four occasions on which each committee convened to address events and issues relevant to the time period covered by this report, numerous items pertinent to safety at the facility were monitored, and are summarized as follows:

Fire Drills: Both live and simulated fire drills were found to have been conducted on the prescribed schedule throughout the period. Reports were filed in a timely manner with the Executive Director. No significant deficiencies or problems were noted.

Facility Inspections: Quarterly inspections were conducted at the facility throughout the period. Utilities systems and equipment were monitored and reported upon regularly; including the facility emergency generator, the fire alarm and sprinkler system, fire extinguishers, kitchen stove hood, security system, electrical systems, and heating and air conditioning equipment. Aside from routine maintenance issues, no other significant facility deficiencies were reported during the period of time covered by this report.

Incident Reports: During the period of time covered by this report, twenty-six (26) incidents involving potential safety concerns were tracked by means of Incident Reports completed by staff. Patterns evident in the completed reports were monitored and addressed by the Safety / Risk Management Committee. The following represents summary data for the period in question:

1.	Runaway/AWOL less than 24 hours	10
2.	Runaway/AWOL in excess of 24 hours	2
3.	Accident or Injury	1
4.	Aggressive or Destructive Act	7
5.	Self-Harm	0
6.	Arrest/Violation of the Law	1
7.	Report of Abuse or Neglect	0
8.	Sexual Impropriety	0
9.	Search and Seizure	1
10.	Adverse Drug Events	32
11.	Hospitalizations	0
12.	Restraints	0
	Total Incidents & Restraints:	**54**

Incident Reports were reviewed throughout the year during the quarterly committee meetings.

Client Grievances: Complaint Forms were available to residents and their families throughout the course of the year. No significant deficiencies or problems were noted. A total of zero (0) Complaint Forms were completed.

Public Complaints: There were no public complaints made this year.

Employee Complaints: There were no employee complaints this year.

Credentialing and Privileging Activities:

Throughout this period, the process of credentialing and privileging staff members was conducted and monitored agency-wide by the Youth Focus Credentialing and Privileging Committee. Furthermore, the Youth Focus Eastside Campus Continuous Quality Improvement Committee reviewed on a quarterly basis the credentialing and privileging process as it impacted Act Together Crisis Care. During the period of time addressed in this report, the process of credentialing and privileging new staff members was found to take place in a timely and efficient manner, with no problems or variances noted.

Performance Reviews:

Annual and probationary employee performance reviews were monitored by the Youth Focus Eastside Campus Continuous Quality Improvement Committee on a quarterly basis. During the period of time addressed in this report, 4 full-time and 3 part-time reviews were conducted and approved.

Utilization Review:

Total Admissions:	149
Total Discharges:	147
Total Re-Admissions:	40
Total Resident Days of Service:	2,392 days
Average Length of Stay:	15.93 days
Average Daily Census:	6.55 residents per day
Safe Place Admissions:	10
Safe Place Referrals	16

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	9	24	33
Black	53	38	91
Asian	0	0	0
Hispanic	9	4	13
Other	6	6	12
TOTAL	77	72	149

Services Provided:

Emergency Crisis Care

Services Needed but Unavailable:

None noted

Applicants Not Accepted for Service:

Total Referrals: 458

Referred Applicants Admitted:	149
Applications Denied:	7
Applications Withdrawn:	316

Premature Termination of Service:

Six (6) clients were discharged from the program prior to the completion due to non-compliant and unmanageable behaviors which negatively impacted other youth in the program.

Pattern or Relationship between variables of cultural and racial identity, respectively, and services, resources, and case dispositions: None noted.

Quarterly Record Reviews

Quality Assurance reviews of open and recently closed Act Together Crisis Care case records were conducted on a quarterly basis. Records were reviewed as dictated by Youth Focus policy #410.

No high-risk interventions were noted in any of the reviewed charts. All relevant forms were present in the case records, and all ratings of assessment, treatment plan, and discharge plan content were average or above. No other suggestions for improvement were noted.

Resident Satisfaction Surveys:

Resident satisfaction surveys were implemented during the course of the present fiscal year as a means of assessing resident satisfaction with various aspects of their experience at Act Together Crisis Care. A survey of resident satisfaction was administered to each client and their parent/guardian during the course of the year. Response trends identified in the results of the resident survey served to identify potential areas for quality improvement in the program.

During the course of this fiscal year, the highest scoring item on the survey involved residents feeling safe while in care at Act Together Crisis Care. The lowest rated items addressed a reduction in stress level for the resident after bring placed at the respite facility and a decrease in feelings of social isolation for the client after receiving respite services.

Results of Continuous Quality Improvement Monitor

CQI Monitor: Impact of Social Media on Outreach Efforts.

Reason for Selection of this Quality Improvement Project: The emergency crisis shelter will be working with an intern to increase its presence in the world of social media. This will be a targeted effort using the agency's website, Facebook page and twitter account to boost community following on social media outlets in an effort to increase outreach to youth. Outreach impact will be tracked and measured by the shelter program manager and the Safe Place director. A comprehensive strategic plan for outreach through vehicles of social media is in process. Our quality improvement goal is to increase shelter outreach efforts by 100% from 94 Facebook likes to 188 in FY 2014-15.

Steps Taken To Support Improvement:

- Accept 3 additional interns for Safe Place outreach support
- Create and implement a social media resource manual/protocol
- Goal to post on the Safe Place Facebook page twice a week

Project Barriers: Intern schedules (no support during Christmas Break and Summer months) and the training/learning curve of interns

Baseline Data Time Period: July 1, 2013 – June 30, 2014

Baseline Data Results: There were 3 Facebook posts during the 2013/14 FY. The "likes" on Facebook remained between 85-95 through this time period.

Improvement Goal: Increase shelter outreach efforts by 100% from 94 Facebook likes to 188 in FY 2014-15.

Project Outcome: The quality improvement goal was met with a 116% increase, with a total of 218 Facebook likes as of June 30th, 2015.

Final Analysis / Recommendations:

The increased intern support was successful in increasing social media outreach. It is recommended Act Together continue to utilize at least two interns during the fall and spring semester to continue to maintain and increase Act Together's social media.

Comparing Outcomes with Other Programs (Benchmark Study)

For this outcome comparison, Act Together Crisis Care examined trends and performance outcomes during the 2014/15 FY. For the purpose of our comparison study, Act Together looked at gender, race, ethnicity, and "placement status discharge" trends.

Act Together Clients Served - 2014/15 FY:

Race/Ethnicity	*Males*	*Females*	*TOTAL*	*Percentage*
White	9	24	33	22%
Black	53	38	91	61%
Asian	0	0	0	0%
Hispanic	9	4	13	9%
Other	6	6	12	8%
TOTAL	77 (52%)	72 (48%)	149	

Act Together Placement Status at Discharge – FY 2014/15

128 youth out of 146 (87.7%) were transitioned to a safe and appropriate long-term placement at discharge.

In comparison, a study by the Consultation Center of the Yale University School of Medicine (March 2006) looked at trends and performance outcomes collected by the Rhode Island Department of Children, Youth & Families for emergency shelter services. The study looked at data over the course of FY2002, FY2003, FY2004, and FY2005.
The average data:

Male: 66%
Female: 34%
Hispanic: 15%
Caucasian/white: 61%
African American: 11%
Asian: 2%
Other: 11%

Discharge Status:
About 20-25% percent exit to permanency
More than half of youth change placements to another shelter at discharge

In looking at the comparison data, it is noted Act Together Crisis Care has a more balanced gender trend than reported in Rhode Island, with Act Together serving 52% males and Rhode Island serving 66%

males. It is reported that Act Together serves a much higher percentage of African American youth at 61% compared to 11% in Rhode Island. Act Together Crisis Care reported 87.7% of youth transitioned to a safe and appropriate long term placement option at discharge however, Rhode Island reported 20-25% discharged to permanency. The study did not define "permanency". Act Together defines permanency as "a safe and appropriate long-term placement" which could be the home of origin, foster home, group home, transitional living program and any other long-term placement option. Therefore, we can conclude case management efforts during placement at Act Together have been overall successful in ensuring youth transition to a long-term placement option.

Program Improvements Made as a Result of the CQI Program:

Act Together Crisis Care program manager has made increased efforts to recruit interns for staffing and administrative support. Due to the nature of shelter funding, staffing support is always a challenge. Intern support can help fill in those gaps. Increased intern support helped achieve the goal to increase social media outreach. Intern support has also provided staffing resources within the shelter providing supervision, crisis response, and facilitating groups. The program manager will continue to connect with local universities to ensure a good working relationship and intern recruiting.

Recommendations for Program Improvement in Upcoming Year

Documentation Compliance and Accuracy
Deficiencies and errors requiring staff correction in documentation in the Act Together Crisis Care client records will continue to be identified as an area to be targeted for quality improvement efforts during the upcoming fiscal year.

Enhanced Staff Training
Staff will continue to receive 24 hours of continuing education as required by DSS licensing laws. Additionally, staff will receive training to address incident reporting, professionalism and boundaries. Enhanced training will be provided in the areas of human trafficking and LGBTQ issues as these are the two population the shelter is increasingly serving.

Policy Review and Enhancement
Develop and improve policies and practices for the shelter, in partnership with the agency Executive Director, Clinical Director, and Operations Director, which are fair-minded and inclusive of the unique needs of LGBTQ, human trafficking victims, and all youth served in an emergency crisis setting.

Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year:

Monitor: The impact of inner agency communication/case management on the average length of stay for youth in the emergency shelter setting.

The Director of Clinical Services, Van Catterall, PhD will facilitate an agency wide case management staffing with all program managers/directors weekly. This will provide an opportunity for Act Together client cases to be staffed with all internal services (Outpatient counseling, Family Preservation services,

therapeutic foster care, day treatment, substance abuse services, PRTF, and transitional living). The goal of the agency wide case management meetings is to open lines of communication within the Youth Focus continuum of care. It is anticipated this will shorten the amount of time it takes to link youth at Act Together with needed services such as clinical assessments, intensive in home services, therapeutic foster placements, etc.

The meetings began on September 9th, 2015. The baseline data on "average length of stay" for youth in the crisis shelter will be June 2015, July 2015, and August 2015.

Quality Improvement Feedback Form

Please use this feedback from to provide suggestions on ways that we can make improvements in our services.

WAYS TO IMPROVE SERVICES:

ADDITIONAL SERVICES NEEDED:

OTHER COMMENTS:

NAME (Optional): _____ DATE: _____