Youth Focus, Inc.

Quality Improvement Reports

Fiscal Year 2015-16

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 this report to provide suggestions on ways to improve our services.

Youth Focus Programs Included in this Report:

Thank you.

Youth Focus Staff

Residential Treatment Center

1. 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.

2. Period of Time Covered by Report:

This report covers the period of the time from July 1, 2015 through the close of the 2015 - 2016 Fiscal Year on June 30, 2016.

3. 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 2015 – 2016 Fiscal Year.

4. 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:

A. 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.

B. Incident Reports: During the period of time covered by this report, ninety-five (95) 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:

2015-2016 Fiscal Year

1. Physical Restraints of Residents – 95
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 - 1
7. Reaction to medication requiring medical care - 0
8. Adverse medication event – 0
9. Self-injury or suicidal – 0
10. AWOL – 3
11. Inappropriate Sexual Behavior – 2
12. Abuse allegation - 2

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

C. 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 has a new oven coming shortly.

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

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

F. Client Grievances: Grievance Forms were available to residents and their families throughout the course of the year. A total of Nineteen (19) 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.

5. 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.

6. 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, 15 full-time and 13 part-time reviews were conducted and approved.

7. Utilization Reviews:

Total Admissions:	25
Total Re-Admissions:	0
Total Discharges:	24
Average Length of Stay:	131 days
Total Resident Days:	4274 days
Average Daily Census:	11.70 residents per day
Average Daily Census (Billable Days)	11.63 residents per day

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	5	5	10
Black	8	4	12
Native Amer.	0	0	0
Hispanic	0	0	0
Other	0	2	2
TOTAL	13	11	24
Race	*Males*	*Females*	*TOTAL*

Services Provided:

Psychiatric Residential Treatment Facility (PRTF)

Services Needed but Unavailable:

None noted

8. Applicants Not Accepted for Service Who Were Eligible:

Total Referrals: 117

Referred Applicants Accepted: 50 (43%)

Referred Applicants Admitted: 20 (17%)

Reasons for Non-Admission:

Clinically Inappropriate/Referred Elsewhere: 67 (57%)
Found other placement prior to bed being free: 25 (21%)

Currently on waiting list: 5

9. 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.

10. Quarterly Record Reviews

Quality Assurance reviews of open and recently closed RTC 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. 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.

11. 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 the doctor spends adequate amount of time with them, that they feel safe. The lowest rated items asked if residents got along with their peers, and feeling as though they have adequate recreation time.

12. Summary of Continuous Quality Improvement Monitor

A. Monitor: Medication Pharmacy 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 pharmacy error reports have decreased since corrective measures were put into place following the baseline period of data collection. (FY 2014-15 we had 14 medication errors and in FY 2015-16 we reduced to 8).

13. 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	69	56	13
Withdrawn / Depressed	69	59	10
Social Problems	69	60	9
Attention Problems	75	61	14
Rule Breaking Behavior	71	61	10
Aggressive Behavior	80	64	16

Youth Focus RTC – through FY 2010/2015

	Pre	Post	Diff
Anxious / Depressed	79.5	65.5	13
Withdrawn / Depressed	75.6	61.2	14.4
Social Problems	70.4	59.2	14.2
Attention Problems	75.8	61.9	13.9
Rule Breaking Behavior	76.7	57.7	19.0
Aggressive Behavior	80.5	61.0	19.5

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

14. Program Improvements Made as a Result of the CQI Program: The CQI monitor tracking medication errors by pharmacy which showed a significant decrease from the initial (14), most recently the pharmacy errors are at 8. In addition we continue to monitor medication errors by nursing staff, showed a significant decrease in medication errors following the targeted intervention. Nursing errors went down from 17 to 6. Our part time nurses continue to have training offered for medication distribution and have increased areas in which we communicate medication changes to aid in decreasing medication errors. Based upon this successful outcome, this CQI monitor has been concluded.

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

16. 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 in FY 2014/15 in efforts to collect baseline data for comparing results as interventions between the facility and the pharmacy are implemented. Over the past year pharmacy errors have been reduced from 14 to 8. We will continue to monitor in the upcoming year in efforts to reduce these errors further. Monthly summary data on incidents will be presented during each quarterly meeting of the Eastside Campus Continuous Quality Improvement Committee.

17. 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

1. **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.

2. **Period of Time Covered by the Report:**

This report covers the period of the time from July 1, 2015 through June 30, 2016

3. **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.

4. **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:

G. 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.

H. 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.

I. 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 – 14
2. Client AWOL – 28
3. Client emergency evaluations for suicidality-9
4. Client medication error-1
5. Client property destruction-3
6. Abuse Allegation-3
7. Client AWOL from another program-1
8. Client destructive behaviors-2

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

J. 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.

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

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

5. **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.

6. **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.

7. **Utilization Review:**

Total Admissions: 24

Total Discharges: 29
Total Students Served: 41
Average Daily Census: 14.21

Students Served (New Admissions):

Race	*Males*	*Females*	*TOTAL*
White	15	1	16
African-Am	6	2	8
Native Amer.	0	0	0
Hispanic	0	0	0
Other	0	0	0
TOTAL	21	3	24

8. 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.

9. Premature Termination of Services by Gender and Race

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

10. Quarterly Record Reviews

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.

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

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. The below average score in the area of client's ability to function after discharge is due to the number of parents who completed the survey with kids who had not yet returned to their school.

The average score for the parent/guardian satisfaction surveys was 3.9 for the 2015-2016 FY.

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

"Job well done. Great school and staff, they care about their students"

"Mell-Burton has things in place but client not using resources"

"Have only had one call from the school since my child returned to public school"

"Mental health techs not appropriately trained"

12. Results of Continuous Quality Improvement Monitor:

CQI Monitor: Medication Error Reduction by Administering Medication as Prescribed

Reason for Selection of this Quality Improvement Project: Despite of the new protocols set into place last fiscal year involving the designation of one identified medication administrator and other checks we continue to have medication errors.

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.
- A designated staff member was assigned to administer medication to clients in the event that the lead medication administrator was absent one day.

Project Barriers:

As during the previous fiscal year, one of the barriers that we've experienced this quarter is that we have not had the medication on hand in the program to administer to the client at the time medication is prescribed. During the fourth quarter the above listed barrier continue to be in place. One of the medication errors involving not having the medication on site involved our client who is transitioning during the middle of the day and getting the medication here presented a challenge.

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Baseline Data Time Period: July 1, 2015 – September 30, 2015(1st quarter)

Baseline Data Results: There were 3 medication errors during this review period.

Improvement Goal: Medication will be administered as prescribed with 0 staff errors.

Project Outcome:

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 2016-2017.

Final Analysis / Recommendations:

Based on the data collected there is evidence to suggest that overall staff error has been minimized after the implementation of the new medication administration procedures. The assignment of this duty to one staff member has helped reduce this number during this fiscal year. Unfortunately, the inconsistency in errors related to no having medication readily available on the premises continue to account for a number of the errors. A number of different procedures/steps have been implemented to address this issue but due to the population served it is apparent that this will continue to be a challenge. At this time, there appears to be a

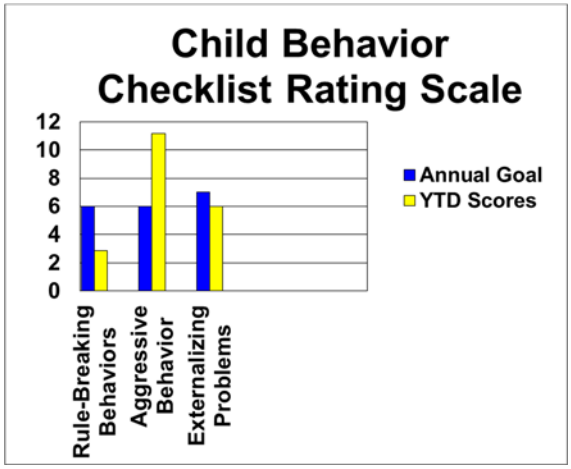
significant improvement in the medication administration process and a new CQI monitor will be evaluated next fiscal year.

13. 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 at least two 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 2015-2016 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 an improvement in the subcategories Rule-Breaking Behavior – 2.9; Aggressive Behavior – 11.2 ; Externalizing Behavior – 6.0. Significant improvement was made in aggressive behavior. It should also be noted that there were several clients admitted in late April and May and post- test have not yet been completed due to the shortened length of treatment. There were several clients who were served who did not have post test scores as there was a month or less of treatment.

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



14. Program Improvements Made as a Result of the CQI Program

During this fiscal year as in previous fiscal years, we have continued to see a high number of high acuity clients. The mental health symptoms of the clients this fiscal year have intensified significantly as the year progressed. As a result of this we had a significant increase in AWOLs of clients that resulted in multiple police contacts and a rise in incident reports for these issues. As a result, we were able to put into place new strategies/interventions for addressing this issue and rewarding those clients who were able to remain on campus. In addition, we updated the behavior system to increase the rewards clients received for positive behaviors.

15. 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 that the needs of the client, their home school and the Mell-Burton program. At the end of the this fiscal year we have made progress towards this continued challenge and have begun the discussion of specific discharge criteria for clients that are agreed upon by both Mell-Burton staff and Guilford County Schools. In addition to this, there has been consideration in updating/revising the current behavior system.

16. Continuous Quality Improvement Monitor to be Addressed in the Upcoming Year

Due to the continued increase in high acuity clients and the rise in number of AWOLs by clients we will monitor this in the upcoming 2016-2017 fiscal year. Our goal will be to have no more than 15 AWOLs this fiscal year. This will be addressed through the recent strategies implemented this current fiscal year as well as improving the crisis response by staff.

17. 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 2016/2017 has been recognized as an important area for ongoing examination in the upcoming fiscal year.

Mell-Burton Structured Day Program

1. **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.

2. **Period of Time Covered by the Report:**

This report covers the period of the time from July 1, 2015 through June 30, 2016.

3. **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.

4. **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 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:

A. 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.

B. 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.

C. 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.

D. Incident Reports: During the period of time covered by this report, twenty-five (25) 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 – 3
2. Client, staff or visitor requiring more than minor medical care - 0
3. Client minor accident or injury, not requiring medical care – 0
4. Client aggressive or destructive act; resulting in suspension – 18
5. Client aggressive or destructive act, police involved - 1
6. Client AWOL- 2
7. Medication error - 0
8. Allegation of abuse of client - 1

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

E. Resident Complaint Forms: Grievance Forms were available to clients and their families throughout the course of the year. There was one grievance filed this year.

5. **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.

6. **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, 10 full-time reviews were conducted and approved.

7. **Utilization Review:**

Total Admissions: 83

Total Discharges: 79

Total Students Served: 105

Average Daily Census: 24.66 per day

Students Served (New Admissions):

Race	*Males*	*Females*	*TOTAL*
White	18	4	23
African-Am	46	10	56
Native Amer.	0	0	0
Hispanic	3	0	3
Other	2	0	2
TOTAL	69	14	83

Applicants Not Accepted for Service:

Total Referrals:	136
Referred Applicants Admitted:	83 (61%)

Early Termination of Service:

Total: 5 clients

8. **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.

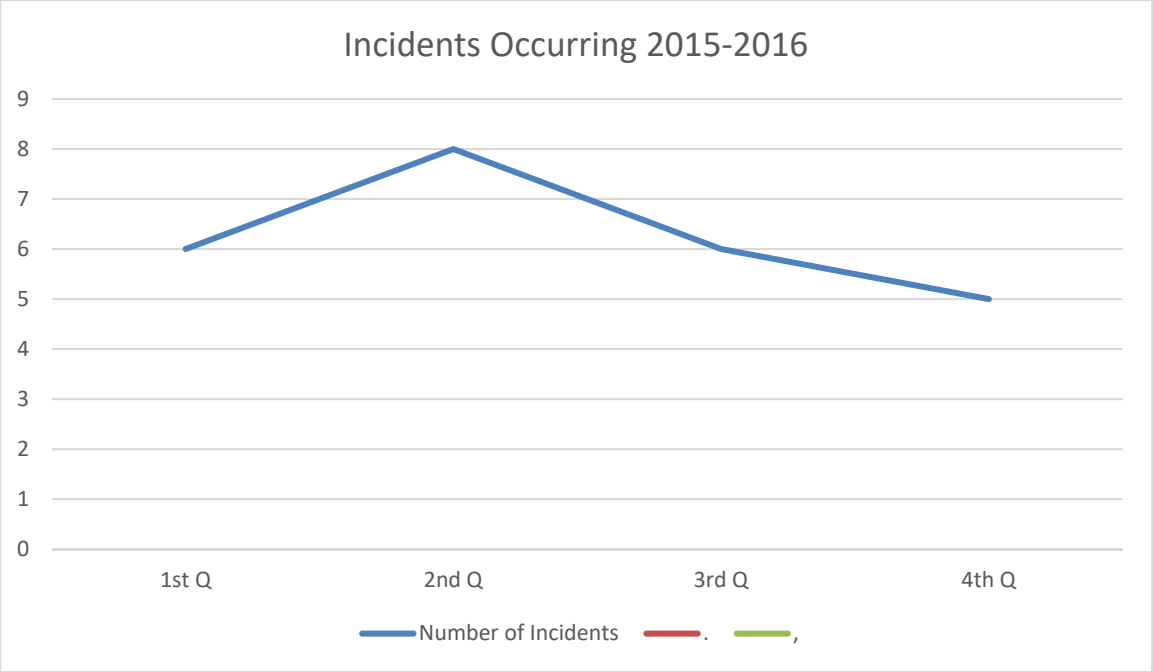
9. **Results of Continuous Quality Improvement Monitors:**

1. Monitor: 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.

A. Quality Improvement Goal: Critical incidents will decrease by at least 5% each quarter as more trainings and new interventions are discussed with staff. Quarterly goal of successful completion of the program will be met.

B. Reason for Selection of this Monitor: The trauma our clients face has been more prevalent in recent times do to PRTF step downs and other more intense services being denied as a result of lower level of care services needing to be tried first.

C. Project Outcome (include data): Client incidents decreased 3 out of 4 quarters with our last quarter having the lowest amount of incidents.



10. Consumer Satisfaction Summary

Survey Findings Summary:

A parent/guardian survey was attempted with 50 former parents. Of the 50 attempted, 32 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. 4.27

2. Staff is appropriate in their interactions with children. 4.39

3. Staff utilizes appropriate interventions with children. 4.09

4. My child's progress towards IEP goals has improved since admission into Structured Day. 3.48

5. My child's ability to engage in appropriate problem solving has improved since admission. 3.60

6. My child's ability to interact with others has improved since admission. 3.63

7. My child's ability to function in public school after attending Structured Day has increased. 3.12

8. There is adequate communication between myself and staff regarding my child's progress in the program. 4.36

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. The amount of parents surveyed increased from last year as a result of attempting to contact parents more often throughout the year instead of all at one time.

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

1. I get enough to eat. 2.9

2. I think the food is good. 3.1

3. School staff responds when I need help or support. 3.7

4. I feel that I am getting a good education. 3.9

5. I feel like the program has good recreational activities. 3.6

6. The therapist (Ms. Sarah, Ms. Megan) is available if I need her. 3.7

7. (Ms. Shawn/Ms. Michelle) is available if I need her. 3.4

8. The building is clean and looks nice. 2.7

9. Staff likes me. 3.7

10. I am able to do better here than I did at my old school. 3.9

11. I understand the point and level system. 4.1

12. I am learning how to get along with other people. 3.4

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 from last year was that they feel as though they do not get enough to eat and that they don't think the food is good. This has improved due to changing where we get lunches from. The lowest score was from thinking that the building is clean and looks nice. A new janitorial service has started which should help improve this and other cosmetic changes to the program will be made.

Possible ways to Improve Services Based on Survey Findings:

The lowest score relates to the building being "clean and looks nice". A new janitorial service has started which should help improve this and other cosmetic changes to the program will be made such as new window treatments and new carpeting.

11. Program Improvements Made as a Result of the CQI Program:

- New staff have been trained and ready to assist in periods of crisis or high acuity
- Staff meetings were increased to once per week (when possible) to address teamwork and consistency when dealing with difficult clients with complex trauma histories
- Trauma informed care became focal point of many staff meeting discussions and trainings

12. Monitor to be Addressed in the Next Year:

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. Utilize different interventions/rewards/consequences within this new framework to decrease early terminations from services from 5 discharges last year.

13. 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 2015 - 2016 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.

14. Recommendations for program improvement:

Addressing the Quality Assurance Monitors noted above 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.

15. 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 2016-17 have been recognized as an important area for ongoing examination in the upcoming fiscal year.

Therapeutic Family Services

1. Introduction: The following report summarizes incidents and issues addressed in the Therapeutic Family Services Program in the provision of services. These issues are monitored and addressed during quarterly Continuous Quality Improvement (CQI) meetings.

2. Period of Time Covered by Report: July 1, 2015-June 30, 2016.

3. Sentinel Events: none.

4. 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. Reports were filed with the Executive Director in a timely manner. No significant issues or problems were noted. In addition, the TFS office conducted 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 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: 4

(2) Minor Injury of Clients: 0

(3) Staff Injury: 0

(4) Property Destruction: 1

(5) Contraband/Weapons: 0

(6) Medication Administration Errors: 3

(7) Runaway: 6

(8) Psychiatric Hospitalizations: 2

(9) Medical Hospitalizations: 0

(10) Client Arrest: 0

(11) Allegations against foster parents: 1

(12) Client reporting suicidal ideation/ or other self-harm: 3

(13) Police involvement due to client behavior: 4

(14) Other-1 (inappropriate sexual activity by client)

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

D. Resident Complaint Forms: Grievance Forms were available to clients and their families throughout the course of the year. No complaints were received this year.

5. 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 TFS.

6. Performance Reviews: Four performance reviews were conducted by the program director in June/July 2016: full time case manager, full time recruiter and two contract case managers.

7. Utilization Review: Utilization rates were as follows for this reporting period:

Total admission: 15

Total discharge: 16

Total resident days: 3039

Average daily census: 8.3

Clients served breakdown: race/gender: 21

Female: (total: 14) Caucasian: 9, AA: 3, H: 2, other:

Male: (total: 7) Caucasian: 3, AA: 2, H: 2

8. Applicants Not Accepted for Services Who Were Eligible: 84 referrals were not accepted into the program during FY 2015-2016. The primary reason children were not accepted was due to a lack of available homes or lack of an appropriate match with a Youth Focus home. Other reasons included placement being found with another agency, client being referred to a higher level of care, or family changing their mind about placing the child into foster care.

9. Premature Termination of Services by Gender and Race: none.

10. Quarterly Record Reviews: A number of missing documents were discovered, including missing discharge summaries. Several forms had not been witnessed. The accreditation process brought out that traditional foster clients have not had treatment plans developed. In addition, quarterly supervisory review of files has not been occurring.

11. Annual Consumer Satisfaction Summary:

Out of 13 clients who discharged during this fiscal year, the program was able to collect 5 surveys from legal guardians and 5 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.)

There were a significant percentage of responses that were positive on the 10 surveys that were returned with some notable exceptions.

SATISFACTION SURVEY ITEMS: Client Survey: 5 were completed. Average response is noted after each item.

1.) I am comfortable sharing personal information about my life with the Youth Focus TFS staff and case manager. 3.8

2.) I believe that the TFS staff and case manager listen to me and my opinions. 4

3.) I am comfortable talking to my foster parents about my problems. 3.2

4.) I can tell my foster parents when my feelings are hurt. 3.8

5.) I enjoy living in the TFS home. 3.4

6.) I like the school I am attending. 5

7.) I feel safe in my foster home. 4

8.) My basic needs (care, clothing, regular meals, and a place to sleep & bathe) are taken care of in my foster home. 4.6

9.) I am in better control of my behavior and feelings since I've been living with my foster family. 4.2

10.) I know I can ask an adult on my team if I need help. 4.4

Average response score: 4.04

Responses from clients were typically varied. The client who gave the lowest marks was the client who, in the opinion of the Program Director, was given the best services by a very dedicated foster family. Lower scores in item 3 related to feeling comfortable talking with foster parents about problems is an area of concern.

Referral Sources – Legal Guardians: 5 surveys were completed. Again, average response is noted after each item.

1.) The TFS staff is available to answer questions and/or address any concerns. 4.8

2.) The TFS staff and foster family treat the child with respect and dignity. 4.2

3.) The TFS staff & foster family are available and ready to help with the child when necessary. 4

4.) I feel involved in the child's service planning process. 4.4

5.) I feel the child's designated problem areas are addressed in the services received. 4.6

6.) I am satisfied with the overall referral process for admission. 4.8

7.) I am satisfied with the communication and feedback given to me by the TFS staff and foster family. 3.8

8.) I am satisfied with the information I receive on the child's progress by TFS staff. 4.8

9.) I am satisfied with the level of professionalism displayed by the TFS staff. 4.6

10.) I am satisfied with the overall quality of the services provided by the TFS staff. 4.6

11.) I would recommend this service to a friend or co-worker who is looking for a foster care placement. 5

Average response score: 4.51

Responses were generally good from referral sources. One referral source was particularly unhappy with a foster family that the agency has since made a decision to request revocation of their license. Item 7 is an area of concern as 2 referral sources were not very satisfied with communication from the agency and the foster parents.

Foster parents: 7 surveys were completed. Average response is noted after each item.

1. The foster care staff is available to answer questions and/or address any concerns. 4.3

2. I am satisfied with the communication and feedback given to me by the foster care staff. 4.7

3. I am satisfied with the level of professionalism displayed by the foster care staff. 4.4

4. I feel that my foster care case manager supports me and the children in my care equally. 4.7

5. The foster care after-hours on-call system adequately serves my after-hours needs. 3.3

6. The foster care staff takes care to match a therapeutic foster child’s needs with what best fits my family and skills. 4

7. The foster care staff advocates for me with the birth family/legal guardian and other professionals on my child’s team. 4.1

8. The foster care program offers training that is informative and relevant to my job as a foster parent. 4.6

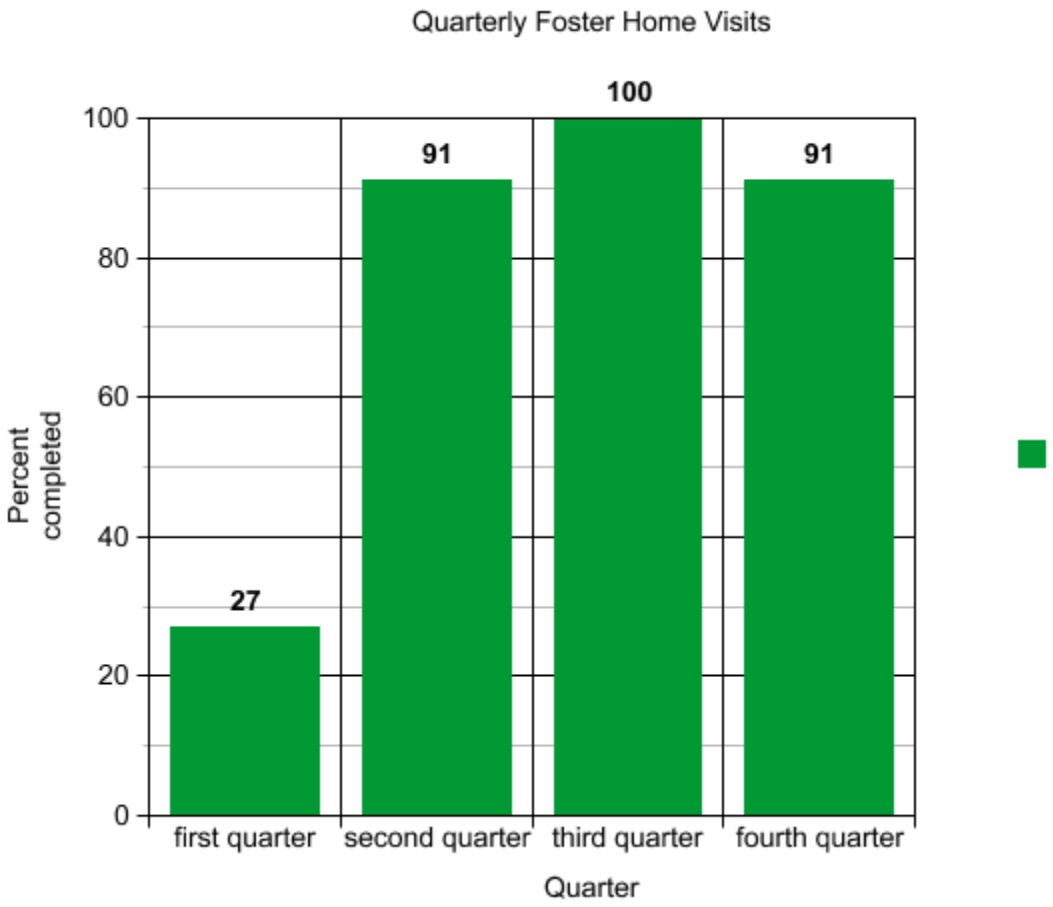
9. I am satisfied with the overall quality of the services provided by the foster care staff. 3.6

10. I would recommend Youth Focus to a friend or co-worker who is interested in becoming a therapeutic foster parent. 4

Strong areas of satisfaction are communication by staff, support for foster parents and foster children equally, and relevant training. Areas of low satisfaction are the on-call after-hours system and the overall quality of the services provided by the foster care staff. Recruiter Julia Perdue will be speaking with foster parents during her next round of quarterly visits to gather more specifics related to the lower scoring items.

12. Summary of Continuous Quality Improvement Monitor:

The issue of failing to complete quarterly visits with existing foster parents has been resolved. The foster care recruiter, who was began work in September 2015, has put a system in place that is effectively tracking the situation and the visits are being completed. For FY 2015-2016, 34 out of 44 quarterly visits were completed, or 77%. This data includes the first quarter, when the recruiter began her employment. First quarter results, prior to the new system for tracking, were only 3 out of 11 visits completed. Since the first quarter, 31 out of 33 quarterly visits were completed on time. Efforts were made to complete all 33 visits but in two instances, the foster families did not respond to requests to schedule, despite a number of attempts made to do so. Quarterly visits have been consistently completed over the final three quarters of FY 2015-2016 with 94% completion. There is a system in place to track the completion of these visits and a staff member dedicated to the task. Recommend this improvement project be discontinued at this time.



13. Comparative Program Study:

The NC Topps website is used by the state to evaluate outcomes for the clients served by the different programs. The site allows a comparison to be made between Youth Focus therapeutic foster care outcomes on selected measures and performance of other providers around the state who also provide therapeutic foster care services. Interviews are conducted upon entry into treatment, every three months in treatment, and post treatment. For this report data was compared from the entry into treatment until the three month point for the following four measures: Hospital Emergency Department visits (percentage of clients who had visited the emergency department three months prior to service), Severity of Mental Health Symptoms (percentage of clients who reported mental health problems to be "none" or "mild"), Presence of Suicidal Thoughts (percentage of clients who reported experiencing suicidal thoughts), and Suspension/Expulsions from school (percentage of clients who reported suspensions/expulsions from school in the three months prior to treatment). The data is divided into child and adolescent populations:

Adolescents:	State Initial	State 3 month	Youth Focus Initial	Youth Focus 3 month
ED visits:	13.9	10.7	25	25
MH Symptoms:	26.2	30.1	0	20

Suicidal Thoughts: 16.6		8.5	25	50
Suspensions:	26	31.2	25	25

Children:	State Initial	State 3 month	Youth Focus Initial	Youth Focus 3 month
(Only one child fell into this category for Youth Focus)				
ED visits:	11.3	9.1	0	0
MH Symptoms: 9.6		12.6	0	0
Suicidal Thoughts: 27.8		14.9	100	0
Suspensions:	24.4	18.8	0	100

Due to low numbers, it is difficult to draw many conclusions from this data.

14. Program Improvements Made as a Result of the CQI Program: Youth Focus has made several changes based on CQI this year. One would be to make more intentional efforts to collect satisfaction surveys from clients, referral sources, and foster parents. A second is to look more closely at foster parent practices to secure prescription medication. The Youth Focus recruiter has inspected each foster parent's current lockbox as well as how they are using a second lock in some fashion to make sure medication is secure. As part of this process, Youth Focus has provided a number of lockboxes when needed by foster parents. Finally, in looking at a pattern of incident reports and other issues, such as frequent moves of clients placed in their home, Youth Focus made the decision to request revocation of one foster home license, as we did not think that this particular home was demonstrating commitment to provide a positive environment for clients or properly supervising some of the clients placed in their care.

15. Recommendations for Program Improvements in the Upcoming Year: TFS will continue to implement a new evidenced base practice for therapeutic foster care called Together Facing the Challenge during FY 2016-2017. TFS staff were trained in the program in February 2016 and the initial round of training for foster parents took place from April 2016-July 2016. The next step is incorporate the concepts into daily practice through the weekly and monthly case manager visits with each family. Implementing Together Facing the Challenge will significantly improve the quality of our foster care services.

16. Continuous Quality Improvement Monitor to be addressed in the Upcoming Year: In lieu of the database that was previously being used to track client file documents, the foster care program has created an excel spreadsheet that tracks both admission and discharge paperwork, as well as ongoing monthly paperwork for each client. TFS will track the completion of the spreadsheet at admission, discharge, and each month that the child is in care with the goal of 100% accuracy for file documents.

17. Summary: The Youth Focus Therapeutic Foster care program has made much progress during this past fiscal year. The program has been through DSS relicensure and is currently going through COA

reaccreditation. As a result, the program has put in place a number of processes to better meet requirements and to provide better services to clients. The current CQI monitor is a good example of an improved system for tracking quarterly foster home visits, which has led to the visits being completed consistently. Satisfaction surveys, outcome data, and incident reports are all being regularly obtained, which helps the program to monitor our services more effectively.

Family Preservation Program (Intensive In-Home Services)

1.**Introduction**: Youth Focus continued to provide Intensive In-Home (IIH) services this year. These services were provided to children at imminent risk of out-of-home placement due to emotional and/or behavioral problems. During the 2015-2016 year the IIH program experienced a number of staffing changes. The program initially had three teams, however, after the resignation of one full time therapist and one contract therapist, the program operated from November 2015 to the end of the year with two teams. The program operated with contract QP staff throughout the year until the decision was made at the end of the fiscal year to add one full time QP to each team. The program currently consists of two full time masters trained and licensed team lead clinicians, two bachelor level full time QP staff, one contract therapist and two additional contract QP staff.

2. Period of Time Covered by Report: Fiscal Year 2015-2016.

3. Sentinel Events: There were no sentinel events in FPS this year.

4. 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 IIH 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**: Fire drills were conducted at the Bardolph office on a quarterly basis. Reports were filed with the Executive Director in a timely manner. No significant issues or problems were noted.

B. **Facility Inspections**: Facility inspections at the Bardolph 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**:

There were 10 incident reports made by FPS this past year.

1. 7/26/15: Client engaged in inappropriate sexual behavior with a younger sibling.
2. 10/16/15: Police were called due to client stealing at Walmart.
3. 10/21/15: Physical aggression of client towards parents.
4. 11/6/15: Physical aggression of client towards parents.
5. 12/9/15: CPS report after a physical altercation between a client and a parent.
6. 2/18/16: Client run away from home.
7. 2/10/16: CPS report made alleging client and parent were smoking marijuana together.
8. 3/8/16: IIH therapist had to physically stop an angry child from running into the street.
9. 5/9/16: Client admitted to inpatient psychiatric unit for suicidal ideation.
10. 5/29/16: Client was cut on her hand after an altercation with her older brother.

Each incident was reviewed by the program director and handled appropriately by IIH staff.

D. **Resident Complaint Forms**: 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 fiscal year.

5. 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 IIH. The database was very instrumental in tracking licensing concerns (training, renewals, etc.).

6. Performance Reviews: The IIH program director completed performance reviews on four full time and three contract staff in June 2016.

7. Utilization Reviews: FPS served 27 new families during this past fiscal year. 11 cases were open at the beginning of the fiscal year, for a total of 38 families served. The goal for the year was to serve 60 families. This goal was not met, partially due to the program decreasing from 3 teams to 2.

Break down by gender and race:

Caucasian male: 9

African American male: 13

Hispanic male: 1

Middle Eastern male: 1

Caucasian female: 6

African American female: 3

Hispanic female: 2

Asian female: 2

Biracial female: 2

Breakdown by age:

Under 7: 1

7-9: 4

10-13: 13

14-17: 20

8. Applicants Not Accepted for Services Who Were Eligible: Youth Focus had a wait list for services throughout much of FY 2015-2016. Eleven referrals who were potentially eligible for Intensive In-Home services were not served by Youth Focus due to no available clinician or due to the length of time they would have had to be on the wait list. Nine of these referrals indicated they were pursuing services with other agencies. One was unable to be served due to the family being Spanish speaking.

9. 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.

10. Quarterly Record Reviews: Quarterly record reviews were completed. A total of 33 records were reviewed this year. Most deficiencies continue to be related to incomplete documentation. A pattern of team members not completing their filing in a timely fashion was discovered and expectations for filing have been reiterated. One file was missing a discharge summary. There were several instances of files not being completed for case closure, such as the post services NCFAS scale.

11. Annual Consumer Satisfaction Summary

The Intensive In-Home 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. Fifteen surveys were returned this 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)?

(93% 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?

(93% 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?

(100% 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?

(93% 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?

(93% of the responses to this item are “very satisfied” or “satisfied”)

Overall, 96% of responses fell into the “very satisfied” or “satisfied” range.

12. 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:

Intensive In-Home Therapists have historically been 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 IIH 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. The results were not good, as only 58% of NC Topps interviews were submitted on time. Significant problems were had in getting the initial NC Topps interview, for which there is no email reminder, on time. The monitor was continued for FY 2015-2016.

Steps Taken to Support Improvement:

- Staff continued to receive email reminders of pending NC Topps interviews that were due. This included both the therapist and the program director.

- NC Topps completion was made a part of the intake process and added to the case opening check-sheet.

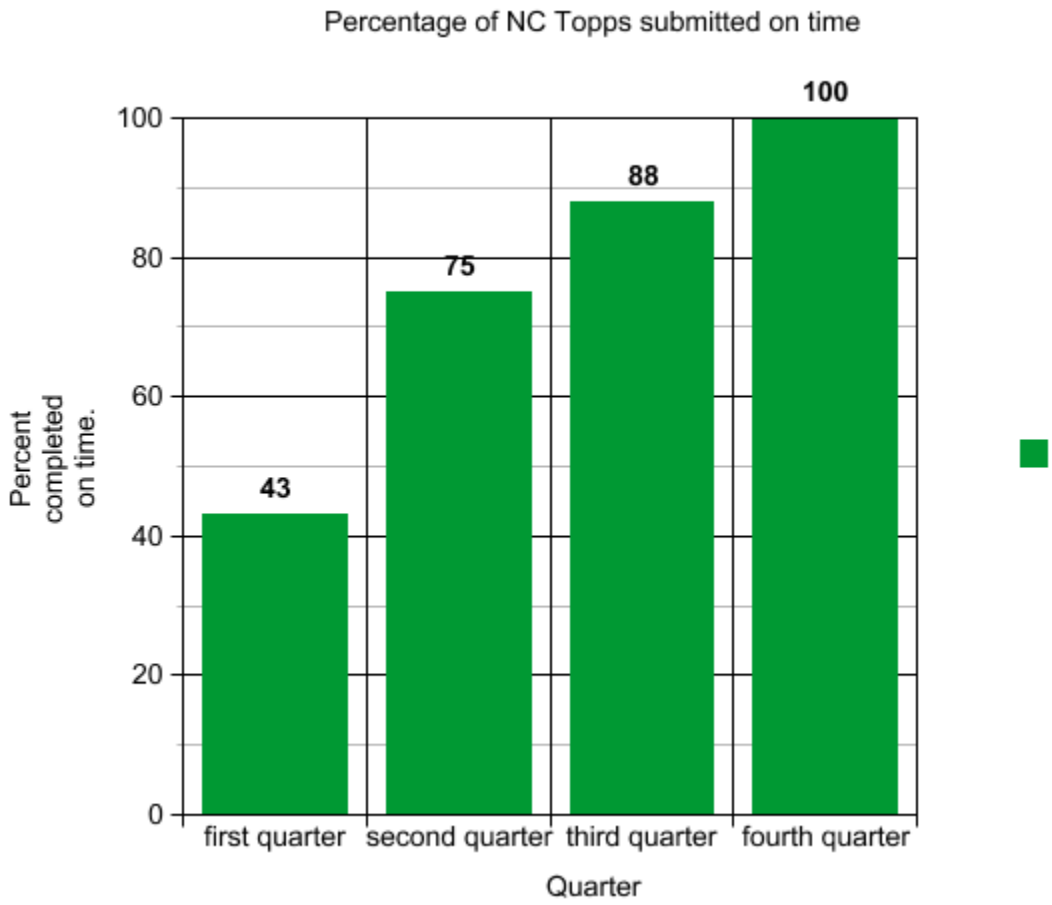
Project Barriers: None.

Baseline Data Time Period: July 1, 2014 – June 30, 2015

Baseline Data Results: 58% of NC Topps interviews were submitted on time.

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

Project Outcome:



The quality improvement goal was met by the fourth quarter. On time completion increased throughout the year and reached 100% by the fourth quarter.

Final Analysis / Recommendations: : NC Topps compliance has been the focus of our CQI monitor for the past two years and, as can be seen from the data above, the percentage of completion has dramatically risen during this past year. The interviews that were not done within the required timeframes were almost

all initial interviews for new cases. Therapists are now conducting the initial NC Topps interview as part of the intake process, which seems to have helped in getting the interview submitted on time. Recommend that this CQI monitor be discontinued at this time.

13. Comparative Program Study:

The NC Topps website is used by the state to evaluate outcomes for the client's served by the different programs. The site allows a comparison to be made between Youth Focus IIH outcomes on selected measures and performance of other providers around the state who also provide IIH services. Interviews are conducted upon entry into treatment, every three months in treatment, and post treatment. For this report data was compared from the entry into treatment until the three month point for the following four measures: Hospital Emergency Department visits (percentage of clients who had visited the emergency department three months prior to service), Severity of Mental Health Symptoms (percentage of clients who reported mental health problems to be "none" or "mild"), Presence of Suicidal Thoughts (percentage of clients who reported experiencing suicidal thoughts), and Suspension/Expulsions from school (percentage of clients who reported suspensions/expulsions from school in the three months prior to treatment). The data is divided into child and adolescent populations:

Adolescents:	State Initial	State 3 month	Youth Focus Initial	Youth Focus 3 month
ED visits:	24.9	15.1	0	0
MH Symptoms:	18.9	29.1	18.8	18.1
Suicidal Thoughts:	33.1	16.5	33.3	7
Suspensions:	37.4	28.4	50	42.9

Children:	State Initial	State 3 month	Youth Focus Initial	Youth Focus 3 month
ED visits:	14.6	8.8	16.7	16.7
MH Symptoms:	8.5	23.6	0	0
Suicidal Thoughts:	25.8	12.3	50	0
Suspensions:	32	22.9	62.5	37.5

Several things stand out: Youth Focus' adolescent clients showed a significant decrease in suicidal thoughts. Both adolescent and child clients showed a decrease in suspensions.

14. Program Improvements Made as a Result of the CQI Program: One area of improvement is program compliance with NC Topps submissions, which has improved with the focus placed on that by the CQI monitor. A second area of improvement refers back to a recommendation from the FY 2014-2105 recommendations for improvement. The IIH program has struggled with being able to assess, authorize, and initiate new cases in a timely fashion. Specific numbers were not compiled, but the length of time it has taken our program from the date a referral was received to the date services were initiated was, in almost all instances, over a month. Efforts were made to change this process but little improvement was achieved in being able to serve families more quickly. After agency discussion, a decision was made to utilize a half time clinician to focus solely on completing intake assessments and initial authorizations. That staff member began working on 7/1/16. It is hoped that having a dedicated staff member to perform this role will allow therapists to focus on serving their clients, while significantly shortening the time that families are waiting for services.

15. 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 is completion of the program checklist for both case opening and case closure activities. Keeping program files in order has been a challenge, particularly when teams consisted of multiple contract workers. By focusing on the use of the program checklist it is hoped that all required activities will be completed in a timely fashion.

A second is the adoption of a new service delivery model that will include an evidenced based model called the Strengthening Families Program, as well as a more laid out method of service delivery that will ensure that key service areas are covered in an organized fashion. This includes a renewed focus on a working safety plan for the family, as well as efforts to develop key protective factors that have been identified as important for families of at risk children.

16. Continuous Quality Improvement Monitor to be addressed in the Upcoming Year: Program director would like to track the completion of the program checklist for FY 2015-2106. This will ensure that key activities for both opening and closing cases are completed on time. Program director will review all files quarterly with a goal of 100% use of the checklist and completion of each item within two weeks of case opening and case closure.

17. Summary: The Intensive In-Home program has continued to undergo significant changes during FY 2015-2016. Two long time employees left the program, one a full time therapist and one a contract therapist. The number of teams decreased from three to two. The program continues to struggle with being able to authorize new cases in a timely fashion. At the end of FY 2015-2016, two new full time QPs were added to the program. A part time clinician has also been added who will only work to complete assessments and initial authorizations. Services to the families involved in the program continue to be strong, as is evidenced by positive satisfaction survey results.

Outpatient Counseling

1. 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 five masters trained and licensed therapists from different disciplines providing mental health counseling some percentage of their time; 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. 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.

2. Period of Time Covered by Report:

This report covers the period of the time from July 1, 2015 through the close of Fiscal Year on June 30, 2016.

3. 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 2015 - 2016 Fiscal Year.

4. 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:

K. Fire & Disaster Drills: Staff in Youth Focus offices conducts monthly safety inspections, documents them and forwards this documentation to the safety director.

L. Incident Reports: There were no incident reports in the outpatient counseling program in the 2015-16 year.

M. 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 an Assistant Director. 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.

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

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

P. 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.

5. 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.

6. Performance Reviews:

Annual and probationary employee performance reviews were completed by supervisors and directors in the Outpatient Program for the 2015-16 year. During the period of time addressed in this report, 4 full-time and 1 part-time reviews were conducted and approved.

7. Utilization Reviews:

The Outpatient Counseling Program provided individual, family and group treatment services to 491 new clients during the reporting period. Along with the carry-over of clients from the previous fiscal year Counseling served a total of 647 clients.

There are three component programs that fall under Outpatient:

1) Psychological testing: 39 psychological evaluations were conducted this year.
2) Active Parenting of Teens: 29 parents participated in the parent groups this year.

3) Future Focus Social Skills: 55 clients were served in the social skills groups.

8. 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.

9. 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.

10. 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: 84
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. Client notes are no longer printed so they are not located in the files. They are completed now in a much more timely manner, but harder to check because you have to log on to Echo and access each client's account to check for notes.

11. Annual Consumer Satisfaction Summary:

Over the course of the 2015 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, 39 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 90 % of respondents expressed satisfaction with six components of the intake process. When asked of their overall satisfaction of Youth Focus services thus far, 87% of respondents rated services as above average. Regarding recidivism, of those responding

with an opinion, 77% felt that their child showed improvement at the time of response. Finally, 92% 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 14 comments, all were considered positive or constructive. Some of the comments and recommendations are as follows:

"I think Youth Focus does a wonderful job. However, it's up to the child if they are going to change for the better."

"More time with the kids doing the talking and listening."

"Have a way for parents to speak with a counselor."

"Thanks a lot."

"Our son was not ready to admit he has a problem. This is the place I will contact once he does."

"Would rather have after work hours available instead of during work hours."

"Thanks for y'alls help."

12. Summary of Continuous Quality Improvement Monitor

A. Monitor: Client Attendance/Engagement
B. Quality Improvement Goal: Increase client attendance by 20%
C. Reason for Selection of this Monitor: Increasing attendance will prove to help the counseling program on two continuums; developing more invested clients and increasing billables. Clients who attend sessions regularly and are engaged in counseling are likely to be more successful in reaching their goals. Additionally, as the counseling program has had cuts in funding this year, it is of increasing importance for therapists to fill their schedules with billable hours. Most of the time, schedules are filled, but clients who are scheduled don't always keep their appointments.
D. Baseline Time Period: July and December of 2015
E. Baseline Data Results: From July to December, 1,622 clients were scheduled. Of the 1,622 clients, 1148 of these clients were seen for their scheduled appointments. Therefore, 71% of our clients from July to December kept their appointments with us.
F. Steps Taken this Quarter to Support Improvement: This quarter we continued with incentives for active clients. Clients earn points for participation, being on time, good behavior reports, etc. Therapists tabulate points at the end of each session and with their total points, clients can earn a treat or save points to buy a bigger treat on a following session. We are positively rewarding clients to keep them motivated to keep appointments. Also, therapists continue to enter attendance data into our database daily

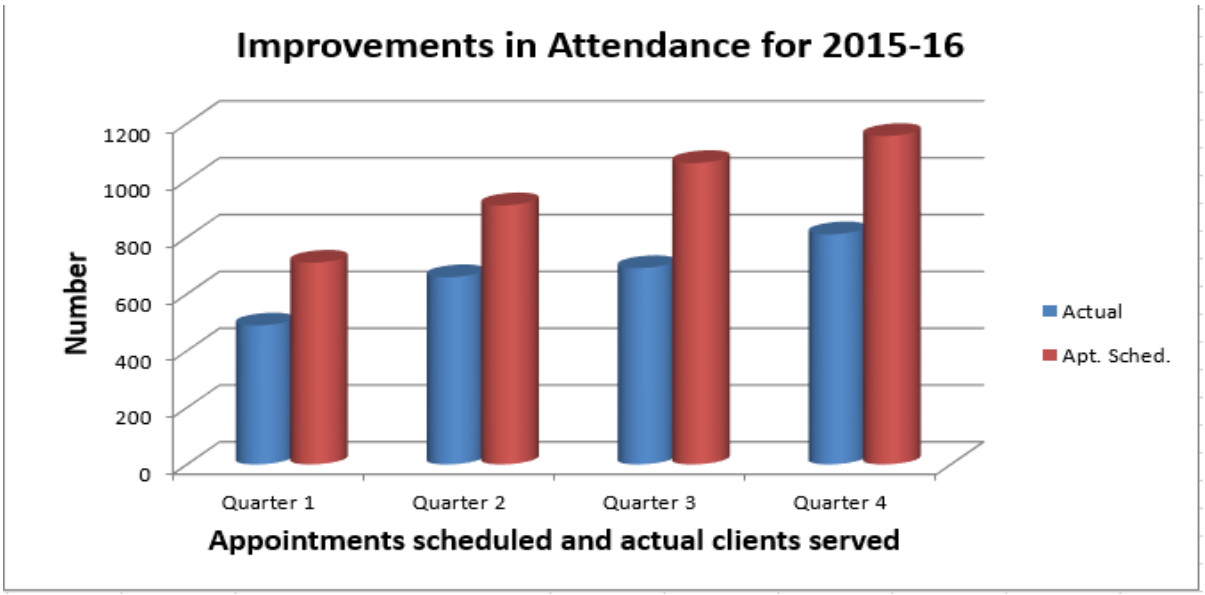
so we can accurately track attendance. Additionally, we have discontinued our walk-in clinic. Clinicians are scheduled every hour and since attendance started improving, there is no longer availability for clinicians to see walk-ins.

G. Barriers to Improvement Encountered this Quarter. We continue to have the barrier of poor attendance associated with court ordered clients. Many of our clients are teens referred by the juvenile court system and are not interested in services, but ordered to be here. They are not motivated by our incentives, but would rather risk being detained as a consequence for not participating.

H. Progress Towards Goal (include data): From April to June, we had 1,165 appointments scheduled for the outpatient program. Of those 1,165 appointments, 355 appointments were cancelled, rescheduled or "no showed". This gives us 30% of our clients that did not their appointments between April and June. This is a 5% improvement compared to baseline data.

I. Project Outcome (include data): Although we were not able to improve our engagement/attendance rate by 20%, we did improve attendance. By scheduling more appointments, we were able to see more clients. Baseline data includes two quarters. For the first two quarters 1148 clients were seen for their scheduled appointments. This quarter alone, 810 clients kept their appointments.

J. Final Analysis & Recommendations: In summary, the many tactics that we tried early in the process such as the walk-in clinic and the client incentives did not appear to be effective. With the walk-in clinic, clients did not like having to wait to be seen with no appointment so that did not help engagement. Additionally, the incentives for clients were not motivating with regard to attendance. It is now hypothesized that the incentive to be earned should have been for the parent who usually has more control over attendance. Finally, scheduling clients to be seen weekly on therapists schedules improved attendance. It was determined that if you schedule more appointments than average, more clients will be seen.



13. Comparative Program Study

This year in the outpatient program we were able to get follow up data on court ordered clients through DJJ. We developed a list of clients referred only by DJJ who were terminated in the year 2014. 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% which is the exact rate we have calculated 2 years in a row.

14. Program Improvements Made as a Result of the CQI Program:

As a result of the CQI monitor this year, we have a new plan for improving attendance/engagement in the outpatient program. Each therapist will develop a reasonably sized caseload and schedule clients in the same time slots for weekly appointments (ex: Jane Doe will be seen every Tuesday at 2:00pm). These weekly appointments at the same time appear to help to keep clients engaged and coming to their appointments regularly. This strategy worked better than any others that we tried this year by far.

15. Recommendations for Program Improvements in the Upcoming Year

We collect data for one of our annual outcomes in a database that holds scores for clients assessed with the CAFAS (Child and Family Assessment Scale). Clinicians complete pre and post assessments for clients in the database and the assessments are scored and saved for clinicians and administrators to access. Unfortunately, this database is not user friendly and the reports produced contain questionable data. Administrators are convinced that switching to another pre/post scoring assessment will be more effective. At this time, multiple assessments are being reviewed.

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

The counseling program will be monitoring client attendance, targeting a 20% increase. Increasing attendance will prove to help the counseling program on two continuums; developing more invested clients and increasing the number of billable services. Clients who attend sessions regularly and are engaged in counseling are likely to be more

successful in reaching their goals. Additionally, as the counseling program has had cuts in funding this year, it is of increasing importance for therapists to fill their schedules with billable hours.

17. 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

1. **Period of Time Covered by Report**
   2015-2016

2. Sentinel Events

The staff of the SAOP program have been assisting with the ASAP residential and day treatment services programs in order to meet the needs of the clients and families that are being served under the agency's substance abuse division.

3. Safety and Risk Management Activities

None

4. 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 June 2016.

5. Performance Reviews

The performance reviews have been completed for both full-time and part time employees as of June 2016. 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.

6. Utilization Reviews

The therapists in the SAOP program served a total of 84 new clients this year. The lower number served from this year is mainly due to the Program Director becoming more

involved with the residential and day treatment programs. Also, JJSAMHP made changes to their referral process this year, and fewer referrals were sent to Youth Focus.

7. Applicants Not Accepted for Services Who Were Eligible

None

8. Premature Termination of Services by Gender and Race

None

9. Quarterly Record Reviews

Quarterly record reviews were conducted by the SAOP therapists. No major deficiencies were noted during the review process. Therapists were reminded to file treatment plans upon completion.

10. Annual Consumer Satisfaction Summary

Same as Outpatient Counseling

11. Summary of Continuous Quality Improvement Monitor

Due to the decrease in client engagement last year, therapists started offering incentives for attending and participating in sessions. Clients and their families received snacks and other incentives during and after sessions. The incentive program upon implementation did not increase engagement, but there was not a decrease in engagement from last year to this year. For the upcoming year, an assessor housed in the DJJ office will be making the referrals to the program, so it is a possibility that those recommended for treatment will be more engaged as they will not view the GAIN as part of the treatment process for entering into outpatient services.

12. 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 2015-2016, eighty 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.

13. Program Improvements Made as a Result of the CQI Program

In order to better facilitate the engagement of client families from the first point of contact, SAOP counselors have been having more contact with families and scheduling intakes themselves. This allows the families to ask more questions from the first contact instead of waiting until the assessment session.

14. Recommendations for Program Improvements in the Upcoming Year

Therapists will be returning to their schedules of mainly serving clients in the outpatient counseling offices rather than splitting time between day treatment and outpatient. This will allow for more time available to see clients and their families and will possibly increase client engagement.

15. Continuous Quality Improvement Monitor to be addressed in the Upcoming Year

SAOP clinicians will continue to monitor the impact of providing incentives to clients on engagement in treatment. The incentive program did not begin immediately at the start of the fiscal year and seemed to have shown improvement toward the end of the year. Therefore, more data is desired.

16. Summary

The SAOP program continues to undergo shifts in staffing and program requirements. However, the program has continued to meet the needs of its clients and provide quality services as evidenced by 80% of clients being abstinent from substances at discharge.

Adolescent Substance Abuse Program (ASAP)

1. Period of Time Covered by Report

2015-2016

2. Sentinel Events

The ASAP program has undergone staffing changes in the last year. A new Program Manager was hired in January 2016, and the clinician position for the group home was eliminated in February 2016 due to budget constraints. The Program Director for Substance Abuse Services has been acting as the lead clinician for the group home.

3. Safety and Risk Management Activities

In January 2016, there was a fire in the kitchen at the group home facility. The clients were not present, and no staff were injured. The fire was contained to the kitchen area. The kitchen was repaired within two weeks of the incident.

The annual DHSR inspection highlighted some areas of the facility that were in need of repair to ensure the safety of the clients and staff. The necessary repairs have been made.

4. 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 June 2016.

5. Performance Reviews

The performance reviews have been completed for both full-time and part time employees as of June 2016. 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.

6. Utilization Reviews

For the 2015-2016 fiscal year, ASAP maintained a 70% utilization rate. This was largely due to the suspension of admissions during the first quarter of the fiscal year by DHSR. ASAP clinicians and staff worked diligently to increase utilization throughout the year, and significant gains were made during the second and third quarters of the year. During the fourth quarter, there were several successful discharges while end of the year testing was occurring for students across the state. Clinicians did not want to disrupt testing and the end of the year academic processes for clients. This lead to more admissions toward the end of June rather than the earlier part of the month.

7. Applicants Not Accepted for Services Who Were Eligible

None

8. Premature Termination of Services by Gender and Race

None

9. Quarterly Record Reviews

Quarterly record reviews were conducted by the ASAP staff. The Program Manager and the Program Director have been working to increase efficiency of filing and to ensure accurate completion of documentation at intake and throughout treatment.

10. Annual Consumer Satisfaction Summary

Based on this year's responses, the levels of satisfaction with the program are mixed. In some areas, ASAP staff are doing well, especially in regards to respecting clients and their individuality. ASAP clinicians are also doing well with communicating to clients when they will leave the program and where they will be going upon discharge.
ASAP clients have multiple concerns regarding the program, including how helpful it is to their lives and the quality of their food. The Program Manager and Program Director will continue to monitor the steps implemented to see if client opinion improves or if additional steps need to be taken in order to ensure client satisfaction with their treatment.

11. Summary of Continuous Quality Improvement Monitor

ASAP has continued to monitor medication errors for the 2015-2016 fiscal year. There has been a decrease in the number of medication errors with most of the errors being due to lack of authorization from the insurance companies for prescribed medication. Client guardians and doctors have been informed of the issues with authorization for medication and have been active participants in the solution process. The Program Manager has implemented more med counts and checks as part of her regular oversight duties.

12. 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 2015-2016, eighty-six 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.

13. Program Improvements Made as a Result of the CQI Program

Due to the Program Director taking on the responsibilities of the lead clinician in February 2016, the amount of time dedicated to direct client care was decreased. As a result, a counselor from SAOP has been assisting with assessments, group sessions, and individual sessions to ensure that clients in the ASAP program are still receiving regular therapy sessions.

14. Recommendations for Program Improvements in the Upcoming Year

Third shift continues to be an issue for the group home facility. Third shift staff are required to complete bed checks of clients every 15 minutes and to call in to a remote location every thirty minutes. There are times when third shift does not make their call-ins. This presents an issue in regards to the safety and supervision of the clients during the night.

15. Continuous Quality Improvement Monitor to be addressed in the Upcoming Year

As a result of the missed third shift call-ins, the Program Manager and Program Director will be more closely monitoring the third shift call-ins. We expect for third shift staff to complete 85% of the required call-ins.

16. Summary

The ASAP program has undergone numerous changes in the last year, including DHSR sanctions and significant leadership changes. These events have greatly impacted the program this year. However, ASAP continues to provide quality service to the youth of North Carolina as evidenced by the seventy-five percent successful graduation rate for this fiscal year and with eighty-six percent of those being discharged from ASAP having a lower reported use of substances at the time of discharge.

My Sister Susan's House

1. 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.

1. Period of Time Covered by Report:

This report covers the period of the time from July 1, 2015 through the close of the 2015 - 2016 Fiscal Year on June 30, 2016.

2. 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 2015 – 2016 Fiscal Year.

3. 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:

Q. 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.

R. 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:

1. Client, staff or visitor requiring more than minor medical care – 2 (admission to the hospital for labor and delivery)
2. Client minor accident or injury, not requiring medical care – 1
3. Client aggressive or destructive act – 0
4. Client aggressive or destructive act, police involved - 0
5. Reaction to medication requiring medical care - 0
6. Adverse medication event – 0
7. Self-injury or suicidal – 0
8. AWOL – 0
9. Inappropriate Sexual Behavior – 0
10. Abuse allegation - 0

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

S. 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.

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

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

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

4. 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.

5. 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.

6. Utilization Reviews:

Total Admissions:	7
Total Discharges:	5
Total Re-Admissions:	0
Average Length of Stay:	205 days
Total Resident Days:	2,311 days
Average Daily Census:	5.67 residents per day

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	0	2	2
Black	2	4	6
Native Amer.	0	0	0
Hispanic	0	0	0
Biracial	2	2	4
TOTAL	4	6	12

Services Provided:

Transitional Living Services

Services Needed but Unavailable:

None noted

7. Applicants Not Accepted for Service Who Were Eligible:

Total Referrals:	61
Referred Applicants Interviewed:	4 (15%)
Referred Applicants Admitted:	3 (75%)
Reasons for Non-Admission:	
Inappropriate / Referred elsewhere	0
Failed to follow up / send requested info	1
Currently on Waiting List	4

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: None noted.

9. 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.

10. 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, we received positive feedback and high ratings in all areas. The residents responded that they 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 but most clients reported they were helped.

11. Summary of Continuous Quality Improvement Monitor

C. Monitor: Physicals within two weeks of admission.

D. Outcome: Data was collected throughout the course of the fiscal year regarding the amount of time it took to obtain physicals and other important documents for clients. MSSH staff improved to having 100% of clients entering the program receive a physical within the first two weeks of them entering the program. Achieving this goal means that as a program we are meeting the requirement established by funding and licensing boards.

12. Comparative Program Study

Teen Living is a similar program to MSSH in Chicago 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/

13. Program Improvements Made as a Result of the CQI Program:

Requiring that clients have a physical or documentation of an appointment prior to moving into the program has assisted in achieving this goal. Continuing to have clients meet this requirement will be essential in meeting the requirements on our licensing agreement and will assist in any client medical needs right away.

14. Recommendations for Program Improvements in the Upcoming Year

To assist clients in meeting their goals and staying on track in the program, it is recommended that the staff track the service plan updates more accurately. These updates are not always done in a timely manner.

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

Monitor: Meeting service plan reviews in a timely manner. The service plan is to be created within 30 days, reviewed at 60 days, 90 days and every 6 months.

16. 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

1. 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.

2. Period of Time Covered by Report:

This report covers the period of the time from July 1, 2015 through the close of the 2015 - 2016 Fiscal Year on June 30, 2016.

3. 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 2015– 2016 Fiscal Year.

4. 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 – 0
(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.

W. 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.

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

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

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

5. 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.

6. 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.

7. Utilization Reviews:

Total Admissions: 2

Total Discharges: 4
Total Re-Admissions: 0

Average Length of Stay: 346 days

Total Resident Days: 1,232 days
Average Daily Census: 3.10 residents per day

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	0	1	1
Black	0	5	5
Native Amer.	0	0	0
Hispanic	0	0	0
Biracial	1	0	0
TOTAL	0	6	6

Services Provided:

Transitional Living Services

Services Needed but Unavailable:

None noted

8. Applicants Not Accepted for Service Who Were Eligible:

Total Referrals:	70
Referred Applicants Interviewed:	8 (12 %)
Referred Applicants Admitted:	3 (38%)
Reasons for Non-Admission:	
Inappropriate / Referred elsewhere	1
Failed to follow up / send requested info	4
Currently on Waiting List	4

9. 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.

10. 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.

11. 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, we received positive feedback and high ratings in all areas. The residents responded that they 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 but most clients reported they were helped.

12. Summary of Continuous Quality Improvement Monitor

Monitor: Follow-up Interviews

Outcome: The spreadsheet created to standardize follow-up with clients once they are discharged from the TLP program made the process much easier and staff was able to complete follow-up interviews at 100%. Initially it was difficult to follow-up with the former clients until alternative methods such as Facebook, social workers, face to face contact and resource providers (with consents in place) were used to conduct follow-up interviews.

13. Comparative Program Study

Teen Living is a similar program to TLP in Chicago 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/

14. **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.

15. 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.

Recommendations for the future would be to follow-up with discharged clients not only for the intervals selected but as often as possible. Keeping up with the clients more often created a better relationship with the clients and made it easier to stay in contact with them.

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

Monitor: Utilization

17. 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

1. 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.

2. Period of Time Covered by the Report:

This report covers the period of the time from July 1, 2015 through the close of the 2015 - 2016 Fiscal Year on June 30, 2016.

3. 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 2015 - 2016 Fiscal Year.

4. 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.

5. 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	24
2.	Runaway/AWOL in excess of 24 hours	14
3.	Accident or Injury	6
4.	Aggressive or Destructive Act	11
5.	Self-Harm	0
6.	Arrest/Violation of the Law	2
7.	Report of Abuse or Neglect	2
8.	Sexual Impropriety	16
9.	Search and Seizure	0
10.	Adverse Drug Events	20
11.	Hospitalizations	4
12.	Restraints	1
	Total Incidents & Restraints:	**100**

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

6. Resident Complaint Forms:

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.

7. 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.

8. 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 6 part-time reviews were conducted and approved.

9. Utilization Review:

Total Admissions:	183
Total Discharges:	183
Total Re-Admissions:	41
Total Clients Served:	192
Total Resident Days of Service:	3,257 days
Average Length of Stay:	178 days
Average Daily Census:	8.9 residents per day
Safe Place Admissions:	6
Safe Place Referrals	11

Clients Served:

Race	*Males*	*Females*	*TOTAL*
White	23	13	36
Black	56	64	120
Asian	0	2	2
Hispanic	10	3	13
Other	6	6	12
TOTAL	95	88	183

Services Provided:

Emergency Crisis Care

Services Needed but Unavailable:

None noted

Applicants Not Accepted for Service:

Total Referrals:	508
Referred Applicants Admitted:	183
Applications Denied:	0
Applications Withdrawn:	325

Premature Termination of Service:

Four (4) 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.

10. 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.

11. 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 items 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 being placed at the respite facility and a decrease in feelings of social isolation for the client after receiving respite services.

12. Results of Continuous Quality Improvement Monitor

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

Reason for Selection of this Quality Improvement Project: Due to an increase of youth served in DSS custody needing placements and the case management challenges of ending placement (shortage of foster placements, mental health service guidelines, shortage of group homes, etc.), the average length of stay in the emergency shelter has increased. It is the goal of the shelter for youth to transition to a stable permanent placement as quickly as possible.

Steps Taken To Support Improvement:

The Director of Clinical Services, Van Catterall, PhD began facilitating an agency wide case management staffing with all program managers/directors weekly in September 2015. This meeting provides 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. The Act Together Program Manager began attending the DSS monthly case staffing meeting with the entire DSS placement team. During this meeting the program manager and placement team have the opportunity to brainstorm the challenges finding placement and talk through potential options. The program manager sends weekly client utilization reports to the local DSS placement team. The report includes DSS youth in care, current length of stay, maximum days remaining (90 days minus the current length of stay), and last day Act Together can serve the youth. This utilization report has helped keep the communication open between DSS and the shelter. It also reminder the DSS placement team Act Together is temporary and stresses the importance of finding a longer term placement option as soon as possible.

Project Barriers: There continues to be a state wide shortage of foster homes, especially traditional foster homes for older teens. The Children's Home youth shelter in Winston-Salem closed on January 1st, 2016 however stopped taking referrals from Guilford County DSS in November. The Children's Home shelter was reported to be a one of their main placement options for crisis placements. Navigating mental health services has been a particular challenge during the fourth quarter. The steps finding a mental health placement puts many barriers in place that prevent transitioning the youth as quickly as possible, i.e.: getting an updated assessment scheduled/completed, limited providers, provider bed availability being full, required paperwork, and authorization process.

Baseline Data Time Period: June 1st, 2015-August 31st, 2015

Baseline Data Results: The average length of stay for DSS youth who were admitted between June-August was 47 days. Note: two youth had 89 day length of stays and one youth had a 3 day length of stay.

Improvement Goal: Decrease the average length of stay for DSS youth to 38 days.

Project Outcome: At the end of the fiscal year, the average length of stay for DSS youth was 33 days.

Final Analysis / Recommendations:

K. Progress Towards Goal (include data):
   a. # of DSS Admissions: 63
   b. # DSS Discharges: 63
   c. Longest Length of stay: 89 days
   d. Shortest Length of stay: 1 day
   e. Average Length of stay: 32 days

Throughout the FY, there were improvements made with inner agency communication and increased referrals/inner agency placements. During the weekly case management calls the program directors also provided additional support and suggestions that aided in potential placements. During the baseline the average length of stay for DSS youth was 47 days. At the end of the FY the average length of stay for DSS youth was 33 days, which surpasses the projected goal of 38 days.
It is recommended the inner agency weekly case management meetings continue to assist with finding placements and to provide case staffing support. It is recommended the program manager continue to communicate with DSS weekly though the utilization report email and attending monthly case staffings. It is recommended the program manager and clinical team continue to work together to navigate the mental health system and learn ways of getting services/placement in a timely manner. The Act Together program manager and staff will continue to advocate for all the youth served and provide support getting the appropriate placements secured as quickly as possible.

13. Comparing Outcomes with Other Programs (Benchmark Study)

For this outcome comparison, Act Together Crisis Care examined trends and performance outcomes during the 2015/16 FY. For the purpose of our comparison study, Act Together looked at gender, race, ethnicity, and "placement status discharge" trends.

Act Together Clients Served - 2015/16 FY:

Race/Ethnicity	*Males*	*Females*	*TOTAL*	*Percentage*
White	23	13	36	20%
Black	56	64	120	66%
Asian	0	2	0	1%
Hispanic	10	3	13	7%
Other	6	6	12	6%
TOTAL	95 (52%)	88 (48%)	183	

Act Together Placement Status at Discharge – FY 2015/16

143 youth out of 183 (78.1%) 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 66% compared to 11% in Rhode Island. Act Together Crisis Care reported 78.1% 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. It is noted, those runaway and homeless youth that were not permanently placed either eloped, were hospitalized, or incarcerated.

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.

14. Program Improvements Made as a Result of the CQI Program:

Youth Focus prioritized increased communication and access to services during this FY. The weekly case management meetings with all Youth Focus Programs being represented has made a positive impact increasing access to services and wait time getting services in place.

Through the CQI process medication count, particularly for controlled substances was identified as an issue. With the assistance of the CQI committee and clinical director, a new medication count protocol was put into place in addition to camera surveillance in the staff office.

The 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. Intern support provided additional 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.

15. Continuous Quality Improvement Monitor to be addressed in the Upcoming Year

Act Together has adopted a new electronic referral spreadsheet to better communicate information related to referrals and to improve the way we manage the waiting list. When youth are referred, staff will upload or save a digital copy of the referral in a folder in Office 365. Then staff will log the referral in a spreadsheet. In the spreadsheet, the staff will be able to keep track of any updates. We will monitor that every referral is logged in the spreadsheet and saved in the referral folder, with a target of 100%.

16. 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 gang involvement, human trafficking, trauma histories, mental health, and LGBTQ issues as these are populations 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.

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: _____