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Performance & Quality Improvement

Q3 Report FY 2023-2024

(2023-2024)

Introduction

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

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

We have expanded the Measures sub-committee to focus on review of the logic models and outputs and outcomes collection tools. We have been updating, streamlining and clarifying our goals and collection of data over the past year. We hope to finish this large, important project in FY 23-24.

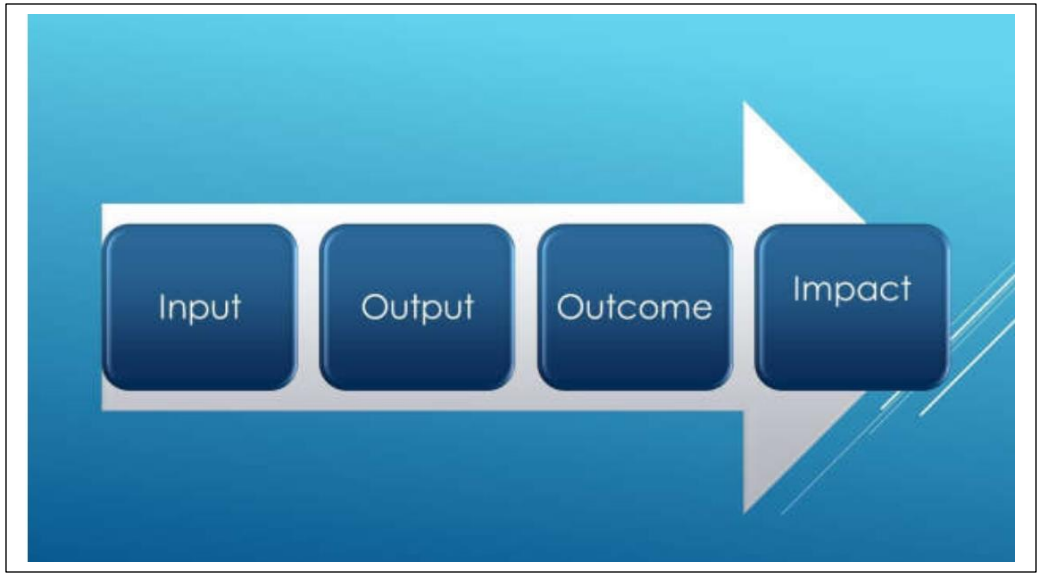
The data contained in this report is for a period of 1 quarter-Q3, January 2024 to March 2024.

PQI Committee Members

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

Outputs & Outcomes

Data collection with purpose and passion



Each program has developed a Logic Model that captures the program's inputs, activities, outputs, and outcomes. Data collection tools have been developed to consistently collect the data. The collection tools are being revised to collect more data and be as user friendly as possible. This will result in more data to analyze and report on in the future. The PQI Committee oversees the data collection and aggregation of the data in order to measure performance and to improve our services and programs, which ultimately leads to better client outcomes. The sub-committee that is working on review and revision of the Logic Models and Collection Tools is making steady progress and hopes to have the project completed in FY 23-24.

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

Key	
Meeting goal	★
Making progress toward or partially meeting goal	➡
Trending low or not meeting goal	⬅

Residential Program

Residential Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Budgeted Average Number of Residents per Day is Maintained	23	20.5	19	17.2	
# of Aggression Replacement Therapy Group Sessions	*	*	100%	*	**
An Initial CANS is Completed Within the First 30 days and is Reviewed Quarterly	*	*	*	*	**
ISP's are Developed and Distributed in a Timely Manner and Monitored Monthly	*	*	7	11	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Percent of Weekly Passed Behavior Management Program (80% is passing)	86%	80%	75%	68%	
Stipend Earned for Successful Program Completion	*	*	67%	50%	
Average Math Grade (60% is passing)	85%	76%	75%	81%	
Average English Grade (60% is passing)	72%	73%	74%	82%	
Participation in Weekly Individual Therapy	*	*	89%	90%	
Youth Return Home or Live Independently in the Community Post Discharge	*	*	67%	100%	
CANS Assessment Shows Change in Functioning Level Over Time	*	*	*	*	**
Residents Attend School/Graduate/earn GED/are Employed at Discharge	50%	75%	100%	67%	
Attain or Partially Attain Goals	*	*	75%	75%	

*indicates new data to be collected
** indicates items with no goal

Q3 Results Detail:
Decrease in passing the weekly CHIPs were due to more negative behavior of the majority of the residents.

Several unexpected discharges and subsequently not completing the program causes a resident to be ineligible for the stipend.

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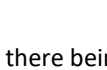
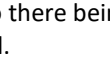
Maryland Community Based Programs

Maryland Community Based Programs Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Number of Clients	20	19	15	15	**
Number of Casework Contacts	571	482	452	497	**
Number of After Hours Contacts	122	188	127	180	**
Number of After Hours Crisis Contacts	0	0	2	0	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Number of Section 8 Code of Conduct Violations	0	0	0	0	
Number of Youth in School and/or Working	12	14	9	7	

** indicates items with no goal

Maryland Foster Care

Maryland Foster Care Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Caseworker Visits Completed as Required	86%	91%	100%	100%	
Treatment and Safety Plans Completed on Time	64%	72%	90%	98%	
CANS Completed for Each Client	57%	91%	94%	93%	
Client has Scheduled Therapeutic/Psychiatric Appointments	86%	85%	79%	89%	
Family Worker Visits Monthly with Families	*	*	*	96%	
Client Received Timely and Ongoing Medical/Dental Care	*	*	*	81%	
Foster Parents Receive Required Annual Training	*	*	*	100%	
Positive Net Gain in Recruiting and Retaining Foster Parents Annually	-	1	1	-	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
At Least 80% of Clients Achieved Their Permanency Plan Goal as Identified by the Court	100%	100%	*	100%	
At least 80% of Clients Have Identified at Least One Supportive Adult to Whom They Can Turn for Assistance in an Emergency	100%	80%	100%	100%	
CANS Reflects Client Improvement Upon Discharge	80%	88%	0%	33%	
85% of Clients Met or Partially Met Their Treatment Plan Goals by Discharge	63%	80%	0%	33%	
Clients Consistently Attended School or Graduated from HS/Obtained GED	100%	100%	100%	67%	
Discharged Clients Experienced Two or Fewer Placements	100%	90%	100%	100%	

* indicates new data to be collected

Q3 Results Detail:
Results are skewed due to there being only 1 client who was discharged.

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Pennsylvania Foster Care

PA Foster Care Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Casework/Client Visits Occur Monthly as Required	100%	99%	99%	100%	
Foster Parents Receive Required Annual Training	100%	100%	100%	100%	
Individual Service Plans and Quarterly Reviews Completed and Distributed in a Timely Manner	*	*	*	*	**
Client Received Timely Ongoing Appropriate Medical/Dental Care	*	*	*	*	**
Referred for Appropriate Outside Services per Rrogram/Recommendations	*	*	*	*	**
Positive Net Gain in Recruiting and Retaining Foster Parents Annually	*	*	*	*	**
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Permanency Plan Achieved	58%	73%	77%	48%	
Placement Stability Maintained	94%	81%	100%	96%	
Client Consistently Attended an Educational Program or have Graduated/Obtained a GED at Discharge	*	*	*	*	**
Clients Met or Partially Met ISP Goals at Discharge	*	*	*	*	**

* indicates new data to be collected
** indicates items with no goal

Q3 Results Detail:
Some children were discharged to a location (another foster home, hospital, etc.) not identified in their permanency plan (reunification or adoption) and will be changed in future reporting to discharge to the same or lower level of care.

Adoption

Adoption Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Number of New SWAN Referrals	110	51	88	87	
Number of New Adoption Finalization Referrals	15	8	9	8	
Number of Family Profile Referrals	18	12	18	16	
Number of Child Profiles Completed	27	34	21	27	
Number of Completed Child Preparation Services	*	*	*	*	**
Number of Completed SWAN Services Invoiced	74	89	74	55	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Number of Families Approved	9	12	10	8	
Number of Finalized Adpotions	8	9	11	7	

*indicates new data to be collected
** indicates items with no goal

Q3 Results Detail:
The number of Completed SWAN services was 30 services below the anticipated goal and down by 19 from the previous quarter.

Crisis

Crisis Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Number of Total Delivered Hours	224	204	210	198	
Number of Telephone Hours	129	92	110	101	
Number of Walk-In Hours	27	43	32	16	
Number of Hours of Mobile Service Provided	129	63	66	82	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Diversion from Hospitalization or a Higher Level of Care	85%	97%	95%	95%	
Provided Recommendations for Interventions, Skills and/or Services/Resources	97%	83%	83%	83%	

Q3 Results Detail:
Low service delivery due to continued low demand for crisis services.

Partial Hospitalization Program

Partial Hospitalization Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Number of Biopsychosocial Assessments Completed	7	7	11	7	
Number of Initial Plans Completed within 5 Treatment Days	7	6	8	8	
Number of Clients	24	25	28	24	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
% of Children Returned to Home School District	80%	33%	75%	92%	
Attainment or Partial Attainment of Goals	80%	33%	75%	83%	
Engagement in Services	*	67%	100%	100%	

*indicates new data to be collected

Family Based Mental Health Services

Family Based Mental Health Services Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Number of Active Clients	33	32	35	30	**
Number of Total Hours Delivered	1104	1337	1104	1047	**
Number of Team Delivered Hours	353	531	528	382	**
Number of Individual Hours Delivered	751	806	576	665	**
Number of Authorized Hours	848	1,395	1,389	1,116	**
Authorized vs Delivered	50%	64%	79%	49%	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Attainment of Treatment Goals	83%	85%	50%	78%	
Engagement in Services	*	58%	55%	86%	

* indicates new data to be collected
** indicates items with no goal

Q3 Results Detail:
Hours and team hours low based on low staffing and low staff performance being addressed through performance plans for the program.

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Intensive Behavioral Health Services

Intensive Behavioral Health Services Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Number of Initial and Ongoing CANS Assessments Completed	87	50	48	64	**
Number of Treatment Plans Completed	143	111	87	110	**
Number of Active Clients	230	223	216	270	**
Number of Delivered Hours	8,357	7,226	7,451	7,398	
Authorized vs Delivered	43%	52%	43%	43%	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Engagement in Services within 180 days	62%	77%	74%	48%	
Attainment or Partial Attainment of Goals	42%	80%	87%	72%	

**indicates items with no goal

Q3 Results Detail:
Staffing shortages resulted in lower delivered hours.

Engagement impacted by changes in insurance coverage and other factors that impact families continuing services.

Outpatient Services

Outpatient Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Number of Referrals Made	677	788	822	760	**
Number of First Assessments Completed	489	536	563	529	**
Number of Hours of Service Delivered	13,327	12,707	13,967	13,918	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Initial Engagement is Evidenced by the Client Attending the First Assessment Appointment After the Referral was Made	74%	67%	68%	70%	
Attainment or Partial Attainment of Goals at Discharge	72%	66%	65%	80%	

**indicates items with no goal

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Finance

CORP-Finance Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Agency Operating Reserves (cash) do not Drop Below 3 Months of Operating Expenses	*	4.8	4.3	4.7	
AR- More than 40% of Revenue Billed will be Collected in 3 of 4 Quarters	*	45%	25%	41%	
Financial Reporting Completed in 30 Days or Less for 3 of 4 Quarters	*	32	29.7	29	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Annually the Agency will Receive a Financial Audit with Financial Statements that Failry Represents the Position of the Agency (unmodified opinion)	*	No Material Findings	*	*	**
The Annual 401k Audit is Completed and Form 5500 is Submitted Timely	*	*	Yes	*	**
The Annual 990 is Completed and Filed Timely	*	*	Yes	*	**
Bi-Weekly Payrolls are Completed Timely	Yes	Yes	Yes	Yes	
Sustainability of the Agency as Evidenced by having Positive Retained Earnings Annually of 1% or Greater	*	-7.9%	2.9%	2.7%	

* indicates new data to be collected
**indicates items with no goal

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Human Resources

CORP- Human Resources Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Strategic Recruitment Activities	*	3	4	4	
Number of Open Positions Posted on Internal Job Board	*	46	100	70	**
Number of Vacancies Filled by Current Staff	*	7	18	55	**
Introductory Period Performance Review and Plan Completed with All New Hires	*	68%	67%	100%	
Number of Interns	*	8	0	5	**
Outcomes Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Positive Net Gain in Regards to Staffing	*	8	-3	6	
100% of New Hires are Retained for Six Months	*	72%	66%	87%	
Utilization of EAP Resources Equal to or Above Industry Standards	*	11%	15%	17%	
At least 90% of Trainings are Completed by the Due Date	*	86%	86%	85%	

* indicates new data to be collected
** indicates items with no goal

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Information Technology

Information Technology Outputs	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q3 Results On Target
Bi-Annual Staff Survey	*	100%	*	100%	
Monthly Technology Trainings Offered to All Staff	100%	67%	33%	122%	
Use Technology Committee to Implement Technological Improvements	67%	100%	0%	100%	
Approved Tech Requests are Completed in a Timely Manner (21 days)	210%	350%	300%	350%	
Outcome Goals	**Q4 22/23**	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q3 Results On Target**
Increased Staff Skills, Abilities, and Proficiency of Technology (% of staff participating in training)	10%	53%	91%	11%	
Paper Usage is Significantly Reduced	**	**	**	**	**
Staff Have the Technology Needed to Complete Their Job Tasks (number of tech requests completed per quarter)	100%	100%	100%	100%	

*bi-annual item, no data for Q4

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INTERNAL&EXTERNAL

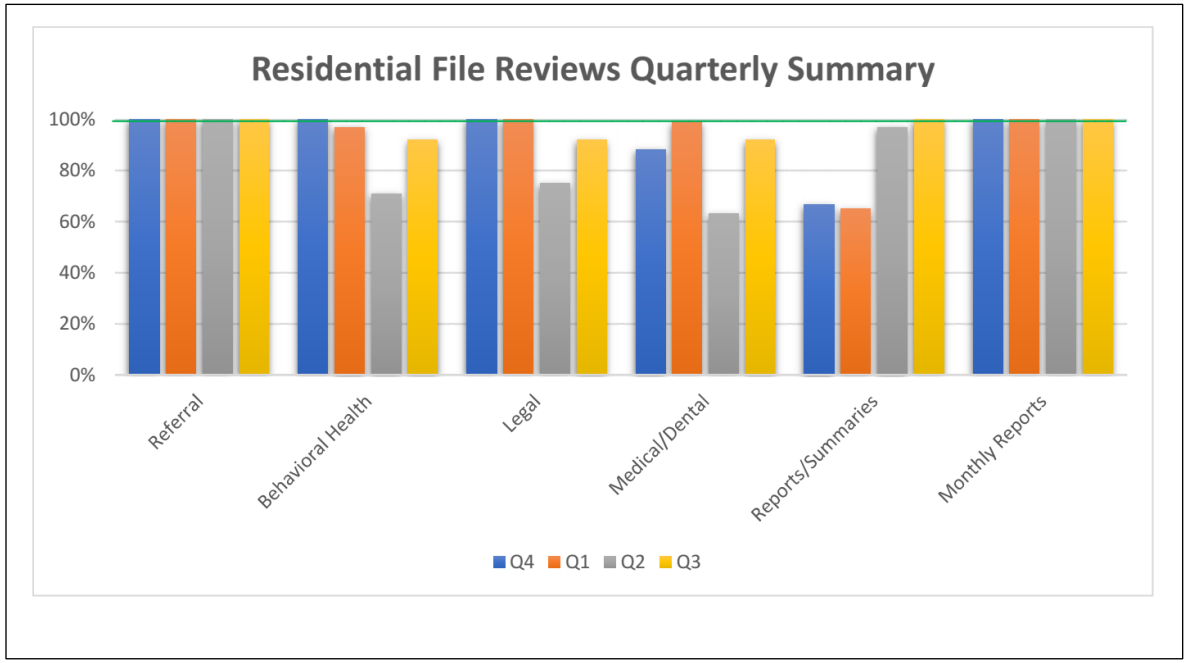
File Audits & Inspections

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

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

Inspection/Audit Type	Running Totals	Jan-March 2024	Oct-Dec 2023	July-Sept 2023	Apr-June 2023
Internal File Audits	864	219	215	209	221
External File Audits	11	1	2	6	2
Licensing Inspections/Full Licensure	19	8	2	5	4

Residential Program Quarterly File Review Totals



Q4 (Apr-June 2023)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 90%.

Q1 (July-Sept 2023)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 94%.

Q2 (Oct-Dec 2022)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 81%.

Q3 (Jan-Mar 2024)
The CONCERN Treatment Unit for Boys (CTUB) conducted file reviews on a total of 6 files.
Overall compliance was 97%.

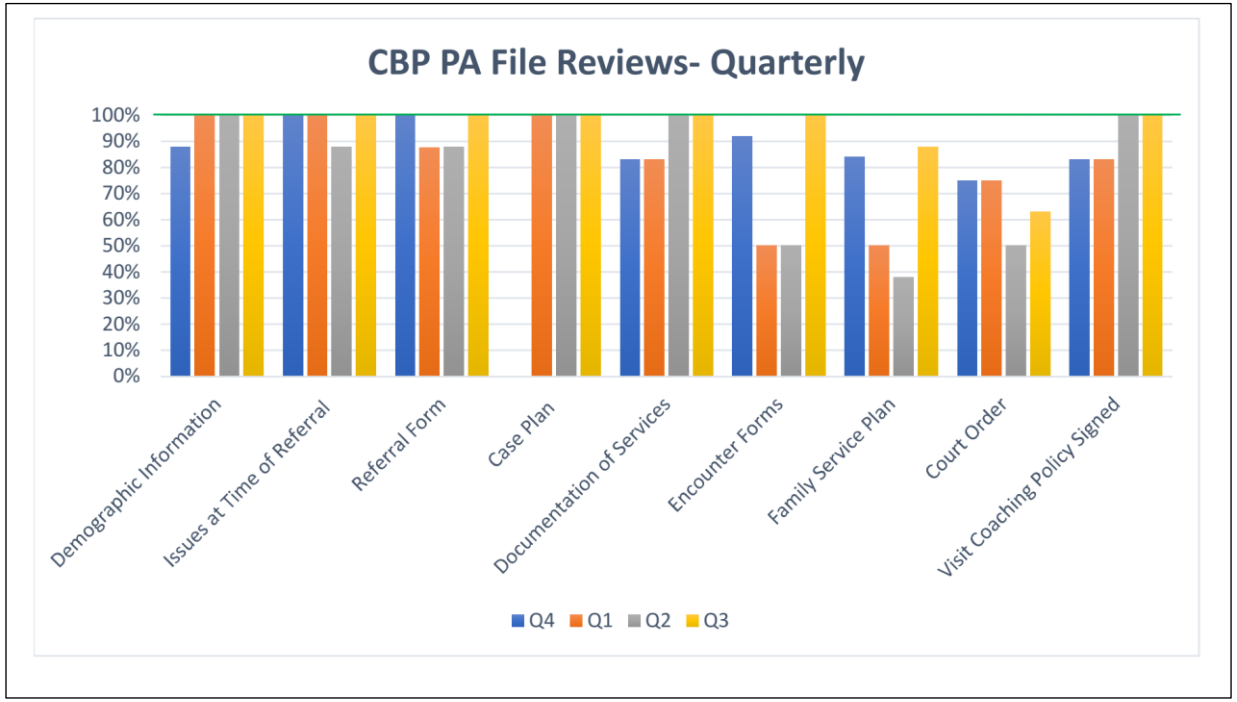
The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicators (QI)	Q4	Q1	Q2	Q3
Behavioral Health				
Treatment Plan (Initial) (QI)	100%	83%	67%	75%
Treatment Plan (Review) (QI)	n/a	100%	n/a	n/a
Reports/Summaries				
ISP- Initial (QI)	100%	100%	100%	100%
ISP 6 month (QI)	n/a	100%	n/a	100%
ISP 12 month (QI)	n/a	100%	n/a	100%
ISP other (QI)	n/a	n/a	n/a	n/a
Monthly Reports				
Monthly Reports (QI)	100%	100%	100%	100%

Quality Indicator Results Detail

For Q4, overall compliance for these items was 100%.
For Q1, overall compliance for these items was 97%.
For Q2, overall compliance for these items was 89%.
For Q3, overall compliance for these items was 95%.

Pennsylvania Community Based Programs File Reviews Quarterly Total



Q4 (Apr-June 2023)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 8 files.
Overall compliance was 87%.

Q1 (July-Sept 2023)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 8 files.
Overall compliance was 81%.

Q2 (Oct-Dec 2023)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 8 files.
Overall compliance was 81%.

Q3 (Jan-Mar 2024)
Community Based Programs in Pennsylvania (CBP PA) conducted file reviews on a total of 7 files.
Overall compliance was 95%.

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

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

Quality Indicator Results Detail

For Q4, overall compliance for these items was 83%.
For Q1, overall compliance for these items was 88%.
For Q2, overall compliance for these items was 100%.
For Q3, overall compliance for these items was 100%.

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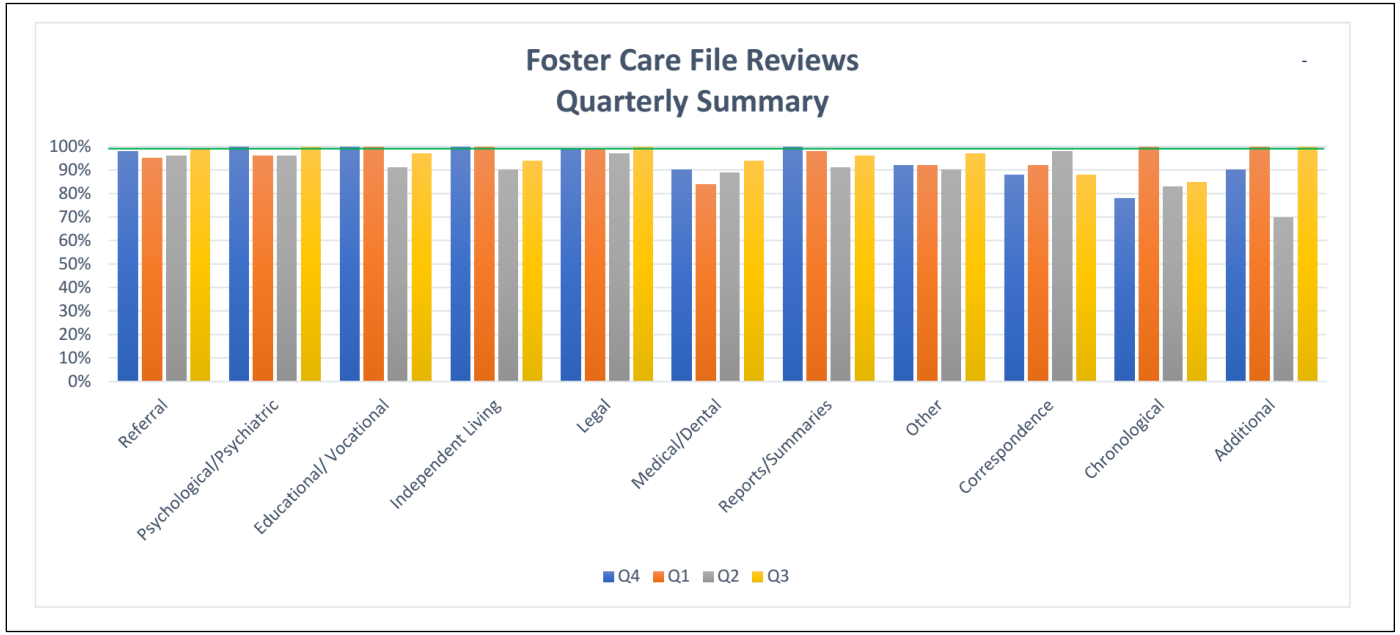
Foster Care Programs File Reviews Quarterly Totals



Q4 (Apr-June 2023)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 27 files. Overall compliance was 94%.

Q1 (July-Sept 2023)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 24 files. Overall compliance was 94%.

Q2 (Oct-Dec 2023)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 24 files. Overall compliance was 93%.

Q3 (Jan-Mar 2024)
Foster Care Sites throughout Pennsylvania and Maryland conducted file reviews on a total of 24 files. Overall compliance was 96%.

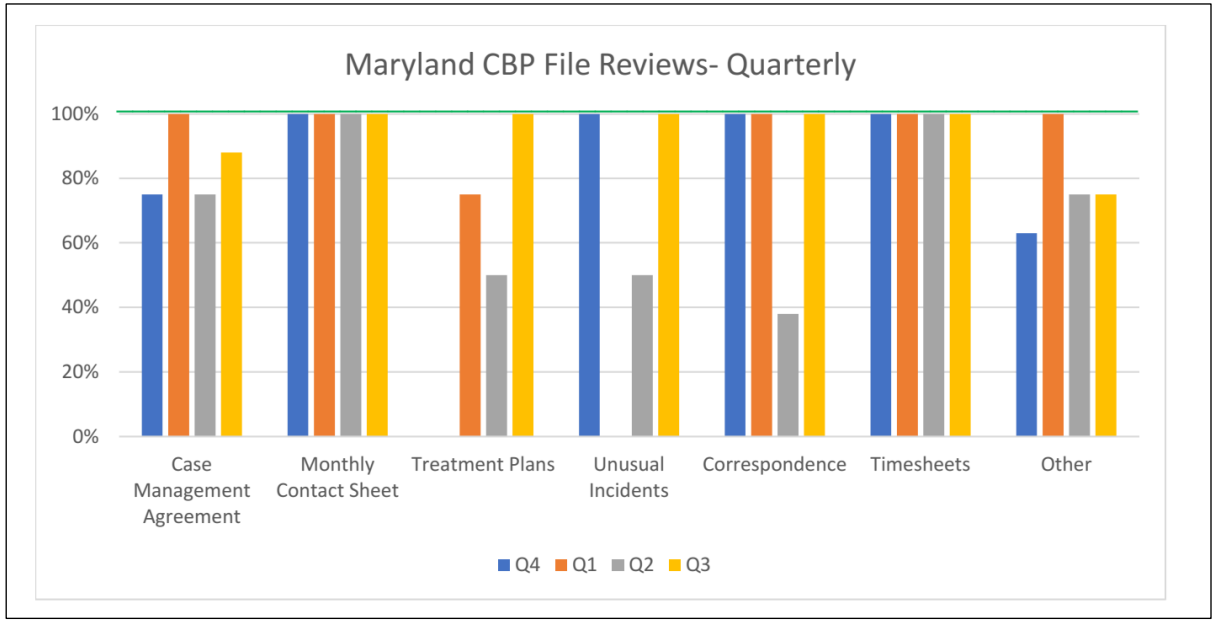
The green line indicates the Key Performance Indicator (KPI) threshold for this line of service (100%).

Quality Indicators (QI)	**Q4**	**Q1**	**Q2**	**Q3**
Reports/Summaries				
Discharge Summaries (QI)	100%	100%	90%	100%
Initial Individual Service Plan (QI)	100%	100%	94%	92%
Quarterly Review/ Updated Service Plan (QI)	100%	92%	89%	88%
Six Month Review/Updated Service Plan (QI)	100%	100%	80%	100%
Chronological				
Client Chronological Report of Case Activity (QI)	80%	100%	83%	88%
Assessment of Safety (QI)	75%	100%	83%	83%

Quality Indicator Results Detail

For Q4, overall compliance for these items was 93%.
For Q1, overall compliance for these items was 99%.
For Q2, overall compliance for these items was 87%.
For Q3, overall compliance for these items was 92%.

Maryland Community Based Programs File Reviews Quarterly Totals



Q4 (Apr-June 2023)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 4 files.
Overall compliance was 78%.

Q1 (July-Sept 2023)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 4 files.
Overall compliance was 96%.
There were no Unusual Incidents in Q3 or Q1.

Q2 (Oct-Dec 2023)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 4 files.
Overall compliance was 67%.

Q3 (Jan-Mar 2024)
Community Based Programs in Maryland (Maryland CBP) conducted file reviews on a total of 4 files.
Overall compliance was 93%.

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

Quality Indicator Results Detail

For Q4, overall compliance for this item was 0%.
For Q1, overall compliance for this item was 75%.
For Q2, overall compliance for this item was 50%.
For Q3, overall compliance for this item was 100%.

Quality Indicators (QI)	Q4	Q1	Q2	Q3
Treatment Plans (QI)	0%	75%	100%	100%

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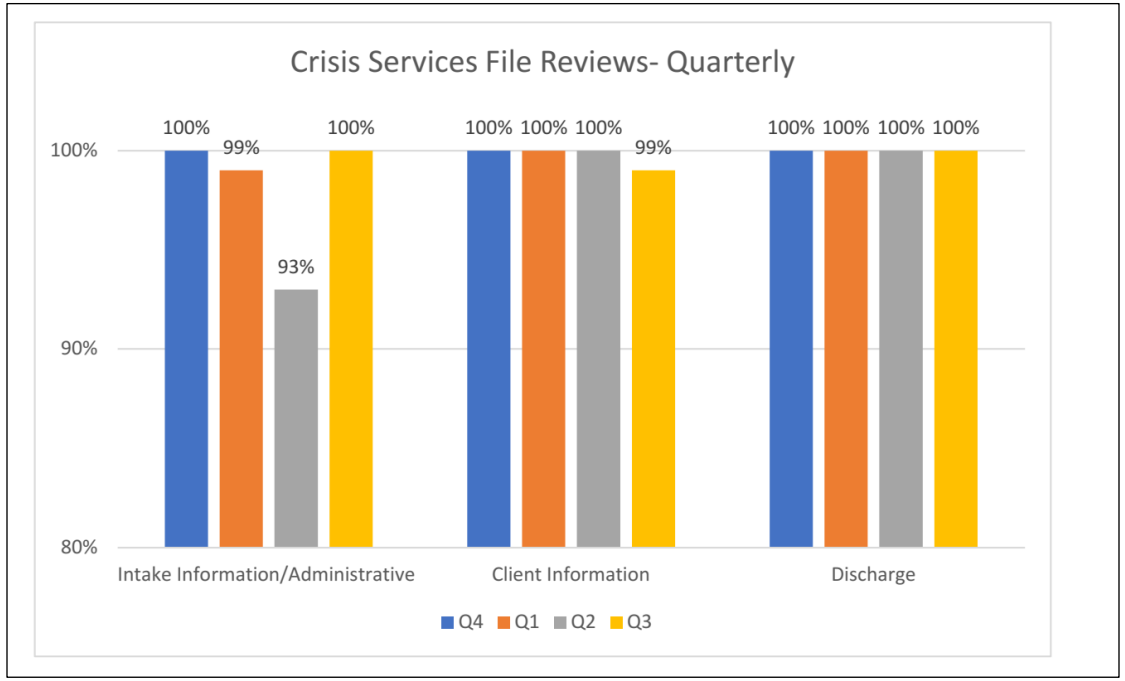
Crisis Services File Reviews Quarterly Totals



Q4 (Apr-June 2023)
Crisis Programs conducted file reviews on a total of 38 files.
Overall compliance was 100%.

Q1 (July-Sept 2023)
Crisis Programs conducted file reviews on a total of 35 files.
Overall compliance was 100%.

Q2 (Oct-Dec 2023)
Crisis Programs conducted file reviews on a total of 36 files.
Overall compliance was 97%.

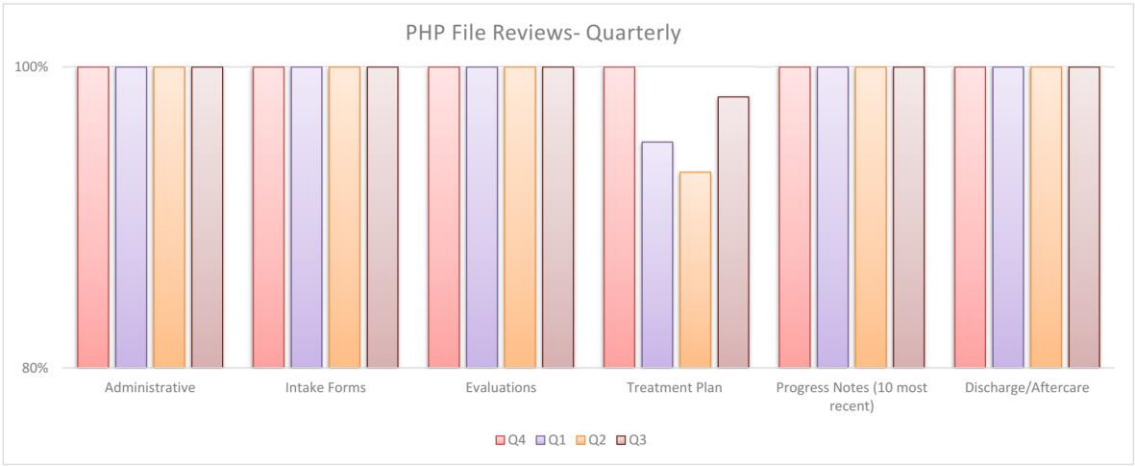
Q3 (Jan-Mar 2024)
Crisis Programs conducted file reviews on a total of 37 files.
Overall compliance was 99%.

Quality Indicator Results Detail

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

Quality Indicators	**Q4**	**Q1**	**Q2**	**Q3**
Client Information				
"D" section of progress note active intervention occurring during the session (QI)	100%	100%	100%	100%
"D" section addressed natural and community supports (QI)	100%	100%	100%	100%
"A" section of the note includes assessment of SI/HI risk (QI)	100%	100%	100%	100%
"A" section of the note includes assessment of D&A needs (QI)	100%	100%	100%	97%

Partial Hospitalization Services File Reviews Quarterly Totals



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

Q4 (Apr-June 2023)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files. Overall compliance was 100%.

Q1 (July-Sept 2023)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files. Overall compliance was 99%.

Q2 (Oct-Dec 2023)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files. Overall compliance was 97%.

Q3 (Jan-Mar 2024)
Partial Hospitalization Programs (PHP) conducted file reviews on a total of 6 files. Overall compliance was 99%.

The Key Performance Indicator (KPI) thresholds for this line of service are either 80% or 100%.
The items requiring a KPI of 80% had an average score of 100%.
The items requiring a KPI of 100% had an average score of 99%.

Quality Indicator Results Detail

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

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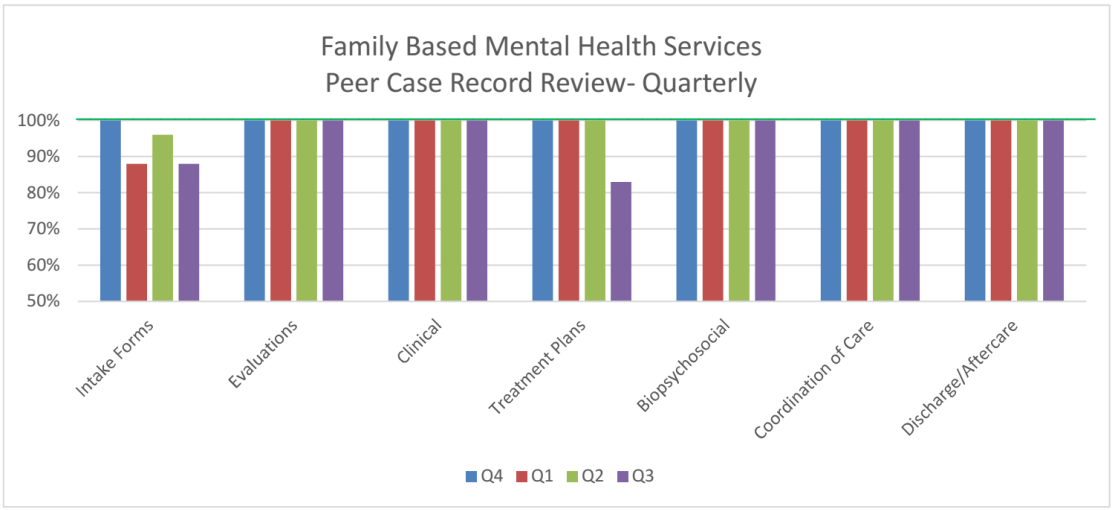
Family Based Mental Health Services File Reviews Quarterly Totals



Q4 (Apr-June 2023)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 6 files.
Overall compliance was 100%.

Q1 (July-Sept 2023)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 6 files.
Overall compliance was 98%.

Q2 (Oct-Dec 2023)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 6 files.
Overall compliance was 99%.

Q3 (Jan-Mar 2024)
Family Based Mental Health Programs (FBMH) conducted file reviews on a total of 6 files.
Overall compliance was 93%.

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

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

Quality Indicator Results Detail

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

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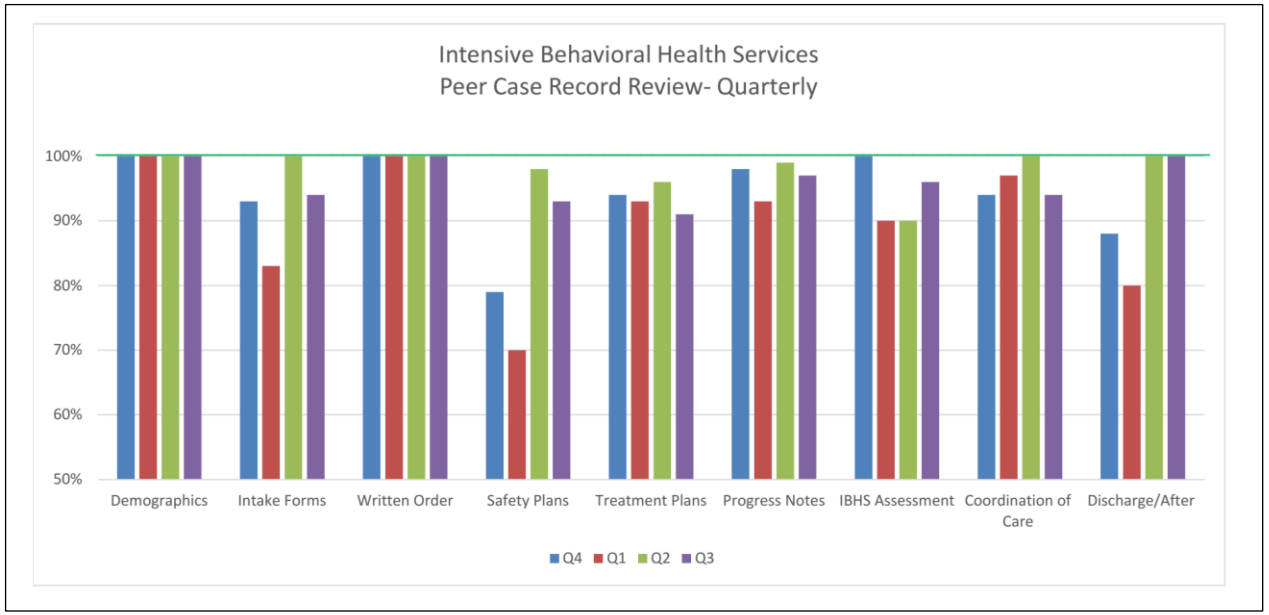
Intensive Behavioral Health Services File Reviews Quarterly Total



Q4 (Apr-June 2023)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 28 files.
Overall compliance was 94%.

Q1 (July-Sept 2023)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 25 files.
Overall compliance was 90%.

Q2 (Oct-Dec 2023)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 24 files.
Overall compliance was 97%.

Q3 (Jan-Mar 2024)
Intensive Behavioral Health Programs (IBHS) conducted file reviews on a total of 24 files.
Overall compliance was 95%.

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

Quality Indicator Results Detail

For Q4, overall compliance for these items was 94%.
For Q1, overall compliance for these items was 91%.
For Q2, overall compliance for these items was 97%.
For Q3, overall compliance for these items was 96%.

Quality Indicators (QI)	Q4	Q1	Q2	Q3
Safety Plans				
Safety/Crisis plans identify specific steps for all settings? (QI)	81%	68%	97%	93%
Safety/Crisis plans identify natural and communirty supports and their role in the plan? (QI)	78%	73%	100%	93%
Treatment Plans				
Treatment plan documents the client, family, and cultural strengths? (QI)	100%	93%	97%	88%
Treatment plan has goals clinically consistent with problems/needs/diagnoses identified in IBHS assessment (QI)	100%	96%	100%	100%
Treatment plan has operationally defined, measurable, objectives to meet goals (QI)	100%	96%	100%	100%
Progress summary includes measurable data for each goal objective (if continued stay/amendment) (QI)	75%	82%	86%	98%
Progress Notes				
"D" section clearly states an active intervention occurring during session (must come directly from Tx plan) (QI)	100%	96%	96%	100%
"D" client's response to the intervention (QI)	100%	92%	100%	100%
"A" section Clinician's interpretation of clients symptoms, level of participation, prognosis, concerns, & interpretation of data comparison (QI)	100%	92%	100%	100%
"P" section states Tx goal/objective focus/setting for next session, any HW given, and any follow-up the therapist will be doing (QI)	92%	92%	100%	87%
IBHS Assessment				
Was a referral made **OR** does treatment plan identify how trauma/MISA is being addressed? (QI)	100%	87%	80%	100%
Recommendations reflect the needs of the client and family (QI)	100%	100%	96%	100%
Coordination of Care				
Evidence of coordination of care with educational and/or vocational systems a minimum of monthly? (QI)	99%	96%	100%	100%
Evidence of coordination of care with other child-serving systems a minimum of monthly? (QI)	100%	95%	100%	83%
Evidence of coordination of care with other behavioral health specialists minimum of monthly? (QI)	83%	100%	100%	100%
Discharge/Aftercare				
Discharge summary addresses al Tx plan goals and is clearly defined (QI)	88%	100%	100%	100%

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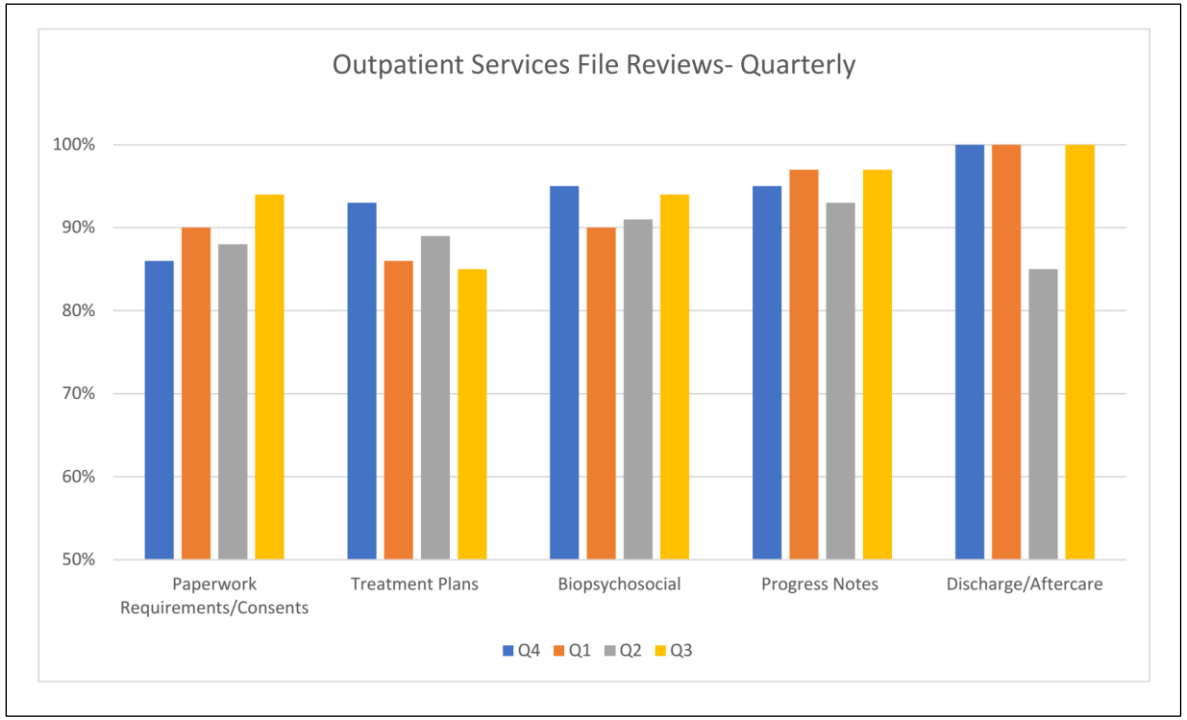
Outpatient Services File Reviews Quarterly Total



Q4 (Apr-June 2023)
Outpatient Programs (OPT) conducted file reviews on a total of 97 files.
Overall compliance was 93%.

Q1 (July-Sept 2023)
Outpatient Programs (OPT) conducted file reviews on a total of 96 files.
Overall compliance was 90%.

Q2 (Oct-Dec 2023)
Outpatient Programs (OPT) conducted file reviews on a total of 101 files.
Overall compliance was 90%.

Q3 (Jan-Mar 2024)
Outpatient Programs (OPT) conducted file reviews on a total of 100 files.
Overall compliance was 90%.

The Key Performance Indicator (KPI) thresholds for this line of service are either 80% or 100%.
The items requiring a KPI of 80% had an average score of 88%.
The items requiring a KPI of 100% had an average score of 92%.

Quality Indicator Results Detail

For Q4, overall compliance for these items was 95%.
For Q1, overall compliance for these items was 90%.
For Q2, overall compliance for these items was 90%.
For Q3, overall compliance for these items was 90%.

Quality Indicators	Q4	Q1	Q2	Q3	KPI's
Treatment Plans					
Transition plan described (supports/resources for client) (QI)	85%	79%	81%	83%	80%
Discharge criteria clearly defined/measurable (QI)	92%	75%	84%	81%	80%
Interventions incorporate client strengths (QI)	91%	75%	73%	51%	80%
Client friendly language used (QI)	99%	92%	99%	99%	80%
Client's strengths listed (QI)	97%	99%	98%	99%	80%
Goals consistent with diagnosis/needs of client (QI)	100%	94%	94%	95%	80%
In updated treatment plans, progress is documented (QI)	95%	91%	92%	83%	100%
Safety Plan: individualized (QI)	97%	92%	84%	93%	80%
Biopsychosocial					
Assessment of client's strengths/needs is made (QI)	99%	95%	97%	100%	100%
Diagnoses are consistent with present features (QI)	91%	85%	85%	88%	80%
Progress Notes					
D section lists intervention listed in Tx plan (QI)	92%	93%	85%	94%	100%
A section lists clinical features, mood, affect, level of cooperation (QI)	94%	96%	99%	100%	100%
Treatment modalities used in session are listed (QI)	100%	99%	97%	98%	100%
P section lists date of next session and goals to work on (QI)	92%	98%	92%	96%	100%

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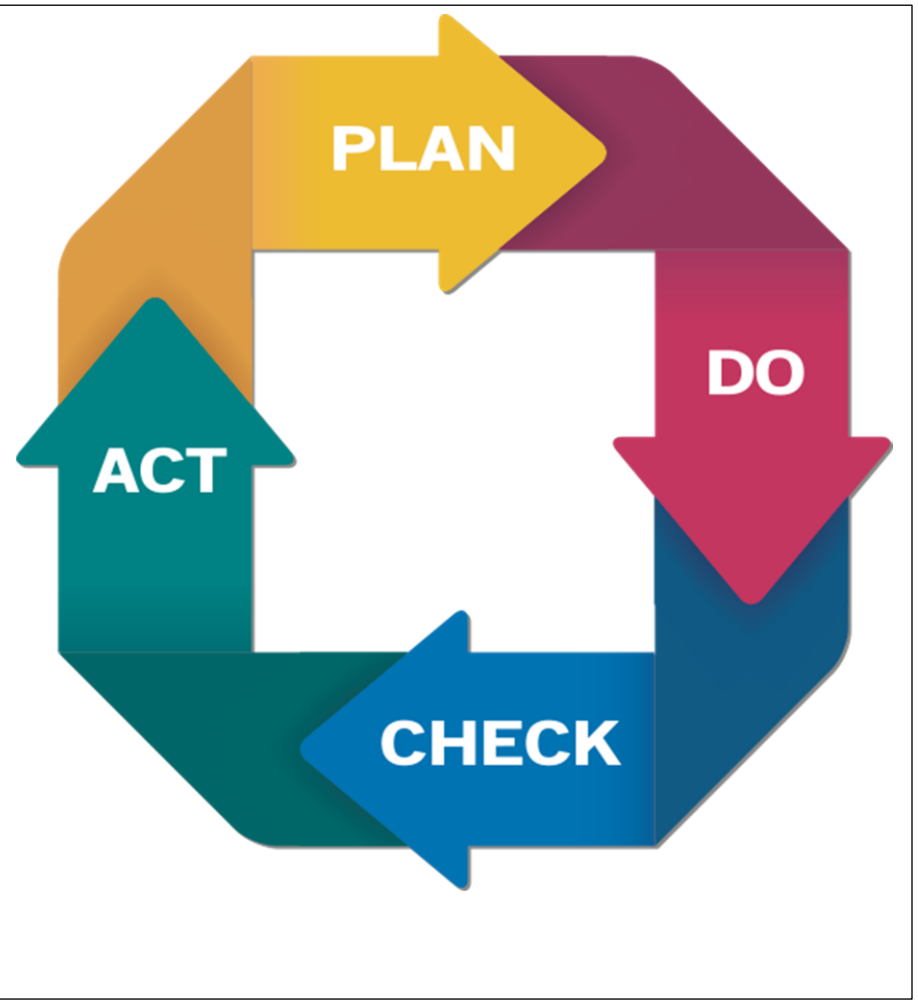
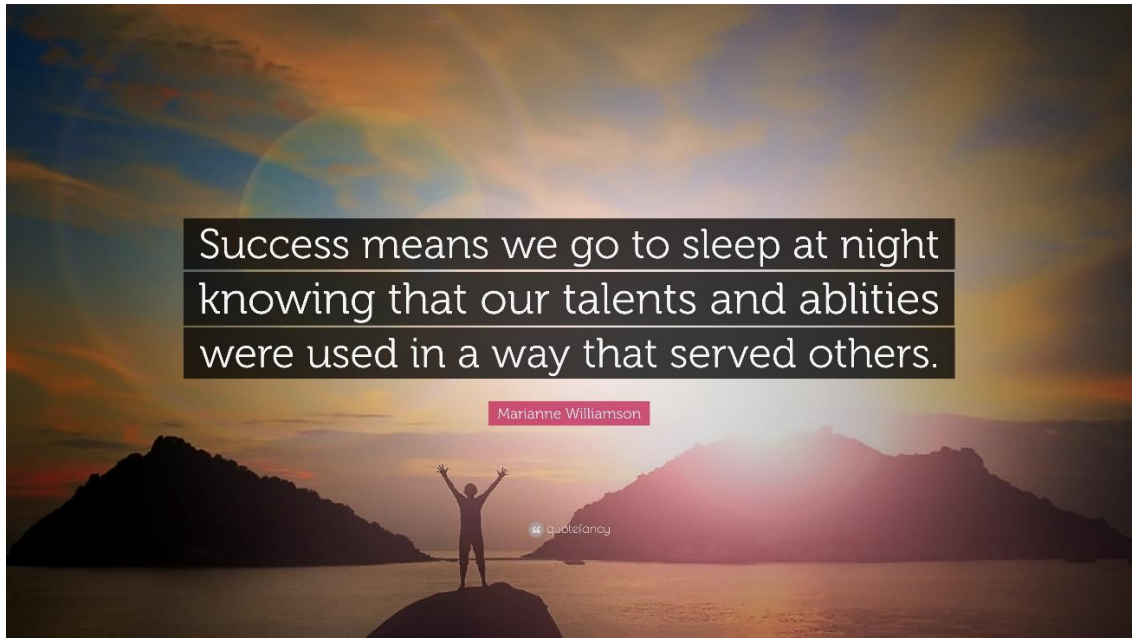


Plan Updates

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

Currently we have 5 Improvement Plans that are in various stages of planning and/or actions and/or checking. The following is a list of the Improvement Plans:

- CTUB Training
- Behavioral Health Training
- Outpatient Treatment Plans
- Family Based Team Services
- Collaborative Documentation



Thank you to all the PQI Committee members who meet monthly as a full committee as well as meeting in the numerous sub-committees that we have. Thank you to the committee members and all the staff who are involved in collecting the data, completing the file reviews, reviewing all the information and then making improvements. Together our efforts will continue to evaluate and improve our operations and services.

This report includes data from Q3 (January 2024 to March 2024) and is a testament to the focus and commitment of staff, especially as it relates to their daily work with clients and their attention to detail when working with the data.

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