Quality Assurance Plan

January – December 2019

Center for Social Change

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EXECUTIVE SUMMARY

Center for Social Change (CSC), is a private, non-profit organization which was established in 1993. CSC is providing a variety of services for adults and children with developmental and medical disabilities throughout the State of Maryland. Center for Social Change's main office is located in Elkridge, Maryland and services are provided throughout Baltimore, Howard, and Prince George's Counties. Currently, Center for Social Change offers Community Housing services for adults and children in CSLA homes, ALUs and group homes. CSC also operates Adult Medical Daycare program, Employment Services, Vocational and Day habilitation programs.

2019 HIGHLIGHTS

Center for Social Change went through the CARF accreditation for the third time in 2016. CSC was granted 3 year accreditation for all the programs including Community Housing for adults and children, CSLA , Employment, Vocational and Day Habilitation and Adult Medical Daycare. As of now CSC will be going through re-accreditation in Feb 2020.

PROGRAM EXPANSION:

Center for Social Change currently operates **43** group homes / assisted living residences which are located in the communities of Randallstown, Windsor mill and in the Laurel / Savage area. At the end of calendar year 2019, 140 individuals were supported in CSC's Community Housing Program. During 2019, a total of 80 individuals received supports at the Employment, Vocational and Day Habilitation Services for. CSC's Adult medical Daycare is providing quality medical care to 33 individuals.

In March 2019, Maryland Department of human services along with Department of Social Services requested our assistance to immediately place 20 youth back in Maryland. CSC responded to this call and opened four new group homes to address the needs of 20 children who were placed out of state due the lack of community housing placements in Maryland. In doing so, CSC incurred a few setbacks. Staff and clinical issues increased due to staff receiving trainings to work in the new homes.

In 2019, CSC continued to render services and supports in DDA's Community Pathways, Community Supports and Family Supports programs. In addition, the following supports and services also has been approved by DDA ,

- Family Peer and mentoring Supports
- Community Development Services
- Family Caregiver Training and Empowerment services
- Nursing Services(Health Case Mgmt)

COMMUNITY EDUCATION, INVOLVEMENT AND OUTREACH:

CSC administrations understands that as a nonprofit organization, it is important to be engaged and relevant to the community that you are located in by becoming an active member in the local area and educating community of the needs of the person served.
Community Integration is a vital goal for CSC. CSC has continued and expanded Participation (or membership) with:

- Maryland Council of Directors of Volunteer services
- Maryland Association of Nonprofits (MANO)
- Maryland Works
- Disability Sports USA
- Liberty Road Business Association (LRBA)
- Liberty Road Community Council (LRCC)
- Fieldstone Community Association
- Maryland Chamber of Commerce
- Baltimore County Chamber of Commerce
- Howard County Commission on Disability Issues (CDI)

CSC actively participates in quarterly and annual meetings of LRBA and LRCC. CSC is an annual Sponsor for the Liberty Road Tree Lighting Ceremony at Randallstown Gateway Park. CSC has provided internship experiences to multiple higher education institutes. As of now, Center is an active field placement for MSW Internships for University of Maryland School of Social Work and has advance year MSW student intern at the Adult Medical Day Care Center.
To achieve community integration for persons served, CSC arranged for persons served to enjoy multiple community activities such as a trip to Ocean city, Bay sox Games, a Ravens Softball Game, Disney on Ice, Six flags , Cruises and holiday parties.

STAFF EXPANSION:

CSC has demonstrated its continued commitment to the development of a strong, skilled workforce to provide highest standards of quality. During the past year, 127 new direct support staff have been hired to help CSC best serve the individuals who have chosen CSC as their provider of choice.
In addition to these new hires, an additional 20 Administrative staff were hired, in several departments, during 2019. These included the hiring of 45 person served who are supported in CSC's Community Housing Program to work in the main administrative office; additional new-hires in HR, Finance, Operations; increased staff in both the Medical Day Care and Day Habilitation Programs; increased staff in the Community Housing Program. At this time CSC has 331 direct care staff, 52 admin staff 1 RN and 4 LPN's. CSC also has contracted with Outside clinical staff to provide services to individuals.

QUALITY ASSURANCE OBJECTIVES 2020

Center for Social Change, has identified the following as the objectives for 2020. These objectives are based on the reviews from OHCQ, and suggestions from the Quality Assurance Committee.

MEDICAL /CLINICAL SERVICES

1. Maintain at least a 97% rate of compliance to completion of scheduled and referred appointments.
2. Maintain the low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 6% yearly.
3. Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented, missing start dates, circles on the front not being explained on the back, medications discontinued appropriately with a reason on back of MAR) so as not to exceed 3% for any given quarter.
4. Achieve a rate of 100% of the completed consult forms to be uploaded in the THERAP on line documentation system.
5. Achieve a rate of 95% in Nursing / Health Case Management and Delegation for interim follow up evaluation after hospitalization.

PERSON CENTERED PLANS & CARE PLANS

(ADULT MEDICAL DAY, COMMUNITY HOUSING), & EMPLOYMENT, DAY & VOCAIONAL SERVICES):

1. Achieve 100% of all IP's being up-to-date in Community Housing, Employment Vocational & Day Habilitation Services.
2. Achieve 100% of all Behavior support plans being reviewed and updated annually in Community Housing, Employment Vocational & Day Habilitation Services.
3. Achieve 100% of IP implementation Within 20 days of annual IP.
4. Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.
5. Achieve 100% of Person Centered care plans completed for Rising Sun Assisted living units.

HUMAN RESOURCES:

1. Achieve a turnover rate of no more than 25% throughout the calendar year 2019.
2. Achieve completion rate 95% DDA-mandated/Core trainings for all staff during calendar year 2020.
3. Achieve and maintain a completion rate of 97 % performance evaluations completed

COMMUNITY RELATION AND ADVOCACY

1. Increase family member satisfaction to at least 95%.
2. Increase Stakeholder satisfaction to at least 99%
3. Increase Staff Personnel Satisfaction to at least 90%
4. Increase at least 10% in Staff personnel Satisfaction survey return rate.

OPERATIONS/ MAINTENANCE:

1. Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
2. Maintain turnaround of addressing maintenance request within 24-48 hours with 85% of completion rate.
3. Update the Maintenance database with no more than 30 days of entry missing.

TECHNOLOGY / HEALTH INFORMATION MGMT

1. Utilizing STED 100% for all mandated trainings throughout the calendar year 2020.
2. Utilizing THERAP at least 80 % for all person served demographics, and Person Centered Plans
3. Utilizing STED 85% for ALU meetings minutes

QUALITY ASSURANCE REPORT 2019

CSC's Quality Assurance report covers the calendar year 2019, and focuses on those Objectives which were identified in the previous year's QA Plan. In many cases, 100% of a given sample set was analyzed. However, due to the large number of program participants and available data, data for some analyses were collected utilizing randomly defined samples. Using information available in agency databases such as THERAP and STEDS , written reports, QA audits , individual's files, stakeholder surveys, etc., objective data was collected and analyzed for selected program areas.

Quality Assurance Objectives for Calendar Year 2019

Medical /Clinical:

- Maintain at least a 97% rate of compliance to completion of scheduled and referred appointments.
- Maintain the low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 6.5 % yearly.
- Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented, missing start dates, circles on the front not being explained on the back, medications discontinued appropriately with a reason on back of MAR) so as not to exceed 3% for any given quarter.
- Achieve a rate of 100% of the completed consult forms to be uploaded in the THERAP on line documentation system.
- Achieve a rate of 90% in Nursing / Health Case Management and Delegation.(includes recognizing potential obstacles to effective delegation, on time F/U after hospitalization etc)

Person Centered Plans and Care Plans (Adult Medical Day, Community Housing & Employment Services):

- Achieve 100% of all IP's being up-to-date in Community Housing, Employment Vocational & Day Habilitation Services.
- Achieve 100% of all Behavior support plans being reviewed and updated annually in Community Housing, Employment Vocational & Day Habilitation Services.
- Achieve 100% of IP implementation Within 20 days of annual IP.
- Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.

Human Resources

- Achieve a turnover rate of no more than 23% throughout the calendar year 2019.
- Achieve completion rate 95% DDA-mandated/Core trainings for all staff during calendar year 2020.
- Achieve and maintain a completion rate of 95 % performance evaluations completed

Community Relation and Advocacy

- Increase family member satisfaction to at least 95%.
- Increase Stakeholder satisfaction to at least 95%
- Increase Employee Satisfaction to at least 90

Operations/ Maintenance

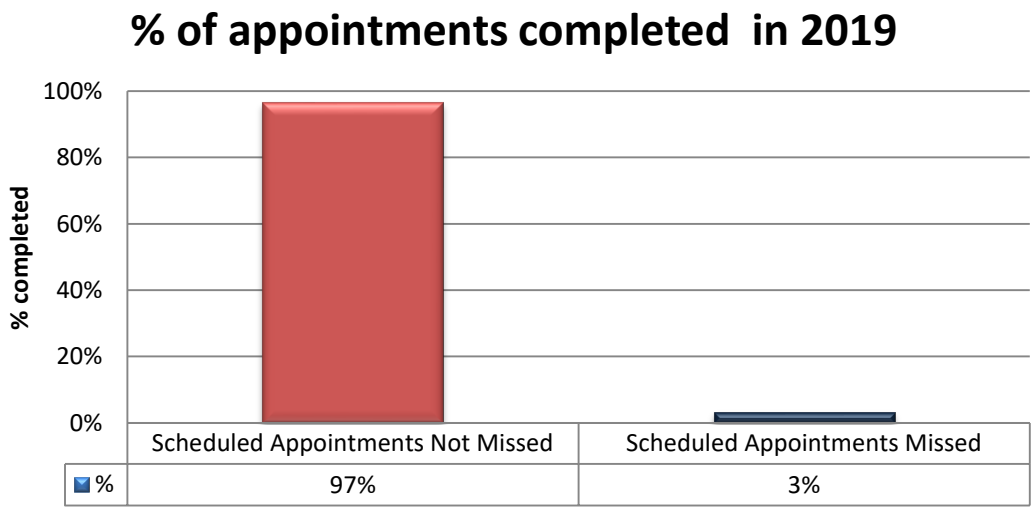
- Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
- Maintain turnaround of addressing maintenance request within 24-48 hours with 85% of completion rate .
- Update the database with no more than 30 days of entry missing.

Technology / Health Information Management

- Utilized THERAP at least 75 % for all person served demographics & Person Centered plans.
- Utilizing STED 80% for ALU meetings minutes.
- Utilizing STED 100% for all mandated trainings throughout the calendar year 2019.

Objective #1-a: Maintain at least a 97% rate of compliance to completion of scheduled appointments. (No more than 3% will be missed)

Data was collected for each individual throughout the year by the Quality Assurance Coordinator. In total, 5378 appointments were performed throughout calendar year 2019.



Summary Results/Discussion:

The results indicate that the goal of a 97% rate of compliance to completion of scheduled medical appointments was met. A total of 5436 were scheduled from Jan – Dec 2019. 5250 appointments were completed on time and 181 were missed.

An assessment of the primary causes for which appointments were missed was completed. For those missed appointments for which a reason was identified, there were few primary reasons that they were missed:

- Transportation/ Traffic issues
- Arriving late at the Dr. Office / Podiatrist didn't show up
- Dr's Office Cancelled the appointment
- Person Served went to the apt and refused to cooperate at the Dr Office

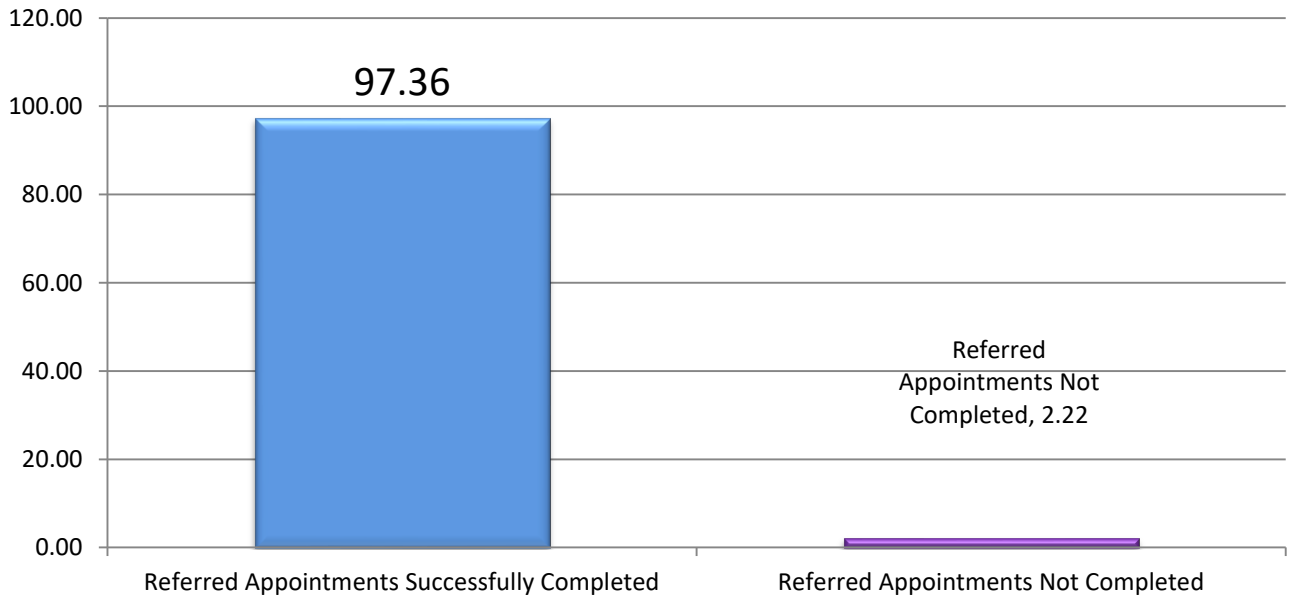
CSC opened new group homes in a very short period of time. That contributed heavily towards missed appointments.

Plan of Action:

The Coordinators who provide status reports concerning whether or not medical appointments were kept as scheduled have been informed that it is their responsibility to provide a valid reason for any appointments missed. As to the reasons for appointments being missed, the most frequently occurring reason is that staff and the individual arrived late at the appointment. Therefore, the time for all appointments will be entered into Therap, the medical scheduling database, as ½ hour prior to the actual appointment time. For each individual, all medical appointment reports were read, and any referrals were identified. It was then further determined whether or not these referred appointments were completed.

Objective #1-b: Maintain at least a 97% rate of compliance to completion of referred appointments. (No more than 3% will be missed)

Based on a review of THERAP from Jan to Dec 2019, a total of 3231 follow up appointments were scheduled. Among those 3146 referred appointments were completed. 76 were missed .These appointments include post – ER, dentist, endocrinology, vision, eye, hearing and other PCP follow up. The results are demonstrated in Graph 2, below.



Results/Discussion:
The results indicate that the goal of a 97% rate of compliance to completion of scheduled medical appointments was met through calendar 2019. The remaining 97.36% of referred appointments were completed. The data for the follow up appointments is as follows,

Scheduled on Therap	3409
Completed	2710
Missed	76
Canceled	178
Re scheduled	413
Not Needed	9
Scheduled	23
Not Scheduled	23
Total – Otherwise Scheduled	**3231**
Total Otherwise completed	**3146**

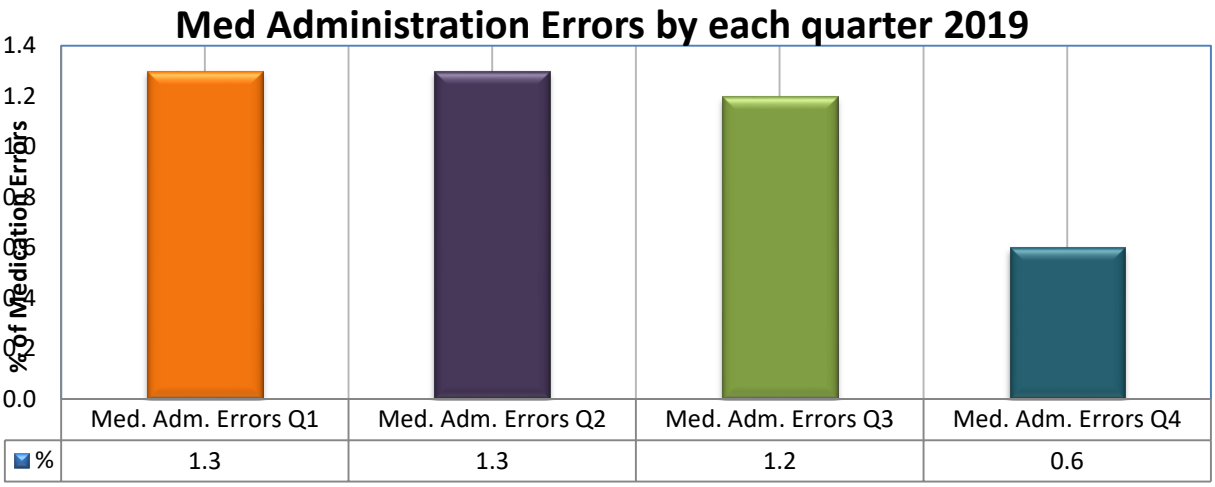
The reasons that a small percentage of referred appointments were not completed are the same reasons that any given appointment might not be kept-

- Problems with transportation at the time of the appointment
- Person Served Refusing
- Cancelled Appointments

Plan of Action:
The Follow up appointments missed due to Dr office not returning calls or not having availability on their schedule for next few months is something is something CSC cannot directly address . However; Clinical specialist make sure to request any first available, canceled apt from the Dr.'s offices. One of the main factor is the appointment in the unfamiliar areas. Staff will be given written copies of directions for such appointments and calls will be made by the Clinical Specialists to inquire about parking situations and requirements to alert staff and Coordinators of available parking and any associated costs. This will be communicated with staff prior and funds will be made available to ensure staff has all resources required. Last minute Staff call outs or person served also contriubute towards the missed apt.

Objective #2: Maintain the low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 6.5 % yearly.

CSC has contracted with Dimensional Health Care Associates for nursing delegation. As per delegation Policies delegating nurses ensure proper documentation and tracking of medication errors as part of a quality assurance plan. The graph indicates the medication administration error rate for the error category "Major Errors." This error category is made of up failures by staff to give medications as prescribed. It is our goal to reach at a level not to exceed 3% medication errors in any given quarter

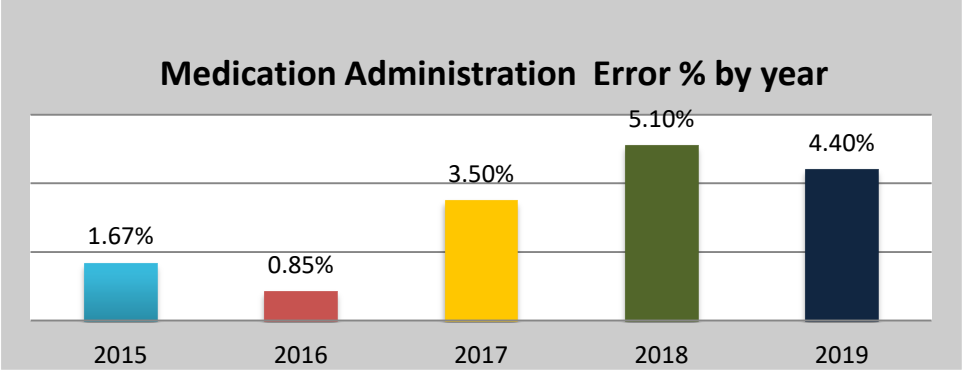


Results/Discussion:

The results indicate that the goal of a less than 3% error per quarter rate was met the for all 4 quarters. The total yearly percentage for 2019 is 4.4% . A yearly comparison shows that the procedures put in place are assisting with improving to reduce medication administration errors under a certain level. Opening up the new group homes clearly was one of the major reason medication errors increased for this year.

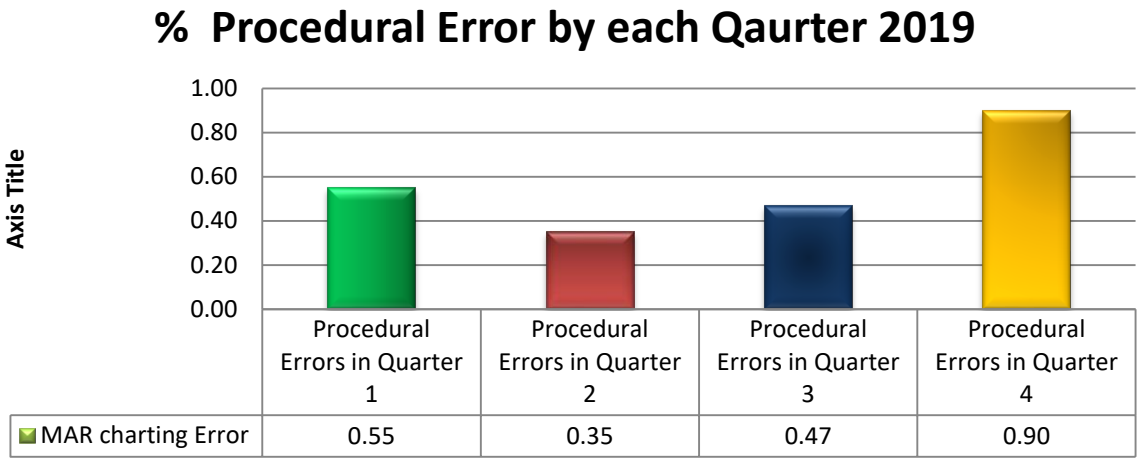
Plan of Action:

CSC has established adequate quality processes and risk-management strategies to prevent medication errors. Coordinators will continue to be required to monitor medication administration at each of their daily house visits. The Quality Assurance team will continue to perform ongoing audits at a frequency of visiting each house approximately 4-5 times a month. Delegating nurses will visit the homes every 45 days. Also Med Rite performs their reviews 4 times a month. CSC will also be monitoring the yearly percentage of the medication errors not to exceed more than 6.5 % per year.

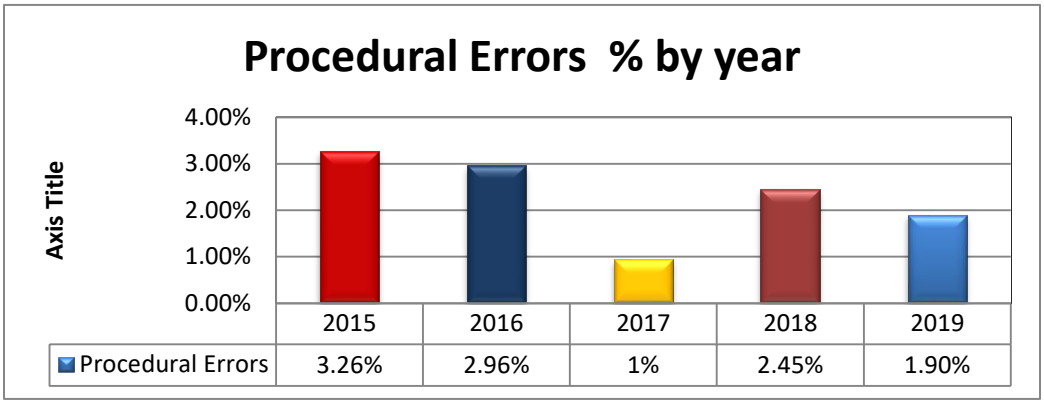


Objective #3: Maintain a rate of occurrence of MAR procedural errors not to exceed 3% for any given quarter

As per delegation Policies delegating nurses ensure proper documentation and tracking of procedural errors as part of a quality assurance plan



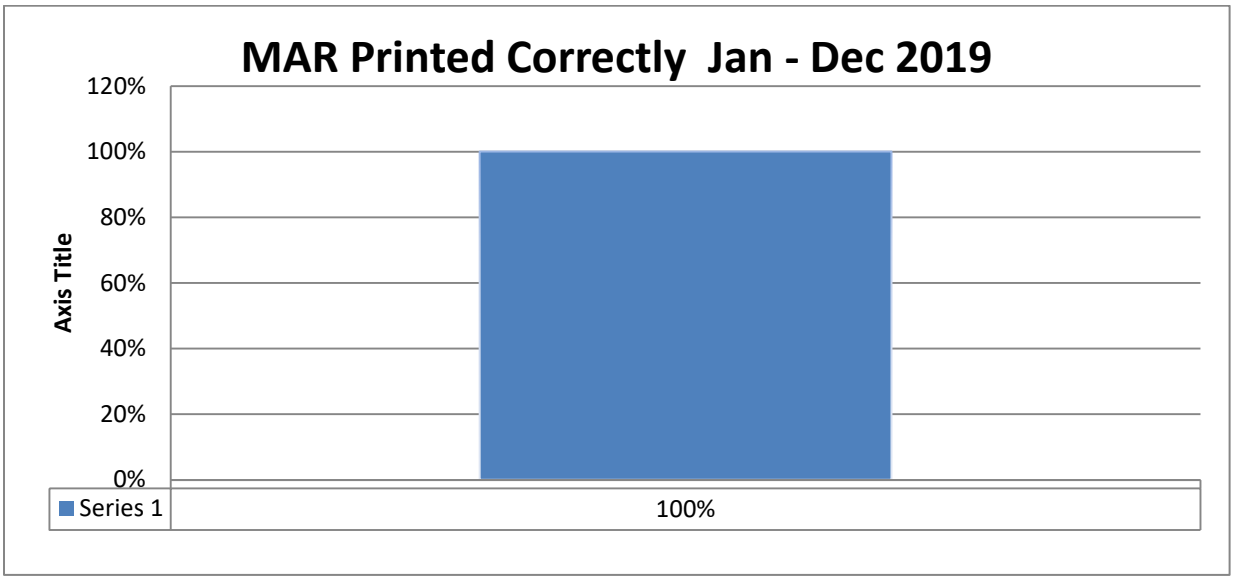
Results/Discussion:
The graph indicates that the goal of a less than 3% rate of occurrence of MAR Charting Errors was met, and exceeded, in all quarters of calendar year 2019.



Plan of Action:
As the goal was met, and as significant improvements were made when compared to the previous calendar year, no changes are planned in the process of maintaining MAR accuracy. It has been noted that compared to last year there has been an increase in the errors mainly due to opening of new houses and issues with staffing which are being addressed.

Objective #4: Maintain 100% rate of MAR's being printed with all the required information (including individual's sex, DOB and delegating Nurse's name)

As Pharmacies continue to increase their involvement in patient care activities they provide to communities or nonprofits , proper and accurate documentation of medical records is absolute necessity. CSC is partnered with Care one Pharmacy to serve the medication needs of our person served.



Results/Discussion:

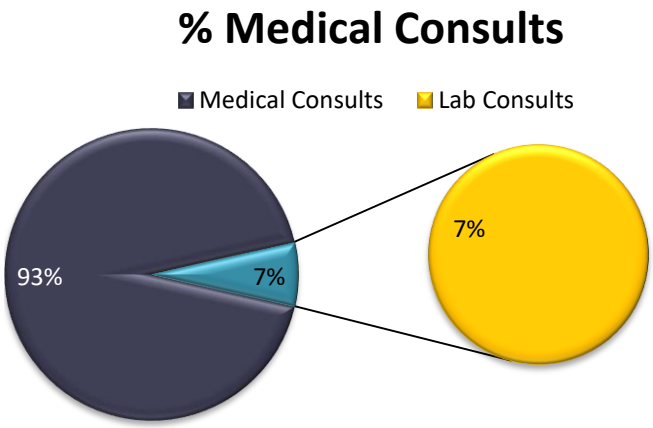
During 2019 four quarterly audits were completed on random individual medical binders. It was noted that 100 % MAR printed without any errors, and with the required information present. All four audits completed were on different information such as person served correct Name, DOB, Gender, Physicians name, Delegating Nurses name, or allergies etc. Audits by clinical and QA staff have been completed and can be located in QA audit section.

Plan of Action:

The Coordinators and Clinical Department will continue to work with Care one Pharmacy to monitor new printed MARs each month to ensure all required information continues to be reflected. Quality assurance audits will be completed planned or randomly and an analysis report will be submitted to Quality Assurance committee.

Objective #5: Achieve a rate of 100% of the completed consult forms to be uploaded in the Therap on line documentation system

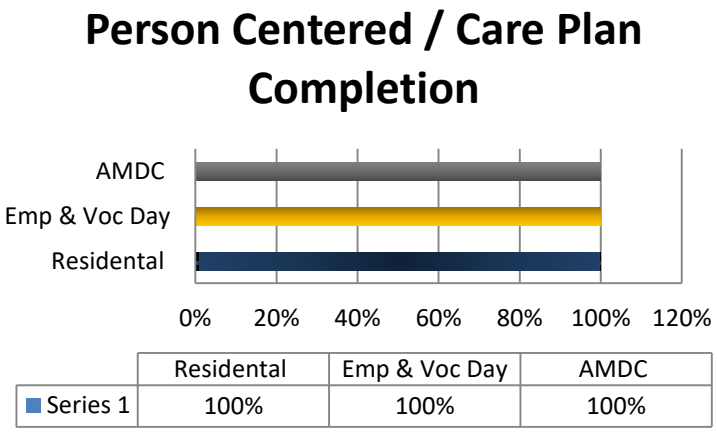
Results/Discussion:
Excluding Phlebotomy when there is a delay in receiving results, a total of 5250 completed consult forms were successfully uploaded in Therap. Lab consults were total 405 Total number of consults uploaded in THERAP was 5655.



Plan of Action:
Clinical specialists will continue to process and upload consultation forms within 48 business hours of completion of each appointment. Quality assurance team will continue to monitor the completion-upload of the consultation form in the Therap online documentation system.

Objective #6: Achieve 100% of all person centered plan's being up-to-date in AMDC , Community Housing, Employment & Vocational Day Habilitation Services.

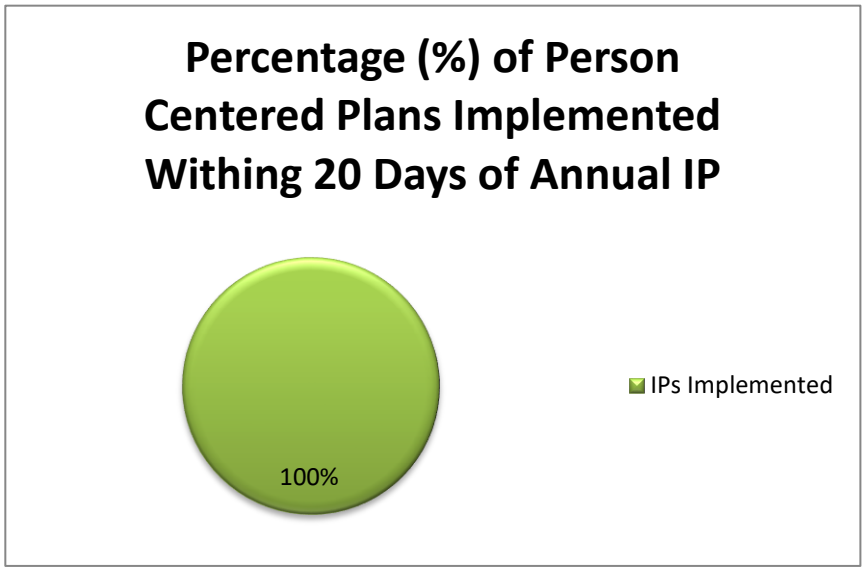
The Quality Assurance Coordinator is responsible to gather the data during Programs meetings where the program specialist report how many Person centered plan are due, completed or upcoming. For this year the entire Person centered plans were audited to determine if the current had been put in place within the required one year from the date of the last plan. A database is kept up to date to identify when the last planning meeting was held and when the next one is due. Program Specialist, update once the planning meeting is occurred for the person served. During the quality assurance monthly meeting the status of the annual meeting is discussed including any delays , or cancelations. Graph below, shows the results of that audit:



Results/Discussion:
During this year there were 253 Individual Plan completed by CSC within 365 days. During the QA meeting , Program specialist provide monthly schedule for individual plans & Implementation to QA manager.

Plan of Action:
The dates for all Person Centered Plans (Community Housing or Vocational) have been entered into a database which calculates the "next IP due date". IP meetings are scheduled based on this database, thereby ensuring that no IP meeting, with a resulting IP, will go beyond the required 365 days. The IP data base is updated every time an IP meeting is completed and IP is implemented within the 20 days for each individual.

Objective #7: Achieve 100% of IP implementation Within 20 days of annual meeting.



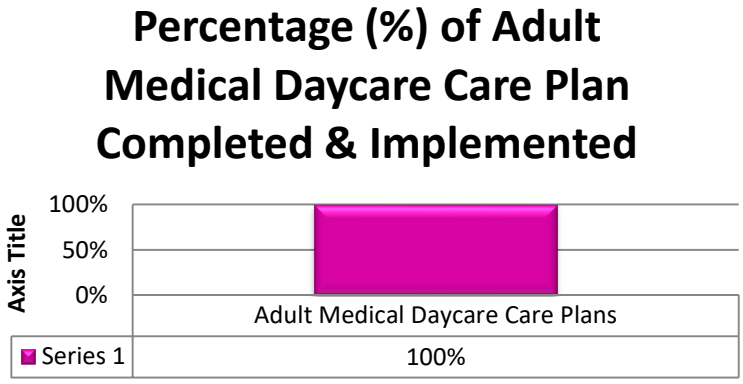
Results/Discussion:
From a total of 253 individuals, 253 annual person centered plans were implemented within 20 days of the annual IP, with 0 IP outstanding.

Plan of Action:
One of the barrier identified is with children's person centered plan is receiving signed documentation from the DSS guardians. Program Specialist will continue to schedule the implementation date as soon as the IP date is confirmed with teams. They will continue to follow up via use of emails and phone calls to ensure they receive the final IP from the Resource Coordinator within the required time for implementation.

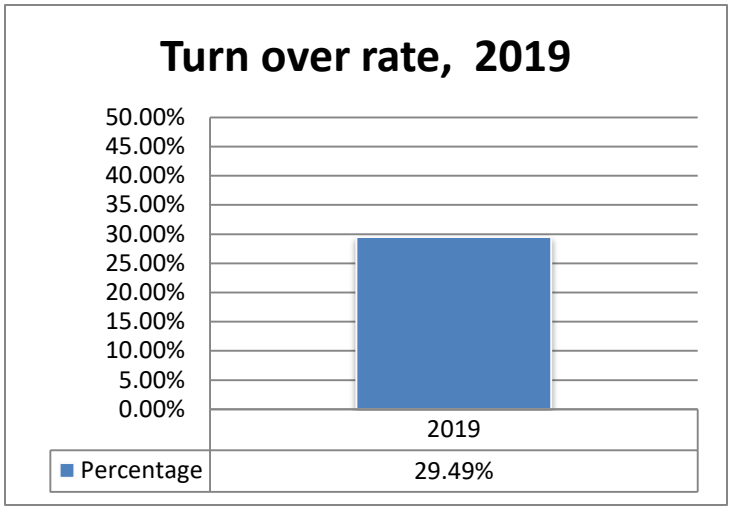
Objective #8: Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare

Results/Discussion:
All Adult Medical Day participants have a care plan completed upon admission and reviewed and updated as necessary every six months. A Social Work evaluation needs to be completed with the first 10 days and a Social Work progress note is due after the 5th Nursing note. ADMC uses a QA client chart form to keep a check on all the necessary forms. The audit completed of all participants displayed 100% were completed and up to date.

Plan of Action:
As the goal was met, no changes are planned in the process of maintaining care plans at Adult Medical Day.



Objective #8: Maintain a turnover rate of no more than 23% throughout the calendar year 2019

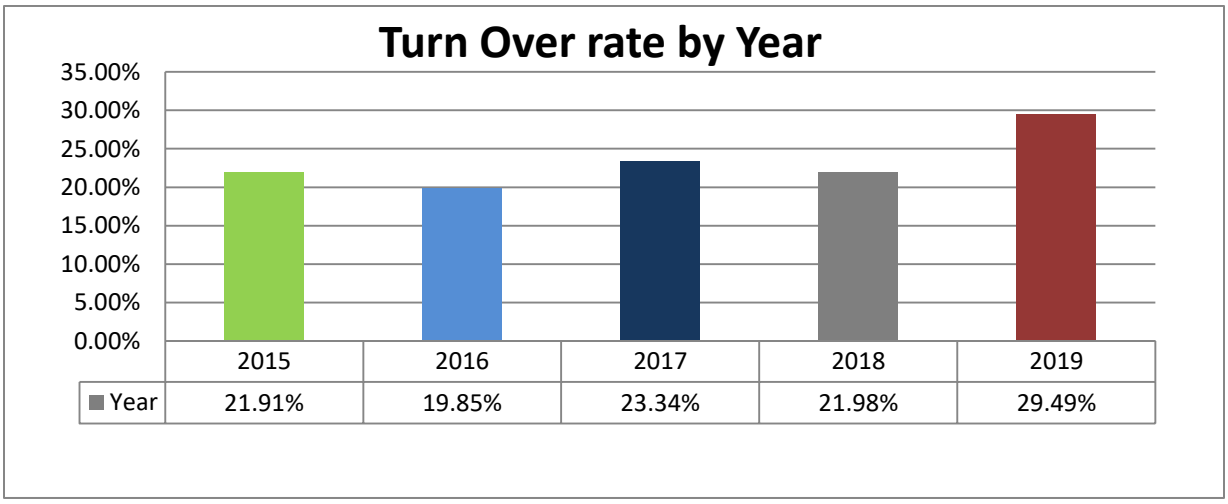


Turnover is defined as anyone leaving the job for any reason, regardless of that staff person's tenure. The rate of turnover was determined by identifying the average number of staff that were active (i.e.- received a paycheck) during 2019, how many staff left employment during 2019, and finally calculating the percentage of staff who left employment.

The average number of Staff Personnel s 668. The number of staff leaving employment during the calendar year was 197.

Results/Discussion:

The goal of maintaining a turnover rate of no more than 23% was not met and has been the highest in the past 5 years. The turnover rate has been steadily decreasing over the past several years however opening 4 more homes contributed towards the increase in the turnover rate.

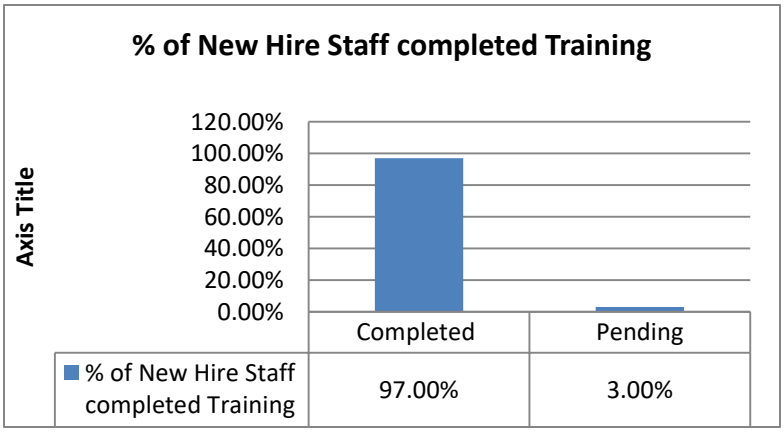


Plan of Action:

A number of incentives for staff have been developed during the previous and past year, and it is the belief of CSC's leadership that these incentives have helped to improve morale, resulting in a decrease in turnover. One of the barriers identified is starting wage which is very close to minimum wage . CSC has offered a sign on bonus to attract potential staff personnel and to address the barrier. Special Recognition Programs with cash bonuses or other rewards; promotion from within the ranks of direct support staff; other special programs. Another barrier is the termination of staff personnel. Awake overnight policy was strictly implemented which resulted multiple resignations by the staff personnel. All of these programs will be continued into the next calendar year, and new programs will be designed and implemented.

Objective # 9: Achieve a completion rate for DDA-mandated/Core trainings 100% for all staff hired during calendar year 2019

Newly hired staffs are required to complete a set of DDA-mandated trainings within 3 months of their hire date. In order to determine the percentage of such trainings which were completed within the required time frame, an audit of HR files was completed to identify those staff who were: a) hired during 2019 and b) who would have been required to complete DDA-mandated trainings by 12/31/19 As each staff member is required to complete 19 DDA-mandated trainings.



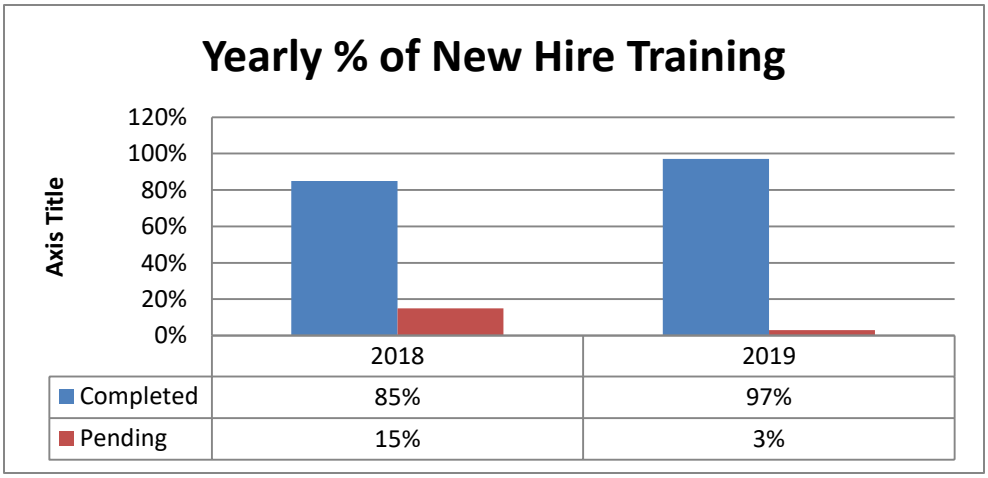
A subsequent audit of calendar year 2019 Training files for these newly hired staff members revealed that out of the 19 DDA required trainings, 8 staff needs to complete these trainings

Results/Discussion:

As of December 2019 , eight new hire staff have 90 days to complete their trainings. That bring the total number of new hire staff to 127 and total training needs to be completed to 2413. The primary difficulty in getting all staff trained within a 30 day period is that many staff has multiple jobs, and scheduling a several-day training can be difficult. Also comparing to the last year when 17 trainings were required, now the staff have to complete 19 trainings. Also quite a few pending results delayed the completion of the trainings. High Turn-over , staff arriving late to the trainings and require to be rescheduled again were also a barrier.

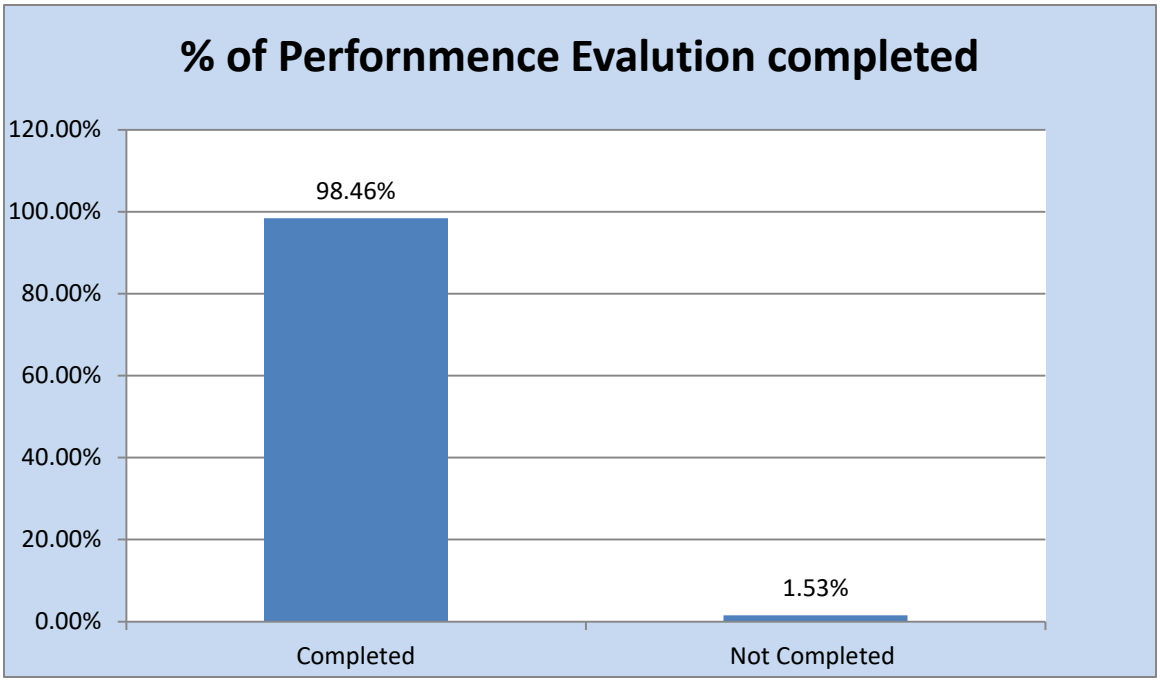
Plan of Action:

CSC will continue to use STED to monitor the completion rate of new hire training, Since this goal has been achieved, CSC developed a new goal of monitoring over all staff training.

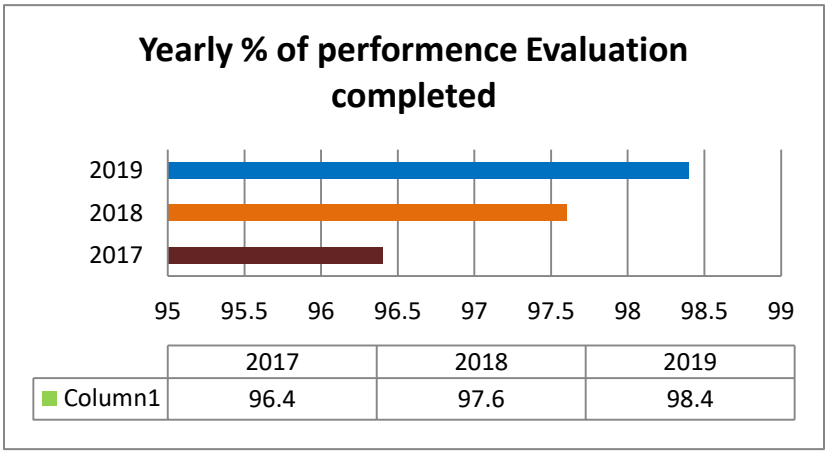


Objective #10: Achieve and maintain a completion rate of 95 % performance evaluations completed on time

A monthly audit of employee records is conducted to ensure that annual staff personnel performance evaluations are completed on time. Graph, below, shows the results of this audit:



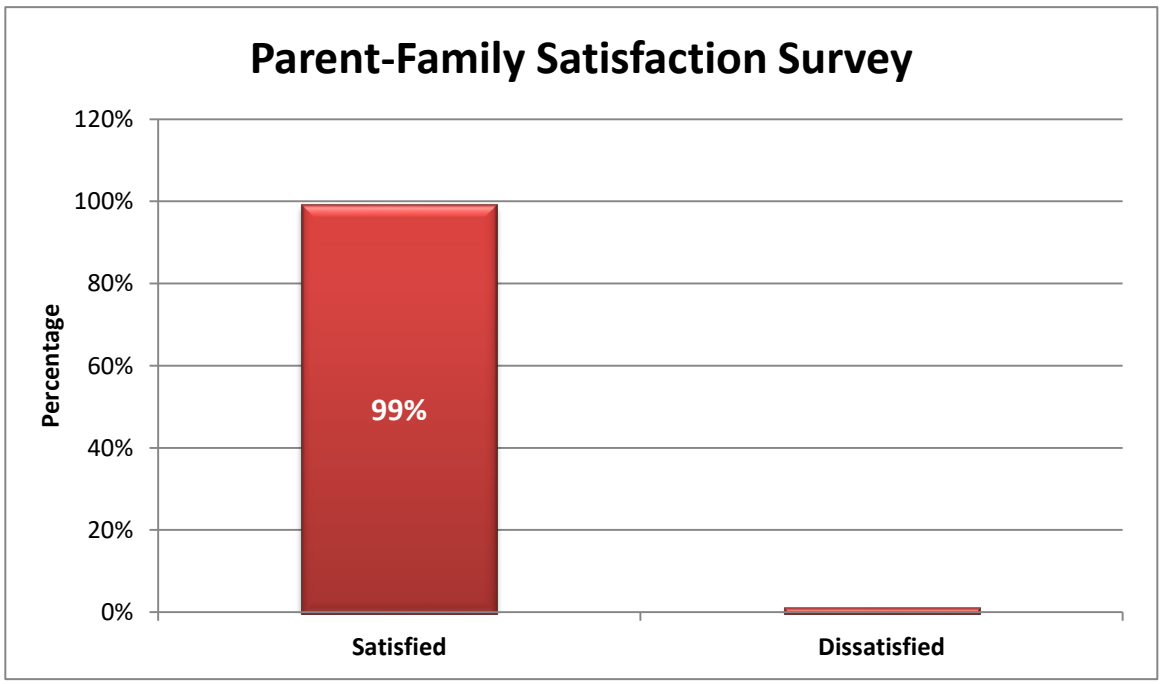
Results/Discussion:
The 98% success rate met the stated Objective. Out of 331 staff, 127 were new hires and their evaluation is due next year. An audit was completed on quarterly performance evaluations. It is noted that even though staff hire date might be different then there actual direct work date. For that reason, 30 + or – days are given for the performance evaluation as the staff are getting their trainings completed after they are hired.
At the end of 2019 there were only 3 incomplete evaluations.



Plan of Action:
A list of evaluations due will be provided to all supervisors at the beginning of each month during the programs meeting. Completion of such evaluations will be monitored weekly throughout the month to ensure timelines are continued to be maintained and met. HR staff meets the coordinators during programs meetings.

Objective # 11: Increase family member satisfaction to at least 95%

For this year we track the level of satisfaction of Individuals served and their family members (parents, legal guardians, siblings who are actively involved in the treatment planning of the individual). It was decided to employ the same survey that was used in previous years for each group so that a comparison could be made between groups. Distribution of family member surveys was done at the Annual IP meeting and during the visits with the individuals.



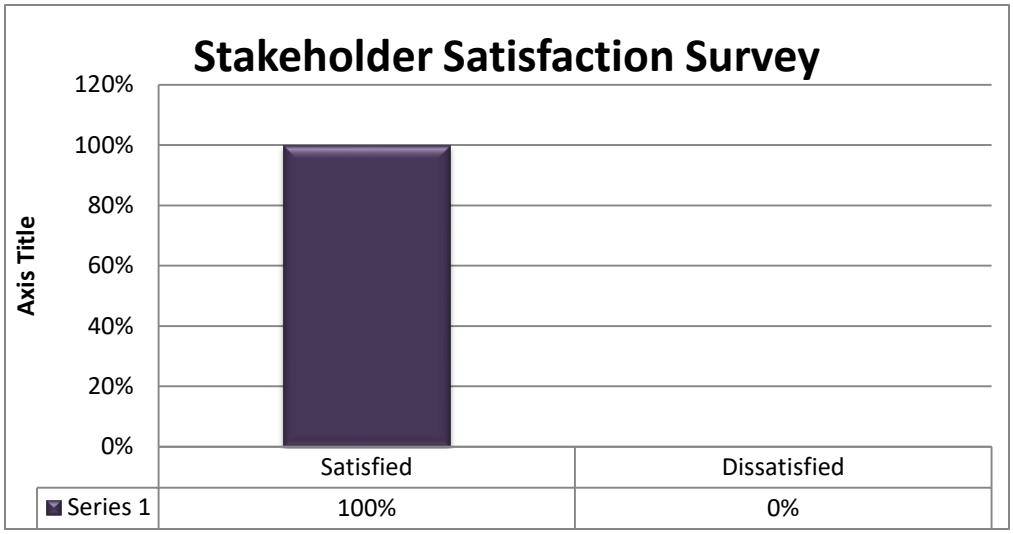
Results/Discussion:
One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions.

Total # of Families Surveyed	**6**
Total # of Satisfied Responses	59
Total # of Dissatisfied Responses	1

Plan of Action:
Program specialist and Coordinators are responsible to maintain contact with the family member on weekly basis. This survey will be repeated in year 2019 to compare the averages of 2019. There has been an decrease in the responses from the family members as well. Program Specialists will provide copies of this survey to family members at annual IP meetings to increase participation.

Objective #12: Increase Stakeholder satisfaction to at least 95%

For this year we track the level of satisfaction of community members and stakeholders. It was decided to employ the same survey that was used in previous years for each group so that a comparison could be made between groups. Surveys to measure stakeholder satisfaction were prepared and disseminated to the stakeholders in July 2019.We are gathering stakeholder input for the purpose of Continuous Quality Improvement (CQI). Doing so will enable us to identify areas of satisfaction (or dis-satisfaction), allowing us to target these specific areas that need improvements.



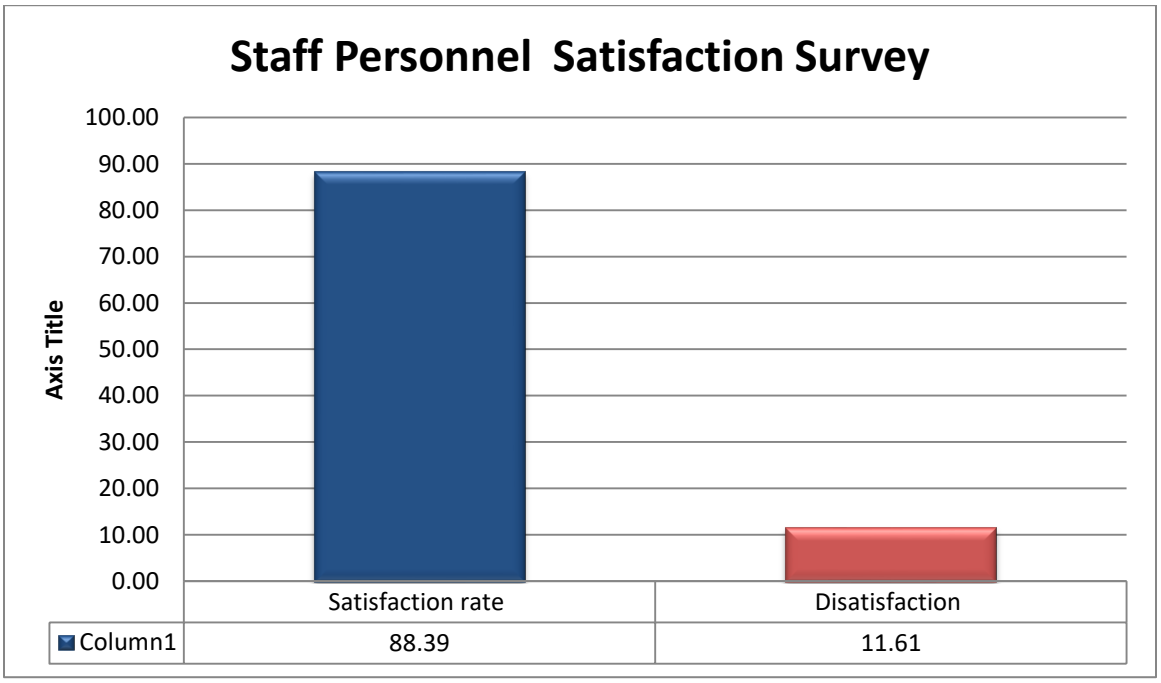
Results/Discussion:
One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions. Only one stakeholder stated no for knowing CSC policies.

Total # of Stakeholders Survey received	**9**
Total # of Satisfied Responses	45
Total # of Dissatisfied Responses	0

Plan of Action:
The highly positive results indicate that no specific Plan of Action is needed. Therefore, the Plan will be to continue the processes that are already in place. CSC will attempt to reach out to more community members including stakeholders, neighbors and member organizations to gather feedback and to increase the number of responses and feedback.

Objective #13: Increase Staff Personnel satisfaction to at least 90%

We are gathering stakeholder input for the purpose of Continuous Quality Improvement (CQI). Doing so will enable us to identify areas of satisfaction (or dis-satisfaction), allowing us to target these specific areas that need improvements. For this year we track the level of satisfaction of staff personnel. It was decided to employ the same survey that was used in previous years for each group so that a comparison could be made between groups. Surveys to measure employee satisfaction were prepared and disseminated to the staff personnel in July 2019.



Results/Discussion:
One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions.

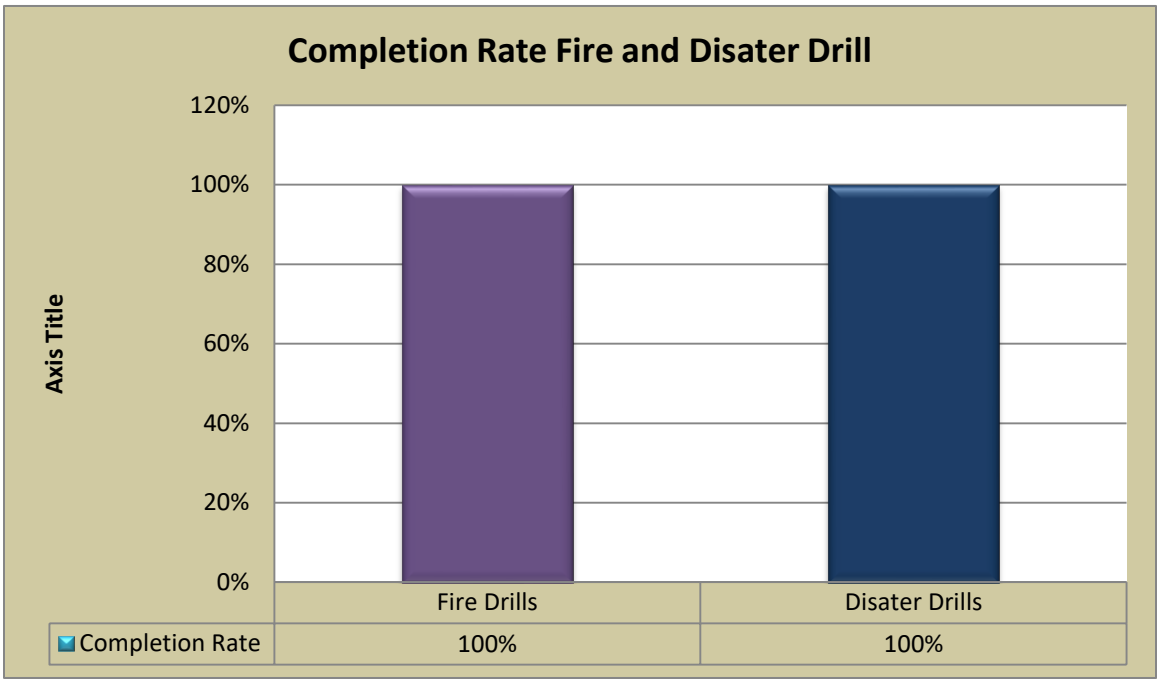
Total # of Staff personnel Survey Received	**81**
Total # of Satisfied Responses	716
Total # of Dissatisfied Responses	94

Plan of Action:
The results looking at all responses, only 11.61 % of all responses were displayed dissatisfaction. Most of these were a result of part time staff not satisfied with benefits provided. One of the barriers identified is starting wage which is very close to minimum wage . CSC has offered a sign on bonus to attract potential staff personnel and to address the barrier . Many part time staff are now offered health insurance. HR will continue to reach out to part time staff to offer full time positions to such staff prior to employing outside applicants to provide positions were all benefits can be deliverable to these staff personnel.

Objective #14: Maintain at least a 100% rate of compliance to completion of fire and disaster drills

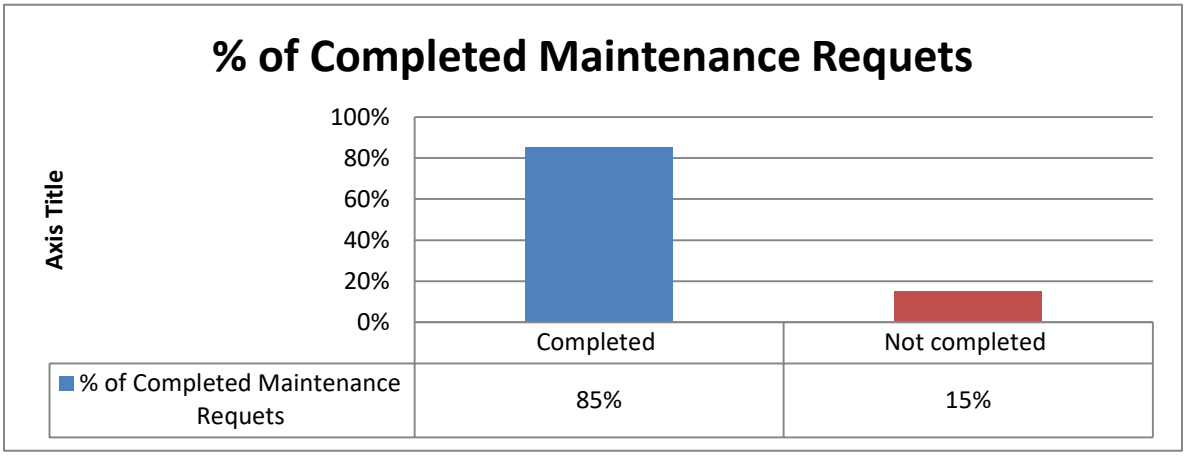
Results/Discussion:
All fire and disaster drills are completed appropriately as required. CSC has implemented a system to complete a disaster drill (now referred to as an emergency drill) monthly and rotating the shift as well as utilizing the various emergencies identified in the CSC Emergency Preparedness Plan. Disaster Drills also included, Bomb Threat, Utility shut off, violence and natural disasters.

Plan of Action:
A schedule of fire drills will continue to be maintained, ensuring each shift completes such drills throughout the year. Disaster drills will continue to occur monthly. The schedule has been modified to include the violent behavior, Natural disaster; utility shut off and bomb threat for all the shifts. No action plan needed.



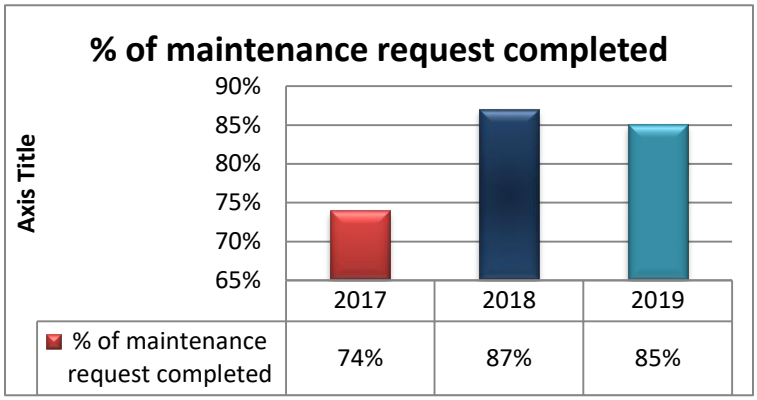
Objective #15: Maintain turnaround of addressing maintenance request within 24-48 hours with completion rate of 85% during a year.

Center for Social Change currently operates **43** group homes which are located in the communities of Randallstown, Windsor mill and in the Laurel / Savage area. Maintenance department receives service request through coordinators and direct staff which is then assigned to different maintenance staff.



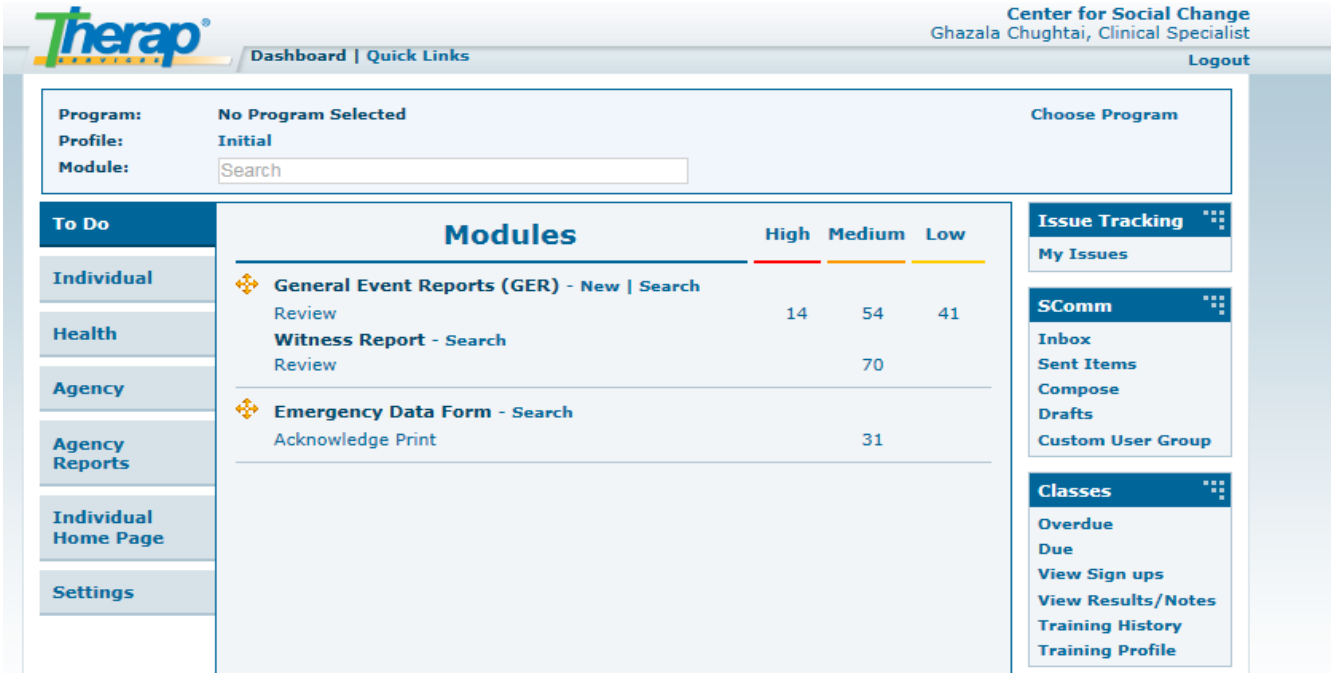
Results/Discussion:
As per the maintenance data base total number of request received in calendar year 2019 were 509 and # completed were 428. Some of the requests were delayed as the staff had to order either new parts for the certain appliances or order the items directly from the store.

Plan of Action:
Staff and coordinators will continue to submit the request to the maintenance department. Maintenance department will continue to work on the request and making sure that the data base is updated on time. A barrier identified is the lack of maintenance staff to complete the maintenance request. HR is in process of filling these positions as of now. Graph below shows that completion rate has increased comparing to last year.



Objective #16. A Utilized THERAP at least 75 % for all people served demographics, IP and outcomes

The objective of using Therap was met. As of now staff is capturing the data for demographics on the system as well as IP / BP and progress. Behavioral incidents are documented on THERAP and report can be generated as needed .



Quality assurance staff are also using and updatining the demographics and are able to pull reports directly from THERAP.

Demographic Report :: Top 10 Diagnosis
Diagnosis Code Report
Diagnosis Report :: all Individuals with the Program Enrollment and Discharge Date This report includes diagnosis details such as ICD 10 Diagnosis Code, ICD 10 Description, and Primary Diagnosis (Yes/No) along with basic details from the IDF such as Program Enrollment and Discharge Date.
Diagnosis Report - All Active Individual (Without Program)
Diagnosis Report - all active Individual by Program
Diagnosis Report - All Active Individual with Program List of Active individuals with all Diagnosis.

Plan of Action:

Staff personnel will continue to use and update THERAP. The objective modified to use Therap at 75% for next year.

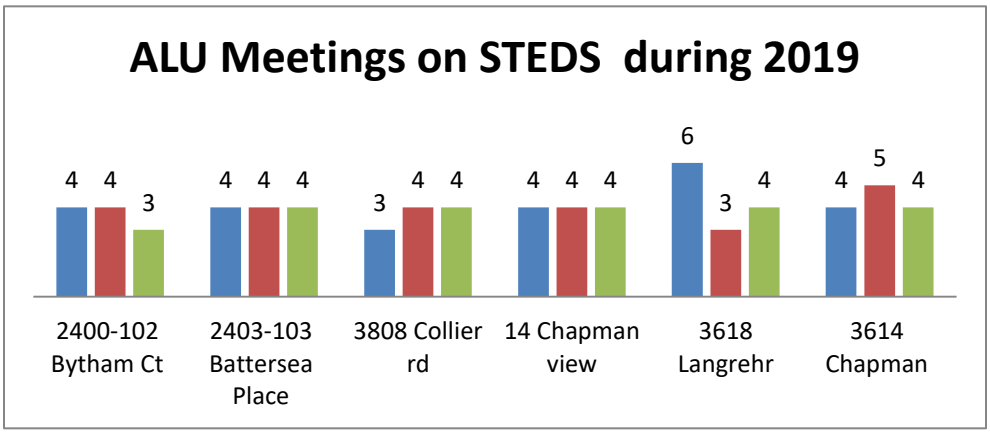
Objective #16. B Utilizing STED 100% for all mandated trainings throughout the calendar year 2019

In 2017, CSC introduced STEDS (Staff Training & Electronic Documentation System) a full-fledged online training and electronic documentation software developed by CSC. STEDS is an in-house software CSC has the flexibility of expanding this system according to CSC's future requirements.

Plan of Action:
Goal of utilizing STEDS 100% for all mandated trainings is met . Staff personnel have access to complete the trainings online using STEDS.

Objective #16. C Utilizing STED 80% for ALU meetings minutes

STEDS , The online documentation section (Friday Packet) of the system has house Meeting Notes – to report each week's house meeting notes to the Program Team. These meeting minutes are used to identify activities And concerns of person served. A sample audit was completed for 6 ALU for the completion of ALU meeting minutes.



Plan of Action:
Goal of utilizing STEDS 80% for all mandated trainings is met . Staff personnel have access to completed ALU meeting minutes for the sample homes. It is noted that few homes are still using paper form for the individual with funds or activity request as a signature is required for the funds request. No action plan is required.

Incident Reporting

Reportable/Non-Reportable Incidents January, 2019 – December 31, 2019

Between January 1, 2019 and December 31, 2019, 286 incidents reportable with an A7 have been reported .The incidents occur with the frequency noted below for the following categories:

Reportable Incidents:

Abuse/Neglect	25
Death	3
Hospital/ER	66
Hospital/Psychiatric	39
Inhumane Treatment	0
Injury	22
Other	11
Police	93
Restraint	0
Sexual Abuse	1
AWOL	25
Theft of Individual's Property or Funds	1
Total	**286**

Internally Investigated incidents

A total of 172 internally investigated incidents occurred during calendar year 2019; these were reported on the A5 form. A breakdown of the types, and frequency of occurrences, is shown below: Generally, the distribution pattern of internally investigated incident types is quite similar to that found in the Reportable Incident list- that is, "Hospital visits" and "Police" visits occur with the greatest frequency in both the Reportable Incident list and the internally investigated incident list. This is, perhaps, not unexpected.

Internally Investigated incidents

Hospital/ER/Psychiatric	108
Injury	5
Police	39
AWOL	9
Other	11
Total	**172**

The majority of the largest incident category, Hospital Visits is visits due to medical issues expected for the individuals involved. Examples include ER visits for: seizures; wound care, g-tube care, behavioral etc .The Standing Committee *(see Appendix B for Standing Committee details*) reviews all incidents to determine whether the responses made by staff and the agency were appropriate, and whether any systemic changes need to be made to avoid such incidents in the future.

Appendices

Appendix A - Resources Used for Data Collection and Analysis

Analysis of Medical/Nursing Services

Therap Online Documentation which contains all information regarding:

- Medical appointments (PCP and specialty)
- Annual physical examinations
- Laboratory workups done
- Hospital/ER visits
- Nutritional evaluations
- Initial nursing assessments
- Nursing Plan of Care
- 45 Day Reviews
- Interim nursing visits (in follow-up to hospital visits)
- The scheduled date for all medical appointments (day/time)
- Whether or not the appointment was successfully kept
- If not kept, reasons why appointments were not kept
- Staff member responsible for ensuring the appointment is kept

Medication Administration Books which contain:

- Current MARs
- Current PMOFs
- Various log sheets (e.g. - blood pressure logs, blood sugar logs, weight logs, seizure logs, etc.)
- Nursing Plan of Care

Analysis of Individual Plans

- Individual Plan/Behavior Plan Database- contains information regarding:
- Start date for IP/BP and for each individual
- Expiration date for IP/BP for each individual
- Required meeting sign-in sheets
- Required individual permission/consent forms
- Copies of IP's and BP's, including goals and Progress Notes
- Implementation dates for IPs

Analysis of staff training

HR Database- contains information regarding:

- Start date for all individual staff
- Documentation of all required personnel information
- Documentation of all required trainings
- Evaluation due dates

Training Database- contains information regarding:

- Schedule for all required pending training for all individual staff
- Documentation of completion of all required trainings for all individual staff
- Expiration dates for all required trainings, certification, etc. for all individual staff

Analysis of Incident Reporting

Incident Reporting Database- containing information regarding:

- Type of incident
- Place of incident
- Date of incident
- Staff involved
- Nature of incident
- Status of A-5/A-7 reporting
- Investigator
- A5 and A7 reports

Analysis of Stakeholder, family, employee Satisfaction

- Stakeholder Survey
- Parent/Family member Survey
- Employee Survey

Appendix B - Members of Standing Committee

Members of the Standing Committee at CSC are:

Review of BPs

Licensee Staff:

- Dana Dimas, Chief of Programs - Chair
  (dana@centerforsocialchange.org)
  6600 Amberton Drive, Elkridge, MD 21075
  410-579-6789

- Thomas Alexander, Operations Manager
  (thomas@centerforsocialchange.org)
  6600 Amberton Drive, Elkridge, MD 21075
  410-579-6789

Community members:

- John Senyard jsenyard@verizon.net

- Patricia Graham patgraham50@yahoo.com

Review of reportable incidents:
Licensee staff:

- John Dimas, Quality Assurance Coordinator (john@centerforsocialchange.org)

- Thomas Alexander
  Operations Manager, CSC (thomas@centerforsocialchange.org)

Community members:

John Senyard jsenyard@verizon.net

Patricia Graham patgraham50@yahoo.com

Alternate member: Sajid Tarar.

The Standing Committee meets at least quarterly.

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