The Bridge Performance Quality and Improvement Plan

October 1, 2021 to December 31, 2021

2nd Quarter

Introduction: The Bridge takes great pride in our many accomplishments. We track our data and report our outcomes to our funders, stakeholders and Board of Directors on a regular basis. As part of our journey toward attaining and maintaining accreditation from the Council on Accreditation we have adopted a new format for reporting our achievements.

The Bridge wants to make this report as easy to read and understandable as possible. We know that many folks who will be reading this report will not be familiar with or frankly not be very interested in a lot of jargon. On that note we are going to keep it simple by reporting on what we planned to do (goal), what we have done so far (output) and what was the result of our efforts (outcome).

The Bridge wants to also share our opportunities for improvement. Sometimes we fall short of our goals and when we do, we want to learn from our experiences and improve. Having a plan in place, executing the plan and assuring its application are very important steps. Sometimes the best laid plans do not work out for a variety of factors; environmental or societal influences as well as State, Federal or local funding trends can impact our work. The main point is that we acknowledge what we can control and adjust our plan to accommodate the things we cannot control.

We welcome your input and feedback. Thank you for your ongoing interest and support of the Bridge. Please contact Margaret Hann, Executive Director, margaret@bridgefamilycenter.org. to share comments or questions.

Bridge overview:

The Mission of the Bridge: To foster the courage and strength in children and families to meet life's challenges and build fulfilling lives.

Based in West Hartford, Connecticut, the Bridge Family Center is a comprehensive, regional nonprofit agency that provides a broad range of services for children and families throughout the Greater Hartford area. Founded in 1969, the Bridge offers a safe haven for children and families in crisis as well as positive, healthy intervention and prevention programs. The Bridge has an expansive array of services that is comprised of the following:

Mental Health Counseling

We have counseling centers in West Hartford, Avon, and Rockville to support children, families, and adults. Our therapy team includes a Psychiatrist. We accept private insurance, as well as Medicare and Medicaid.

Residential Services

We offer a safe haven for teens and young adults throughout our region, many of whom have experienced significant trauma. A high percentage of the girls we care for are victims of Domestic Minor Sex Trafficking. We provide:

- Short-Term Assessment and Respite youth shelters throughout Greater Hartford and beyond for children ages 11-18 (DCF referred);
- Therapeutic Group Home for boys ages 13-18 (DCF referred);
- Emergency Shelter for homeless children and teens ages 13-17;
- Transitional and Independent Living programs for young adults ages 16-21.

Youth and Family Services

For more than four decades, we have served West Hartford as its Youth Service Bureau. We offer school-based programs, emergency in-school counseling response, positive youth development programs, mentoring, parenting services, and the West Hartford Teen Center.

Family Resource Center

Our Family Resource Center is a vital source of support for young children and parents. We offer significant parent education, in-school support groups for children going through divorce or separation, reading readiness programs, developmental screenings, after-school learning and enrichment activities, before- and after-school daycare for preschoolers, social skills groups, and early childhood intervention programs.

With an annual budget of $8 million, the Bridge Family Center serves nearly 9,000 young people each year. Bridge Family Center services are funded by private donations from individuals, foundations, corporations, and organizations; the Town of West Hartford; the State of Connecticut Departments of Children and Families (DCF) and Education; and the U.S. Department of Health and Human Services. The Bridge is governed by a Board of Directors composed of 16 individuals from West Hartford and the Greater Hartford community. About 160 staff members carry out the programs and services of the Bridge.

Section 1.

Finance and administration:

The Finance and Administration Department of the Bridge also includes our human resources department. This department supports the entire organization. The need is evidenced by the ability for the entire Bridge to function smoothly.

The Finance and Administration Department played a pivotal role in our ability to move to a telehealth platform within one week of the pandemic. Finance also manages our IT systems. They prepare monthly financial reports that are shared with the Bridge Board of Directors and our funders. The Director of Finance and Administration works with an independent auditor that reports on our fiscal practices and position to our board and funders annually. This department manages our fiscal internal control practices and assures that all fiscal reports are submitted accurately and in a timely fashion.

Human resources works with all Bridge programs to attract and maintain qualified staff to all of our programs. They keep abreast of all developments regarding employment laws and trends.

Goal: The Finance and Administration Department strives to more efficiently manage the Bridge's finances and employee needs.

Outputs/Outcomes:

Maintain residential staffing levels equivalent to 80% of 392 program hours. **Outcome:** 78% of the 392 residential program hours were filled by Bridge direct care staff. This is below the goal of 80% of program hours.

90% of new hire background checks will be completed within 3 weeks of offer being made. **Outcome:** 54% of new hires were on boarded within 3 weeks. This is below the goal of 90%.

Operating reserves will be maintained at a level to cover one month of our annual expenses per our policy. **Outcome:** 100% achieved – remains unchanged.

85% of Bridge technology needs will be supplied within 3 days of request. **Outcome:** 95% of technology needs were met with 3 days of request. Goal was exceed thereby increasing productivity.

Bridge financial reports will be 95% accurate prior to be sent out to the Finance Committee and Board. **Outcome:** 100% of Bridge financial reports were completed and reviewed on time. There were no known errors that needed correction. During the quarter there were 3 errors that impacted previous financial statements but they were outside the 3 month target goal.

Keep abreast and put in place backup systems and new technologies that allow Bridge staff o have access to Bridge systems as evidenced by "up time" reports showing any system outages. **Outcome:** Bridge system up time is 100%

Improvement Plan:

Currently the Bridge is experiencing difficultly hiring and onboarding staff, turnover is higher than the desired goal, youth worker compensation is lower than peer organizations.

The Bridge is increasing youth worker pay, streamlining the workflow process for resume review and scheduling interviews. Further changes will address problem areas in the recruitment process. These may be most significantly impacted by a change to the Bridge payroll company.

We are continuing to review areas related to staff compensation, recruitment and retention in an effort to attract and retain more qualified staff. This effort will result in a longer staff retention period and longevity. This will be measured by at least 80% of direct care hours for residential programs being filled by Bridge employees and new employees onboarding within three weeks from the offer of employment.

Action steps included increasing follow up with applicants to improve the background check process and continuing to review youth worker compensation and feedback to increase longevity/reduce turnover. While only 54% of new staff were onboarded within the three week goal, the average time of the 13 new employees was 3.01 weeks, and no employee was more than four weeks. Increased follow-up to candidates that have not returned paperwork or completed Concentra testing is necessary. In addition, during this time frame, Concentra turnaround seemed to be slow due to COVID, resulting in longer waits for appointments for TB & physicals. Additional support in HR will improve the consistency of follow-up with candidates. Already low staffing levels complicated by the COVID outbreak and some employee relation/performance issues contributed to the just missed goal of 80% of direct care hours being completed by Bridge staff. We are continuing to hire and the recent increase to the starting rate seems to be attracting more candidates.

Section 2:

Family Resource Center (FRC)

Goal: Through a variety of educational groups, the FRC will inform families about child development, best practices in parenting, personal growth and community resources.

Outputs/Outcomes:

FRC staff is successfully trained in National Family Support Network (NFSN) standards of quality care for family strengthening and support. **Outcome:** FRC staff are fully trained in NFSN. Achieved March 2021

FRC Parent Educator trained and certified in Positive Discipline. **Outcome:** Staff trained in Positive Discipline and two trained in Circle of Security. Achieved January 2021

20 parents enrolled in Parent Leadership Training Institute initiative. **Outcome:** 22 parents enrolled. Achieved December 2021

At least 80% of parents attending FRC programs will complete the program. **Outcome:** 90% of parents complete FRC programs. Positive Discipline- 100%

At least 90% of parents completing an FRC program will submit a program evaluation form. **Outcome:** 55% of parents complete evaluation form. Positive Discipline 100%

Improvement Plan:

The Family Resource Center offers 2 parent education programs: Circle of Security and Positive Discipline. Our goal is six to eight parents enrolling in Circle of Security, at least 80% of those parents will complete the program and 90% of those parents will complete a program evaluation. Our goal is 8 to 12 parents will enroll in Positive Discipline, at least 80% of those parents will complete the program and 90% of those parents will complete a program evaluation. In both programs enrollment numbers meet the goals but 80% of parents do not always complete either program and therefore 90% of parents do not fill out the program evaluations.

Action steps include a review of dates and times of day of parent education groups to determine attendance numbers. Parents are currently offered a choice or day or evening sessions. FRC staff will determine which time was more popular. For example our Circle of Security (COS) program was offered both in the afternoon and evening. Most parents selected the afternoon session this quarter. In order to vary the time of the COS session we will be offering Fall evening sessions. Incentives for attendance will be discussed as an option.

All FRC staff members have been trained and certified by the National Family Support Network, March 2021. The FRC Parent Educator is trained and certified to offer the Positive Discipline Parenting Program, January 2021. Both the Parent Educator and the Family Liaison are trained and certified to offer the Circle of Security parenting program, April 2017.

As of December 31, 2021, 6 parents enrolled in Positive Discipline which was offered virtually. All 6 parents (100%) completed the program and completed the on-line evaluation. No incentives were required.

22 parents interviewed for and were accepted into the Parent Leadership Training Institute which will be held virtually on Wednesday evenings through June. The program begins on January 21,2022 with a virtual 2-day Retreat.

Section 3

Mental Health Services and School Based Counseling

Goal: The Bridge Outpatient Psychiatric Services provide quality mental health care to children, adolescents, adults, families and couples with a wide range of clinical needs. Our ongoing goal is to meet the steadily growing and wide ranging mental health needs of the communities we serve. We do this by providing high quality outpatient therapy and medication management to our clients.

Outputs/Outcomes:

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Outputs/Outcomes:

A total of at least 10,000 appointments will be held each year. As of 12.31.21 we have held a total of 5,938 appointments which is 59% of our goal. **Outcome:** The mental health clinics began utilizing the Ohio Scales evaluation tool as a means to measure a decrease in symptoms associated with treatment needs in April 2021. Our goal is show a 75% decrease in symptoms. Progress towards this outcome will be reported in the next fiscal year.

A total of at least 350 intake assessments will be administered each year. As of 12.31.21 we have completed 152 intakes (43% of our goal). Our total goal last year was 100 intakes. **Outcome:** Will increase number of new initial assessments by 25%. Currently we have increased new initial assessments by 43%.

A total of at least 900 clients 6 will be treated each year. As of 12.31.21 we have treated 564 clients. Which is 63% of our goal. **Outcome:** The clinics will maintain 325 open cases. As of 12.31.21 we have 371 cases open. Which is 114% of our goal. We will achieve an increase in number of kept appointments by 25%. Currently increased number of kept appointments by 5% (currently have 5,938 kept appointment this year vs 5,616 last year).

Improvement Plan:

Currently, the Bridge Outpatient Clinic does not have a pre/posttest assessment in place to measure the success rate of our services. A recent review of our program through the COA process revealed that the clinic has difficulty assessing meaningfulness of our services due to the lack of standardized metrics.

The Bridge counseling center will begin to use data obtained from pre-test assessments to inform treatment planning goals. Post-test results will indicate a decrease in symptoms associated with those treatment needs. During the intake assessment process, each client will complete a pre-test assessment to obtain a baseline rating of clinical needs. This pre-test data will be recorded in each client's chart. The client's therapist will complete an updated assessment until the time of discharge. This data will be documented in the clients chart. At discharge, a post-test assessment will be completed, and data will be documented. The Clinical Director will review these outcomes in individual supervision with the assigned Therapist. At minimum, post test results will reveal a 75% decrease in symptoms associated with treatment needs.

Per the last update action steps included training all staff on new pre/posttest implementation. Therapists will discuss outcomes with Clinical Director during individual supervision. Findings will be reviewed quarterly. Data will be incorporated from pre-test assessment into treatment plan goal.

As of 12.31.21 all therapists have been trained on the Ohio scales and have started to implement this assessment at all intakes, discharges, and yearly for ongoing clients to measure success.

As of 12.31.21 the Bridge counseling center is working on increasing our compliance with Crisis and Safety plans becoming completed with every client. Results based on chart audits revealed 60% compliance with this measure currently. Benchmark for this improvement plan is 90%. Therapists will continue to work with their clients and update crisis and safety plans with all clients.

As of 12.31.21 the Bridge has improved with all parties signing Treatment plans in a timely manner at a rate of 90% compliance.

The Bridge Counseling Center will continue to strive for excellence and continue to improve and monitor these improvement plans.

Section 4:

Youth and Family Services Mentoring Program

Goal: The Bridge Youth and Family Services Mentoring program provides quality mentoring relationships to youth, with an emphasis on adolescents. Young people need caring and supportive adult relationships; youth at risk in this community often rely on external support provided by Bridge Mentors. Our ongoing goal is to meet the individual needs of the in the West Hartford Community. We do this by forming and modeling healthy relationships with supportive and caring adults in a therapeutic mentoring capacity.

Outputs/Outcomes:

A total of 38 mentees have been seen as of 12/31/21. Our goal was 20; 190% of goal reached. 308 sessions have been conducted as of 12/31/21.Our goal was 330; 147% of

goal reached. During summer mentoring, which ended before 8/31/2021, 7 youth and 11 summer mentoring group sessions were conducted with a goal of 5 youth (140% of goal) and 12 sessions (92% of goal).

Outcome: Ongoing survey results reveal 81% of participants reported increased self-esteem; goal was 85%. Additionally, 63% reported increased perception of a strong social support system; goal was 85%. Finally, ongoing survey results reveal that 75% of mentees report progress toward the achievement of a personal goal. The goal was 85%. Effective goal setting and measuring was implemented this quarter and is an ongoing area of focus. Related to the first two metrics, it appears that many initial surveys reflected unrealistically high scores regarding those measures. The theory is that as the mentoring relationship deepened, the scores were more reflective of the actual value. If this theory bears out, the percentage will increase during the next review period after the mentoring relationship has had further impact.

Improvement Plan:

The Bridge Youth and Family Services Mentoring program has taken this opportunity to increase the use of measureable goals, as well as to formalize and streamline the documentation process. These two improvement plans work in concert with each other to create a comprehensive documentation chart that follows the mentee from referral, engagement (with both the family and the mentee) and assessment, to goal setting, weekly sessions, documentation, and finally to termination and a thorough closing summary. At this point, all new documentation has been integrated. A workshop on SMART goal setting has increased the quality of goal setting across all mentoring relationships. All goals have been written with measurement in mind – they are not always easily measureable, and this will be an area for continued improvement through coaching, training and monitoring.

Section 5:

Therapeutic Group Home (TGH) and Short Term and Assessment and Respite (STAR) Programs-Group Living Situations (GLS)

Goal: The STAR programs and Eleanor House provide individual, family and group therapy as well as crisis stabilization (STARS), proactive daily interventions, and on-site services aimed at effectuating positive change.

Outputs:

NOTE: The TGH converted to a QPC. The TGH closed 10/28/21 so the data period for the TGH is 7/1/21-10/28/21.

90% of Monthly Treatment Planning Progress Reports (MTPPR) will be completed. 7/1/21-10/28/21 96% of required MTPPR's were completed. Goal exceeded.

90% of required STAR comprehensive assessments will be completed. 7/1/21-12/31/21 88% were completed, 2% short of goal.

85% of scheduled individual clinical sessions will be completed. 7/1/20-12/31/21 72% of STAR individual sessions occurred, 13% short of goal. 91% of TGH sessions occurred, exceeding goal. Overall GLS 73%, 12% short of goal.

85% of scheduled family clinical sessions will be completed. 7/1/21-12/31/21 100% achieved for all GLS programs. Goal exceeded.

85% of scheduled group clinical sessions will be completed. 7/1/20-12/31/21 49% of STAR group sessions occurred, 36% short of goal. 89% of TGH group sessions occurred. Overall GLS 50%, 35% short of goal.

GLS youth will participate in 85% of offered recreational activities. 7/1/21-12/31/21 GLS recreation participation was 66%, 19% short of goal.

90% of scheduled Proactive Daily Interventions (PDI) will occur and comply with Private Non-Medical Institution (PNMI) standards. 7/1/21-10/28/21 100% of required PDI's were completed. Goal exceeded.

Outcomes:

Program efficacy will be evidenced by 75% successful discharges 7/1/21-12/31/21 70% of STAR discharges were successful, 5% short of goal. 60% of TGH discharges were successful, 15% short of goal. Overall GLS 69% successful, 6% short of goal.

95% of Quality Assurance Surveys completed by stakeholders will be positive. 7/1/21-12/31/21 achieved for all GLS programs.

100% compliance with DCF licensing and successful license renewals 7/1/21-12/31/21 achieved for all GLS programs.

100% of required aftercare contacts will be achieved. 7/1/21-12/31/21 68% of contacts occurred, 32% short of goal.

Improvement Plan

Evaluating data for the period 7/1/21-12/31/21 (STAR programs) and 7/1/21-10/28/21 (TGH) several outcomes fell short of goal. The TGH closed on 10/28/21 and only fell short on one goal, successful discharges. The STAR programs fell short in 6 areas: 1. Successful discharges 6% short of goal 2. Aftercare contacts 32% short of goal 3. Completed STAR Assessments 2% short of goal. 4. Individual clinical sessions 13% short of goal. 5. Group clinical sessions 36% short of goal. 6. Resident participation in recreational activities 19% short of goal.

The Director of Residential Services and Director of Girls Services will check-in with Program Directors, Program Managers and Clinical Coordinators during individual and group supervision meetings in regard to these areas, and all success indicators, to ensure that we are on track.

GLS aftercare contact attempts met goal but DCF and residents' new placements were inconsistent in responding to emails and calls, likely due to the pandemic with DCF's workforce working remotely. To improve outcomes the Director of Residential Services or Director of Girls Services will continue to push DCF for placement plan updates and timelines. The Program Director or Program Manager will continue to send a monthly report to the Director of Residential Services or Director of Girls Programs that will summarize information including completed aftercare contacts.

Action steps include consistently reviewing with DCF and Bridge clinician residents' discharge plans and timelines. Reports will be completed each month by the Program Director summarizing information from the previous month and will include LIST and aftercare progress. Issues will be identified and addressed in real time.

Section 6:

Goal: The Moving On Project **(**MOP) seeks to prepare young men for a successful transition to the Bridge Community Housing Assistance Program/Independent Living Program (CHAP/ILP). CHAP prepares young adults for independence by giving them the necessary skills. Staff teaches life skills, assists with enrollment in post-secondary education, ensures access to medical needs, and assists in securing and maintaining employment.

Outputs:

All MOP youth will complete the initial LIST Assessment within 21 days of their intake at MOP. Updated LIST Assessments will occur for MOP youth at the six month mark and every six months thereafter until discharge from MOP. 7/1/21-12/31/21 69% of LIST initial assessments and updates were completed, 21% short of the goal of 90%.

A total of 87 CHAP youth will complete Learning Inventory of Skills Training (LIST) assessments annually. All CHAP clients completed their LIST assessments.

MOP youth will have an initial treatment plan completed within 96 hours of intake at MOP. The treatment plan will be updated every 90 days. 7/1/21-12/31/21 100% of MOP Treatment Plans were completed and updated at required intervals.

and CHAP youth will have a Treatment Plan annually. CHAP youth had treatment plans. 100% of the treatment plans will be updated at the required 90 day intervals. 100% completed.

Action Discharge Plans were completed for all CHAP clients, 100% completed.

Outcomes:

Program efficacy evidenced by 74% planned discharges in FY22. (CHAP).

MOP 20% of discharges were successful (one out of five), 55% short of goal.

90% of clients will show an improved LIST score after 6 months. This outcome was achieved 100% for MOP/CHAP clients who completed the LIST.

MOP youth attended 84% of Life Skills sessions for the period 7/1/21-12/31/21, 1% short of goal.

64% of MOP youth were employed for the period 7/1/21-12/31/21, 11% short of goal.

100% of MOP youth during the period 7/1/21-12/31/2, who were required to be in an educational program, were enrolled in a school program, meeting goal. Of those youth school attendance was 31% (60% if three outliers are removed). 60% is 15% short of goal.

70% of clients participated in their school program. Target 60% CHAP

48% maintained part time employment. Target 50% CHAP

100% of Action Discharge Plans were completed for CHAP clients

Improvement Plan:

The Bridge is going to improve MOP outcomes that fell short of goal for data period 7/1/21-12/31/21. Areas where we fell short: 1) 69% of LIST assessments were completed, 21% short of goal. 2) Only 31% of school days were attended (3 outlier youth accounted for 29% of that number). Goal for school attendance is 75%. 3) 64% of youth were employed. Goal is 75%.

MOP program efficacy will be evidenced by 75% planned discharges (MOP). 7/1/21-12/31/21 20% of discharges (one out of five) were successful, 55% short of goal.

Action steps include an enhanced review of discharge plan with DCF and MOP Program Director and timeline for discharge to include specific time bounded action steps. Other steps include assuring that MOP residents are connected with community resources to support their discharge plan including area employers, faith based communities and more. MOP has developed a community resource guide and assures that community linkages are fostered.

If CHAP is the discharge plan, staff will connect MOP residents with CHAP staff and as well as successful CHAP clients so that the MOP resident can gain hands on exposure to CHAP.

The CHAP Program goal was to improve the completeness of each client's Action Discharge Plans (ADP). Currently, the procedure states that the ADP are to be completed at intake, then reviewed and updated every 90 days of treatment. Over the past year, there has been an overall decrease in treatment plans being signed by all parties, on time. The goal of this improvement opportunity is to improve the random file

review scores, specifically in treatment planning, to a minimum of 80% for 2 consecutive quarters. CHAP achieved this goal with 100% efficiency.

The CHAP program April file audit indicated 79% completeness which was below the minimum level. The most recent file audit indicated significant improvement. The June random file audit resulted in a 96% completeness. The improvement plan will continue into the next quarter. The 2nd quarter file audit indicated a 94% quality completeness.

Summary: The journey towards quality improvement is ongoing. This report is the first of many that the Bridge will be sharing. We have a long history of improving our services and engaging our service consumers in order to offer responsive programs. Reaching our goals will take asking the difficult questions and taking risks with a focus on performance improvement. The Bridge is fully committed to doing our very best. We acknowledge that we always have room for improvement.