2023 Key Performance Indicators

Domain	Target/ Goal	Measurable Objective	To Whom applied	When Measured	Data Source	Extenuating Influencing Factors	Results to Date
Efficiency	Shall meet 85% or higher for **Post Payment Reviews**	Peer reviews will be completed quarterly and meet 90% or higher.	Administration and management	Quarterly	Peer Review forms, PPR audits	Inability for staff to complete review due to needs at their facilities.	**August 4, 2023 (Eastpointe):** Improvement action plan required. NCTOPPS information was not input correctly. Training was provided to the leads and case managers for their specific service area. **Goal was met.** **October 2, 2023 (Sandhills):** POC required. Initially it was stated that coordination of care for clients was not being shown- documents were provided to Sandhills to prove this was occurring. Some training for staff had lapsed due to losing a trainer for the agency- this was corrected and all trainings are up to date. It was noted that a staff's notes were not individualized and did not appear therapeutic in nature- this staff has been re-trained and their supervisor closely reviews their notes. Once POC was submitted, Sandhills stated "Sandhills Center has determined that the deficiencies noted in the original Report of Findings have been minimized or eliminated.Additional follow-up is not necessary at this time, and we are considering this review closed effective November 22, 2023." **Goal was met.** **Peer Reviews 2023:**

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							Peers reviews were not conducted every quarter due to illness and injury being present in the QI department. The 3rd quarter peer review was not completed due to this. Also the number of peer reviews completed did not meet requirements. In 2023 Focus served 524 clients- 52 clients records should have been reviewed while only 14 records were reviewed for the year. **This goal was not met.**
Efficiency	Shall meet 85% compliance for **DHSR License Surveys**	Random audit checks	Facility QP Leads and Human Resources	Annually	Licensure Compliance Check sheet	Need to develop form Changes in state policies	**January 5, 2023 (Burkwell):** POC required. An IRIS report was not completed in the 72 hour time frame. This IRIS report incident was corrected. Staff were retrained in documentation and incident reporting. **No further communication was provided about the POC.** **January 5, 2023 (Landing):** POC required. An IRIS report was not completed in the 72 hour time frame. This IRIS report incident was corrected. Staff were retrained in documentation and incident reporting. Also in this POC the water temperature for the facility fluctuated too much. **No further communication was provided about the POC.**

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Domain	Target/ Goal	Measurable Objective	To Whom applied	When Measured	Data Source	Extenuating Influencing Factors	Results to Date
Efficiency	Shall meet 85% or higher compliance for DHSR **Construction Surveys**	Random audit checks	Residential House Managers and Director, QP Leads and maintenance workers.	Annually	Construction Compliance Check sheet	Need to develop form Changes in state policies	This occurs once every two years. Last construction survey occurred in 2022. The state was contacted to ask for a specific checklist in order to develop the form. Form has not been developed yet.
Efficiency	The number of **on- the-job injuries** will be no more than 4 in a calendar year.	The number of on-the-job injuries will be no more than 4 in a calendar year.	Program Director and Human Resources	Quarterly	Administrative Outcomes Report	Client restraints Time pressure or deadlines Significant mental workload	**2023 Accidents:** Workman's Comp (WC) claims – • Employee only: 1 • Employee w/ client: 2 Accidents not involving WC - • Employee only: 0 • Employee w/ client: 0 Total for the year is 3; goal was no more than 4. **This was met at 100%**
Satisfaction	Improve **staff satisfaction** to reduce turnover rate.	Employee Satisfaction and Turnover Rates	QI, HR and Administrative Director	Bi-annually	Employee Satisfaction surveys Random Employee Questionnaires	Company benefits, advancement opportunity, workload stress, co-worker relations, supervisor support, burnout and competitive compensation, employee participation in surveys.	**Staff Turnover rates:** • Terminations: 15 • Resignations: 35 **Staff Satisfaction rates:** The average Employee Satisfaction was 68.72 %. This average has decreased approximately 4.93% from the previous year, this could be due to the number of participating employees also decreasing. In 2022, an average of 55 employees, per survey term, participated in the satisfaction survey that was provided twice in 2022- whereas an average of 32

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							employees, per survey term, participated in the satisfaction survey that was provided twice in 2023. **This goal was not met.**
Effectiveness	100% on **Service competencies and required training** for all direct-care positions.	Employee Certification	Human Resources, QI Director	As needed and measured yearly	HR Files	Limited availability of trainings and training methods as well as limited availability of trainers to accomplish the trainings needed.	Some certifications/trainings were not completed within the required timeframe due to limited availability for these trainings via the MCO's. Examples of such are systems of care and person centered thinking. An average of 8 staff are required to complete these trainings and currently there are no training days available for these- these trainings must be completed by a registered trainer. All in house training has been completed per time frame requirements via state regulations for all staff. **This goal was not met.**
Satisfaction	A minimum of 85% **client satisfaction**	Clients will be provided a satisfaction survey in the months of April and October.	All active clients	Bi-Annually	Satisfaction surveys	Staff knowledge and experience, lack of client participation.	**2023 averaged results:** Residential Level III –89.48% Day Treatment – 90.6% Outpatient/SBT – 85.4% **This goal was met.**

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This 2023 Key Performance Indicators has been updated, reviewed, approved and adopted by the Local Leadership Team:

Kathy Wilson — 1/5/2024

Quality Improvement Director — Date reviewed

Jana Brown, LCSW — Jan 5, 2024

Jana Brown, LCSW (Jan 5, 2024 14:23 EST)

Clinical Director — Date reviewed

Amy Fairchild, MD — Jan 9, 2024

Amy Fairchild, MD (Jan 9, 2024 16:44 EST)

Medical Director — Date reviewed