Center for Social Change

QUALITY ASSURANCE PLAN

JANUARY - DECEMBER 2021

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Table of Contents

EXECUTIVE SUMMARY

Center for Social Change 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 Anne Arundel Counties. Currently, Center for Social Change offers COMMUNITY HOUSING services for adults and children in assisted living, CSLA homes, ALUs and group homes. CSC also operates ADULT MEDICAL DAYCARE PROGRAM, EMPLOYMENT SERVICES, VOCATIONAL and DAY HABILITATION PROGRAMS.

2021 HIGHLIGHTS

Center for Social Change went through the CARF accreditation for the **Fourth time in 2020**. CSC was granted 3-year accreditation for all the programs including Community Housing for adults and children, CSLA, Assisted Living, Employment, Vocational and Day Habilitation, and Adult Medical Daycare. The Board of Directors reviewed the 2021 Outcomes and progress for Center for Social Change.

PROGRAM EXPANSION

Center for Social Change currently operates **41** 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 2021, 140 individuals were supported in CSC's Community Housing and Assisted living Program. During 2021 there were 24 admissions, mostly to the Children's Program and 10 discharges throughout 2021.

During 2021, due to the COVID pandemic Employment, Vocational and Day Habilitation and Adult medical day programs were closed until April 2021. The programs opened slowly with 50% participation on alternating days until May 2021 when all individuals were arranged to return. Some individuals chose to continue to participate virtually.

COVID-19 PANDAMEIC IMPACT

There are unique stressors and challenges that could worsen mental health for people with disabilities during the COVID-19 crisis. As the United Nations Human Rights agency states in their guidance for covid-19 and the rights of persons with disabilities that while the COVID-19 pandemic threatens all members of society, persons with disabilities are disproportionately impacted due to attitudinal, environmental and institutional barriers that are reproduced in the COVID-19 response. They may experience intensified feelings of loneliness in response to physical distancing measures.

Persons with disabilities face specific barriers in carrying out their daily lives in the community due to COVID-19 response measures. In particular, stay at home restrictions that do not consider their needs create disruptions and new risks to their autonomy, health and lives.

In addition, some persons with disabilities, such as persons with psychosocial disabilities and autistic persons, might not be able to cope with strict confinement at home. Short and careful outings throughout the day are key for them to cope with the situation.

CSC'S KEY ACTIONS AND PRACTICES FOR PERSON SERVED DURING PANDAMIC:

- Identify and remove barriers to treatment including ensuring accessible environments (hospitals, testing and quarantine facilities), as well as the availability and dissemination of health information and communications in accessible modes, means and formats.
- Ensuring the access to technology at group hoes such as IPADs for telehealth visits.
- Ensuring the continued supply and access to medicines for persons with disabilities during the pandemic.
- Ensured ample access to PPE to staff and person served.
- Ensured priority testing of persons with disabilities presenting symptoms.
- Ensure access to Internet for remote learning and ensure that software is accessible to persons with disabilities, including through the provision of assistive devices and reasonable accommodation.
- Developed accessible and adapted materials for students with disabilities, to support remote learning.
- Employment and Vocational person served began participation on alternating days until May 2021 when all individuals were arranged to return. Some choose to continue to participate virtually.

COMMUNITY EDUCATION, INVOLVEMENT AND OUTREACH

In 2021, 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 have been approved by DDA.

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

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. During the Pandemic, CSC has continued its 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. During 2021, these meetings were attended via zoom. CSC is an annual sponsor for the Liberty Road Tree Lighting Ceremony at the Randallstown Gateway Park. CSC continued its support even though CSC person served were not able to attend the ceremony itself.

To achieve community integration for persons served, CSC arranged for persons served to enjoy multiple community activities such as a trip to Ocean city, Disney on Ice, Six flags, 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, 55 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 7 Administrative staff were hired, in several departments, during 2021. 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 295 direct care staff, 49 admin staff, 1 RN, and 5 LPN's. CSC also has contracted with Outside clinical staff to provide services to individuals.

QUALITY ASSURANCE OBJECTIVES

2022

Center for Social Change, has identified the following as the objectives for 2022. These objectives are based on the reviews from OHCQ, and suggestions from the Quality Assurance Committee.

MEDICAL /CLINICAL SERVICES

1. Maintain at least a 98% 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 5% 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

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

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

HUMAN RESOURCES

1. Achieve a turnover rate of no more than 24% throughout the calendar year 2022.
2. Achieve completion rate 95% DDA-mandated/Core trainings for all staff during calendar year 2021.
3. Achieve and maintain a completion rate of 97 % performance evaluations completed

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 THERAP at least 80 % for all person served demographics, and Person Centered Plans
2. Utilizing STED 85% for ALU meetings minutes

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 return rate among Staff/Stakeholder and family member satisfaction survey.

QUALITY ASSURANCE REPORT 2021

CSC's Quality Assurance report covers the calendar year 2021, 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 2021

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.

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

PERSON CENTERED PLANS & CARE PLANS:

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 2021.
2. Achieve completion rate 95% DDA-mandated/Core trainings for all staff during calendar year 2021.
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

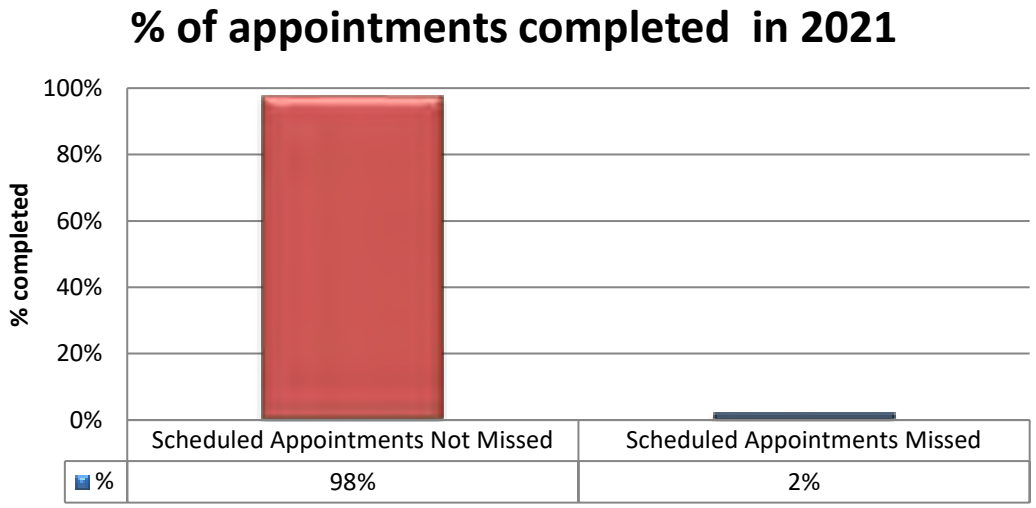
1. Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
2. Maintain turnaround of addressing maintenance request within 24-48 hours with 85% of completion rate.
3. Update the Maintenance database with no more than 30 days of entry missing.

TECHNOLOGY/ HEALTH INFORMATION

1. Utilizing STED 100% for all mandated trainings throughout the calendar year 2021.
2. Utilizing THERAP at least 80 % for all person served demographics, and Person Centered Plans
3. Utilizing STED 85% for ALU meetings minutes

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 3728 appointments were performed throughout calendar year 2021.



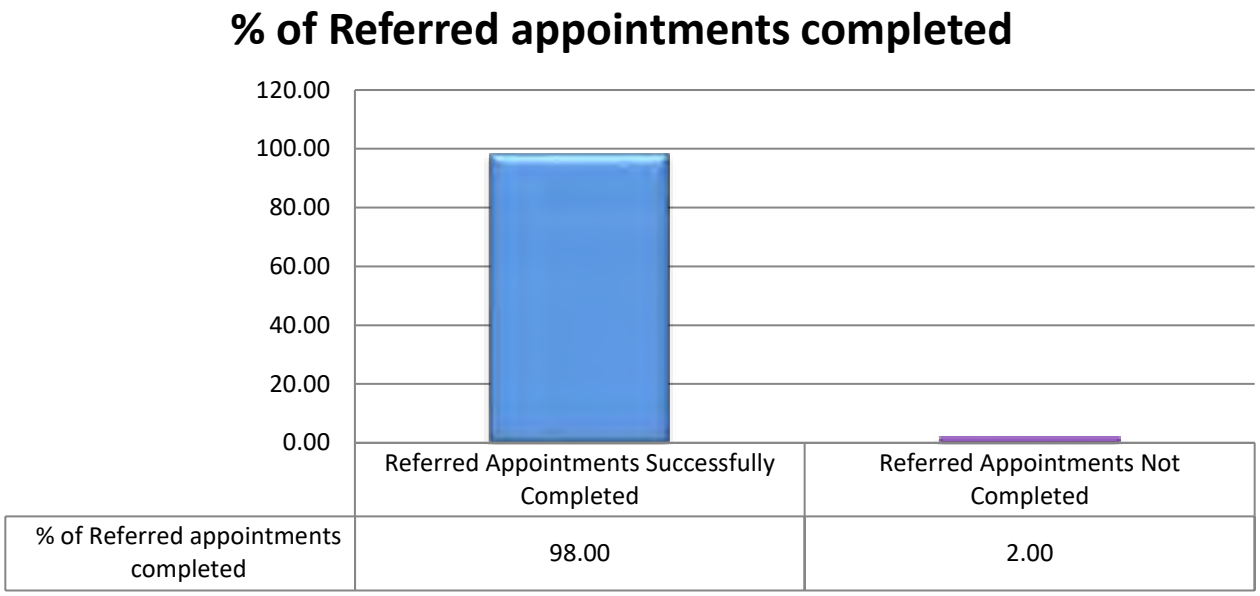
Summary Results/Discussion:
The results indicate that the goal of a **97.6 %** rate of compliance to completion of scheduled medical appointments was met. A total of 3818 were scheduled from Jan – Dec 2021. 3175 appointments were completed on time and 90 were missed.
An assessment of the primary causes 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:

- COVID delays /Cancellation
- Person Served went to the apt and refused to cooperate at the Doctor's Offices.

Plan of Action:
Due to COVID pandemic, medical appointments are being priorities by the need/ availability. 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 pandemic related. 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 2021, a total of 3818 follow up appointments were scheduled. Among those 3798 referred appointments were completed. 90 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.



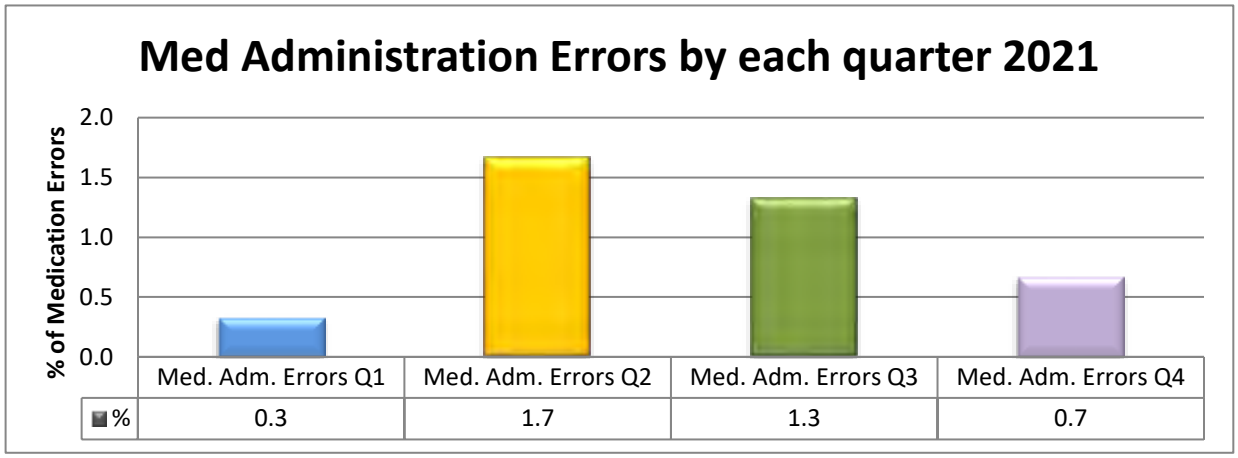
Results/Discussion:
The results indicate that the goal of a 98% rate of compliance to completion of scheduled medical appointments is met through calendar 2021. The remaining 97.36% of referred appointments were completed. The data for the follow up appointments is as follows,

Scheduled on Therap	3818
Completed	3798
Missed	90
Cancelled	370
Re scheduled	370
Declined	146
Total – Otherwise Scheduled	**3818**
Total Otherwise completed	**3798**

Major reason of small percentage of referred appointments were not completed is the pandemic. Clinical staff dealt with high number of rescheduled and cancelled appointment as the specialty medical office were not prepared to treat patients with the extra safety precautions due to COVID pandemic as well as active outbreaks, causing appointments to be rescheduled. As more specialty offices started taking patients back, Clinical specialist have made sure to request any first available, canceled apt from the Dr.'s offices.

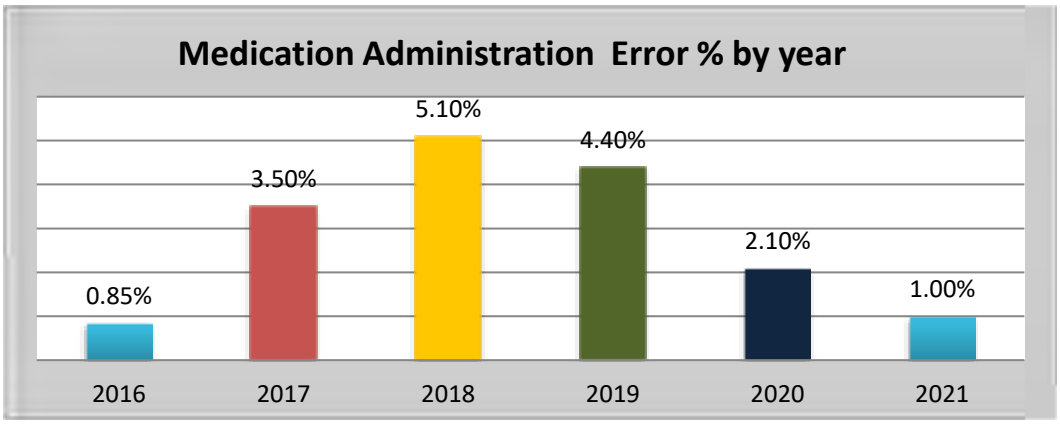
Objective #2: Maintain the low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 6 % yearly.

CSC has continued its contract 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



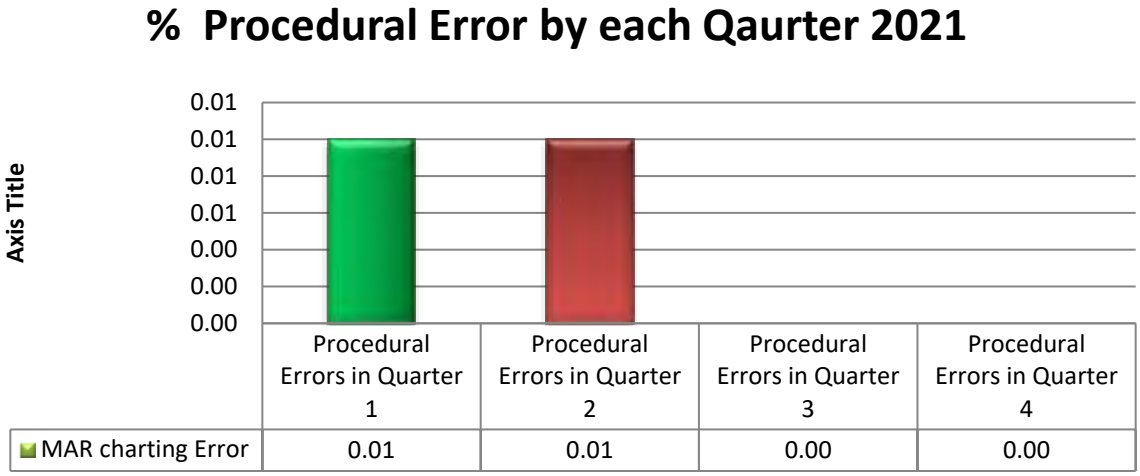
Results/Discussion:
The results indicate that the goal of a less than 3% error per quarter rate was met for all 4 quarters. The total yearly percentage for ***2021 is 1%***. A yearly comparison shows that the procedures put in place are assisting with improving to reduce medication administration errors under a certain level. The pandemic and slower communication for needed resolution had a direct impact on medication errors 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 % per year.



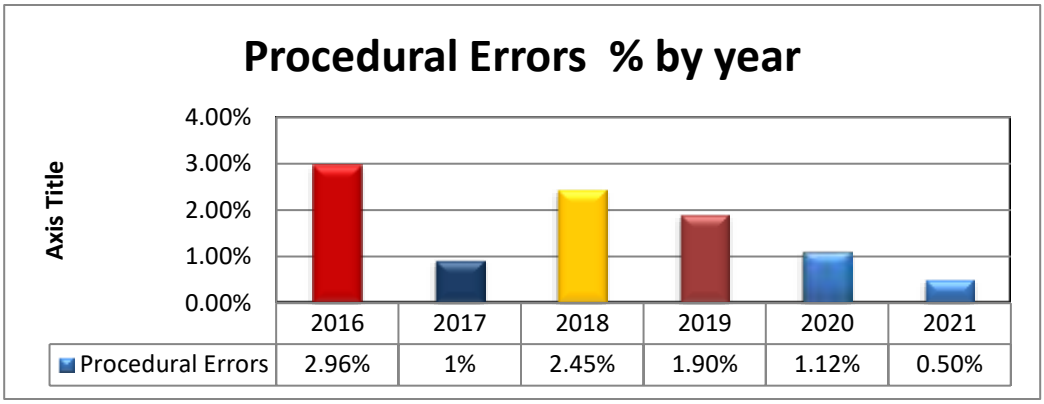
Objective 2.A: Maintain a rate of occurrence of MAR procedural errors not to exceed 3% for any given quarter.

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



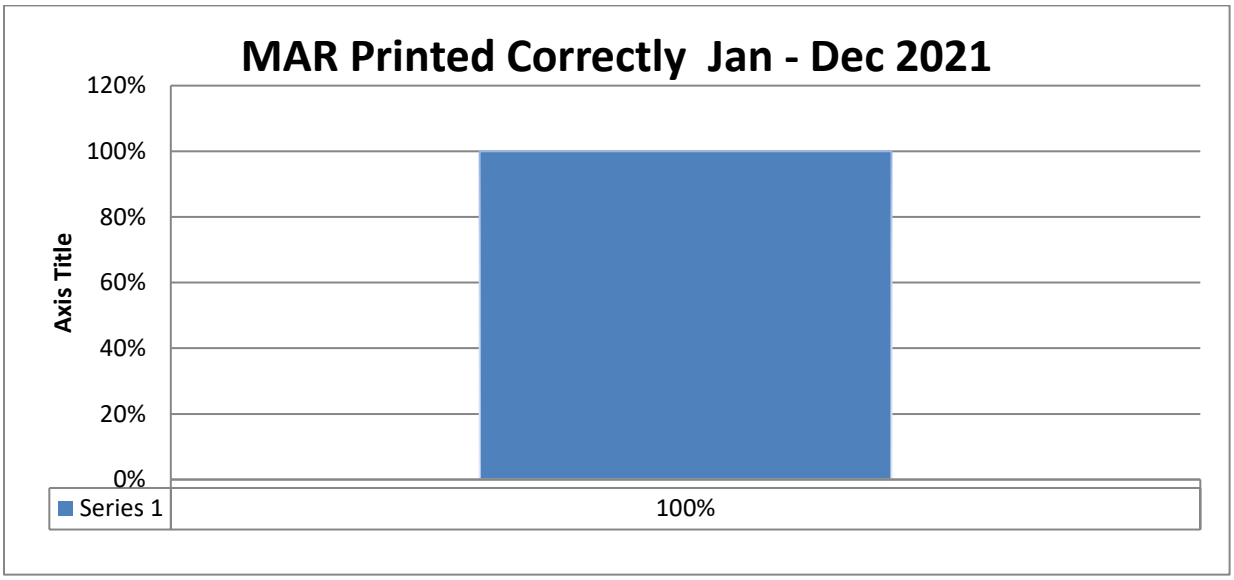
Results/Discussion:
The graph indicates that the goal of a less than 3% rate of occurrence of MAR Charting Errors was met, procedural errors were noted for all four quarters is at .5 % during 2021.

Plan of Action:
As the goal was met, and as significant improvements were made when compared to the previous calendar years, no changes are planned in the process of maintaining MAR accuracy.



Objective 3: Maintain 100% rate of MAR's being printed with all the required information (including individual's sex, DOB and delegating Nurse's name)

During the COVID pandemic, 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 2021, 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.

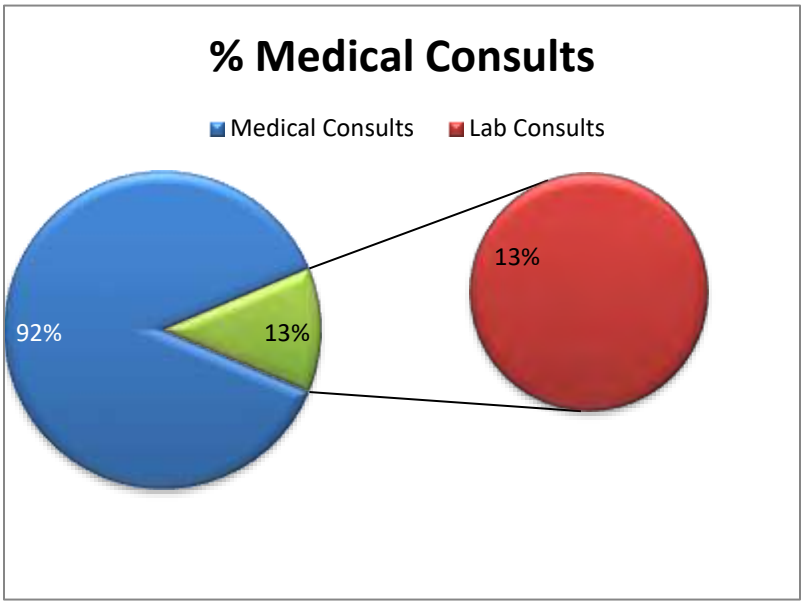
Plan of Action:

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

Results/Discussion:
Based on the audit, a total of 3728 completed consult forms were successfully uploaded in Therap. Lab consults were total 543 Total number of consults uploaded in THERAP was 6860.



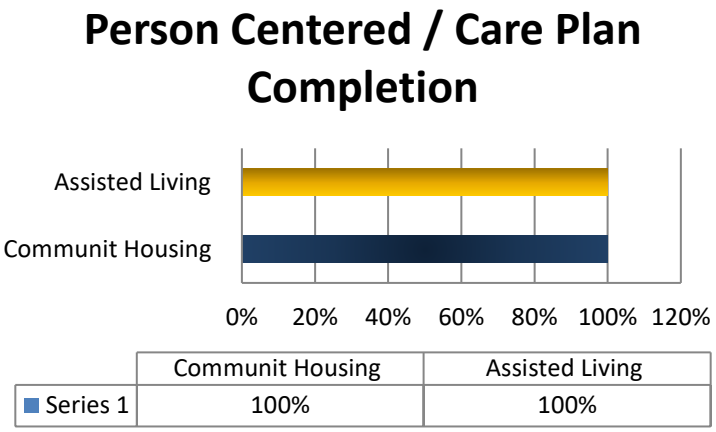
Plan of Action:
During 2021, the biggest challenge for Clinical specialists was to receive the completed consultation forms. Clinical staff will continue to process and upload consultation forms completion of each appointment. Quality assurance team will continue to monitor the completion-upload of the consultation form in the Therap online documentation system.

Objective #5: Achieve a rate of 95% in Nursing/Health Case Management and delegation for interim follow up evaluation after hospitalization.

Results/Discussion:
Goal met
During 2021, there were 141 emergency room visits/hospitalizations that required follow up from the Delegating Nurse. 100% of all emergency room visits/hospitalizations have had completed follow up by the delegating nurse within 24 hours.

Objective #6: Achieve 100% of all Person Centered plan's being up-to-date in AMDC, Community Housing, Assisted Living, 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:



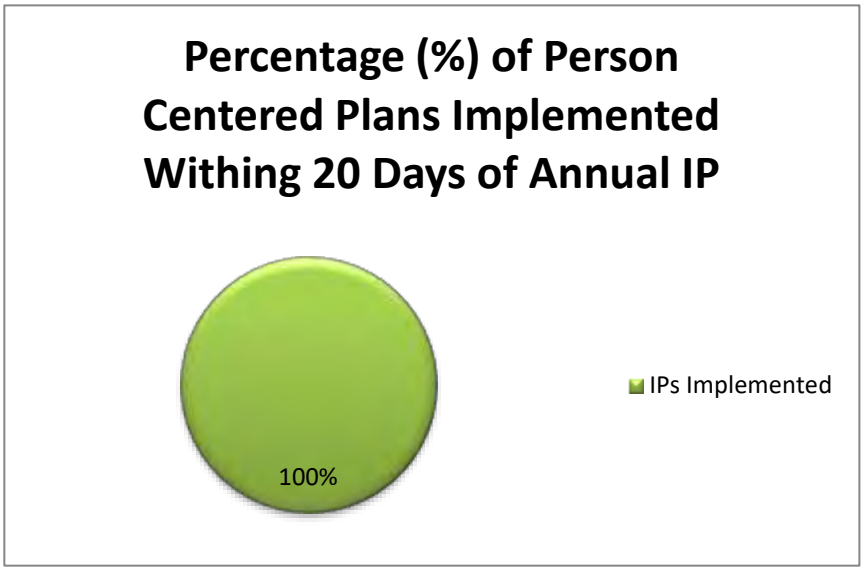
Results/Discussion:
The barrier during 2021 was to complete the annual plans on time via tele conferences. Service coordinators not having access to zoom online conference also was a barrier.
During 2021 for community housing, there were 216 Individual Plans, and 35 care plans for assisted living were completed by CSC within 365 days. These include the Adult medical day, Employment, Vocational and day habilitation annual IP. During the QA meeting, Program specialist provide monthly schedule for individual plans & Implementation to QA manager.

Plan of Action:
Program specialist will continue hold in-person meetings as well as to use Zoom teleconference to hold Annual IP meetings to ensure meetings continue to be held on time.

Objective #7: Achieve 100% of all Behavior Support Plans being reviewed and updated annually in Community Housing, Employment Vocational and Day Habilitation services.

Results/Discussion:
Goal met
In preparation of the annual meeting, the Behavior Plan is sent to the developer with the behavioral data to complete the annual draft prior to the meeting to discuss at the annual meeting. One barrier is obtaining the review and signature from court appointed guardians for implementation as many meetings are not held in person, rather via teleconference. Of the 216 annual meetings, 151 required behavior plans to be reviewed and updated at the time of the meetings. 100% behavior plans were reviewed and updated.

Objective #8: Achieve 100% of IP implementation Within 20 days of annual meeting.



Results/Discussion:
From a total of 130 individuals, 130 annual person centered plans were implemented within 20 days of the annual IP, with 0 IP outstanding.

Plan of Action:
One of the barriers 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.

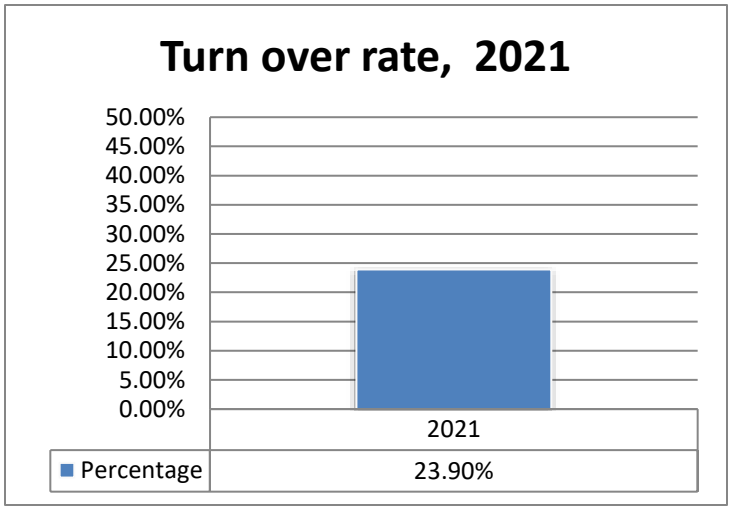
Objective #9: Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare

Results/Discussion:
Goal met
Adult Medical Day reopened April 2021. All care plans were completed and implemented within 10 days. The six-month reviews were completed and implemented within the 5 work days.
Plan of Action:
The Registered Nurse will continue to hold care plan meetings either in person or virtually to ensure all care plans are completed and implemented as required.

Objective #10: Achieve 100% of Person Centered care plans completed for Rising Sun Assisted living units.

Results/Discussion:
Goal met
The Assisted Living Units for Center for Social Change provided services for 20 seniors through the waiver for older adults. All care plans were completed and implemented within 10 days. The six-month reviews were completed and implemented within the 5 work days.

Objective #11: Maintain a turnover rate of no more than 25% throughout the calendar year 2021

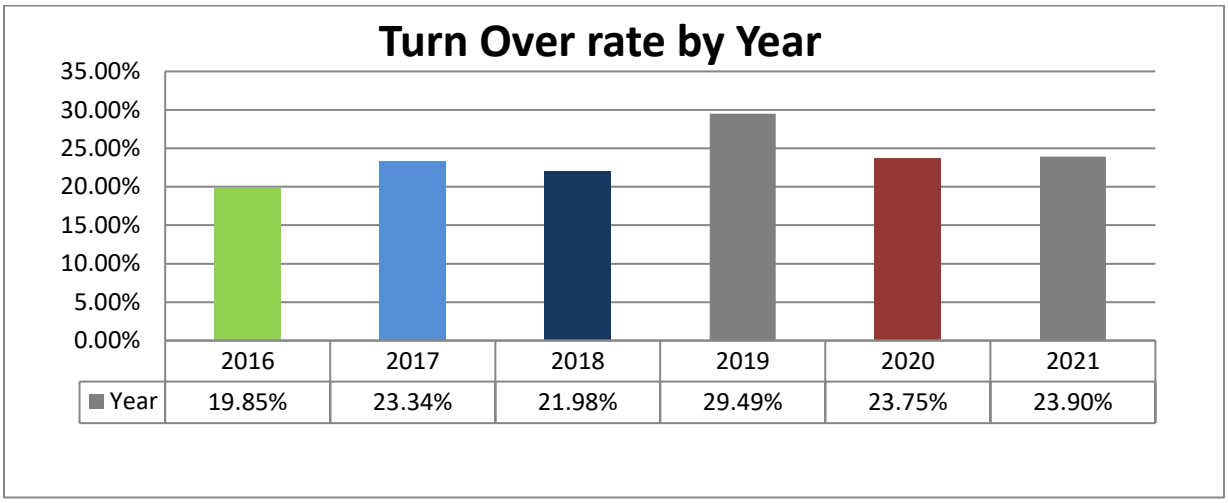


Turnover is defined as anyone leaving the job for any reason, regardless of that staff person's tenure. The rate of turnover was determined by identifying the average number of staff that were active (i.e.- received a paycheck) during 2021, how many staff left employment during 2021, and finally calculating the percentage of staff who left employment.

The average number of Staff Personnel s 498. The number of staff leaving employment during the calendar year was 119.

Results/Discussion:

The goal of maintaining a turnover rate of no more than 25% was met by. The turnover rate has been steadily decreasing over the past several years however COVID pandemic has effected the turnover rate during 2021.



Plan of Action:

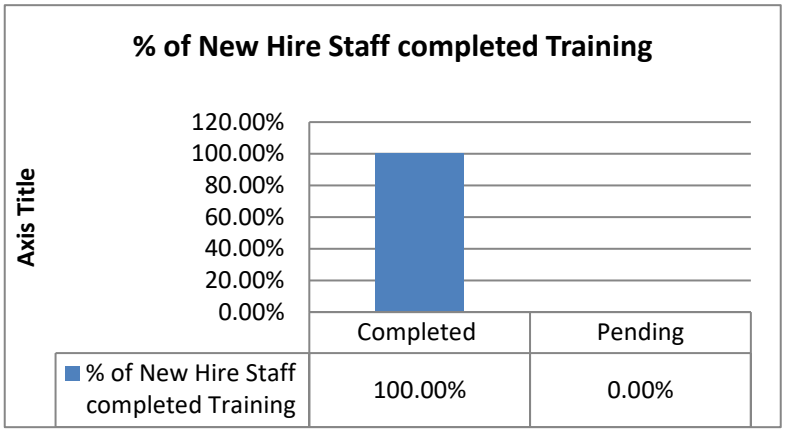
The COVID-19 crisis has put the spotlight on the long-term care (LTC) facilities. To address the staffing during pandemic CSC took the following actions:

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 #12: Achieve a completion rate for DDA-mandated/Core trainings 95% for all staff hired during calendar year 2021

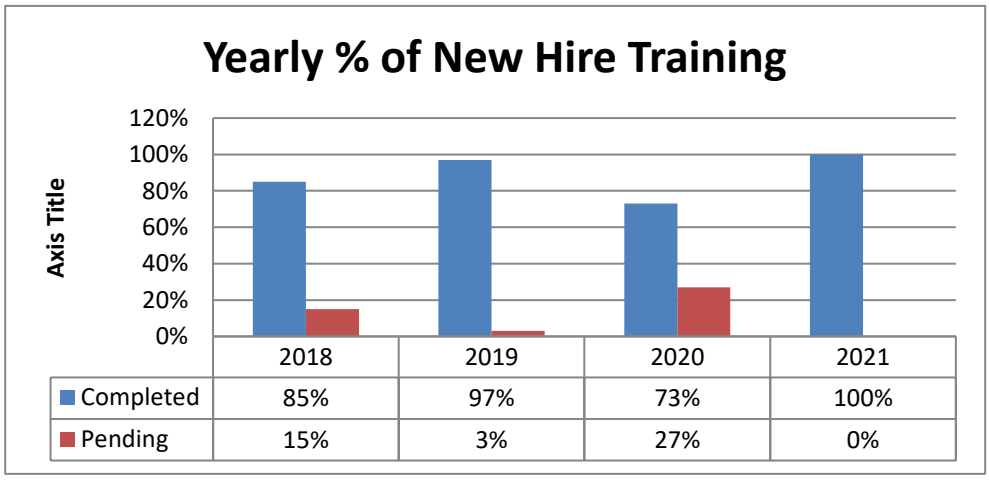
Newly hired staffs are required to complete a set of DDA-mandated trainings within 3 months of their hire date. In order to determine the percentage of such trainings which were completed within the required time frame, an audit of HR files was completed to identify those staff who were: a) hired during 2021 and b) who would have been required to complete DDA-mandated trainings by 12/31/21 As each staff member is required to complete 18 DDA-mandated trainings.

A subsequent audit of calendar year 2021 Training files for these newly hired staff members revealed that out of the 18 DDA required trainings, Total # of staff with Pending Trainings 2021 is 0.



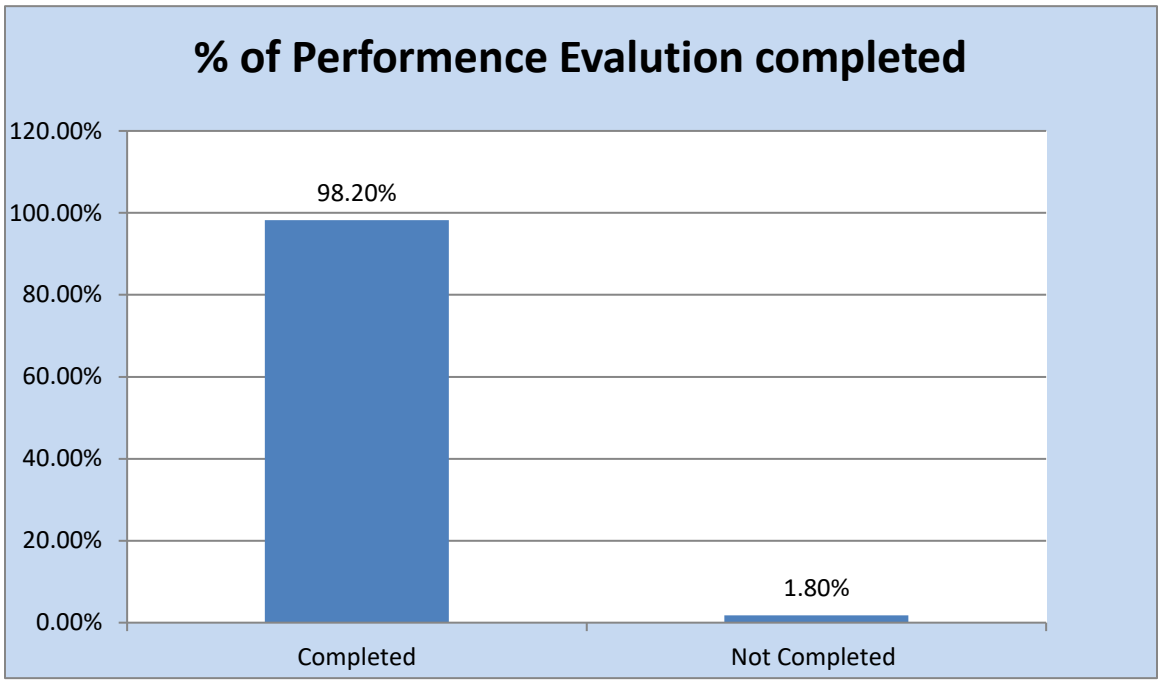
Results/Discussion:
As of December 2021, 55 new hire staff have 90 days to complete their trainings. The primary difficulty in getting all staff trained within a 90-day period is that many staff has multiple jobs, and scheduling several-day training can be difficult. A Training Coordinator is assigned to generate a report weekly for Coordinators to follow up with staff. Goal is met.

Plan of Action:
CSC will continue to use STED to monitor the completion rate of new hire training.



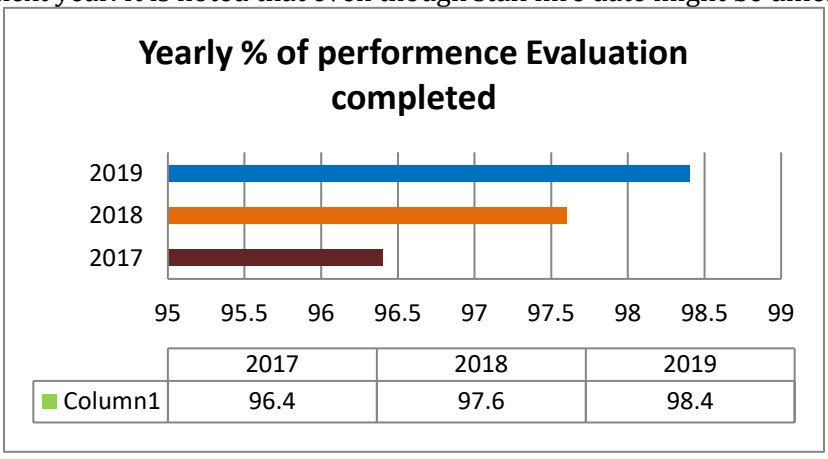
Objective #13: Achieve and maintain a completion rate of 97 % performance evaluations completed on time

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 98.2% success rate met the stated Objective. Out of 487 staff, 55 were new hires and their evaluation is due next year. 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 2021 there were 3 incomplete evaluations.



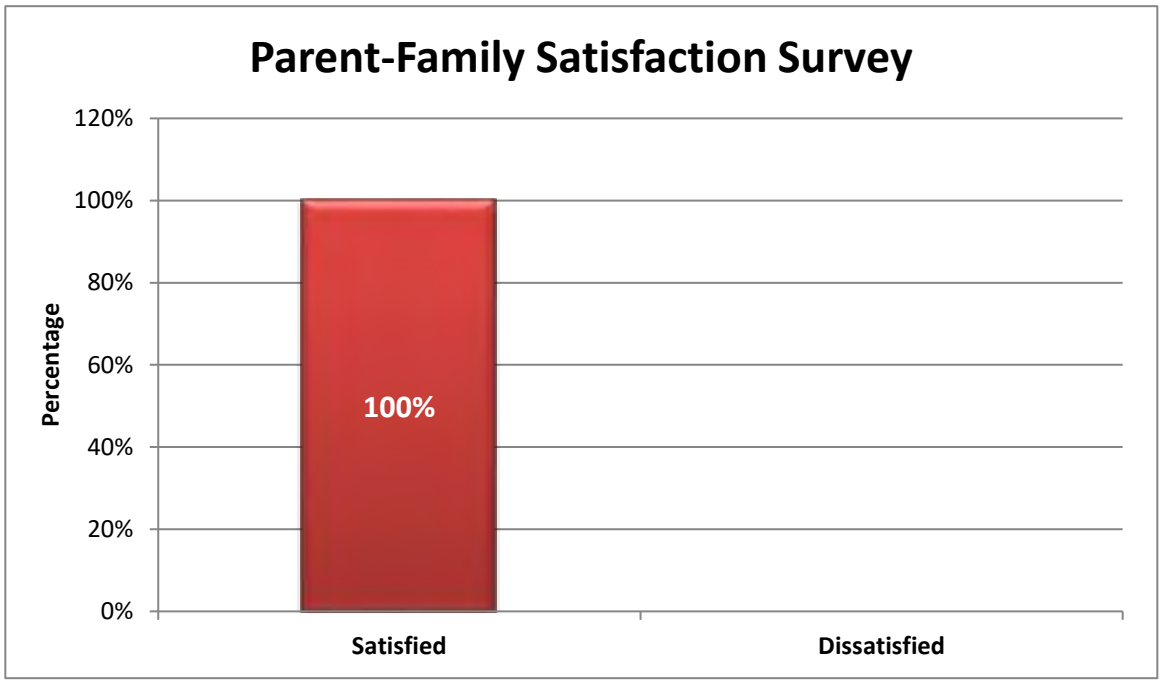
Plan of Action:

Aside from the pandemic, one of the barriers identified is Coordinators are assigned new staff they are not familiar with. Another barrier was the delay of paperwork coming to HR office due to pandemic.

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 # 14: Increase family member satisfaction to at least 95%

For 2021 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	**10**
Total # of Satisfied Responses	100
Total # of Dissatisfied Responses	0

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 2022 to compare the averages of 2021. Program Specialists will continue to provide copies of this survey to family members at annual IP meetings to increase participation.

Objective #15: Increase Stakeholder satisfaction to at least 99%

For 2021, 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 2021.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.

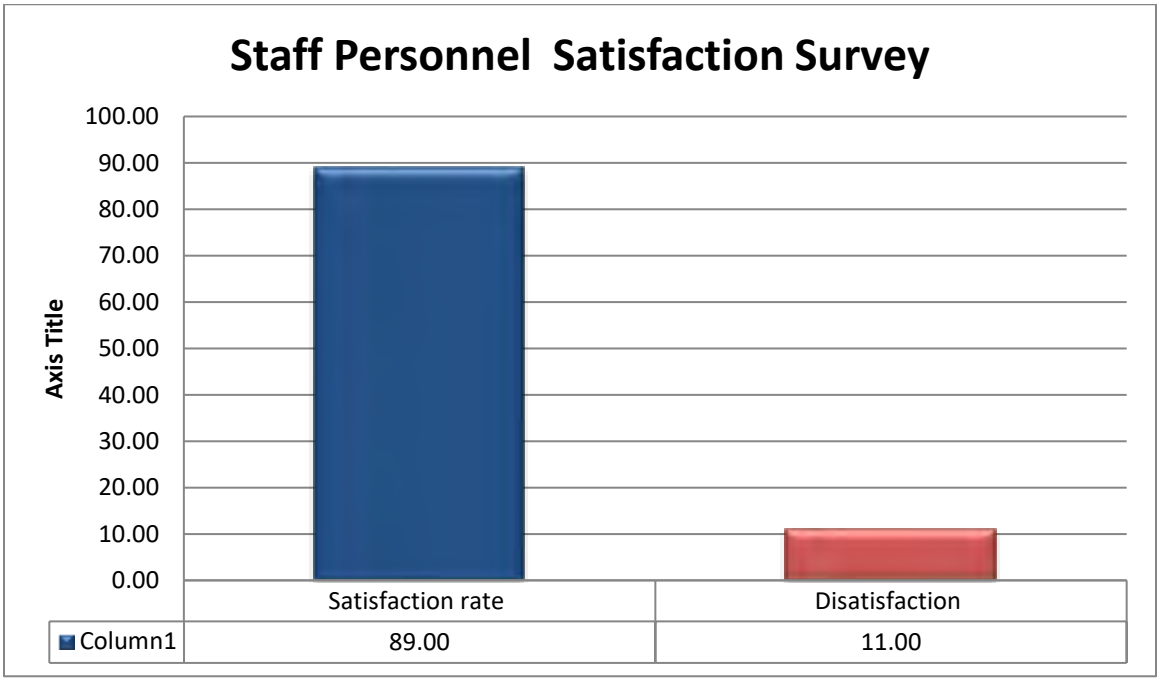
Results/Discussion:
One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions. Only one stakeholder stated no for knowing CSC policies.

Total # of Stakeholders Survey received	**6**
Total # of Satisfied Responses	42
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 #16: Increase Staff Personnel satisfaction to at least 90%

For 2021 due to pandemic it was more important to gather staff personnel feedback. Surveys to measure staff personnel satisfaction were prepared and disseminated to the staff personnel in July 2021.



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. It is felt that less staff participated this year in the survey due feeling overwhelmed during the continued pandemic.

Total # of Staff personnel Survey Received	**93**
Total # of Satisfied Responses	790
Total # of Dissatisfied Responses	120

Plan of Action:
The results looking at all responses, only 11 % 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 re-evaluated starting rates as well as existing staff pay rates. 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.

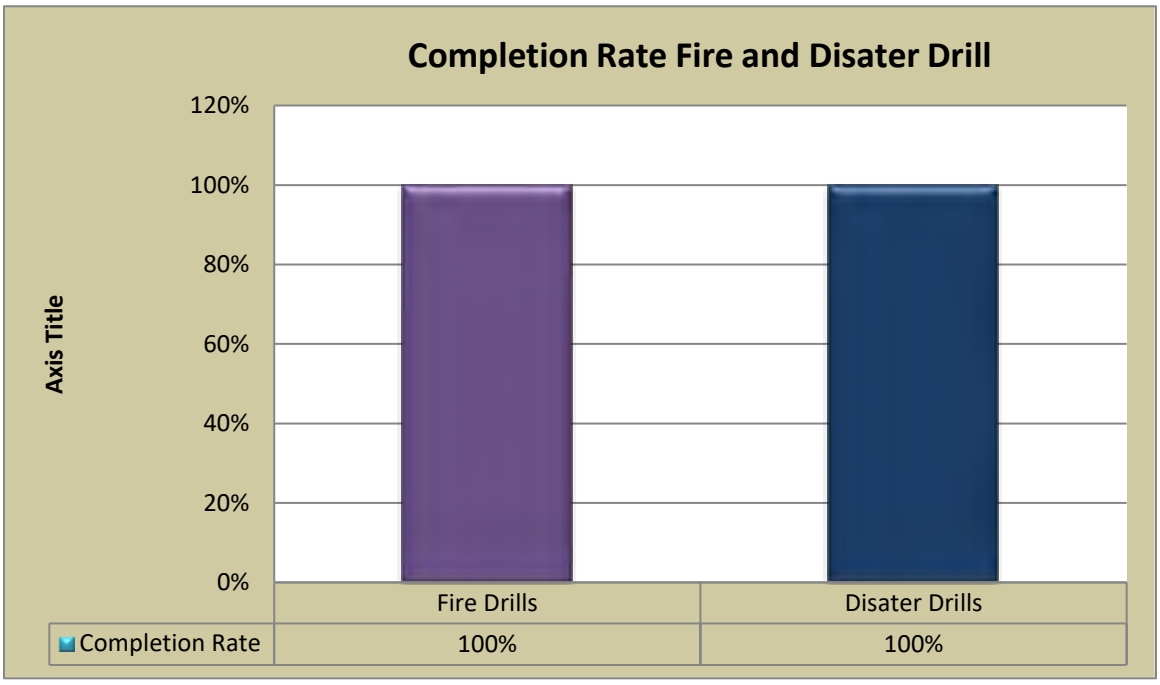
Objective #17: Increase at least 10% in staff personnel Satisfaction survey return rate.

Results/Discussion:
Of the 292 direct support staff in 2021, only 93 staff returned the satisfaction survey. This is only 32% of staff returning the survey. This has increased 2% since 2020, but failed to increase return at least 10%. The number of staff retained and the longevity of the staff's employment may have led to the slight increase in return.

Plan of Action:
To assist in increasing staff satisfaction, starting rates and pay rates for staff that have been employed for 9 or more years have been re-assessed to ensure all are paid at competitive rates for the years of services. This will hopefully bring about more staff feeling compelled to return a satisfaction survey.

Objective #18: Maintain at least a 100% rate of compliance to completion of fire and disaster drills

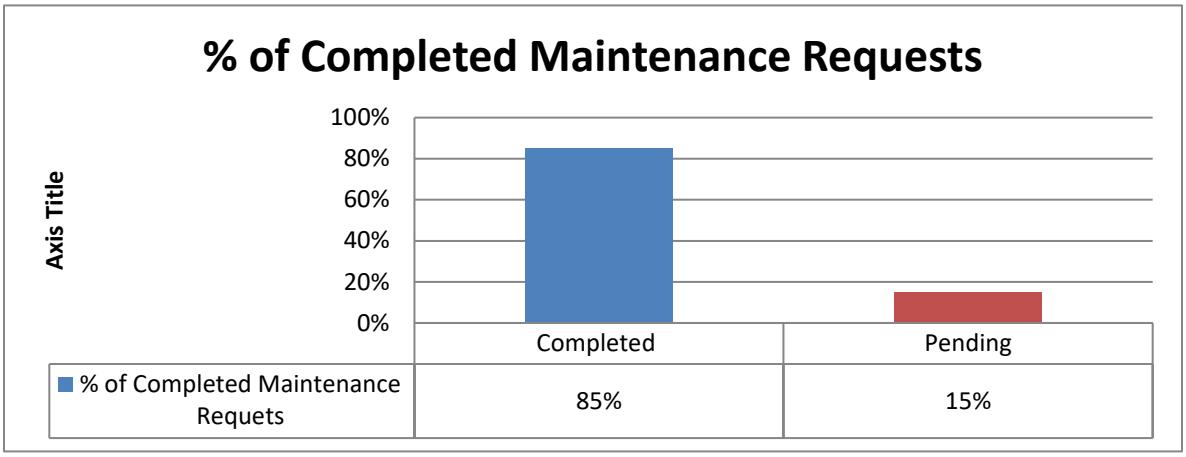
Results/Discussion:
All fire and disaster drills are completed appropriately as required. CSC has implemented a system to complete a disaster drill (now referred to as an emergency drill) monthly and rotating the shift as well as utilizing the various emergencies identified in the CSC Emergency Preparedness 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.

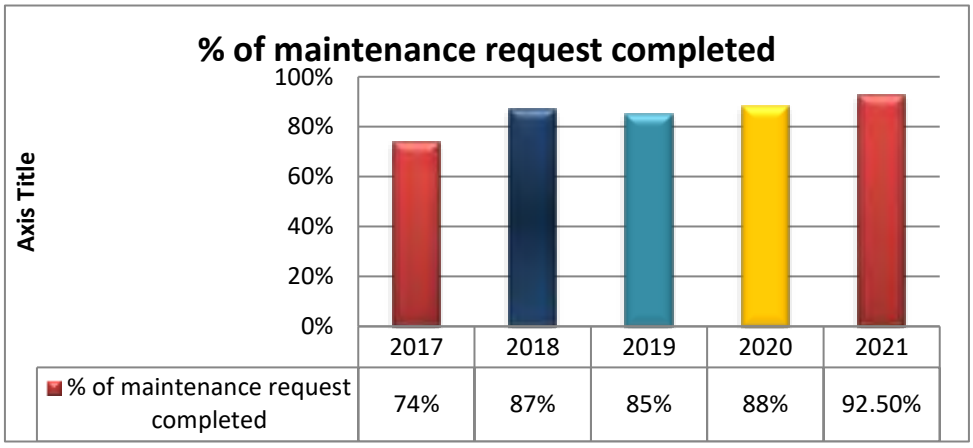
Objective #19: Maintain turnaround of addressing maintenance request within 24-48 hours with completion rate of 85% during a year.

Center for Social Change currently operates **41** 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 2021 were 612 and # completed requests was 48 hours was 518. 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. Due to pandemic, the wait time to receive items was increased. One of barrier for apartment group homes was Issue reported to leasing office for repair and CSC was not authorized by the easing office to make such repairs.

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 #20: Update the Maintenance database with no more than 30 days of entry missing.

Results/Discussion:
As per the maintenance data base total number of request received in calendar year 2021 were 612. It is the responsibility of the Program Manager to enter any noted maintenance request either recommended by a quality assurance home inspection or personal knowledge of any need. Computers in the home as well as office computers are equipped to make such entries within one business day. All 100% maintenance requests have been entered into the maintenance database with such time in 2021.

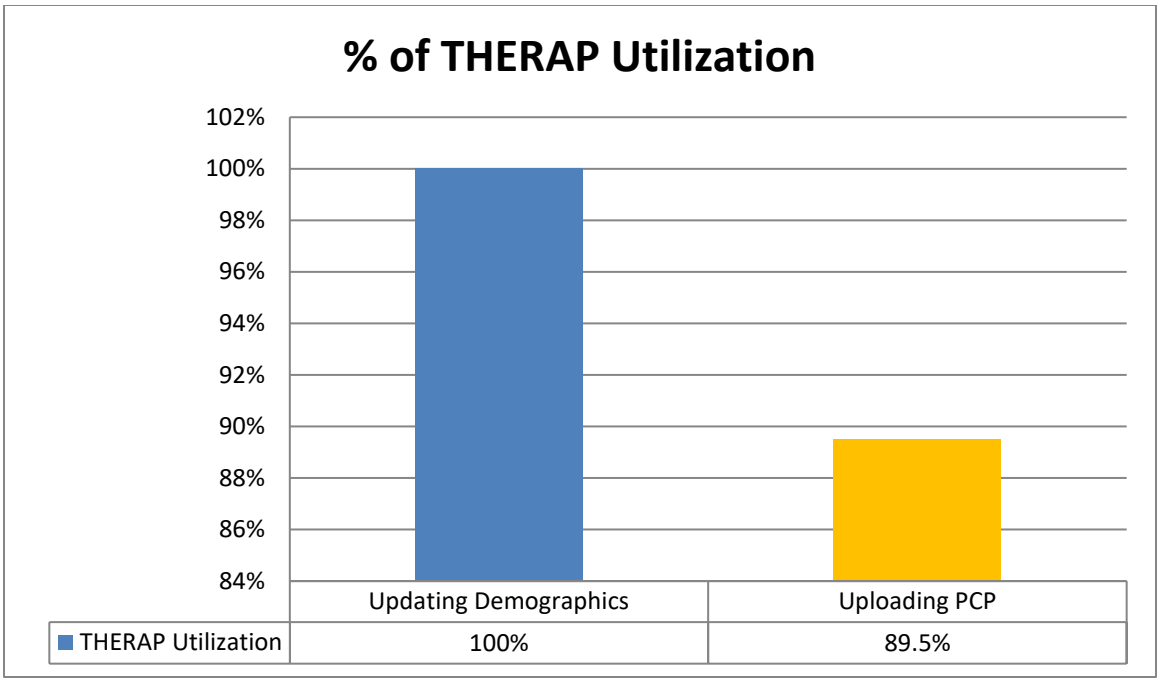
Objective #21 Utilizing STED 100% for all mandated trainings throughout the calendar year 2021

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. All trainings, except for CPR, First Aid, CMT, and MANDT which are in person trainings, are completed by all staff via STEDS.

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

Objective #22 Utilized THERAP at least 80 % for all people served demographics, IP and outcomes

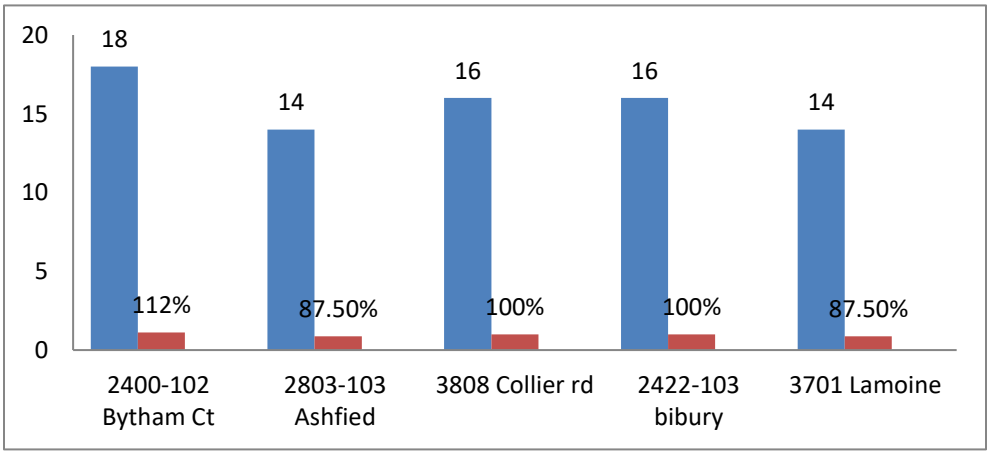
The objective of using Therap was met. As of now staff is capturing the data for demographics on the system as well as IP / BP and progress. Behavioral incidents are documented on THERAP and report can be generated as needed. Quality assurance staff is also using and updating the demographics and are able to pull reports directly from THERAP. Goal was met for uploading PCP on THERAP.



Plan of Action:
During 2021, program specialist were new to the agency and becoming familiar with agency procedures and the Therap system. Additionally, Therap is changing the Individual Plan sections for new uploading of each plan. Program Specialists will receive further training to ensure

Objective #23 Utilizing STED 85% 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 5 ALU for the completion of ALU meeting minutes. Audit was completed for Jan, March, July and Oct. Total number of meeting was 16 for ALU. Following are the numbers each ALU achieved.



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, 2021 – December 31, 2021
Between January 1, 2021 and December 31, 2021, 157 incidents reportable with an A7 have been reported. The incidents occur with the frequency noted below for the following categories:

Reportable Incidents:

Abuse	9
Death	4
Hospital/ER	40
Hospital/Psychiatric	30
Inhumane Treatment	0
Injury	12
Other	20
Police	88
Restraint	0
Sexual Abuse	0
AWOL	51
Theft of Individual's Property or Funds	0
Total	**157**

Internally Investigated incidents
A total of 69 internally investigated incidents occurred during calendar year 2021; 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	52
Injury	1
Police	18
AWOL	2
Other	7
Total	69

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. The numbers of incidents are larger as some incidents are counted above for both investigated and internally investigated under both categories, although the incident was reported by the highest level of reporting need in PCIS2.

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 date

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

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**.** During the 2021 calendar year the Standing Committee met on January 16, 2021; April 16, 2021; July 16, 2021; October 15, 2021.

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