HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

# ANNUAL PERFORMANCE ANALYSIS


Artwork by Jocelyn
HAMHDS 2016 Wellness Series: Paint Your Story

## JULY 2015 • JUNE 2016

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# MANAGEMENT SUMMARY

Henrico Area Mental Health & Developmental Services (HAMHDS) is pleased to present the Annual Report for Fiscal Year 2016 showcasing the activities and initiatives of the past year to address vital issues and to improve the quality of care for individuals with mental health, substance use and addiction issues, and intellectual disabilities. We have continued to focus on health and wellness and are committed to assuring access to quality healthcare and promoting better health outcomes for the people we serve. Highlights:

- Continued our partnership with The Daily Planet in providing primary care services sixteen hours a week to individuals at our East Center. This partnership was recognized by the Virginia Healthcare Foundation through the receipt of the Unsung Hero Teamwork Award.
- Coordinated agency-wide planning to implement a Telehealth strategy and procure equipment with State grant funding. Began providing psychiatric services to two of our programs through telepsychiatry.
- Began implementation of the Dartmouth College evidence-based InSHAPE wellness program through a grant awarded by the National Council for Behavioral Health to improve the physical health of individuals with co-occurring serious mental illness and obesity. InSHAPE focuses on increased exercise and improved life style changes.
- Increased healthy living in residential homes for individuals with intellectual disabilities by growing vegetable gardens, selecting healthy food alternatives through the guidance of a certified nutritionist volunteer, and partnering with a local organization to provide mind/body activities such as chair Zumba.
- Provided Mental Health First Aid for adults and youth and developed suicide prevention initiatives.
- Completed screenings for the Governor's Access Plan (GAP) enabling eligible individuals' access to health insurance.

We continue to strengthen our comprehensive emergency response system. We remain committed to improving the experience and outcomes for individuals receiving services when they interact with the criminal justice system and expanding our role supporting public safety agencies in the community. The Crisis Intervention Team (CIT) has trained over 1,460 first responders from Henrico and over 35 other public safety agencies in the forty hour training. A team of 70 CIT instructors provided over 3,000 hours of instruction during the facilitation of sixty-two CIT classes. The Crisis Receiving Center (CRC) has expanded the hours of operation offering a safe and appropriate location for emergency mental health evaluations and triage to occur. Jail diversion efforts have been enhanced to divert, coordinate and clinically manage the needs of individuals who have a mental illness resulting in expanded treatment options in the jail setting, positive outcomes upon release and reducing incarceration costs while keeping our community safer.

On July1, 2016, we welcomed individuals with Developmental Disabilities (DD) into services as we became the single point of entry. Extensive planning occurred in preparation for the Waiver Re-Design as part of our on-going participation of the Department of Justice Settlement Agreement. We look forward to developing long-lasting partnerships with DD providers to ensure individuals live successfully and are fully integrated in our community.

In the year ahead we will have a strategic focus on procuring and implementing a new Electronic Health Record, providing same day access to services, and assuring the provision of high quality services for individuals with Developmental Disabilities. We will continue to strengthen existing partnerships and develop new ones. We will promote wellness and recovery in all service areas.

The Board and staff express our appreciation and thanks to the Boards of Supervisors of Henrico, Charles City and New Kent Counties for their ongoing support of our mission. Their commitment and the work of our diverse, talented and dedicated staff make a difference in the lives of many individuals.

Brenda A. Brown
Board Chair

Laura S. Totty
Executive Director

# STRATEGIC GOALS AND STRATEGIC PLANNING

**Summary of Agency Strategic Initiatives**
During FY16 cross functional workgroups continued their work on the below strategic initiatives. Their work became incorporated into the agency's work as the agency began another cycle of their strategic planning process.

- Create a Wellness/Recovery Focused Culture
- Department of Justice (DOJ)/ Centers for Medicare/Medicaid Services Transformation Team
- Explore Electronic Health Records Systems
- Develop a Behavioral Health Home Model of Service

**Agency Workgroup:**
An agency workgroup also pursued the following:

- Maintaining and supporting a high performance organization

The following information lists their FY16 accomplishments and action plans for FY17.

**Create a Wellness/Recovery Focused Culture**

Physical Environment:
- VCU School of Design presented designs for Woodman Lobby
- Currently renovating Woodman Lobby based on these trauma informed designs
- Hung 136 pieces of client art at 4 main locations (RMP, PF, EAST Center, Woodman) Woodman is scheduled to have art hung on July 8th.
- 2 Brown bags for both clients and staff to create art

Staff Trained in "WE" Model of Service Delivery:
- Trauma Informed Training Part 2
- My Side of the Story Brown bag series – every other month, clients from a designated program come and share their experiences, they include what worked, how services might be improved.
- All admin staff with f/f contact with clients, mandatory Mental Health (MH) 1st Aid Training in the first year, all other admin staff and all Community Support Services (CSS) staff this training is optional

Wellness Promotion:
- Have trained 2 additional MH 1st Aid Trainers and attempting to have more people trained
- In Shape Grant awarded, 1 staff being trained as a personal trainer
- Quit VA presenting on smoking cessation program that both staff and clients can access

Goals/Action Plans for upcoming year:
  - It was recognized that this work group is one of an ongoing nature. AMT approved for this committee to be added to our currently complement of ongoing committees. The committee will have revolving membership.
  - Continue art work project and identify additional site after RMP
  - Complete MH 1st Aid Training in FY17
  - Continue Wellness promotion implementing In Shape grant

**Department of Justice (DOJ)/ Centers for Medicare/Medicaid Services Transformation Team**
- Provide updates to Leadership Group as needed
- Monitor the Waiver Redesign details
- Prepare to assume single point of entry for the Developmental Disability population
- Prepare to assume single point of entry for statewide priority-based waiver waitlist.
- Prepare for Intellectual Disabilities (ID) to fall under Developmental Disabilities (DD) and become known as Developmental Disabilities Case Management (DDCM)
- Prepare to change Residential billing from hourly to daily
- Prepare to change Day support and Group Supported Employment to hourly billing and prepare to implement new services in redesigned waiver

- Transition from CSB coordination of slot allocations to DBHDS managing all waiver slot allocations through newly Waiver Slot Allocation Committee.
- Implement new Employment/Day Services documentation requirements per audit
- Prepare for residential and day services integrated activities requirements
- Continue to comply with current guidance around settlement agreement requirements
- Participate in DBHDS Regional Rapid Response 100 days Housing Supportive Services voucher Initiative

FY16 Accomplishments

- Created a DOJ/CMS Settlement Agreement Implementation team
- Created several implementation workgroups
- Participated in a DBHDS Licensure audit
- Participated in a DOJ Independent Reviewers audit
- Participated in a DBHDS audit
- Participated in DMAS audit
- Met with several DD Private Providers and discussed DD Case Management contract
- Identified members for new Waiver Slot Allocation Committee
- Participated in Waiver Expert Training
- Completed prioritizations and VIDES
- Participated in full implementation for new SIS A/C entry.
- Received DD Waiver Screening Guidance.
- Received DD Diagnostic Review Document
- Participated in Regional Support Teams
- Participated in National Core Indicators
- Participated in Regional DD Private Provider Forum and regional DBHDS Provider forums
- Sent levels/tiers on each individuals to all providers
- Completed and received license modification for non-centered based services
- Created new Residential ISP/Assessment plans, Residential daily billing process completed; including billing monitoring tool.
- Redesigned new documentation system for day services and began preparation for new service plans.
- Completed 100 days DBHDS Regional Rapid Response Housing Voucher Initiative
- Awarded Regional Capacity Building Grant for Housing Supportive Services for individuals with I/DD
- Gathered information as requested for the state on Supports Intensity Scale Validation to assist with Waiver re-design information
- Participated in Virginia Waiver Management System (WaMS) Training
- Participated in ongoing Delmarva Person Centered Reviews (PCRs)- assess support delivery systems which included:

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| Individual Interview Tool | Support Coordinator Interview Tool | Provider Interview Tool | Observation Review Checklist |
| Family/Guardian Interview Tool | Support Coordinator Record Review Tool | Provider Record Review Tool | ISP QA Checklist |

Goals/Action Plans for upcoming year:

- Develop a process for implementation of WaMS
- Prepare on-boarding for DD Private Provider CMs
- Prepare for additional Data Collection elements
- Create and prepare DD Case Management unit
- Monitor and develop systems/implementation for compliance with CMS rule on settings in both Day Services and Residential as the requirements from the state become more clear.
- Created new Residential ISP/Assessment plans, Residential daily billing process completed; including billing monitoring tool.
- Create and implement new system of documentation of services including billing system, daily documentation and new planning process to meet authorization requirements for newly redesigned waiver services in Employment and Day Services.
- Incorporate implementation of plans as part of the work of CSS Management Team.

**Explore Electronic Health Records (EHR) Systems:**

- The recommendation to the Agency Leadership Group, "To seek approval from the County to move from the Cerner system to another EHR system through an RFP process" was approved in the summer of 2016.
- The recommendation gained support from both County IT and County Finance.
- A Capital Improvement Plan (CIP) was submitted in the FY17 budget to the County Manager for the recruitment of a consultant and procurement of an EHR system.
- The Board of Supervisors approved the CIP in April 2016.
- A Request for Proposal to procure a consulting firm to help the Agency write and choose the new Electronic Health System was released in May. The award will be announced in July/August 2016.

Goals/Action Plans for upcoming year:

- Form a workgroup to work with the consulting firm to write and choose the Electronic Health Record
- Begin planning the implementation of the new Electronic Health Record system with the new vendor

**Develop a Behavioral Health Home Model of Service**

Through the strategic planning process, it was recognized that there is growing interest and need for Behavioral Health Homes for individuals with mental illness and substance use disorders, particularly those individuals with severe and persistent mental illness. Recent research has indicated that individuals with severe and persistent and mental illness die on average 25 years earlier than the general population. These early deaths are due in large part to preventable diseases, but these individuals often lack access to basic primary care services.

In FY16 we continued our efforts to integrate behavioral health care and physical health care services through the following strategies:

- We continued our partnership with The Daily Planet in providing Primary Care Services to clients at our East End location. Our partnership was recognized by the Virginia Healthcare Foundation through the receipt of the Unsung Hero Teamwork Award.
- We established contracts with three insurance companies to provide Enhanced Care Coordination (ECC) Services. ECC services are provided to eligible clients who have severe and persistent mental illness and a co-occurring chronic physical health condition. The focus of ECC is to ensure that clients are attending appointments and following up on issues related to their behavioral health and physical health challenges. Staff involved in providing this service participate in specialized training provided through VACSB that focused on increasing staff's knowledge of medical conditions and related resources.
- This year we had two staff trained in the evidence based InShape Program. This Program is designed for people with severe and persistent mental illness who also have been diagnosed with obesity. This program involves one of our staff becoming a certified personal trainer. Through a partnership with Henrico Parks and Recreation, our staff will work with clients on using gym and community facilities to exercise. The Program also includes education about nutrition, cooking and healthy eating. We anticipate beginning to provide the InShape Services in the first quarter of FY17.

Goals/Action Plans for upcoming year:

- We will work on continuing to strengthen our partnership with the MCO's offering Enhanced Care Coordination services
- We will continue our partnership with The Daily Planet to provide Primary Care Services
- We will begin our partnership with Henrico Parks and Recreation to provide the InShape Services
- This planning will be incorporated into the work of the Clinical and Prevention Management Team

**Maintaining and supporting a high performance organization:**

- Workgroup researched HPO training and recommended providing training opportunities for the entire agency
- An outside facilitator offered three ½ day trainings in February and March 2016. Training concentrated on HPO concept, "A High Performance Organization of is one that thrives on meeting its goals through a culture of participatory leadership/decision -making, empowered employees and open communication." Over 300 employees attended one of these sessions.
- The trainings were followed by a ½ day session with the facilitator and all of Leadership Group and Supervisory staff. Information from the trainings was discussed, summarized and shared with all staff.
- Information from the groups was incorporated into the SWOT analysis for the strategic plan.
- Overall Agency Culture is strong and effective work practices are in place to move the agency forward
- On-going the County of Henrico, Human Resources' Organizational Learning and Talent Development Program offers training on High Performance Organizations, staff is encouraged to participate in this training opportunity

Goals/Action Plans for upcoming year:

- In 2016-2017, the workgroup will continue with future training and employee engagement activities.

# FY16 PROGRAM ACCOMPLISHMENTS

**Administration**

Division

- Created an Employee Recognition Committee for the Division and other clerical staff who support the work of the Division

Agency

- Began receiving insurance payments by electronic funds transfers
- Automated a new Inspection & Drill System
- Implemented new debit machines with chip readers at 4 locations
- Analyzed and restructured business support operations to align with location traffic and volume
  - Expanded business support at Providence Forge
  - Expanded financial support at the East Center
  - Redesigned Court Order process
- Analyzed an Restructured Reimbursement to align with managed care model
- Evaluated and Streamlined Onboarding processes
  - Added QMHP/QIDP qualification guidance to Supervisory Tools (on the intranet)
  - Evaluated processes and improved Intranet Directory accuracy
  - Assessed and reorganized the Agency Orientation Day
    - Eliminated duplicative required training
    - Included an opportunity for new staff to meet consumers participating in day services and receive a group home tour
- Began the Woodman Lobby redesign incorporating Wellness and Trauma Informed concepts
  - Engaged VCU Design students who presented their concepts to the Agency through and Open House
  - Incorporated many of their concepts into a vision for the future Lobby
  - Completed the Children's room redesign
- Enhanced the Cerner system so Access Staff could easily link a client's insurance with an appropriately credentialed clinician to make the first appointment
- Over 30 PC Monitors were redeployed to connect with laptops for better visual capacity
- Continued Carpet replacement project by installing new carpet in Woodman Building A

County

- Converted to Voice Over IP at 6 locations (all except Cypress)

State

- Coordinated an Agency-wide workgroup to implement a Telehealth strategy and procure equipment with State Grant Funding
  - Equipment was installed and staff began to meet via the new technology
  - Telehealth policy and forms were drafted
  - West PACT prescriber and Jail prescriber began treating clients through Telepsychiatry
- Assisted in designing new forms for the State funded Jail Diversion Program's data gathering, reporting and set up as well as procuring and installing furniture and computer equipment
- Began planning and designing critical administrative initiatives related to implementing the DOJ Final Rule
  - Coordinated the Onboarding process for DD private providers to ensure they have the appropriate paperwork, background checks and training to provide the services under the HAMHDS license
  - Created and revised forms to meet the DOJ data gathering and reporting requirements
  - Created Excel databases for ID waiver day services consumers which automated incremental data outcomes tracking
  - Designed the new billing modalities for ID Day Services, ID Residential Services and DD Case management
  - DD Case Management Contract management

Federal

- Converted from ICD9 coding platform to ICD10/DSM5
- Implemented the Patient Portal in Cerner to meet Meaningful Use measures

Volumes Processed

- Financial Management: 8,071 A/P Payments totaling $7.2 million, 271 Requisitions for purchase orders
- Facilities Management: 1,119 Work Orders completed, 176 Projects completed (not including the Lobby project)
- Reimbursement: 42,187 Insurance claims , 20,635 client statements
- Information Services: 1,275 Work Orders completed
- Front Desk Calls/month: Woodman: 5,500, East: 4,000, RMP 1,700, PF: 675
- Front Desk Traffic/month: Woodman: 1,100 (without groups & meetings), East: 1,100, RMP: 500 (300 more with CCP), PF: 300

**Clinical and Prevention Services**

**Adult Substance Abuse/ Adult Mental Health Services**

- Implementation of aftercare community group
- Implementation of voucher program for methadone lead to increased engagement numbers – up to 70%+ engagement
- Increased the number of clients assisting with the purchase of methadone
- Recovery Event for the Community in September – joint effort with Henrico Drug Court
- New partnership with Fan Free Clinic – came and provided free HIV testing
- Initiation of a Dual Diagnosis group, collaboratively provided by partnership between ARS and SUD
- Initiation of a DBT skills only group for ARS, collaboratively provided by partnership between ARS and MH
- Implementation of walkin for D32
- Development of a new group for D32 clients – now provide 4 groups
- Overall expanded our group complement
- Renewed partnerships with local hospitals and CPS regarding substance exposed infants
- Participating in county wide Heroin Task Force
- Clients participated in “My Side of the Story”
- Provided training at all CIT academies
- Reallocated staff to meet walkin demand, developed scheduled back up for walkin
- Procedure manual now located on the P-drive
- Outreach system implemented for the mothers of substance exposed infants
- Expanded coverage of methadone stipend for post partum mothers
- Entered partnership with Bundle of Joy child care to provide care for dependent children while parents are in treatment
- Participating on county wide Heroin Task Force

Jails:

- Awarded a new jail diversion grant
- Improved partnerships with the courts, Sheriff, police and commonwealth attorneys
- Provided MH 1st Aid training to 3 Sheriff academies
- Hired the first peer
- Implementation of Telehealth
- Applied for NACO award for MRT groups in the jail

Courts:

- Number of evaluations completed = 519 72 were competency /sanity evaluations

**Adult Recovery Services**

- Continued to demonstrate the effectiveness of case management services with 92% of individuals experiencing either a reduction in hospitalization admissions or remaining at zero hospitalizations
- Continued partnership with Daily Planet and implemented participation in Enhanced Care Coordination as part of integrated healthcare
- Began using telepsychiatry services with the West ICT Team
- Began implementation of the InSHAPE wellness program
- Provided employment services to 47 consumers. 87% were successfully employed during the year.
- Received a NACo Award for innovative residential programming.
- Enhanced Lakeside Center by implementing additional structured programming in the daily schedule.

**Emergency Services**

Crisis Intervention Team (CIT):

- Expanded our services at the Crisis Receiving Center from 12 to 18 hours a day
- Provided 1,670 face to face emergency assessments.
- Continued to provide monthly CIT classes to police, fire and sheriff first responders and have trained 100% of the 655 police officers as of May 2016 and 100% of the 121 Communication Officers.
- Expanded CRC partnership to include New Kent Sheriff's Office and are actively training their sheriff deputies in 40 hour CIT training with the goal of 100% trained.
- Coordinated with Children's Response and Stabilization Team (CReST) and the Regional Educational Assessment Crisis Response Habilitation (REACH) Team.
- Began planning for implementation of Same Day Access

**Youth & Family**

- Provided Intensive Care Coordination Services to eight youth at risk of residential placement, using a high-fidelity wraparound model of services
- Continued our partnership with court services, serving fifty youth and their families in Court Alternative Program Substance Abuse (CAP-SA) psycho-educational groups
- Continued to expand our role as Children's Services Act (CSA) case managers for youth receiving residential or community-based services; as of June, 2016, we were providing CSA case management to 45 youth
- Increased the flexibility of our staffing for conducting VICAP Assessments through the use of contract staff, conducting 843 VICAP assessments by May 31, 2016
- Served 14 youth in Crisis Response & Stabilization Services (CReST) a new regional program for youth in Crisis.
- Negotiated increased on-site hours and services at Juvenile Court Services, to begin in July, 2016
- Increased number of youth served with case management services by 12%, increasing targeted case management revenue by 20% (3rd quarter revenue data)

**Prevention**

- Counter Tools/Merchant Education- environmental strategy focused on mapping tobacco-product vendors and providing education regarding VA laws on sale to minors; 241 stores identified
- Annual Spring College Tour to VSU and Randolph Macon Community College
- Teen Job Prep Program (TJPP) provided forty-one 14-15 year olds with job training and a paid summer work experience
- Bewellva.org - developed by regional suicide prevention collaborative of Prevention Managers; Henrico homepage developed (see link on HAMHDS intranet); contracts with Radio One and I-heart radio to educate community via PSAs re: CSB and other community resources
- MHFA - Prevention staff trained 179 persons to date including Sheriffs, county employees, social work and human service interns, youth serving organizations, CERT volunteers and faith community. MHFA video developed by HC Media Services featuring Prevention MHFA trainer
- Summer Heat Henrico County Community Day -disseminated Prevention information/resources re: suicide and substance use prevention, healthy relationships, parenting, etc.
- Henrico Extension Program partnership with 4-H
- Wellness Hip-Hop Poetry Slam planned by Youth Ambassadors leadership group

**<u>Community Support Services</u>**

**Division**

- Monitored Department of Justice and Waiver Re-design processes and began implementation of sections required
- Assisted individuals in attending the General Assembly and speaking to their legislators
- Two CSS staff served on the Region IV Quality Council
- Hosted REACH training for staff
- Intake/Eligibility and Case Management collaborated to complete Priority Categories for all individuals on the Urgent and Non-Urgent waiting list and the new VIDES assessment for all individuals meeting Priority 1
- Identified and recommended to Department of Behavioral Health and Developmental Services membership for the Waiver Slot Allocation Committee
- Began meeting with Developmental Disabilities Case Management Private Providers
- Participated in a Developmental Disabilities Case Management Forum
- Staff participated in the DOJ Rapid Response Housing Initiative
- Staff applied for the Regional VHDA Capacity Grant for housing

**Intake/Eligibility and Case Management**

- Restructured intake team and hired two case managers to be prepared for CSBs becoming the Central Point of Entry for individuals with Developmental Disabilities.
- Played a significant role in the conversion from ICD 9 to ICD 10.
- Absorbed the waiver screening and waitlist monitoring for infants to 3 years old who are in our Early Intervention program.
- Advocated and prepared for a new process to screen the I/DD intakes with a new access number and staff coverage of the phone.
- Began the process of sorting/organizing the individuals with DD who will become part of Henrico Area CSB in the near future.
- Provided assistance to the CSS Community Teams on a number of projects during the year.
- Continued to participate in SIS verification audits, National Core Indicators, Delmarva surveys, Department of Justice audits, Licensing audits, Department of Behavioral Health and Developmental Services quality audit, and Department of Medical Assistance Services audits
- All Case Management and Case Management supervisory staff completed additional CM modules
- Case Management supervisory staff completed Waiver Re-Design Experts training
- Case Managers participated in Waiver Re-Design training
- Staff served on the Commonwealth Catholic Charities Guardianship Panel
- Staff participated in the Henrico County Transition Fairs and in the New Kent Council Outreach Committee activities
- Case Managers supported individuals to apply for the special Housing Vouchers earmarked for individuals with Waiver or on the Waiver Waiting List
- Notified providers of DBHDS assigned Level and Tier for each individual and all the individual's providers of service

**Housing**

- Housing case manager became a member of Region IV DOJ Housing Committee H
- Henrico was a "high performer" on agency SEMAP audit for FY16

**Employment and Day Services and Residential**

- Staff are represented on several state advisory Boards including the Employment First Advisory Group and the Community Engagement Advisory Group both for the Department of Behavioral Health and Developmental Services
- Staff have been appointed to a 3 year term on the Employment Services Organizations Advisory Group with the Department of Aging and Rehabilitative Services
- Received successful audits from DMAS and the Department of Labor
- Revamped data system for individuals receiving Waiver services
- Implemented several pilots towards improving community inclusion services to those who attend day services
- Several staff were commended for excellent customer service by Van Go and families on how they handled a vehicle accident outside the enclave where several consumers and the Van Go driver were injured
- National Developmental Disability month was celebrated at a talent show at Hermitage Enterprises
- Graduated one individual from front office training program to a full time individual placement; placed three individuals from Hermitage into jobs using Supported Employment
- Developed new ISP/Assessment form for Residential
- Group home staffing changed schedules to accommodate client's declining dementia diagnosis and address increased support needs
- Client and staff participated in the Art project
- A client, with late stage Alzheimer's Disease, who loves all things transportation, was able to visit the train station and see the process
- Sherbrooke staff participated in training with a certified Nutritionist to support a client with a new diagnosis of diabetes
- Inception of the HAMHDS Residential Health and Wellness Initiative 10/2015
- Green Run and Gayton received significant home improvements

**Parent Infant Program:**

- Staff received training in conjunction with Substance Abuse staff regarding maternal substance abuse. There is continued collaboration to address the needs of pregnant mothers who use substances.
- Parent Infant Program participated in a collaborative program with Healthy Families in Charles City County

**<u>Quality Assurance</u>**

- Experienced a 70% increase in external audits/program reviews
- 32 staff trainers provided instruction on a variety of areas such as: First Aid, CPR, and AED, Prevention of Violence, Therapeutic Options, Cultural Awareness, Brown Bags, Wellness series: My side of the Story, Mental Health First Aid, Electronic Health Record system and other professional training outside of their normal duties

# FY17 ADMINISTRATIVE AND PROGRAM INITIATIVES

## Administrative

Agency

- Continue and complete the Woodman Lobby redesign, incorporating Wellness and Trauma Informed concepts
- Complete the new Business Process & Procedures Manual which includes re-evaluating processes, smoothing workflows and writing new procedures for each aspect of Administrative/HIM/Business Processes related to Support functions

County

- Continue Carpet replacement project by installing new carpet in Woodman Existing building, 2nd Floor and Lobby
- Coordinate and Agency-wide workgroup to evaluate and enhance the content and improve accuracy of information on the Internet Website

State

- Complete the design and implement the administrative initiatives related to implementing the DOJ Final Rule
- Begin planning, billing modalities redesign and changes in processes for the MLTSS (Managed Care) State Initiative
- Expand the use of Telehealth in practice
- Build the billing modalities for telepsychiatry
- Add another Telehealth conference room with additional State Grant funding
- Complete training and training materials to staff

Federal

- Implement electronic Lab Order process in Cerner to meet Meaningful Use measure

## Clinical and Prevention Services

- **InShape** is an evidenced base program for individuals with severe and persistent mental illness who also have been diagnosed with obesity. As part of this program one of our staff members has obtained certification as a Personal Trainer. In collaboration with Henrico Parks and Recreation, we will begin offering this program to eligible clients in the first quarter of FY17.
- **Phase II of Counter Tools - Merchant Education**: The Department of Behavioral Health and Developmental Services is leading an effort to shift Prevention Services to focus more on environmental strategies rather than more individualized, program based services. As part of this shift in focus, Henrico Prevention staff will be providing education to local merchants who sell cigarettes. The education will focus on laws related to selling tobacco to youth.
- **Henrico Youth Survey**: In November, 2016, the Too Smart 2 Start Coalition in conjunction with Henrico Public Schools will sponsor a survey of high school students. The survey focuses on youth attitudes and behaviors related to alcohol, tobacco and drug use. The results of the survey help identify areas of focus for our Prevention Services.
- **Expanded Focus on Opiate Treatment**: In response to the growing epidemic of opiate use, our Substance Use Services are undertaking a number of initiatives. We are exploring opportunities to expand our medication assisted treatment (MAT) through coordination with insurance companies and other providers in the area. In addition, we are working closely with local hospitals' labor and delivery units to provide immediate coordination and treatment to mothers of substance exposed newborns. We have also developed a partnership with a local child care provider to expand our child care services for parents who want to participate in treatment but lack adequate child care.
- **Implementation of Evidence Based Employment Services**: We recognize that employment is a key component for many people recovering from severe and persistent mental illness. The Individual Placement and Support (IPS) model of vocational services is an evidence based approach to assisting individuals with mental illness become employed. Our vocational staff will be trained in the model this year and begin implementation of this evidence based program.
- **Expand provision of dual diagnosis groups (ARS/SUD Services)**: In FY16 we piloted a dual diagnosis group for individuals with severe and persistent mental illness and substance use disorders. This group was co-facilitated by staff from our Substance Use program and staff from Adult Recovery Services. This pilot proved successful and we plan to expand these services in FY17.
- **Enhanced Care Coordination**: In FY16 we signed agreements with 3 insurance companies to provide Enhanced Care Coordination to their members with severe and persistent mental illness who also were diagnosed with a chronic medical condition. The goal of this program is to better coordinate the medical and psychiatric services that individuals receive resulting improved quality of life and decreased visits to emergency rooms and hospitals. We will continue to expand this program in FY 17 through enrollment of more individuals.
- **Expanding on-site services at Juvenile Court Services**: At the request of the Court Services director, with new funding that recently became available, we are finalizing a memorandum of agreement that will increase our on-site hours from eight to sixteen per week effective July 1st. We will continue conducting mental health and substance

abuse assessments for the juvenile court and probation officers, and will begin to expand the range of on-site services we provide as need dictates.

- **Suicide Prevention Activities**: In FY16 staff attended the Zero Suicide Academy as part of larger strategy to addressing the rising number of suicides and suicide attempts. In FY17 we will implement use of structured tools to assess risk for suicide, and structured response and intervention for those individuals identified as being at highest risk.
- **Peer Services**: Our agency has a long history of providing Peer Specialist services. We have expanded the role of peers to include work in the Crisis Receiving Center and in the jail. The Department of Behavioral and Developmental Services has also been working to enhance the role of Peer Specialists through developing a certification process for peers. In FY17, we hope to be able to begin billing for Peer Specialist services. We continue to look for opportunities to expand our Peer Specialist Services in Substance Use Services and to work toward our long term goal of supporting a peer run drop in center.
- **Henrico Crisis Intervention Team (CIT)** is providing three 1 ½ day training sessions to certify individuals to become trainers for Crisis Intervention Team for Youth. The training is sponsored by Policy Research Association (affiliated with SAMHSA), and will be offered to Henrico and other CIT trained responders from across the state. The individuals receiving this training will become instructors for CIT responders to provide specialized training in understanding and effectively working with children and families in crisis.
- **Henrico CIT** will provide one train-the trainer session in Mental Health First Aid for Public Safety to CIT trained responders. This five day training will be provided to Henrico and other responders from the State. Those trained will be qualified to provide MH First Aid to other public safety first responders.

**Community Support Services**

- To assure the provision of high quality services for individuals with Developmental Disabilities.

**Intake/Eligibility**

- Implement DD single point of entry and eligibility determination

**Residential**

- Implement Department of Justice changing requirements, Waiver Re-design requirements and Centers for Medicaid and Medicare Rules on integration and setting.

**Parent Infant Program**

- Improve transition from Parent Infant Program to long term Case Management services.

**Case Management Services**

- Implement Department of Justice changing requirements, Waiver Re-design requirements and Centers for Medicaid and Medicare Rules on integration, setting, and Conflict Free Case Management.
- Create partnerships with private providers of Developmental Disability services.

**Day Services and Employment**

- Implement Department of Justice changing requirements, Waiver Re-design requirements and Centers for Medicaid and Medicare Rules on integration and setting.

## AGENCY OUTCOMES AND PERFORMANCE IMPROVEMENT MEASURES

**ADMINISTATIVE OUTCOMES**

| | |
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| **Efficiency Objective:** To improve the collection rate of net charges for Unit 1200 to 85% by June 30, 2016. | **Results:** 65%, not met |
| **Recommendations/Action taken:** The Reimbursement Department made great strides in several areas to include, restructuring, training, and staffing. During the year and 4th quarter in particularly, the Reimbursement Department was challenged with the resignation of seasoned staff, acclimating staff to new job duties and assuming job duties of staff out on long term medical leave. The implementation of purchased medications also transpired in FY16 causing an increase in receivables. | **Performance Improvements:** We dedicated an analyst to work with management and clinical staff in the area of purchased meds and billing injections along with E&M codes out of the 1200 unit. We will continue to improve business process to meet the goals as we continue process improvement necessary to reduce the amount net charges pending adjudication. |

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| **Efficiency Objective:** Collect at least 97% of net charges for dates of service for June 2015 thru May 2016, improving the collections | **Results:** 90%, not met |
| **Recommendations/Action taken:** Improved focus and ability to balance all pay source/benefit plans was realized over the year as skill sets improved. The Reimbursement Supervisor continued to work directly with CAPS AR staff on specific AR issues by running additional reports and having staff focus on areas where marked improvement in revenue could be realized. | **Performance Improvements:** Overall, in an effort to realize more consistency, the Reimbursement Supervisor has implemented reimbursement group bi-weekly training sessions and one on one session that focus specifically on the A/R of the individual analyst. |

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| **Objectives for the Coming Year**<br>Efficiency - To improve the collection rate of net charges for Unit 1200 to 85% by June 30, 2016.<br>Stakeholder Satisfaction - Improve customer service satisfaction of court staff rating to 9; improve timeliness-Court staff will receive the court orders within 4 weeks of the scheduled evaluation. |

**ADULT SUBSTANCE ABUSE OUTCOMES**

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| **Access Objective:** Clients admitted to the program will be seen within 14 calendar days for the next available appointment following the walk in intake. | **Results:** Highest # of days was 11, met |
| **Recommendations/Action taken:** Quickly developing a positive therapeutic relationship is vital to substance use disorder treatment. By ensuring that clients are seen quickly for their second appointment this positively impacts the clients' ability to engage fully in services. | **Performance Improvements:** During this fiscal year, we met our objective of ensuring their second appointment was within 14 days of the initial assessment. In many instances, the second appointment was within a week or less. We will continue to work to maintain these results. |

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| **Effectiveness Objective:** 60% of clients opened to this service will receive 2.25 hours of service within the first 30 days of service. | **Results:** Monthly percentages exceeded 60% target, met |
| **Recommendations/Action taken:** Continuation of actively outreaching to clients who do not present for services and invite them back appears to work with building the therapeutic relationship resulting in increased engagement numbers. | **Performance Improvements:** Exceeded this year's program target of 60% each month and we also exceeded the State Dashboard Target of 68%. |

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| **Effectiveness Objective:** 30% of clients admitted to services will be retained in services for a minimum of 6 months. | **Results:** Monthly percentages lower than 30% target, not met |
| **Recommendations/Action taken:** It is difficult to determine what the results are in fact for adult SUD treatment as this is being measured for both youth and adults, requested a report separating these. | **Performance Improvements:** We are experiencing difficulties teasing out details of the SUD treatment with current reporting capabilities; continue efforts to mine available data, request ability to drill down in State dashboard data. |

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| **Consumer Satisfaction Objective:** 80% of clients surveyed in September and March will rate their overall satisfaction with the session as satisfied utilizing the SRS. | **Results:** 96.2%, met |
| **Recommendations/Action taken:** 259 surveys were completed by our clients. We are pleased that we surpassed our objective and will continue to work to provide exemplary services to our clients. | **Performance Improvements:** Our staff work diligently to develop a positive therapeutic relationship with our clients and to provide meaningful interactions. |

**Objectives for the Coming Year**
Access - Clients admitted to the program will be seen within 14 calendar days for the next available appointment (group and individual sessions combined) following the walk in intake.
Effectiveness - 60% of clients opened to this service will be retained in services for a minimum of 3 months
Effectiveness - 26% of clients admitted to services will be retained in services for a minimum of 6
Consumer Satisfaction - 80% of clients surveyed in September and March will rate their overall satisfaction with services.

**ADULT MENTAL HEALTH OUTCOMES**

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| **Access Objective:** Clients will be scheduled for a follow up appointment within 14 calendar days of call to central access. | **Results:** Highest monthly average is 41 days. Lowest monthly average is 16 days, not met |
| **Recommendations/Action taken:** With 4 staff on FMLA leave, we did not meet our goal. It is clear that the requests for service far exceed our ability to provide the service given the few number of clinicians available. | **Performance Improvements:** The agency has begun the planning process for same day access which will alleviate this problem and will ensure that clients are seen in a much timelier manner. |

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| **Consumer Satisfaction Objective:** 80% of clients surveyed in October and April will rate their overall satisfaction with the session as satisfied utilizing the SRS. | **Results:** 98%, met |
| **Recommendations/Action taken:** Over the year 149 surveys were returned with 596 responses completed. 12 responses scored below 8. Therefore a total of 98% of the responses were at 8 or above thus exceeding our objective. | **Performance Improvements:** The satisfaction surveys that were completed by clients this year have demonstrated that our clients are pleased with the services that they receive, feel that the therapeutic relationship is sound and that they are able to get the services that they need to improve their lives. |

**Objectives for the Coming Year**
Effectiveness - Clients will be scheduled for a follow up appointment within 14 calendar days of call to central access
Consumer Satisfaction - 80% of clients surveyed in September and March will rate their overall satisfaction with services at a 4 or 5 on the survey.

**CHARLES CITY/NEW KENT OUTCOMES**

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| **Access Objective:** Clients will be seen for initial appointment within 10 days of contacting Access. | **Results:** average 13.3 days, not met |
| **Recommendations/Action taken:** PF did not meet the 10 day goal for initial assessments. This is largely due to staffing issues. Out of the entire year, PF was fully staffed approximately 4 months out of 12 months | **Performance Improvements:** Despite trying to make changes to allow easier access for clients through intake, PF still missed the 10 day goal. We will continue this measure in FY17 |

**Objectives for the Coming Year**
Access – Clients will be seen for initial appointment within 10 days of contacting Access.
Effectiveness – Clients show rates for initial assessments will improve by 75% by clinicians contacting client prior to appointment.
Satisfaction – 80% of clients surveyed in October and April will rate their overall satisfaction with the session as satisfied utilizing the SRS.

**LAKESIDE CENTER OUTCOMES**

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| **Access Objective:** 100% of consumers referred to the program will be admitted within 15 days from receipt of the referral. | **Results:** average 15 days, met |
| **Recommendations/Action taken:** In late FY15, a new DMAS regulation which mandated that licensed staff conduct assessments created new challenges to expeditious program access. As a result, we modified our goal of getting individuals opened to services from 10 days to within 15 days of the referral. On average, for FY16, we were able to meet the target of 15 days. In our tabulations, each quarter all individuals coming from CSH were excluded given the unpredictability of these particular referrals. | **Performance Improvements:** Outside of an influx of referrals, our current process adequately met the need. External factors such as waiting for the individual to visit before proceeding with scheduling an orientation appointment; waiting for the SAI to respond to email correspondence offering available orientation dates; individuals electing to take appointments beyond the next available slot(s); and the rescheduling of appointments were standard influences that served to slow down the process. In FY17, we will attempt to open individuals within 10 days of the referral. |

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| **Effectiveness Objective:** The "dead referral" rate will not exceed 15% (consumer who did not attend at all within 30 days). | **Results:** 12/75 or 16%, not met |
| **Recommendations/Action taken:** Until the fourth quarter of this year, we were on target to exceed our goal. Prior to the fourth quarter, our "dead referral" average was 12%. "Dead referral" rates are lower when an individual tours the program prior to a referral being made. | **Performance Improvements:** Given that there were an influx of referrals without the individual first having a tour, it appears that we will need to continue to educate the SAI's about the process and work collaboratively toward a common goal of meeting the needs of our the clients in the most efficient way. For FY17, we will strive to further reduce the rate to 10%. |

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| **Effectiveness Objective:** There will be an overall reduction in LSC suspensions as a result of alternative intervention (baseline is over 10 suspensions). | **Results:** 2, met |
| **Recommendations/Action taken:** In FY16, our program strived to decrease the number of program suspensions by employing alternate interventions. Although we did not track suspensions in previous years, the volume of incident reports reviewed by the agency was indicative of a need. Alternatives to suspension used were: increased 1:1 support, meetings with CM, changes to ISP, formal letters to the member indicating what behaviors were being identified as those that could result in suspension. | **Performance Improvements:** For the year, we are pleased to report that there were only two suspensions for the entire year. Both of the suspensions for the year occurred in the fourth quarter. Although the total number of suspensions from the previous year is not known, we do know that our efforts resulted in an overall significant reduction in suspensions. |

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| **Efficiency Objective:** There will be improved coordination of care with other providers over the last two years will be documented in the record at least 85% of the time. | **Results:** 16/19 or 84%, not met |
| **Recommendations/Action taken:** The second quarter is ultimately what prevented us from meeting the annual target, as we were only able to achieve a score of 60%, due largely to one particular staff having more difficulty in this area than the others. We scored 100% in both the 3rd and 4th quarters! 100% score had not occurred over the previous two years in this outcome measure. | **Performance Improvements:** In FY17, the objective has been revised to reflect best practice for continuity of care which includes the SAI as well as other collateral contacts such as additional agency providers, private providers, family members, and/or ALF administrators. We will strive to achieve 100% compliance on this measure. |

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| **Satisfaction Objective:** 90% of consumers surveyed will report being "satisfied" with services. | **Results:** 81%, not met |
| **Recommendations/Action taken:** We decided to meet with members individually to verbally conduct a satisfaction survey to be more effective at eliciting feedback about the program. We also modified our sample population to be a random sample of individuals who had been in the program for two years or less. We hypothesized that newer members might provide more informative feedback. | **Performance Improvements:** Verbal surveys were more person-centered, our hypothesis was not supported as the results were no more or less informative than paper. The efficiency of the verbal survey makes it a more desired method. We plan to conduct verbal surveys with sample populations who have attended the program for 10+ yrs, 5-10, and 0-5 to determine if there is any variance. |

| **Satisfaction Objective:** 100% of stakeholders (adult home operators and family care home staff) will respond with an 8-10 rating to all survey questions | **Results:** 90%, not met |
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| **Recommendations/Action taken:** In FY16, twelve surveys were mailed out, but only 5 (42%) responses were received, despite a follow up letter being sent to request that the surveys be returned. Of the five surveys, three (60%) received 10's on every question, leaving the other two respondents responsible for the lower than desired average score. However, it should be noted that all surveys (100%) received the answer "yes" to Question #6, which asked the stakeholder (ALF) if they would recommend this program to others. The question that received the lowest score (83%) was Question #3, which states, "How would you rate information received from LSC staff regarding various announcements, such as Holidays, special events, social outings, etc." as two scores were a five and a six. This same question has been the lowest scoring in previous years and really is not a reflection on our level of communication with the ALF providers. Residents of ALF's are asked to take home monthly newsletters for the stakeholders to be aware of holidays, special events, announcements, and the monthly menu. Generally, this question has been answered with relation to inclement weather or unexpected events in which the County had closed or had a delayed opening. | **Performance Improvements:** Consideration is being given to mailing a Monthly Newsletter to stakeholders, particularly in winter months with instructions about how to obtain closing or delayed opening information. Despite results that did not achieve our goal, we believe that we continue to have positive relationships with our stakeholders and that they view our program as being beneficial. In FY17, our stakeholders to be surveyed will be family and/or significant others involved in the care of the individual in order to receive feedback from another important part of the individual's system. |

**Objectives for the Coming Year**

Access - 100% of consumers referred to the program will be admitted within 10 days from receipt of the referral
Effectiveness - The "dead referral" rate will not exceed 10% (consumer who did not attend at all within 30 days)
Effectiveness - As a result of alternate intervention, LSC suspensions will occur in less than 10% of incidents.
Efficiency - Evidence of Care Coordination with other healthcare providers (i.e. SAI, MHSB, Vocational, ALF/Residential, Private Providers) will be documented in the record 100% of the time over the past year.
Consumer Satisfaction - 90% of consumers surveyed will report being "satisfied" with services as evidenced by an 8-10 rating to all survey questions
Stakeholder Satisfaction - 90% of family/significant other stakeholders will respond with an 8-10 rating to all survey questions

**MH CASE MANAGEMENT OUTCOMES**

| **Access Objective:** 100% of non-crisis clients will be seen within 7 business days of the initial attempt to access services. | **Results:** annual average 8.08 days, not met |
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| **Recommendations/Action taken:** Staffing vacancies on the 3 case management teams was a significant issue in the second and third quarters of this year which unfortunately coincided with an increased demand for services during the same period resulting in longer than desired client wait times. Once these staffing vacancies were resolved in the fourth quarter, wait times reduced significantly to well below the desired target. | **Performance Improvements:** The agency is currently in the planning stages of moving to a same day access model of services, which would have a dramatic impact on the intake process and potentially eliminate wait times for services completely, This would therefore make it possible for a client to be seen the day they choose to seek services and hopefully having a positive impact on client engagement and retention. |

| **Effectiveness Objective:** Newly opened clients will demonstrate an 80% reduction in hospitalization rate or will maintain 0 hospitalizations. | **Results:** 86%, met |
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| **Recommendations/Action taken:** 223 clients were opened, 101 were closed or transferred to another service prior to the 9 mos. 122 clients remained active in CM services 9 mos post admission. 105 experienced a reduction in hospitalization or remained at 0 hospitalizations or 86% of the total cases. The results demonstrate a clear reduction in the hospitalization rates of clients that remain in CM services for at least 9 mos which is encouraging. | **Performance Improvements:** A significant number of clients continue to terminate case management services prior to the 9 month mark (45%), but this number has been trending downward over the past couple years from 57% last year and from 59% the previous year. Increased engagement efforts by case managers and supervisors have undoubtedly played a central role in this trend and has aided in this client retention. |

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| **Efficiency Objective:** 50% of newly opened case management clients will receive a minimum of 4 hours of case management services within the first 90 days of service | **Results:** 65%, met |
| **Recommendations/Action taken:** Staff supervisors have worked closely with their case management staff to maximize their engagement efforts during this initial phase of treatment to engage them services as this is a critical time in developing the therapeutic alliance between case manager and client to build recovery goals. | **Performance Improvements:** During the reporting period 65% of newly opened clients to case management services received at least 4 hours of case management services within the first 90 days of service, significantly exceeding the target of 50%. |

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| **Satisfaction Objective:** 90% of clients will respond with the two highest ratings to all questions on the satisfaction survey. | **Results**: 95%, met |
| **Recommendations/Action taken:** The client satisfaction rates for clients receiving mental health case management services remain quite positive for FY16. We received a total of 264 consumer surveys which was a significant increase in the number of surveys returned as compared to FY15, up 53%. 95% of the responses given being one of the top two ratings. We added some additional survey collection points within the agency in hopes of gathering additional surveys, which proved to be quite successful in gaining a higher overall survey return rate. This strategy actually produced the highest number of returned surveys in at least the last 5 years. | **Performance Improvements:** The overall return rate of the surveys was at 36% up from 26% from FY15. We will continue to look at ways of maximizing the number of surveys returned to continue to gain a broader client view of services received. The overall results were shared with the case management teams and staff specific feedback was shared with individual staff in clinical supervision meetings with their supervisors which has been helpful in understanding the clients' view of services provided and to inform and enhance services provided. |

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| **Satisfaction Objective:** 90% of those responding to the survey will respond with the two highest ratings to all questions on the stakeholder satisfaction survey. | **Results:** 97%, met |
| **Recommendations/Action taken:** Agency prescribers and staff from Lakeside Center Psychosocial Rehabilitation and agency Mental Health Skill Building were asked to rate and comment on the case management services and the collaboration that they have had with each case manager that they have worked with in the past year. We received a large number of returned surveys (101) from the various secondary services and the results were quite positive. 97% percent of the responses were one of the top 2 ratings, which was quite encouraging. This was even up somewhat as compared to last year at 94%. | **Performance Improvements:** The overall results were shared with case management teams and staff specific feedback was shared with individual staff in clinical supervision to inform and enhance the collaborative efforts between the services and to hopefully in turn improve client services and outcomes. |

**Objectives for the Coming Year**

Access - Non crisis clients will be seen within 7 business days of initial attempt to access services.
Effectiveness - Newly opened clients will demonstrate an 80% reduction in hospitalization rate or will maintain 0 hospitalizations.
Efficiency - At least 50% of newly opened case management clients will receive a minimum of 4 hours of case management services within the first 90 days of service
Consumer Satisfaction - 90% of client responses will be one of the two highest ratings to questions on the satisfaction survey.
Stakeholder Satisfaction - 90% of HAMHDS prescribers' and ARS Collaborative Services providers' responses will be one of the two highest ratings to questions on satisfaction survey rating case managers and clinicians within CM&A.

**IN-STRIDE MANAGEMENT OUTCOMES**

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| **Access Objective:** Consumers referred for YARS will have an assessment completed for admission to the program, on average, within 7 days of acceptance of the referral. | **Results:** 4.4 days, met |
| **Recommendations/Action taken:** There were a total of 17 new referrals accepted into the program this fiscal year. The average time that they were seen for a face to face assessment was 4.4 days, which is lower than the 7 we had anticipated. This is largely due to the efforts of the clinical supervisor and the clinician being available to have a quick turn around after a referral has been completed. | **Performance Improvements:** These face to face assessments are being provided in several office locations, community settings, and consumers' residence. This helps expedite the referral so the consumer is linked to treatment quickly. This demonstrates the teams understanding of how important early treatment can be for a consumer diagnosed with psychosis. |

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| **Effectiveness Objective:** There will be a decrease in the number of hospitalizations from InSTRIDE recipients. | **Results:** reduced 8 to 3, met |
| **Recommendations/Action taken:** Overall there was a large decrease in the number of hospitalizations since the first quarter which was the beginning of the InSTRIDE program. The first quarter had a total of 8 hospitalizations which was more than the next three quarters combined with the largest in the fourth quarter. Providing intense services has been able to help reduce hospitalizations. Consultation with the psychiatrist is happening weekly to assist in monitoring symptoms in conjunction with weekly case management and/or individual therapy. | **Performance Improvements:** As the program continues to build, we hope that there will continue to be a steady decline in hospitalizations due to the intensity of the services being provided and the ability of staff to intervene sooner with frequent contacts and collaborate with the psychiatrist when necessary. |

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| **Effectiveness Objective:** 100% of consumers will participate at least quarterly in activities within their community such as vocational, educational, or recreational. | **Results:** as of June 19/26 or 73%, not met |
| **Recommendations/Action taken:** This objective was something that is also measured by the state and is a very important part of engagement and treatment for the young adult population. Having a Supported Employment and Education Specialist (SEES) on the team has helped to keep consumers engaged and aware of activities that are happening in the community. He is also a good liaison for the school if there are consumers still engaged in school or interested in getting their GED. With the success that was seen this past fiscal year, we will continue to monitor this outcome and hopefully keep consumers active members of their community. | **Performance Improvements:** By the fourth quarter, a significant number of consumers were participating in community activities. Since there were several new referrals this quarter we did not meet this goal with 100% engagement, but will continue to strive to keep consumers active members of the community. |

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| **Efficiency Objective:** 100% of program orientation packets, initial assessment, and initial individual service plans will be completed within 30 days on all new referrals to In-STRIDE services | **Results:** 100%, met |
| **Recommendations/Action taken:** This objective was easily managed while having only 1 individual complete the assessment with the consumer. This is also often easily accomplished as the consumers are coming to the assessments with family members who can assist in providing historical information. | **Performance Improvements:** We will continue to monitor this objective to see if the increase in referrals has an impact on our ability to manage the paperwork requirements. |

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| **Satisfaction Objective:** Consumer's will complete a service satisfaction survey to rate the services being provided to them at a "2" or lower. | **Results**: 1 of 15 questions had 95% responses indicating satisfaction, the remaining questions had 86% or lower, not met |
| **Recommendations/Action taken:** Majority of the consumers rating their satisfaction on question 1 which asked , "I like the services that I receive here". The lowest level of satisfaction was on question 4, "I deal more effectively with daily problems." Staff will work with consumers on this identified weakness and results to be compared to next year. | **Performance Improvements:** This being a new program and often the clients are still learning about the mental health system and their diagnosis it might be more difficult for them to gauge their satisfaction. Due to the nature of this population and their resistance to become engaged in services, it could lead to less than satisfactory outcomes. |

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| **Satisfaction Objective:** The InSTRIDE Physician will complete a Practitioner Outcome Survey to rate the symptom management of the clients participating in services. The goal would be for the physician to average a score of "2" or lower for each question. | **Results:** 2 of 11 questions had an average score < 2, not met |
| **Recommendations/Action taken:** Based on the surveys collected this fiscal year the average score was 2.8. This is higher than the target goal of a scoring a 2 or lower, but does still demonstrate that services are impacting the consumers being served and that satisfaction is continuing to improve. | **Performance Improvements:** We will continue to use this tool as a way to monitor stakeholder satisfaction for the next fiscal year. |

**Objectives for the Coming Year**

Access - Consumers referred for InSTRIDE will be contacted, on average, for an assessment within 7 days of notification of the referral.

Effectiveness - There will be a decrease in the number of hospitalizations from InSTRIDE recipients as compared to the previous year.

Effectiveness - Consumers will participate at least quarterly in activities within their community such as vocational, educational, or recreational

Efficiency - Program orientation packets, initial assessment, and initial individual service plans will be completed within 30 days on all new referrals to InSTRIDE services

Consumer Satisfaction - Consumer's will complete a service satisfaction survey to rate the services being provided to them at a "2" or lower.

Stakeholder Satisfaction - The InStride Physician will complete a Practitioner Outcome Survey to rate the symptom management of the clients participating in services.

**MH PACT OUTCOMES**

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| **Access Objective:** Increase access to health care services experienced by persons receiving PACT/ICT services. Such individuals will see a health care provider, to include primary care providers, specialists, dentists, optometrists, etc., but not including emergency room treatment, at least once per year, benchmark is 75%. | **Results:** 80%, met |
| **Recommendations/Action taken:** Both East and West teams were able to successful get over three fourths of their clients to attend appointments with a community health provider, and most of these clients were seen by more than one provider in the community. It is also important to remember that this data does not include the numerous appointments attended with the agency psychiatrist whom might also address some issues with the client, nor does it include the clients who are being taken to appointments by family members, Medicaid transportation, or even the ones who are able to drive themselves. | **Performance Improvements:** We are going to continue to monitor this goal as it has become part of our practice model that we address all aspects of the individual including their medical diagnoses. |

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| **Effectiveness Objective:** There will be a decrease in the number of hospital bed days among PACT and ICT service recipients as compared to the number of crisis stabilization bed days, benchmark is 13 | **Results:** 10, met |
| **Recommendations/Action taken:** For the East PACT Team the total ratio for the FY16 ended up being .07 and the West ICT team at .14. The overall ratio for both teams for this fiscal year was .10, which is lower than what we would have expected and again implies that CSU is not being utilized as much as we would like. In looking at the data and the specific cases, it would be difficult to have made another decision based on the acuity the of clients mental status. | **Performance Improvements:** Some inpatient hospitalization clients were not able to consent to treatment which is part of admission to CSU. Also at the beginning of the year CSU was not taking anyone who was on a controlled substance which made referrals harder as many people are prescribed these medications to treat their ongoing symptoms. Also CSU often times does not have available beds when needed and will not take people who have significant medical needs. This also has an impact on our utilization of the CSU. This will continued to be measured in FY17 so that we are thinking of the less restrictive option for individuals in crisis situations. |

| **Efficiency Objective:** 100% of program orientation packets, PACT/ICT assessments, and initial individual service plans will be completed within 30 days on all new referrals to PACT or ICT services. | **Results:** East =40%, West= 70%, not met |
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| **Recommendations/Action taken:** There were a total of 15 new referrals for East PACT and 6 (40%) had all required paperwork completed within the 30 days. This was a significant drop from last fiscal year where we had a percentage rate of 100%. West ICT had a total of 10 new referrals and 7 (70%) had all the requires paperwork completed within 30 days. This is largely due to changing the process to having the supervisor complete all the initial intakes and having the assigned SAI present to move forward with the treatment planning as well upon opening. | **Performance Improvements:** There were a few cases that had circumstances out of their control, but for the most part there is a huge area of improvement. With the success seen on the West ICT team, East PACT is also going to start a new process of having the supervisor complete the initial assessment with the SAI to hopefully move the orientation process along faster and more efficiently. This also makes it more comfortable for the client to meet the SAI during the transition to a new program. This will again be on the outcomes for FY17 to monitor the effectiveness of changing the orientation process. |

| **Satisfaction Objective:** 86% of consumers will rate their satisfaction with PACT and ICT services a "4" or higher on the PACT/ICT Consumer Satisfaction Survey. | **Results:** 90%, met |
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| **Recommendations/Action taken:** Cumulatively, the West ICT and East PACT Teams had 21 clients complete the survey. The percentage rating their satisfaction at 4 or higher, per question, was as follows: question #1= 78%, #2 83%, #3 96%, #4 100%, #5 81%. There were a total of 22 surveys collected between the East and West teams. The combined satisfaction rating of a 4 or higher was 90%. Compared to last year, the data represented was collected from a smaller sample size. This has been an ongoing trend over the last two fiscal years. However, despite the smaller sample satisfaction overall was 4% higher at 90%. | **Performance Improvements:** For the upcoming fiscal year we have left this survey as a rating for consumer satisfaction and we will start issuing these surveys when clients are seen at the office for their monthly psychiatrist appointments. This will hopefully help increase the sample size for a more accurate picture of the consumers feeling like services are goal directed and recovery focused. |

| **Satisfaction Objective:** Consumers families will rate their satisfaction with PACT and ICT services at a "4" or higher on the PACT/ICT Family Satisfaction Survey. | **Results:** overall satisfaction rating of 4 or higher for both teams was 72%, established a baseline |
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| **Recommendations/Action taken:** This year we switched our stakeholder survey from hospital social work staff to families, we had poor response rates from hospitals. There were a total of 12 surveys collected during the third quarter for FY16. The average rating for the East PACT team was 92% and for the West ICT 63%. The overall satisfaction rating of 4 or higher for both teams was 72%. Despite both teams' efforts to collect the surveys either through the use of mailing the surveys with paid return postage envelopes or direct contact there was a very low turnout of completed surveys. | **Performance Improvements:** Due to the low turnout it will be hard to determine any significant findings to improve/maintain current practices. But with the data reported for this quarter it is possible that the West ICT team has some areas of improvements that could be made with their current clients. The East PACT team seems to have a consensus of being pretty satisfaction with the services being provided. If this measure is used again we will have to collectively make changes to the way the data will be collected to give us a larger sample size. |

**Objectives for the Coming Year**

Access - Increase access to health care services experienced by persons receiving PACT/ICT services. Such individuals will see a health care provider, to include primary care providers, specialists, dentists, optometrists, etc., but not including emergency room treatment, at least once per year.

Effectiveness - There will be a decrease in the number of hospital bed days among PACT and ICT service recipients as compared to the number of crisis stabilization bed days.

Efficiency - Program orientation packets, PACT/ICT assessments, and initial individual service plans will be completed within 30 days on all new referrals to PACT or ICT services.

Consumer Satisfaction - Consumers will rate their satisfaction with PACT and ICT services a "4" or higher on the PACT/ICT Consumer Satisfaction Survey.

Stakeholder Satisfaction - Consumer's families/identified primary support system will rate their satisfaction with PACT and ICT services at a "4" or higher on the PACT/ICT Family Satisfaction Survey.

**MH RESIDENTIAL OUTCOMES**

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| **Access Objective:** Vacancies in the program will be offered and accepted within 45 days from the date a resident vacates the home to the move-in date of a new resident. | **Results:** 57 days, not met |
| **Recommendations/Action taken:** This year there was one vacancy which was filled in 57 days. While we did not meet our goal of 45 days there were two main factors that contributed to the delay in admission: 1. there were few referrals for this level of care. 2. The person selected was initially hesitant to accept adding to the delay in admission. | **Performance Improvements:** |

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| **Effectiveness Objective:** Four out of five or 80% of residents will demonstrate increased independence with caring for their morning and evening routine as evidenced of needing less prompts/direction to brushing their teeth and wearing clean clothes that fits, matches, and are weather appropriate. | **Results:** 51.6%, not met |
| **Recommendations/Action taken:** During the first two quarters one resident was significantly challenged in managing her mental health symptoms requiring a great deal of staffs' prompting, direction, and support. This resident's increased needs resulted in her discharge from the program. A 2nd resident has a progressive neurological disorder. His needs have significantly increased and it is anticipated that his condition will continue to deteriorate and he will require a higher level of care. | **Performance Improvements:** Some residents demonstrated increased independence in performing ADL's as evident by them needing less prompts and direction from staff. As mentioned, a resident with progressive neurological disorder will continue to decline and he will require more intensive services than what can be provided at Walton Farms. |

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| **Effectiveness Objective:** 100% of residents will score an average of three on a scale of 1-5 on the community activity sheet that measures appropriate social behavior when on community outings in order to further promote community integration and reinforce social skills developed. | **Results:** 100%, met |
| **Recommendations/Action taken:** The residents enjoyed a variety of community activities, allowing them to be more fully integrated into the community. Staff provided the needed support to assist the residents with building skills, such as expressing their needs, exchanging money, and respecting the personal space and boundaries of others. | **Performance Improvements:** Staff provided the needed support to assist the residents with building skills, such as expressing their needs, exchanging money, and respecting the personal space and boundaries of others. |

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| **Efficiency Objective:** Increase the coordination of care between residential staff and the residents' day treatment programs as evidenced by 100% having monthly documentation of in the resident's EHR. | **Results:** 80%, not met |
| **Recommendations/Action taken:** We are pleased we sustained the progress made in meeting this objective with the last three quarters scoring 100% of monthly contact with the staff of the residents' day treatment program. | **Performance Improvements:** These monthly contacts have shown to improve staffs' relationships among residential and day program staff as well as improving coordination of care for the residents. The improved relationship between program staff was also evidenced on the stakeholders' satisfaction survey where communication was rated high. |

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| **Satisfaction Objective:** Four out of five residents will respond with an 8-10 rating to focus group survey questions. | **Results:** 5/5, met |
| **Recommendations/Action taken:** A focus group provided the residents with an opportunity to give feedback and suggestions about residential services they received. The information received was shared with residential staff and was used to improve services. | **Performance Improvements:** We are pleased that the average score to all questions was a 9. |

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| **Satisfaction Objective:** Four out of five stakeholders (stakeholder is defined as the staff assigned to the resident in their day treatment program) will respond with an 8-10 rating to all survey questions. | **Results:** 4/5, met |
| **Recommendations/Action taken:** Surveys were sent to the residents' day treatment program staff as a follow-up from the initial survey sent during the first quarter. The survey asked the following questions: 1. How would you rate the communication of pertinent information regarding your consumer and the residential staff, 2. How would you rate the responsiveness of the residential staff to your questions/concerns regarding your consumer, 3. Do you believe that living in residential services has helped your consumer and, if so, how would you rate their progress, 4. Please rate your overall satisfaction with the services that your consumer receives in residential services, and 5. Would you recommend our program to others (all answered yes to this question). | **Performance Improvements:** All surveys were returned and 4/5 answered with an 8-10 score on all survey questions. The residents were very positive about their living situation and the residential services they receive. Question one received high ratings and was the one that had the most comments, which were all positive. The two questions that scored below an eight were from one staff that rated a seven for questions three and four. This staff person works with a male resident who has a progressive neurological condition and progress made for him is very limited. It is anticipated that in the near future this person's needs will be greater than what the program is designed to provide. |

**Objectives for the Coming Year**

Access - Vacancies in the program will be offered and accepted within 45 days from the date a resident vacates the home to the move-in date of a new resident.

Effectiveness - There will be improved relationships between the residents as evidenced by a decrease in peer complaints.

Effectiveness - Three out of five residents will show an increase in level of independence as evidenced by successfully completing the Home Safety Evaluation Checklist, and staying home without supervision and/or incident for at least 7 consecutive hours during this evaluation period.

Efficiency - Improved communication between staff and resident's family and or legal guardian will occur as evidenced by monthly contact and documentation in the resident's EHR.

Consumer Satisfaction - Four out of five residents will respond with an 8-10 rating to focus group survey questions.

Stakeholder Satisfaction - Four out of five stakeholders (stakeholder is defined as the resident's family or legal guardian) will respond with an 8-10 rating to all survey questions.

**MH SKILLS BUILDING OUTCOMES**

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| **Access Objective:** MHSS will open 90% of referrals within 7 days of referral from case manager. | **Results:** 44%, not met |
| **Recommendations/Action taken:** Thirty-four consumers were opened this past fiscal year compared to only twenty-four consumers in the previous fiscal year. Of these 34 consumers, 15 were opened within 7 days. As a result, 44% of consumers were opened within 7 days of referral compared to only 33% last year which is an 11% improvement. The average wait period for the year was 18.5 days compared to 17 days in the previous fiscal year which was not an improvement; however, for the second half of the fiscal year, the average wait period was only 12 days which was the direct result of the MHSS supervisors starting to communicate to the referring case manager that if he/she is unable to initially schedule the MHSS assessment within 7 days of completing the referral form to let MHSS supervisor know, so that other measures can be taken to open consumers to MHSS in a more timely manner. | **Performance Improvements:** Even though substantial improvement has been made, the goal of having 90% of consumers being opened within 7 days was not achieved. Although MHSS supervisors has been ensuring that initial assessments are scheduled within 7 days from referral, factors such as clients missing their initial appointments continues to be a barrier to achieving 90%. As a result, this goal should be modified to reflect this reality which should be based on the results of the final two quarters (61%) which was when we started implementing our new strategy of ensuring that case managers schedule initial assessments within 7 days. This new objective should then read that "MHSS will open 80% of referrals within 7 days of referral from case manager. |

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| **Effectiveness Objective:** 25% of all consumers discharged from MHSS will be considered "successful." "Successful discharge" is defined as a consumer achieving their ISP goal(s), and did not require transfer to another provider. | **Results:** 33%, met |
| **Recommendations/Action taken:** 39 consumers were discharged from MHSS with 13 (33%) of these discharges completed treatment with no referral being made. The remaining 26 were discharged for a variety of reasons. | **Performance Improvements:** Since this objective was achieved for this fiscal year, but not in the previous year, this objective will again be tracked and measured for the next fiscal year. |

| **Efficiency Objective:** MHSS staff will document monthly collateral contacts 90% of the time. | **Results:** 92%, met |
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| **Recommendations/Action taken:** MHSS supervisors providing monthly reminder emails to staff to complete collateral contact notes appears to have been efficacious. Supervisors should continue to provide reminder e-mails to help sustain this positive trend, and solidify these gains. | **Performance Improvements:** We experienced an 8% increase over the previous fiscal year with collateral contacts being documented 92% of the time. Constant reminders help sustain these results. |

| **Satisfaction Objective:** 90% of consumers will respond positively to each survey question as evidenced by a score of 8 or higher for every question. | **Results:** 71%, not met |
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| **Recommendations/Action taken:** Even though this objective was again not achieved this year, overall results did exceed last year's results by one percentage point (71% versus 70%), and especially in terms of consumers' self perception of progress where results increased by 8 percentage points (51% versus 43%). | **Performance Improvements:** Results may continue to be negatively skewed as we successfully discharge consumers (i.e. the 13 consumers who achieved their goals this past fiscal year), as these are the consumers who are going to feel better about the services received. These results were shared with the MHSS team. |

| **Satisfaction Objective:** 80% of ARS case manager responses will be in the excellent range (8-10). | **Results:** 89%, met |
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| **Recommendations/Action taken:** With this fiscal year's results being so close to last year's results, MHSS has clearly continued to do an excellent job collaborating and communicating with its primary stakeholder (case managers). Clearly, case managers view MHSS as a recovery focused service which has helped shared consumers improve and grow. | **Performance Improvements:** MHSS is viewed at responding in a timely manner (98%), being collaborative (95%), having monthly contact (95%), and being recovery-focused (95%). In terms of consumer improvement, MHSS had 64% in the excellent range which was just one percentage point lower than last year, and certainly within the range of random error. Based on these results, no action needed to be taken except communicating outcomes to MHSS team. |

**Objectives for the Coming Year**
Access - MHSS will open 80% of referrals within 7 days of referral from case manager.
Effectiveness - 25% of all consumers discharged from MHSS will be considered "successful."
Efficiency - MHSS staff will document monthly collateral contacts 90% of the time.
Consumer Satisfaction - 80% of ARS case manager responses will be in the excellent range (8-10).
Stakeholder Satisfaction - 90% of consumers will respond positively to each survey question as evidenced by a score of 8 or higher for every question.

**MH VOCATIONAL OUTCOMES**

| **Access Objective:** Increase the number of participants that have received employment services by an additional fifteen. | **Results:** increased by 22, met |
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| **Recommendations/Action taken:** The goal of increased persons served with vocational services was surpassed for the year by seven, goal was set at 15 and we ended the year with 22 new participants in the program. Improvement is due to more interaction with referring teams and explanations around meeting referrals with the case managers present. | **Performance Improvements:** Overall, the case managers have increased the numbers referred and those referred were prepared to start the job development process. The 4th quarter was instrumental with the success rate, 9 participants enrolled in last quarter alone. |

| **Effectiveness Objective:** Twenty-four (24) additional assigned-program participants will become hired during evaluation period. | **Results:** 19, not met |
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| **Recommendations/Action taken:** Although the goal of twenty-two new jobs was not reached, the team made a great effort in reaching nineteen. We were only about to secure eleven jobs in the first three quarters. That represents one-half of the yearly goals. Whereas, eight individuals becoming employed in the fourth quarter shows a substantial increase. | **Performance Improvements:** Warmer weather temperatures and companies tendency to increase hiring in the spring attribute to the increase of jobs obtained. The team will discuss ways to better prepare for the decline in employment over the winter months through increasing job contacts and encouraging more participation by potential job seekers during the holiday season. |

| **Efficiency Objective:** Full time job coaches will reach at least fifty direct service hours monthly. | **Results:** 56, met |
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| **Recommendations/Action taken:** The average of fifty direct service hours was accomplished in each quarter. The only month that the average dropped under that figure was January(42%) which is consistent with other indicators; that being the program experiencing lower success/jobs obtained in the winter months. This is further evidenced by a quarterly figure of 51% observed in the third quarter (January-March). | **Performance Improvements:** Additional outreach, encouragement and scheduling will be implemented during the upcoming year to facilitate more favorable results with overall vocational services. |

| **Satisfaction Objective:** 90% of responding program participants will score a rating of at least "8" satisfaction level on a scale of 0 to10. | **Results:** 95%, met |
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| **Recommendations/Action taken:** The goal on consumer satisfaction was reached during both measured quarters and for the year. The team will continue to offer employment dinners and meeting activities that will gauge participant satisfaction, ideas and suggestions that will improve vocational services. | **Performance Improvements:** 17 or 18 participants provided ratings of at least 8 with regard to satisfaction of vocational services. The individual that scored services lower (7) provided a comment of "wanting a raise or higher pay". The assigned job coach met with individual at a later date with insight on steps to take in order to possibly get a pay increase. |

| **Satisfaction Objective:** 90% of responding employers will score a rating of at least "8" satisfaction level on a scale of 0 to 10. | **Results:** 100% |
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| **Recommendations/Action taken:** The stakeholder satisfaction was measured at 100% for the year. The team has discussed the attempt(s) to offer focus groups. But it was decided to continue with telephone outreach and some face to face contacts with employers to gather information that will be pertinent to program growth and job retention. | **Performance Improvements:** The issue of attending a focus group was discussed with employers. Several of the employers reported the times to meet for possible focus groups created scheduling difficulties. Only two felt their work schedule would allow them to attend. We will continue with telephone outreach and face to face contacts to gather information. |

**Objectives for the Coming Year:**
Access - Increase the number of participants that received employment services by eighteen.
Effectiveness - Staff will assist program participants with obtaining twenty-two additional jobs during evaluation period (7/1/16-6/30/17).
Efficiency - Full time job coaches will average at least fifty direct service hours monthly.
Consumer Satisfaction - 90% of responding program participants will score a rating of at least '8" on a scale of 0-10.
Stakeholder Satisfaction - 90% of responding employers will score a rerating of at least "8" satisfaction on a scale of 0-10.

**PREVENTION OUTCOMES**

| **Access Objective:** 100% of consumers will be approved for admission into the CONNECT program within 5 business days of request for services. | **Results:** 100%, met |
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| **Recommendations/Action taken:** There were a total of 33 new admissions for FY16. Youth continue to be admitted to the program based on capacity. During the past year there was no waiting period for any Connect sites and youth were approved at the time of registration. | **Performance Improvements:** All 33 new admissions were approved at the time of registration. Community-based access facilitated youth starting participation in the program immediately. |

| **Effectiveness Objective:** 95% of CONNECT of 1st – 3rd grade participants shall be reading on or above grade level. | **Results:** 83%, not met |
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| **Recommendations/Action taken:** Of the 23 1st -3nd graders who completed the school year in Connect, 10 (43%) were new admissions. Nineteen participants (83%) were reading on or above grade level and 9 (39%) achieved Honor Roll by the end of the school year. Only 69% of these youth were reading on grade level at the beginning of this school year. Of the four students who did not achieve grade level in reading, 3 are receiving modified instruction in their educational plans. Despite not reaching the 95% objective, significant academic progress in reading was made by 1st-3rd graders this school year. | **Performance Improvements:** The challenge of part-time staff shortages in Connect continued, although a few new staff were added. Additionally, new mandates from DBHDS required restructuring of full-time staff roles and time. Progress achieved this year can be attributed to the highly qualified and dedicated staff. In some programs interns from area colleges and universities, supervised by Prevention staff, provided support to programming. A variety of community partners also provided enrichment activities that support Connect's academic objective. Moreover, Prevention staff continue to promote collaboration and better communication between the Connect program, parents and schools in an effort to improve youth academic skills and overall educational experience. |

| **Effectiveness Objective:** Students will show a decrease in favorable attitudes towards Alcohol, Tobacco and other Drugs (ATOD) as demonstrated by the evaluation outcomes of evidence-based curriculums implemented in the community. | **Results:** decrease in favorable attitudes obtained, met |
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| **Recommendations/Action taken:** Among the early elementary group who received AL's Pals, 10% began the curriculum with favorable responses to alcohol and tobacco use and decreased to 3% after implementation. The 3rd and 5th graders who began the LST curriculum with favorable responses toward ATODs virtually remained the same. Seventy-six percent (76%) of 3rd and 5th grade responses on the post-test reflected unfavorable attitudes toward ATODs. Post–test responses from the small sample of 7th graders showed 70% of the youth's responses were unfavorable to ATODs. Two participants left the program prior to post-testing and it is not known how their responses would have affected outcomes in this small sample. Also noted in the outcome results for the older youth is a trend over the past few years toward more youth reporting "unsure" in their attitudes toward ATODs. | **Performance Improvements:** Due to small sample sizes, the result of these outcome measures cannot be deemed representative all the Connect program participants. Consequently, the program decision to conduct outcome measures with sub-samples of Connect youth may need to be revisited in order to more clearly discern the overall impact of the substance abuse prevention curriculums implemented. |

| **Efficiency Objective:** Prevention Services shall implement environmental approaches, in collaboration with community partners, to address substance use prevention and mental wellness as measured by the delivery of 2 community-level activities annually | **Results:** 6, met |
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| **Recommendations/Action taken:** Prevention Services exceeded its objective for FY16 by implementing numerous strategies that included Project Sticker Shock implemented in two localities, co- sponsoring a community forum with the Henrico Too Smart 2 Start Coalition, launching social marketing campaigns (www.bewellva.com and www.henricoprevention.org), and hosting a wellness - themed poetry event developed by the Youth Ambassadors Leadership Group from various Prevention programs. | **Performance Improvements:** Prevention Services also participated in a new state initiative called Counter Act aimed at stopping the sale of tobacco, vapor and alternative tobacco products to minors. All of the aforementioned strategies are focused on the promotion of behavioral health wellness in the communities served by HAMHDS. In particular, information collected from the annual community forum and is integrated into a comprehensive community needs assessment to determine specific resources, programs and strategies that can best benefit the communities served. |

| **Satisfaction Objective:** 85% of CONNECT participants (3rd grade and above) shall give a response of 1 (i.e., agree) on the consumer satisfaction survey | **Results:** 82%, not met |
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| **Recommendations/Action taken:** This year Connect program site was closed due to unforeseen circumstances, which contributed to the reduced total number of participants that received the survey in the spring. Favorable participant rating of the program rose slightly from fall to spring. On average for the school year, 82% of youth rated the program as beneficial, falling slightly short of the objective. | **Performance Improvements:** Approximately 13% of youth were unsure and 5% disagreed. Favorable comments focused on positive relationships with staff, homework assistance and skill building, and other enrichment opportunities afforded by the program. Participants' critical comments primarily focused on the food served, the desire for more fieldtrips and the lack of certain amenities (more computers, more games, etc.). |

| **Satisfaction Objective:** 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree) on the satisfaction survey | **Results:** 99%, met |
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| **Recommendations/Action taken:** Surveys from parents and other community stakeholders were collected in the fall and spring. The Stakeholders Satisfaction objective was exceeded. Parents and community stakeholders rated the Connect program similarly with an average rating for this year of 99%. | **Performance Improvements:** Both viewed the Connect program as a safe, constructive place where youth can get academic support and develop life skills. Both also noted the staff's positive relationship with participants, parents and the schools. Many of the parents who participated in the survey have multiple children enrolled and have participated for several years. Most critical comments centered on the need for expanding program hours. |

**Objectives for the Coming Year:**
Access - Consumers will be approved for admission into the CONNECT program within 5 business days of request for services.
Effectiveness - 95% of CONNECT of 1st – 3rd grade participants shall be reading on or above grade level.
Effectiveness - Students will show a decrease in favorable attitudes towards Alcohol, Tobacco and other Drugs (ATOD) as demonstrated by the evaluation outcomes of evidence-based curriculums implemented in the community
Efficiency - Prevention Services shall implement environmental approaches, in collaboration with community partners, to address substance use prevention and mental wellness as measured by the delivery of a media campaign and merchant education activities annually
Consumer Satisfaction - 85% of CONNECT participants (3rd grade and above) shall give a response of 1 (i.e., agree) on the consumer satisfaction survey
Stakeholder Satisfaction - 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree) on the satisfaction survey

**YOUTH & FAMILY OUTCOMES**

| **Access Objective:** 100% of Youth & Family non-crisis consumers will be seen within 14 days of initial attempt to access services | **Results:** 3 of 12 months, not met |
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| **Recommendations/Action taken:** Youth & Family Services non-crisis consumers were seen within 14 days of initial attempt to access services for only three months out of this fiscal year. This was impacted by multiple, extended staff vacancies and medical leaves that diminished teams' capacity to provide access slots for new clients. | **Performance Improvements:** One of the vacant positions was in our Virginia Independent Clinical Assessment Program [VICAP], which by contract requires referrals to be seen within 5 or 10 days of referral. Coverage of this program was prioritized over non-crisis consumers, and therefore, lengthened waits for routine non-crisis consumers. The agency has initiated a contract with MTM services to develop Same Day Access services over the next eighteen months, which will create an alternative mechanism for addressing demand for services across programs. |

| **Effectiveness Objective:** Youth &Family Services Outpatient clinicians will see their clients within 14 days of their Initial session 90% of the time. | **Results:** 59%, not met |
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| **Recommendations/Action taken:** Youth and Family Services met the 14 day engagement goal an average of 59% of the time during this year. This measure is impacted by a number of factors. Some factors include; a change in housing or treatment status immediately following initial evaluation such as: the youth entering into detention or moving to a higher level of care (such as Intensive In Home Services). Additionally our families often lack reliable transportation and may not be able to attend the appointment scheduled. Finally, it is noted that in many instances where a client isn't seen within the first 14 days following the intake, there are documented efforts at telephonic outreach. | **Performance Improvements:** The youth and families we serve have many psychosocial stressors that contribute to crisis driven responses by them. This creates difficulty in managing their appointments and remaining engaged in the treatment process. We are very aware of these factors and work with community resources and case management activities to mitigate as many of them as possible. We are continually looking for ways to increase the level of engagement with all clients. |

| **Effectiveness Objective:** Youth & Family Services staff will conduct a face to face visit with client/families receiving targeted case management services every 30 days at least 85% of the time. | **Results:** 39%, not met |
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| **Recommendations/Action taken:** During this past year 39% of clients enrolled in case management services were seen face to face every month. This measure is above the Medicaid requirement which is "a face to face every 90 days with the client". After providing additional training to staff members the number of clients seen face to face every 90 days has increased putting us closer to the 85% benchmark. | **Performance Improvements:** Utilizing a benchmark of 85% of clients to be seen every 30 days does not seem like a reasonable benchmark considering the Medicaid requirement is one face to face every 90 days. One area that will continue to skew our data is that clients who are in residential facilities or are managed for FAPT purposes do not require as many face to face contacts. Having these youth included in our data could be a potential reason for our percentages to be so low. Moving forward into the next fiscal year, we will be looking case management engagement in the first 60 days of service. |

| **Effectiveness Objective:** Reoffending rates will remain at or below 10% for MST clients during the course of treatment. | **Results:** 12%, not met |
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| **Recommendations/Action taken:** The quality improvement outcome was to look at the percentage of youth who avoided reoffending and keep the overall percentage below 10% of all youth. The identified baseline was around 25%. Results from the current year included the following quarterly results related to reoffending: Q1: 25%, Q2: 25%, Q3: 20%, Q4: 0%. Annual results: 12%. The reoffending rates declined as the year progressed which mirrored the increase in caseloads. The increase in caseloads was a result of an intensified partnership with the court services unit. | **Performance Improvements:** The increased communication and collaboration with CSU staff likely had a positive impact on keeping youth and families. Actions taken to improve this outcome measurement include doing community stakeholder education and outreach, making family stabilization a priority in the team, educating stakeholders about making appropriate referrals and monitoring treatment plans. MST staff continue to work with community agencies to identify alternatives to placement outside of the home. Engagement and buy-in from probation staff was a focus for the team this year as we had a number of challenges during this year with maintaining consistent referrals (largely due to changes in funding streams). Caseloads increased as the fiscal year progressed. |

**Objectives for the Coming Year**

Access - 100% of Youth & Family non-crisis consumers will be seen within 14 days of initial attempt to access services.
Effectiveness - Youth &Family Services Outpatient clinicians will see their clients within 14 days of their Initial session 90% of the time.
Effectiveness - newly opened case management clients will receive a minimum of 3 hours of case management services within the first 60 days of service to be considered engaged.
Effectiveness - Reoffending rates will remain at or below 10% for MST clients during the course of treatment.

**CSS CASE MANAGEMENT OUTCOMES**

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| **Access Objective:** 100% of individuals will be seen within 20 days of assignment to "Eligibility Complete" unit | **Results:** 81%, not met |
| **Recommendations/Action taken:** 81% of individuals were seen within 20 days from receipt by Program Manager to the first face to face meeting with the case manager. Annual Leave taken by the receiving Team Leader delayed some assignments to Case Managers, delays due to personal reasons for the individual, arranging for interpreter services in one case and challenges experienced due to the need for Case Managers to cover for vacancies all contributed to individual first face to face visits occurring in over 20 days of assignment to long term Case Management. | **Performance Improvements:** A different system for Case Manager assignment will be developed to compensate for the times when staff are using personal leave. Efforts are underway reduce staff vacancies and the resultant effect on service delivery. |

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| **Effectiveness Objective:** 100% of individuals 18 and over interest in employment will be discussed at the time of the annual meeting. | **Results:** 94%, not met |
| **Recommendations/Action taken:** The annual result is 94% (667 individuals were asked and the answer recorded of 707 total annual review meetings in the time period). School status, individual age and intensive medical need contribute to the question not being asked and answered on the form that pulls the data. Case Managers were reminded to ask the question directly and answer the question on the form regardless of information gathered at other points of the meeting. | **Performance Improvements:** Of the 6% either employment was not discussed, the question's answer had not been selected, or the assessment had not been final approved by the supervisor. We will continue to remind case managers to ask about employment and strive to reach 100% goal. |

**Objectives for the Coming Year**

Effectiveness - For individuals 18 and over interest in employment will be discussed at the time of the annual meeting.
Effectiveness - Discussions about community engagement opportunities will occur at the time of the annual meeting.
Effectiveness - Individuals receiving enhanced developmental case management services will receive at least one face-to-face contact per month.
Effectiveness - Of the individuals receiving enhanced developmental case management services who received monthly face-to-face contact; they will also receive one of those contacts every other month in their residence.
Efficiency - Multi Service Progress Notes will be final approved within 5 days of opening.

**CSS HERMITAGE AND CYPRESS DAY SERVICES OUTCOMES**

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| **Access Objective:** 100% of the individuals referred to a Day Service program will be contacted within 20 days to discuss/schedule an assessment or visit. | **Results:** 88%, not met |
| **Recommendations/Action taken:** Overall our results were 15/17 individuals referred being contacted within the 20 day window for an overall total of 88%. We will continue to evaluate how this outcome area is measured and tracked and evaluate the manner in which referrals to the program are handled. | **Performance Improvements:** We are getting close to meeting this goal. This will continue to be measured in 2017. |

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| **Effectiveness Objective:** OES: 80% of those in the non-waiver programs of STEP, Cypress and Hermitage will have an employment goal in their ISP. | **Results:** 91%, met |
| **Recommendations/Action taken:** Over the course of the year, there were 34 annuals held within the work unit for STEP, Hermitage and Cypress. These were individuals who had an annual when attending one of the programs. Of those 34 individuals, 31 had some type of documented employment goal. This is a 91% rate, which exceeds our goal of 80%. This indicates a strong commitment to work on the part of the individuals and a concentrated effort on the part of the staff to help individuals understand that their reason for attending Hermitage, Cypress or STEP is to earn a paycheck. | **Performance Improvements:** The breakdown between programs is Hermitage 21 of 23; STEP 6 of 6 and Cypress 4 of 5. The reason for not having an employment goal in all cases was personal preference for doing more community/recreational activities. Two of three were of retirement age. Because of the emphasis on employment first, this outcome will continue into FY2017 with a goal of 90%. |

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| **Effectiveness Objective:** COI: 80% of the individuals in a waiver program at Hermitage, Cypress, STEP or LEP will have an outcome related to community integration in their ISP. (Community Integration is defined as an activity in the community on an on-going basis or as a volunteer at a community site with a ratio of no more than 3 individuals per 1 staff member). | **Results:** 97%, met |
| **Recommendations/Action taken:** Over the course of the year, 65 individuals had annual reviews and of those 63 had a goal around community activities. This is a 97% rate, demonstrating a strong commitment by both individuals and staff to ensure that choices are being provided to engage in the community, even in a center-based program. This exceeded our goal of 80%. | **Performance Improvements:** The breakdown by program was HE – 23/24; Cypress - 7/7; STEP - 21/21 and LEP - 11/12. The two individuals who did not have a community goal was due to health issues that prevented their participation. Due to the large percentage of individuals with this goal, the work we have done over the last few years seems to have become part of the regular services we provide and there is no longer a need for an outcome. The emphasis within the state is to assist individuals who are in center-based day programs to expand their thinking into work. In FY17, we will offer work/employment opportunities to these individuals and track how many individuals have both a community goal and an employment related goal. |

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| **Efficiency Objective:** COI and OES: Ensure proper documentation and appropriate reporting for the DOJ Settlement. Utilization Reviews will be conducted between May – June 2016 on all waiver charts with annuals from January to April, 2016 and will determine compliance with the new formatting for Outcomes and data collection started on January 1, 2016. The results will show a minimum of 90% compliance. | **Results:** 94.7%, met |
| **Recommendations/Action taken:** A random sampling of waiver charts was used to review outcomes written in February, March and April of 2016. Documentation was also reviewed. A total of 19 charts were reviewed – 2 from Cypress, 5 from LEP, 6 from STEP and 6 from HE Voc unit. Of the 19 charts, 17 had written outcomes in compliance with the new formatting. The documentation in all charts showed significant improvement over the 4 months and are all currently meeting the requirements identified in the DMAS audit. | **Performance Improvements:** When looking at both components – the outcomes and the data collection, 36 of 38 components were meeting requirements for a compliance rate of 94.7%, meeting this outcome. As we continue to adapt data collection to the changing requirements from the DBHDS and DMAS, this increased scrutiny will continue to be important. |

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| **Efficiency Objective:** 95% of the billing documentation will match the information keyed and billed in Anasazi. | **Results:** 98.6%, met |
| **Recommendations/Action taken:** A billing review was completed in March, looking at December, 2015; January 2016 and February 2016 data. The charts that had been chosen for the utilization reviews were reviewed for accuracy between the HCFA report (which reflects the units billed) and the hand-written attendance logs maintained for Medicaid Waiver. Discrepancies were found, evaluated and corrected. There were 13 total charts, representing 20% of the waiver charts in LEP (3), HE workshop (4), Cypress (2) and STEP (4). There were a total of 632 service days keyed with 623 keyed and recorded accurately for a rate of 98.6% compliance. | **Performance Improvements:** All 9 errors have been corrected and did not result in any monetary reconciliation with Medicaid. The errors found were correctable. Staff was thanked for their diligence in ensuring billing accuracy despite the volume of data being kept while being reminded of the need for continued accuracy and legibility of handwriting. |

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| **Satisfaction Objective:** 90% of the individuals will respond with a positive response (always or almost always) when asked if they are satisfied with the work and/or activities they have been offered. | **Results:** 90.9%, met |
| **Recommendations/Action taken:** Overall the clients report being satisfied with their programming. Many reported the desire to explore and to engage in their community more either as a consumer shopping, eating out or walking in the park. The programs with a work component had individuals speaking of their dream to do more work and possibly explore work or volunteer opportunities in the community. STEP and Voc both had individuals who are very interested in learning or practicing their computer skills. Many have voiced an interest in Arts and Crafts, Music classes, gardening and singing. The ice cream truck is extremely popular at Hermitage in all programs. | **Performance Improvements:** As we approach the next year, the movement is towards encouraging individuals to become more fully integrated in the community. This will mean providing them with opportunities to explore what community employment looks like. Develop relationships through volunteering or express themselves in a community based art class that is completely integrated. Arts and Crafts, cooking as well as computers also appear to be popular in house activities as alternates to work activities. We will work together to person center our services and focus on providing meaningful experiences and supports. |

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|---|---|
| **Satisfaction Objective:** 90% of the Families and Caregivers will respond with a 4 or 5 on a satisfaction survey. | **Results:** 100%, met |
| **Recommendations/Action taken:** Two focus groups were held on June 14, 2016; one in the morning and one in the early evening, in order to try to accommodate the schedules of the parents who work and the aging parents who prefer daytime activities. We had 15 attendees at 10 AM and 11 attendees for the 5:30 PM meeting along with 3 consumers. These family members represented 20 consumers from all different programs. They were verbally asked and then asked to complete a written survey. They expressed total satisfaction in both ways. Areas for improvement were listed on continuing to provide the whole range of services and to allow choice. This was a message that resonated throughout the discussion. | **Performance Improvements:** No one had any concerns about more community interactions with supports and they supported the idea that if a person wants to work in the community they should. Many expressed concerns about the aging process and how we would need to ensure we provided activities that reflected the aging population. |

**Objectives for the Coming Year**

Access - 100% of the individuals referred to a Day Service program will be contacted within 20 days to discuss/schedule an assessment or visit.

Effectiveness - For OES: 90% of non-waiver individuals will have an employment goal in their ISP and for COI: 50% of the waiver individuals will have an employment goal in their ISP.

Efficiency - A new time tracking method will be used beginning in August 2016. Beginning with the 2nd quarter, a random sample (15%) of the consumers will be checked for accurate completion with a goal of 95% of the notes meeting the requirements for a progress note.

Consumer Satisfaction - 90% of the individuals will respond with a positive response (always or almost always) when asked if they are satisfied with the work and/or activities they have been offered.

Stakeholder Satisfaction - 90% of the Case Managers will respond positively to their satisfaction on a survey.

**CSS GROUP AND INDIVIDUAL SUPPORTED EMPLOYMENT OUTCOMES**

| | |
|---|---|
| **Access Objective:** 100% of Individuals will be seen by the employment specialist within 10 days of assignment from the supervisor. | **Results:** 60%, not met |
| **Recommendations/Action taken:** There were 10 referrals received that resulted in a person accessing our services. Of those 10, 6 were seen by the employment specialist within 10 days. The four not seen were due to difficulties actually meeting with the individual. Often, phone contacts had been made within the 10 days. All attempts are made to meet with the individuals as soon as possible after we are notified of the referral. | **Performance Improvements:** The program has developed strategies and will have new processes in place to connect within the time frame, including better documentation of the initial date contact was made. The outcome next year will be adjusted to include phone connections within the 10 days. |

| **Effectiveness Objective:** 90% of the individuals in job development will be placed in an integrated job of their choice within 4 months of their start date. | **Results:** 0%, not met |
|---|---|
| **Recommendations/Action taken:** During this year we tracked individuals who entered job developed and estimated that we could find them a job within 4 months. What we found was that for most individuals, that was not a reality. We analyzed the data and discovered that for some individuals, it was their needs and for others, we determined that we needed to change some strategies for helping them find work. | **Performance Improvements:** Several of the individuals we have in job development have been in that phase for a prolonged period of time. While we did not meet this outcome, we did develop new strategies that will result in both effectiveness and efficiency outcomes for next year. We will be changing our intervention strategies, particularly for those who seem to be long-term unemployed. We will then monitor placement successes to determine if this change in strategy for finding work has helped. |

| **Efficiency Objective:** Documentation of all services and plans will meet an overall 94% compliance in the Utilization Review. | **Results:** 90%, not met |
|---|---|
| **Recommendations/Action taken:** For the year there have been 21 charts reviewed for individual supported employment. Those 21 reviews evaluated a total of 494 elements. We were in compliance with 445 elements for a rate of 90%. While this is below our expected results of 94%, it is above the final results of last year and at the minimum expectation for the agency of 90%. In reviewing the results, 39% of the errors were from two charts and those errors have been addressed. Without those two charts, our compliance rate is 94%. | **Performance Improvements:** In comparing the results to FY2015, the problem areas last year were not the problem areas this year and in fact, other than those two charts, most errors were not duplicated. Training on ensuring compliance with paperwork will continue to occur and the Utilization Review results will be shared with staff on an on-going basis, but will not be part of the Outcome measurements for next year. |

| **Satisfaction Objective:** 90% of individuals in both Group and Individual Supported Employment services will express satisfaction with supports provided by their Training/Employment Specialist. | **Results:** 98%, met |
|---|---|
| **Recommendations/Action taken:** We attempted to ask all consumers in the Individual and Group Supported Employment programs their satisfaction. Only 44 individuals responded (a total of 36% of consumers) and of those, 43 or 98% responded with a 4 or 5 on a 5-point scale. | **Performance Improvements:** There were no comments that indicated areas for improvement. Staff will continue to monitor satisfaction when they complete their quarterly reviews. |

| **Satisfaction Objective:** 90% of the Businesses/Employers for both Group and Individual SE will express satisfaction with the services offered by the program by answering with a 4 or 5 on a 5 pt. scale. | **Results:** 100%, met |
|---|---|
| **Recommendations/Action taken:** Out of the 34 surveys mailed, 4 were returned. All expressed a 5 Very Satisfied. 3 surveys were mailed back (return to sender). Therefore our rate of return was 13% (4 of 31). While the rate of return was low, it is clear satisfaction is high. | **Performance Improvements:** Many studies have shown that businesses are more likely to return a survey if dissatisfied. We will be looking at methods that might result in more responses next year. |

**Objectives for the Coming Year**

Access - Individuals will be contacted by the employment specialist within 10 days of assignment from the supervisor.
Effectiveness - Development and implement 6 informational sessions for consumers regarding alternative work options and /or exposure to non-traditional jobs.
Efficiency - 30% of those who attend the informational sessions will find a job by June 30, 2017.
Consumer Satisfaction - 90% of individuals in both Group and Individual Supported Employment services will express satisfaction with supports provided by their Training/Employment Specialist.
Stakeholder Satisfaction - 90% of the Case Managers for both Group and Individual SE will express satisfaction with the services offered by the program by answering with a 4 or 5 on a 5 pt. scale.

**CSS INTAKE OUTCOMES**

| | |
|---|---|
| **Access Objective:** 100% of individuals referred to the agency for services will have a face to face intake meeting within 10 days of the first contact. | **Results:** 2 out of 12 months, not met |
| **Recommendations/Action taken:** The current intake schedule includes 7 intake slots each week shared between two intake staff and the program coordinator as back up. In most cases families are able to schedule an appointment within 10 days if they choose. Each month during this year there were situations where the individual or family wanted an appointment further out than 10 days. Staff have also been flexible in altering times and days of intakes to meet individual needs. | **Performance Improvements:** Going forward the intake team has decided to keep the current schedule into the new fiscal year. As we become the central point of entry for individuals DD effective 7/1/16 we will reassess the schedule regularly to make sure there are enough slots available so individuals have access to intake in a timely manner. |
| **Objectives for the Coming Year**<br>Access - 100% Individuals referred to the agency for services will have a face to face intake meeting within 10 days of the first contact. | |

**CSS RESIDENTIAL OUTCOMES**

| | |
|---|---|
| **Efficiency Objective:** 90% residents will participate in at least 2 community inclusion activities of choice per month. | **Results:** 90.42%, met |
| **Recommendations/Action taken:** There were four months during FY 2015-2016 (1/3 of the year) that the HAMHDS Residential homes were not able to meet at least 2 community inclusions each month. The months that were not met were due to residents illness, refusals or weather conditions. Residents typically chose activities that were familiar to them and rarely stepped out of their comfort zones. Staff did introduce unique activities for residents to try periodically. Staff from one home mentioned that an activity was found for one residents but the residents refused to participate; his housemate asked could he go instead and reportedly really enjoyed attending. | **Performance Improvements:** Staff continues to ask residents what activities they want to participate in each week/month, and offer suggestions when they find other activities advertised. Recommendation: This outcome will continue as written until each quarter is met at the minimum cited percentage. |

**Objectives for the Coming Year**
Effectiveness - 90% residents will participate in at least 2 community inclusion activities of choice per month.
Effectiveness - 50% of the HAMHDS Residential clients will be supported in improving their health by losing at least one (1) pound per month or 12 pound by the end of the fiscal year.
Effectiveness – HAMHDS Residential clients will be supported in improving their health by measuring metabolic labs and recording positive changes for 100% of residents each quarter.

**PARENT INFANT PROGRAM OUTCOMES**

| | |
|---|---|
| **Access Objective:** The Infant and Toddler Connection of Henrico Area will meet or exceed the December 1 child count, the Part C state office determine this to be 44. | **Results:** 62, met |
| **Recommendations/Action taken:** The Infant and Toddler Connection of Henrico Area met the December 1st child count (62 infants). We worked closely with the NICU's in the area to gather recent assessments and reports that would assist our evaluation teams in determining eligibility. | **Performance Improvements:** In the past, we conducted monthly orientations at the NICU for parents and we believe that those efforts improved our relationship with the NICU's and their follow-up clinics. We continue to look for various child-find activities. |

| | |
|---|---|
| **Access Objective:** The Infant and Toddler Connection of Henrico Area will conduct 10 child find activities this fiscal year. | **Results:** 100%, met |
| **Recommendations/Action taken:** This year's child find outcome has not only increased PIP's child count, but it has helped our system establish and build relationships in the community. These relationships have created a more streamlined process for the families referred to our system. | **Performance Improvements:** PIP will continue this outcome in the up and coming year. Although this goal was not achieved, the impact of the activities helped raise awareness of Early Intervention services. As a result, our program witnessed the highest child count growth in the state. |

| | |
|---|---|
| **Efficiency Objective:** 100% of children discharged from Early Intervention Services will have all of their transition steps and services completed on their IFSP. | **Results:** 100%, met |
| **Recommendations/Action taken:** Of the 330 children discharged from Early Intervention services this year, 330 of the children had 100% of their transition steps and services on their IFSP completed. The program attributes this year's results to the restructuring of the discharge process (transition steps and services are reviewed by supervisor prior to discharge). | **Performance Improvements:** Annual Part C desk review was completed this quarter. Results for overall (provider/Parent Infant Program) transition desk review was reported this quarter. The results combined PIP charts with those discharged from Children's Hospital. Due to incomplete charts submitted from the provider agency, the annual chart review resulted in non-compliance. Our program is currently going through a correction process with the State Part C office and hopes to correct non-compliance by September 2016. |

**Objectives for the Coming Year**

Access - The Infant and Toddler Connection of Henrico will meet or exceed the December 1 child count determined by the Part C office.

Effectiveness - The Infant and Toddler Connection of Henrico Area will conduct 3 transition conference meetings in collaboration with Henrico Part B Preschool Special Education Program this fiscal year.

Efficiency - 100% of children will be discharged from ITOTS no later than 1 day before their third birthday.

Baseline: 100%

# OFFICE OF THE SECRETARY OF HEALTH & HUMAN RESOURCES (OSHHR) AGENCY PERFORMANCE MEASURES

HAMHDS has met targets in the majority of the OSHHR measures; of 20, 13 were met. Two of the five Behavioral Health Quality targets were met. MH Engagement, SA Engagement, and SA Retention did not meet established targets. Research into these measures showed consumers remained engaged each month after admission but total services hours did not meet the OSHHR benchmarks of 4 hours in the 90 days following a MH admission or 2.25 hours in the 30 days following an SA admission. SA Retention was difficult to meet due to shorter treatment program durations running less than the OSHHR measures. Five of the seven Developmental Quality targets were met.

**Office of the Secretary of Health & Human Resources (OSHHR) Agency Performance Data**
**Henrico Area MH/DS Dashboard FY2015**

| **Behavioral Health Quality Measures** AIM IS TO BE ABOVE TARGET | target | 7/15 | 10/15 | 11/15 | 12/15 | 1/16 | 2/16 | 3/16 | 4/16 | 5/16 | 6/16 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Intensity of engagement in adult mental health case management | 68% | 73% | 76% | 77% | 77% | 76% | 74% | 74% | 73% | 75% | 77% |
| Intensity of engagement in adult substance abuse outpatient services | 63% | 72% | 77% | 76% | 77% | 77% | 77% | 77% | 77% | 77% | 77% |
| Intensity of engagement in child mental health case management | 73% | 49% | 49% | 42% | 43% | 43% | 44% | 44% | 44% | 43% | 45% |
| Retention in community substance abuse services (adult & youth) **3 mo** | 60% | 51% | 51% | 51% | 51% | 52% | 52% | 52% | 53% | 52% | 52% |
| Retention in community substance abuse services (adult & youth) **6 mo** | 26% | 17% | 19% | 18% | 18% | 19% | 19% | 19% | 20% | 21% | 21% |

| **Bed Utilization Measures** AIM IS TO BE BELOW TARGET | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult Civil TDO Admissions per 100k pop | 5 | 7 | 7 | 4 | 3 | 2 | 2 | 2 | 3 | 2 | 4 |
| Adult Forensic TDO Admissions Per 100k pop | 1 | 2 | 2 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 0 |
| Hospital Bed Utilization per 100k pop – Civil TDO Admissions | 294 | 25 | 26 | 79 | 51 | 37 | 60 | 60 | 149 | 60 | 153 |
| Hospital Bed Utilization per 100k pop – Forensic TDO | 51 | 35 | 62 | 58 | 66 | 54 | 44 | 44 | 43 | 44 | 43 |
| Hospital Bed Utilization per 100k pop – Civil Legal Status | 1070 | 539 | 518 | 437 | 405 | 393 | 431 | 431 | 603 | 431 | 610 |
| Hospital Bed Utilization per 100k pop – Forensic Legal Status | 606 | 305 | 336 | 482 | 469 | 407 | 372 | 372 | 360 | 372 | 408 |

| **State Hospital Measure** AIM IS TO BE BELOW TARGET | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Forensic state hospital bed utilization (Central) | 31% | 33% | 33% | 33% | 33% | 33% | 31% | 31% | 33% | 31% | 34% |

| **Developmental Quality Measures** AIM IS TO BE ABOVE TARGET | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percent receiving F/F Developmental Case Management services | 90% | 85% | 91% | 89% | 80% | 86% | 85% | 85% | 79% | 83% | 89% |
| Percent receiving in-home Developmental Case Management services | 90% | 91% | 86% | 86% | 86% | 84% | 81% | 81% | 77% | 74% | 76% |
| Health and Well Being Goal Measure | 84% | 98% | 98% | 98% | 99% | 98% | 98% | 98% | 98% | 95% | 95% |
| Community Inclusion Goal Measure | 84% | 97% | 98% | 98% | 98% | 98% | 97% | 97% | 97% | 94% | 94% |
| Choice and Self-Determination Goal Measure | 84% | 98% | 98% | 98% | 98% | 98% | 97% | 97% | 97% | 94% | 94% |
| Living Arrangement Stability Measure | 84% | 98% | 98% | 98% | 98% | 98% | 97% | 97% | 97% | 96% | 96% |
| Day Activity Stability Measure | 84% | 98% | 98% | 98% | 98% | 98% | 97% | 97% | 97% | 96% | 96% |

| **Training Center Measure** AIM IS TO BE BELOW TARGET | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Training Center Census | -1% | -2.2% | -3.2% | -1.5% | -2% | -5.9% | -6% | -6% | -6% | -2.1% | -2.2% |

Delivering Enhanced Case Management face-to-face and in-home services were difficult to meet with increased caseloads. These targets were challenging state wide.

The OSHHR Performance Measures have been incorporated as another component of the Agency's Continuous Quality Improvement Plan. If targets are not met, those measures will be adopted and become a program outcome so that trends and development areas may be identified and pursued.

For the coming year DBHDS announced the OSHHR Performance Measures would be shared quarterly rather than monthly to the Secretary of Health and Human Services and a quarterly summary format will be created. A subgroup of the VACSB Data Management Committee will continue to examine the measures and review targets.

# POST DISCAHRGE INFORMATION FOR CARF SERVICES

Post discharge information is collected for CARF services. The post discharge surveys are mailed approximately 30- 60 days after the client is discharge from a CARF service. At least two questions are asked in each survey, including a satisfaction question and a question that refers back to the program goals. Survey questions are reviewed and updated as needed on an annual basis to correspond with the current goals and objectives. In order to complete a timely annual report, the reporting period covers the period of April 1, 2015 through March 31, 2016.

During this fiscal year, ten separate services were tracked. A total of 239 surveys were mailed and 17 were returned. The response rate for programs ranged from 0% to 33.3% with an average response rate for all of the CARF services of 7%, down from the response rate of 14% for FY15. Individual comments are forwarded to the respective program.

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

**FY2016 ANNUAL POST DISCHARGE REPORT**

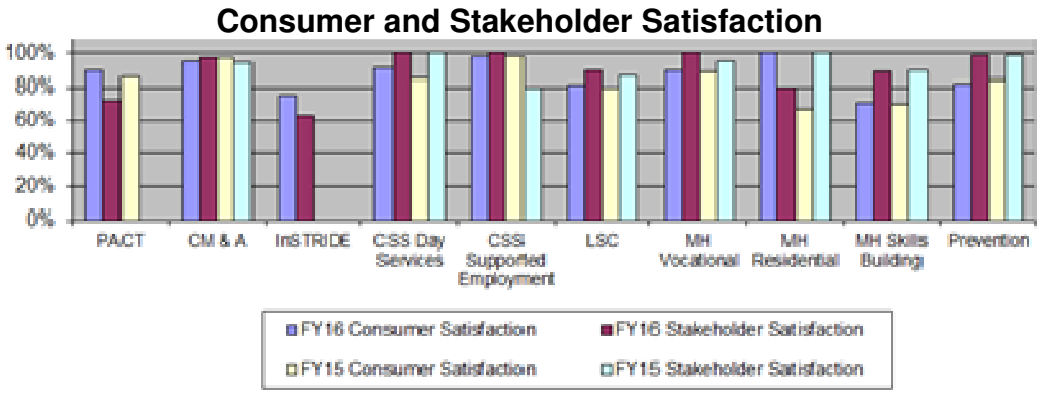
| HAMHDS | CARF | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Discharges by Program (Apr 2015 - Mar 2016)** | | | | | | | | | | | | | | |
| CM&A | MH Case Management | 12 | 11 | 12 | 6 | 15 | 17 | 9 | 17 | 9 | 11 | 12 | 16 | **147** |
| PACT | Assertive Community Treatment | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 3 | 1 | 2 | 1 | 1 | **11** |
| MH Day Support | MH Community Integration | 0 | 3 | 0 | 1 | 0 | 4 | 3 | 2 | 2 | 1 | 3 | 3 | **22** |
| MH Residential | MH Community Housing | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| MH Vocational | MH Community Employment | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 2 | **9** |
| MH Supported Svcs | MH Supported Living | 2 | 0 | 0 | 2 | 1 | 2 | 2 | 0 | 3 | 4 | 3 | 5 | **24** |
| LEP | ID Community Integration | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | **3** |
| ID Supp Employ | ID Community Employment | 0 | 0 | 2 | 1 | 1 | 1 | 2 | 1 | 0 | 5 | 3 | 2 | **18** |
| Sheltered Employ | ID Organizational Employment | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | **3** |
| ID Group Supp Empl | ID Community Employment | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Total** | | **16** | **18** | **15** | **11** | **18** | **26** | **17** | **25** | **17** | **23** | **23** | **30** | 239 |

| HAMHDS | CARF | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total | Response Rate% |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Survey Response Rates (Apr 2015 - Mar 2016)** | | | | | | | | | | | | | | | |
| CM&A | MH Case Management | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 1 | **5** | 3.4% |
| PACT | Assertive Community Treatment | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | 9.1% |
| MH Day Support | MH Community Integration | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | **3** | 13.6% |
| MH Residential | MH Community Housing | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0% |
| MH Vocational | MH Community Employment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0% |
| MH Supported Svcs | MH Supported Living | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | **3** | 12.5% |
| LEP | ID Community Integration | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** | 33.3% |
| ID Supp Employ | ID Community Employment | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | **4** | 22.2% |
| Sheltered Employ | ID Organizational Employment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0% |
| ID Group Supp Empl | ID Community Employment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0% |
| | | **1** | **0** | **1** | **1** | **1** | **2** | **1** | **1** | **1** | **4** | **1** | **3** | **17** | **7%** |
| Response Rate | | 6% | 0% | 7% | 9% | 6% | 8% | 6% | 4% | 6% | 17% | 4% | 10% | 7% | |

# SATISFACTION

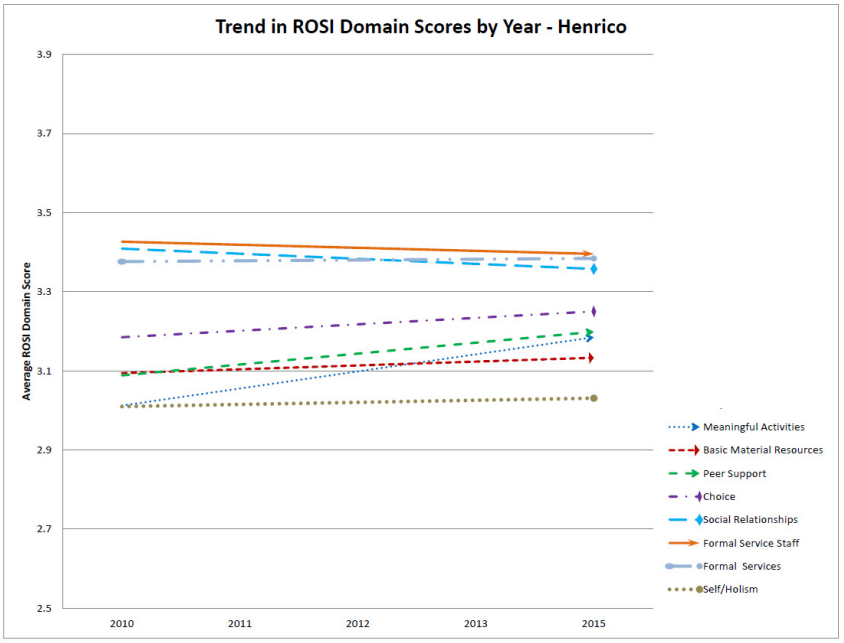
## Agency Satisfaction Survey

HAMHDS directly conducted Consumer and Stakeholder satisfaction surveys in CARF programs. Results below indicate all responders report a satisfaction rate with services between 63% to 100%, with the majority of responses indicating at or above 89%. Six programs demonstrated an increase in consumer satisfaction ratings, and four programs demonstrated an increase in stakeholder satisfaction.




## Recovery Oriented System Indicators (ROSI) Survey

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) annually administers the Recovery Oriented System Indicators (ROSI) Survey for mental health services in Virginia. HAMHDS invites individuals in the Case Management and PACT/ICT services to complete the survey. In accordance with the DBHDS Performance Contract, each CSB provides the department a statistically valid sample of five percent or a minimum of 70 consumers, whichever is larger. From the DBHDS website, consumers can access the ROSI survey in English or in Spanish. The ROSI survey is designed to measure consumer perceptions in eights areas: Meaningful Activities, Basic Material Resources, Peer Support, Choice, Social Relationships, Formal Service Staff, Formal Services and Self/Holism. Consumers select their response from a range: (1) “Strongly Disagree” to (4) “Strongly Agree”, and (1) “Never/Rarely” to (4) “Almost Always/Always”. The following chart shows Henrico’s trends in the ROSI domain scores from 2010 through 2015. For most domain scores the trends have been towards more positive perceptions of Henrico’s recovery orientations over time.



# QUALITY HEALTH INFORMATION

**Outcomes**

Record reviews were completed on approximately 20% of Medicaid charts and 10% of non-Medicaid charts; 905 Quality reviews and 439 Administrative reviews were done in FY 2016. Two thirds of ID programs were 90% + compliant with standards reviewed. There was a decrease in compliance in Case Management due to several factors including regulation changes and staff turnover. Three fourths of MH/SA programs were 90%+ compliant with standards reviewed, an increase from last year, with gains seen across several programs. ICT/PACT and two case management teams fell in compliance. Administration (Financial & HIM combined) was 95%+ compliant in both divisions.

**FY17 Objectives for the Coming Year**

- Continue improvements of the Utilization Review process
- Identify and report trends to program managers & AMT
- Update reviews for ID programs to reflect new regulations
- Begin quality reviews for DD case management
- Review at least 5% of every prescreeners emergency evaluations
- Continue training to ensure documentation meets all requirements

**FY 2016 CSS RECORD REVIEW RESULTS SUMMARY**

| | FY2016 | FY 2015 | FY 2014 | Comments |
|---|---|---|---|---|
| | | | | *CST updated Waiver review form in Jan 16. |
| NORTH 1 WAIVER | 81% | 92% | 93% | down from FY15 |
| EAST 1 WAIVER | 86% | 92% | 96% | down from FY15 |
| EAST 2 WAIVER | 85% | 95% | 98% | down from FY15 |
| WEST 1 WAIVER | 96% | 98% | 98% | |
| WEST 2 WAIVER | 91% | 94% | 95% | |
| | | | | *CST updated non-Waiver review form in Jan 16. |
| NORTH 1 SPO | 89% | 87% | 89% | up 2% from FY15 |
| EAST 1 SPO | 79% | 92% | 91% | down from FY15 |
| EAST 2 SPO | 91% | 93% | 98% | |
| WEST 1 SPO | 98% | 97% | 99% | |
| WEST 2 SPO | 85% | 95% | 96% | down from FY15 |
| HERMITAGE VOC | 94% | 96% | 95% | |
| CYPRESS VOC | 97% | 98% | 100% | |
| ENCLAVES | 94% | 93% | 94% | |
| LEP | 99% | 98% | 98% | |
| STEP | 98% | 97% | 98% | |
| SUPPORTED EMPLOYMENT | 91% | 89% | 95% | up 2% from FY15; above 90% |
| RESIDENTIAL | 90% | 90% | 95% | |
| ID ADMINISTRATIVE | 97% | 97% | 95% | |

Represents area in compliance 90% or better
Represents areas where results are below 85%, in BOLD is under 80%
Represents areas that improved by more than 5 percentage points
Represents areas that improved by 1-4 percentage points (not done in 90%+ range)
Represents areas that dropped (not done in 90%+ range)

## FY 2016 MH/SA RECORD REVIEW RESULTS SUMMARY

| | FY2016 | FY2015 | FY 2014 | Comments |
|---|---|---|---|---|
| ESP/OUTPATIENT | 91% | 96% | 90% | |
| ESP/PRESCREENING | 98% | 96% | 97% | |
| YOUTH & FAMILY EAST | 93% | 89% | 85% | up 4% from last year; above 90% |
| YOUTH & FAMILY WEST | 88% | 89% | 90% | down slightly from FY15 |
| MHOP EAST/WEST | 95% | 94% | 81% | |
| MHOP/SA/YOUTH PF | 95% | 93% | 88% | |
| SA EAST | 90% | 85% | 90% | up 5% from last year; above 90% |
| SA RMP | 95% | 92% | 89% | |
| LAKESIDE CENTER | 93% | 91% | 87% | |
| LAKESIDE CTR VOC | 93% | 88% | 92% | up 5% from last year; above 90% |
| PACT EAST | 87% | 91% | 90% | down from FY15 |
| PACT WEST | 83% | 87% | 89% | down from FY15 |
| CM&A EAST | 83% | 84% | 86% | down from FY15 |
| CM&A WEST 1 | 86% | 89% | 86% | down from FY15 |
| CM&A WEST 2 | 91% | 88% | 87% | up 3% from last year; above 90% |
| CM&A PF | 91% | 87% | 84% | up 4% from last year; above 90% |
| MH SUPPORTED SVS WEST | 97% | 97% | 94% | |
| MH SUPPORTED SVS EAST/PF | 91% | 88% | 89% | up 3% from last year; above 90% |
| MH RESIDENTIAL | 93% | 91% | 97% | |
| PHYSICIAN | 88% | 86% | | up 2% from last year |
| MH ADMINISTRATIVE | 95% | 91% | 93% | |

Represents area in compliance 90% or better
Represents areas where results are below 85%, in BOLD is under 80%
Represents areas that improved by more than 5 percentage points
Represents areas that improved by 1-4 percentage points
Represents areas that dropped

# EXTERNAL AGENCY REVIEWS

**Outcomes**

Over the last year the agency experienced a significant increase (70%) in external audits/program reviews. The agency explored additional venues other than secure email exchange to send electronically health information records more efficiently, such as the DBHDS secure file transfer. We will continue to research more efficient methods to transmit health information records electronically. The agency purchased a high efficiency scanner to increase the speed at which documents are converted to electronic files. Reviews were sent by secure email exchange-Cisco, fax and mail. The majority (99%) of reviews were completed within the specified timeframes.

| | FY16 | FY15 | FY14 |
|---|---|---|---|
| **Total number of Reviews:** | **79** | **44** | **23** |
| Admin: | 2 | 3 | 1 |
| C&P: | 32 | 13 | 7 |
| CSS: | 31 | 25 | 7 |
| Across All Divisions: | 10 | 3 | 8 |
| # of Desk Reviews: | 64 | 36 | 14 |
| # of Onsite reviews: | 11 | 8 | 9 |

External reviewers included: DMAS (Department of Medical Assistance), DBHDS (Virginia Department of Behavioral Health and Developmental Services), CMS (Center for Medicare and Medicaid), HHS (Department of Health and Human Services), Anthem, Virginia Supportive Housing, DOJ (Department of Justice), VHDA (Virginia Housing Development Authority), National Core Indicators Survey (NCI), Board of pharmacy, Human Rights, Va Premier, DOL-Department of Labor

Types of reviews include: mortality reviews, SIS (Supports Intensity Scale), risk adjustment, re-validation for enrollment, payment error rate measurement, fidelity review, attestation forms, long term care, REACH, Delmarva-Quality Service Review, self-certification, DATA elements payment error rate measurement, routine inspection, HEDIS (Healthcare Effectiveness Data and Information Set), staff charting, compliance, ensure safety plan, re-assess crisis/safety plan, Health Care Compliance

**FY17 Objectives for the coming year:**

- Meet audit deadlines
- Continue to explore additional venues other than secure email exchange to send electronically health information records more efficiently
- Explore new methods to track audits

## RISK MANAGEMENT / INCIDENTS AND COMPLAINTS

**FY16 Accessibility Plan Annual Summary:**

During FY16 the following accessibility projects were completed to include: installation of additional parking lot lights at the East Center location; repaving of the parking lot at Woodman as well as continued participation in the statewide initiative around employment of individuals with disabilities. There were no formal requests for accommodations brought to the attention of the Risk Management committee this fiscal year however individual staff and programs offer accommodations on-going throughout the year (i.e. meeting sites; meeting times; "jigs" for work programs; etc.).

**FY16 Risk Management Summary:**

The Risk Management Committee summarized the following areas of identified risks for FY16.

Service Delivery: Continued implementation of requirements and recommendations from the Department of Justice related to waiver re-design and CSB's becoming the central point of access for individuals with Developmental Disabilities. ID Day and Residential services have also been making changes in their programs to increase opportunities for individuals to participate in full integrated activities within the community. Continued the partnership with the Daily Planet and increased the hours they provide medical support to our clients each week. Clinical services continue to adhere to changes in Medicaid standards in regards to programming and documentation. Began the process of exploring Same Day Access for the agency.

Computer Resources: The agency continues to explore an alternative electronic health record. This has been approved by the County Board of Supervisors and the next step is to identify a consulting firm to assist with development of the RFP. We purchased and installed Telehealth equipment. This has increase access to psychiatry services for many of our individuals in clinical and jail services.

Confidentiality: We continue to review confidentiality policies and move toward compliance with developing a full electronic health record.

Financial: The conversion from DSM IV/ICD 9 to DSMV/ICD 10 was successfully completed this year. A group of staff from across the agency programs have been working to prepare for billing and rates changes due to the waiver re-design.

Critical Incidents: The Critical Incident continues to meet quarterly to review incidents and shares report with Risk Management committee. The committee continues to look at trends especially around suicides.

Vehicle Safety and Maintenance: Quarterly vehicle checks continue to be completed by assigned programs. Staff attends required safe driving classes every 3 years. Annual driver's license checks continue to occur.

Emergency/Disaster Response and Recovery: Supervisors review disaster plans at a minimum yearly with staff during meetings. All program (day services and group homes) sites maintain a supply of emergency food, water and other emergency supplies. We had the opportunity to put these policies into real life practice during 2 inclement weather incidents this year. A 16+ inch snow storm in February and a severe storm in June.

Health and Safety: Staff continued to place all safety drills in our on-line system. We continued to offer Mental Health First Aid classes to all county employees. Henrico Police and Fire Departments assessed the following buildings for safety (personal): Woodman, East Center and Richmond Medical Park. Security was increased to full days at both our Woodman Rd. and East Center locations.

Regulatory Compliance: Staff completed required trainings. Chart reviews were completed and entered into Chart Tracker.

Media Relations and Social Media: The agency works closely with the Henrico County Public Relations and Media Services for press releases and the airing of community awareness and educational videos viewed on the County's community TV channel HCTV. Three press releases occurred in the FY16 including the annual Henrico Too Smart to 2 Start Coalition's "It takes a village Community Forum" through Prevention Services, the 3rd anniversary of the Crisis Receiving Center at Parham Doctor's Hospital, and the Virginia CIT Peer Of The Year Award awarded to a Peer

Specialist of the agency. The Agency does use Social Media to provide information to the community on Facebook including; Hermitage Enterprises, Too Smart 2 Start Coalition, Youth-Ambassadors and henricoconnect.wordpress.com. Prevention Services is approved to text participants as they are not providing treatment services and therefore no health information is involved. Staff strongly adheres to the Agency's social media policies and procedures.

**FY17 Objectives for the Coming Year**
The major objective for the Risk management Committee will be to re-evaluate the work and membership of the committee.

## CRITICAL INCIDENT REVIEW

**Incident Review Summary: Fiscal Year Comparison: 2015 & 2016**

| Incident Type | Total FY15 | Total FY16 |
|---|---|---|
| Assault by client | 14 | 7 |
| Behavioral incident | 22 | 20 |
| Biohazard incident/bomb threat | 0 | 0 |
| Communicable Disease | 0 | 0 |
| County vehicle | 2 | 7 |
| Death-accidental | 3 | 6 |
| Death-likely homicide | 0 | 0 |
| Death-likely suicide | 0 | 4 |
| Death-natural causes | 28 | 31 |
| Fall- with injury requiring medical attention | 13 | 5 |
| Fall- without injury | 73 | 45 |
| Fire | 1 | 1 |
| Illness (e.g. seizure, diabetic reaction) | 8 | 21 |
| Licit/Illicit drugs or weapons | 1 | 0 |
| Med incident- med error requiring medical attention | 0 | 0 |
| Med incident- med error with *NO* adverse reaction | 22 | 22 |
| Other | 25 | 16 |
| Property damage | 6 | 3 |
| Property loss/theft | 6 | 8 |
| Self-injurious behavior | 3 | 8 |
| Serious injury | 0 | 2 |
| Sexual incident | 1 | 3 |
| Suicide attempt | 23 | 30 |
| Threats/violence | 6 | 2 |
| Violent crime by client | 0 | 0 |
| Totals | 257 | 241 |
| Restraints | 3 | 1 |

**Brief Description of "Other" for Fiscal Year 2016**

| | | |
|---|---|---|
| 1. | Minor push by client | ID Group Home |
| 2. | Clt seriously assaulted (not within our agency, but reported to us) | MHOP |
| 3. | Choking | Lakeside Center |
| 4. | Minor injury | Woodman |
| 5. | Minor injury | Woodman |
| 6. | Minor injury | ID Group Home |
| 7. | Elopement | Lakeside Center |
| 8. | Client illness reported to staff | SA Unit |
| 9. | Elopement | CM&A East |
| 10. | Minor injury | Hermitage |
| 11. | Minor injury | Cypress |
| 12. | Minor injury | Woodman |
| 13. | Minor injury | Community Outing: ID |
| 14. | Minor injury | ID Group Home |
| 15. | Possible pushing by client | ID Group Home |
| 16. | Unusual behavior (unclear if it was illness or behavioral incident) | East Center |

**Review of FY15 compared to FY16**
Critical incidents were regularly reviewed, analyzed, and addressed as appropriate. No specific trends were noted requiring significant or organizational-wide interventions. Of note, there were significantly fewer falls this year. The agency is serving more complex clients and behavioral incidents continue to reflect this complexity. In response to an increased number of suicides and attempts again this year, the agency continues to work on a model of "Zero Suicide" which includes policies and procedures to reduce or eliminate suicides and attempts. The agency continues to provide education and training to support staff in their duties.

## STAFF TRAINING

**Outcomes**
Agency employees have the opportunity to obtain training through the County of Henrico Employee Development and Training, Human Resources Department and with Henrico Area Mental Health & Developmental Services.

The Department of Human Resources-General Government offers opportunities for employees to enhance their skills in all of the County's core competencies. Organizational Learning and Talent Development offers classes in the categories of leadership/professional development, management, and technology.

The Department of Information Technology enrolls staff into five mandatory courses. "You Are the Target", "Social Engineering", "Browsers", "Email and IM", and "Passwords".

Fitness/Wellness Classes are available to Permanent General Government and HCPS Employees.

Training is provided at orientation and annually thereafter through a combination of methods, classroom, online, or through supervisor or team training.

Model of Care Training and Provider Overview & Module of Care Training is required by Commonwealth Coordinated Care Project for contract with CMS, DMAS, and MCO (Anthem, Va. Premier, Beacon) for MH Programs and ID Community Support Teams. There is Preadmission Screening Certification for Emergency Services and other pre-screeners in the agency.

Henrico Area Mental Health & Developmental Services has a group of First Aid, CPR, and AED, Prevention of Violence, Therapeutic Options, Cultural Awareness, Brown Bags, Wellness series: My side of the Story, Mental Health First Aid, Electronic Health Record system and other professional training.

Approximately 74 classroom style training sessions were offered. Staff register for training directly through the use of an internal web-based system known as MyTraining.

Examples of training offered included:
My Side of the Story-wellness series; SA recovery/ Families of Individuals with ID/ PIP, What is Transracial, Charleston S.C., Reconcile, Resolve & Recover, Understanding Me Helps Me Understand Others", Self-Check: Serving a Diverse, Practicing Cultural Humility: LGBTIQ Community, The Hungry Heart– Opiate addiction and it's treatment, Treatment /Resources for Blind and Hard of Hearing, How Children Learn About Aging Through Media, Religious Diversity in the Workplace, Current Events and the Impact on Thinking, Still Bill - Black History Documentary, Black History Games, Generational Styles, Black Lives Matter, High Performance Organizations, Music Over the Ages, Mindfulness ~ For Your Clients, Supervisees, and Yourself, 4 Generations in 1 Workplace, Virginia Veteran and Family Support, CAN - The Story of Can Truong, REACH Training - Continuum of Crisis Care and Resources for the I/DD Population, Spirituality & Professional Boundaries in Behavioral Health Settings, Jane Elliott - Brown Eyed/Blue Eyed Experiment, Personal Stories of Opiate and Heroin Abuse "Chasing the Dragon"

Over the past year:
- American Red Cross First Aid/CPR Trainers met with our Red Cross representative to review changes.
- New Red Cross purchases included; knee pads, 8 updated Trainer manuals, CPR shields, 2 Instructor kits with back pack, lungs for Mannequins, combo packs, 20 Participant manuals, batteries
- Prevention of Infectious Diseases is provided online
- New Blended learning class for Red Cross was offered (refresher training)
- Recertified 6 Therapeutic Options trainers
- Red Cross Agreement was renewed for 3 Years
- Cultural Competence/Awareness Instructors added

**FY17 Objectives for the coming year**
- Add 2 new Red Cross trainers
- Add 2 new Therapeutic Option trainers
- Research options for tracking training requirements

## INFORMATION TECHNOLOGY

**Outcomes**
The Information Technology Plan is reviewed annually to assess projects progress, update timelines, add accomplishments and initiatives. For FY16 some major accomplishments included the implementation of Telehealth/Conferencing, converting from ICD9/DSM4 to ICD10/DSM5, implement DOJ required forms changes, assist in the setup and implementation of several new programs such as Jail Diversion and In-STRIDE, attesting to Meaningful Use Modified Stage 2 by implementing the Patient Portal and Ultra-Sensitive exchange.

**FY17 Objectives for the coming year**
Our goals for FY17 are to continue to expand the Telehealth initiative adding additional sites and expand its use within the program areas, begin the search for a new EHR system using the services of a consultant to guide us through this important process. Once the vendor is selected the ITS team will be heavily involved in the conversion and implementation process transitioning our current files over to the new system, setting up new forms and training staff. Other goals for the coming year include adding lab orders electronically, completing the implementation of the new reporting requirements of the DOJ settlement and new DD regulations, and work on the Same Day Access Initiative. The website is the final area in which the team is updating both the internet and intranet sites to current standards.

# CULTURAL AWARENESS AND COMPETENCY

## Outcomes

**CACC Meetings**
Meetings were held every 6 weeks to continue development through implementation of the Cultural Awareness & Competency Committee FY 2016 Plan. A retreat for CACC members was held on July 1, 2015 at Hidden Creek Park.

In FY16 the CACC committee began to promote more staff involvement with presenting brown bags and ideas. The quote bubble: "CACC wants to hear from you…" was posted on all of the cultural bulletin boards throughout the agency, was posted within the agency newsletter Quality Matters, and was sent out via email to solicit ideas from staff. There have been some positive responses from the initiative, with 2 new brown bags scheduled from staff who are non-committee members.

**Brown Bags, Trainings, & Orientations offered**
**The following Brown Bags and trainings were offered by CACC to staff during the 2016 fiscal year:**

- July 29, 2015 at Woodman. "What is Transracial?" presented by Michelle Johnson.
- August 27, 2015 at Woodman. "Charleston SC. Reconcile, Resolve & Recover", presented by Lena Thomas and Michelle Johnson.
- September 23, 2015 at the East Center. "CACC 101 Sensitivity Training: Understanding Me Helps Me Understand Others", presented by Serina Gaines and Michelle Johnson.
- October 1, 2015 at Woodman. "Practicing Cultural Humility: LGBTIQ Community", presented by Michele Zehr.
- November 4, 2015 at Woodman. "CACC 101 Sensitivity Training: Understanding Me Helps Me Understand Others", presented by Crystal Silvester and Courtney Lewis-McGrath.
- November 18, 2015 at Richmond Medical Park. "Providing Treatment and Developing Resources for Clients who are Vision Impaired and Deaf/ Hard of Hearing", presented by Jennifer Lawhorn and Susanne Wilbur from the Virginia School for the Deaf and Blind.
- December 14, 2015 at the East Center. "How Children Learn About Aging Through Media and Literature". This brown bag was presented by Dr. Ed Ansello from the Virginia Center on Aging- School of Allied Health Professions, and Virginia Geriatric Education Center.
- January 19, 2016 at Woodman. "Religious Diversity in the Workplace: Unique Customs and Basic Beliefs of Diverse Religious Traditions." Presented by Rabbi Ahuva Zaches.
- February 2016- Black History Month:
- Weekly trivia was held.
- February 2, 2016 - Black History Games and Prizes at Woodman.
- February 8, 2016 - Showing of "Still Bill" documentary at Woodman presented by Shameake Boomer.
- February 9, 2016 - Black History Games and Prizes at Richmond Medical Park.
- February 18, 2016 - "Black Lives Matter" presented by Major Clarence Hunter at Woodman.
- February 22, 2016 - Showing of "Still Bill" documentary at East Center presented by Brandy Coullier.
- February 24, 2016 - "Music Over the Ages" at East Center presented by Mike Harris.
- February 26, 2016 - Black History Bingo at Lakeside Center presented by Tracy Hicks.
- March 9, 2016 at Woodman. CACC 101 Sensitivity Training: "Understanding Me Helps Me Understand Others" presented by Courtney Lewis-McGrath and Sue Shires.
- March 17, 2016 at Woodman. CACC 102: "Cultural Aspects of Our Community – Train the Trainer Session" presented by Serina Gaines, Yvonne Russell, and Michelle Johnson. During this training 2 additional CACC members were trained to facilitate the CACC 102 training.
- April 13, 2016 at Woodman. CACC 102: "Cultural Aspects of Our Community" presented by Michelle J. and Serina.
- April 14, 2016 at Woodman. "Virginia Veteran and Family Support" presented by Matthew B. Rollston, Veteran Resource Specialist with Virginia Department of Veterans Services.
- May 6, 2016 at Providence Forge. "Four Generations in One Workplace" presented by Serina Gaines.
- "Virginia Veteran and Family Support" was also presented by Matthew B. Rollston, Veteran Resource Specialist with Virginia Department of Veterans Services, to the Emergency Services Program staff during 2 staff meetings held in May, 2016 at Woodman.

- June 24, 2016 at Woodman. Showing of Jane Elliott's Browned Eye, Blue Eyed Experiment conducted with college students, and discussion presented by Crystal Silvester.
- A total of three Cultural Awareness & Competency Committee members are trained to provide Orientation to new employees.
- A total of 5 Cultural Awareness & Competency Committee members are now trained to provide CACC 102 trainings to staff. We also have additional former members of CACC that are able to assist in providing this training.
- A total of 5 Cultural Awareness & Competency Committee members are now trained to provide CACC 101 trainings to staff. Two members were trained during CACC 101 training offered on November 4, 2015. We also have additional former members of CACC that are able to assist in providing this training.
- In FY16 the name of the CACC 102 Training was changed from "Understanding My Community" to "Cultural Aspects of Our Community."
- Training agenda and materials for CACC 101 training were updated/amended during FY16.
- Orientations are offered on an as needed based upon hiring new staff. Cultural Awareness & Competency Committee continued to provide orientation to new staff. The power point presentation is updated prior to each orientation offered to provide relevant information regarding trainings and brown bags being offered. New employees were oriented to the Cultural Awareness & Competency Committee mission and annual plan at each Orientation. They are also provided with information about how to contact committee members and are encouraged to participate creatively and collaboratively to help bring new cultural related ideas to the agency.
- All staff is required to attend at least one cultural or linguistic training per fiscal year. This is evident based upon yearly staff acknowledgement form submitted by each employee and is maintained in his/her HR record.

**Black History Month**

- Brown Bags were offered each week of February at different HAMHDS locations. See above for details regarding brown bags.
- Weekly trivia was provided to all staff for participation via email. Correct answers were provided to all staff and winners received prizes.
- Agency boards provided information regarding Black History Month and community offerings to celebrate this.
- Black History Bingo was conducted at Lakeside Center.

**Translation/Interpretation Services**

- The Cultural Awareness & Competency Committee began the process of maintaining the list of interpreters and the rates of those interpreters.
- The committee also starting to work on maintaining the list of bilingual staff and is working on processes for determining what staff is bilingual and willing to offer interpretation assistance to other staff members.
- Staff continues to use interpreters to address needs of consumers and their families. Staff has expanded to using more accredited community providers for interpretation with consumers.
- Cultural Awareness & Competency Committee members have collaborated with qualified community providers for interpretation services in order to obtain information about rates and services offered, and to possibly expand list of providers with whom HAMHDS is contracted and to compare with those with whom we are currently contracted.
- Staff continues to utilize Cyracom for interpretation services available via phone with consumers. (Cyracom is a full service language provider that focuses on healthcare.) Network of Care is also available for staff to assist with translation. (Network of Care is a website that provides resources to consumers and their families, including translation services for documents.)
- Signage in different languages regarding human rights and availability of interpretation services is posted at Woodman, East, Providence Forge, and Richmond Medical Park locations.
- Key forms (i.e. Human Rights brochure, Code of Ethics, authorization of release) have been translated into Spanish, for use with consumers. These are available to staff via the intranet, staff provides these to consumers upon intake when applicable.
- Two HAMHDS staff are qualified bilingual interpreters.
- Cultural Awareness & Competency Committee members have begun to research and to discuss implementing new processes regarding interpreter services and Cyracom.

**Provision of Culturally Relevant Information to Staff**

- Education regarding HAMHDS's values and commitment to cultural competency, as well as the Cultural Awareness & Competency Committee mission and CLAS standards, is provided at each Orientation by a CACC member to new employees, at least bi-monthly.

- Cultural sensitivity and awareness trainings are offered by the Cultural Awareness & Competency Committee members within the CACC 101 Training: "Understanding Me Helps Me Understand Others" and CACC 102 Training: "Cultural Aspects of Our Community" classes at least annually. In FY16 the name of the CACC 102 Training was changed from "Understanding My Community" to "Cultural Aspects of Our Community."
- All HAMHDS staff is notified of Cultural Awareness & Competency Committee trainings via email and intranet postings.
- The Cultural Awareness & Competency Committee Annual Report is provided to all agency staff via email and as posted on the Public Drive, which includes recent local demographics/statistics, as well as those served by HAMHDS. The agency continues to maintain a diverse workforce in leadership, management, support service, and direct service personnel.
- Diversity bulletin boards are maintained at Woodman, East, Hermitage, Providence Forge and Lakeside Center to provide education and information regarding culturally relevant monthly celebrations. Multicultural calendars were purchased for 2016 by the agency and posted on these boards. Below is a picture of the Diversity Board at the East Center with information regarding religious diversity that was posted during January, 2016. The Cultural Awareness & Competency Committee email address (diversity@henrico.us) continues to be maintained for staff to submit comments and questions. Use of this email address has increased during FY16 by staff.
- The Cultural Awareness & Competency Committee folder is maintained on the Public Drive and available to staff at any time. This folder includes the Cultural Awareness & Competency Committee meeting minutes, training materials, etc.
- Information regarding offerings by the Cultural Awareness & Competency Committee is posted within the agency newsletter, Quality Matters.

**Community Partnerships**

- Henrico Area Mental Health and Developmental Services, and the Cultural Awareness and Competency Committee would like to thank the following organizations for their partnerships during the 2016 fiscal year:
  - Dr. Ed Ansello from the Virginia Center on Aging- School of Allied Health Professions, and Virginia Geriatric Education Center.
  - Jennifer Lawhorn and Susanne Wilbur from the Virginia School for the Deaf and Blind.
  - Michele Zehr, founder of We2, LLC: Women's Experiential Empowerment.
  - Major Clarence Hunter, Jr. Deputy Chief of Police of the Patrol Bureau for Henrico County.
  - Ahuva Zaches, Rabbi of Congregation Of Ami – Reformed Synagogue.
- One HAMHDS staff is a member of Virginia Department of Behavioral Health and Developmental Services' Steering Committee with the Office of Cultural and Linguistic Competence.
- One HAMHDS staff is a member of the Area Planning and Services Committee on Aging with Lifelong Disabilities. A practical training session was held at the Eastern Henrico Recreation Center in November, 2015 entitled "The Champion's Toolbox: Healthcare Advocacy for Aging with Lifelong Disabilities". A conference was held at the Double Tree Hilton in Midlothian in June, 2016 entitled "Engaging the Brain: Aging with Lifelong Disabilities".
- Multiple community providers have been brought in to provide culturally competent trainings/brown bags to HAMHDS staff. See above for details.
- The agency's Health and Wellness Committee was established to address client wellness. The agency implemented a project to display consumer artwork. The committee continued to collect artwork from clients, frame them, and display then throughout various locations within the agency. Art was displayed at Richmond Medical Park, East Center, and Providence Forge in FY16. A current HAMDHS committee is working to add more consumer artwork in more locations. This is supported by the Cultural Awareness & Competency Committee. A member that serves on the CCAC committee also serves on the Wellness Committee to bridge information. Below are pictures of consumer artwork displayed at Richmond Medical Park.
- HAMHDS staff attended the 5th annual Building Bridges Conference on ID and DD in Racially, Ethnically and Linguistically Diverse Communities. This conference was held in October 2015 and was entitled "Transforming Relationships Using Intercultural Development Models".
- HAMDHS staff Pat Hill was appointed to the Statewide Cultural and Linguistic Competency Committee in 2014, and she remains a member. She works on the Community Engagement subcommittee that plans the National Minority Mental Health Media Contest. Pat Hill also channels information from the Statewide Cultural and Linguistic Competency Committee to employees within the agency.

- HAMHDS has continued to work with the Virginia Department of Health and Office of Cultural Awareness and Competence Program to assist in linking refugees in Henrico County with services/resources. HAMHDS staff is member of the Richmond Refugee Mental Health Council that discusses progress with program. During FY16 we have received about 12-13 referrals for refugees to be linked with mental health services, from the Health Department.

**Accessibility to Services**

- A new Voice Over IP phone system has been implemented in FY16. This new system makes it possible to have the agency's after-hours phone greetings delivered in both English and in Spanish. The Agency Management Team has approved a plan for adding the after- hours telephone greeting in Spanish. The greetings verbiage has been sent to County IT. County IT is scheduled to have the Spanish greetings in place by at the beginning of FY17, no later than the end of August 2016.
- See above regarding translation/interpretation services available for staff's use with consumers to promote access to services. CACC is continuing to research and expand these services.
- Wheelchairs are available at Woodman and East Center locations for use with consumers when appropriate.
- Elevator access is available at Woodman to reach second floor adult services.
- Doors at Woodman can be automatically opened with use of button for individuals with disabilities.
- A welcome environment for children is provided within the children's area in the lobbies of Woodman and East. In FY16 the children's area was redesigned to provide a more interactive experience for children while they are waiting for services, and work has begun in implementing this design.

**FY17 Objectives for the Coming Year**

The Cultural Competency Committee will develop and implement the FY17 Cultural Competency Plan and when finalized it will be posted to the Agency Intranet.

## DEMOGRAPHICS

**Counties of Henrico, New Kent and Charles City**

The US Census Bureau data reported below was last updated in 2015.

According to the US Census Bureau, quick facts for 2015, there are about 325,155 people in Henrico County, 58.9% White/Caucasian, 30.2% Black/African American, 0.4% were Alaskan Native, American Indian, 8.2% Asian, 0.1%, Native Hawaiian and Other Pacific Islander persons, 2.3% Multi-racial, 5.5% of Hispanic or Latino Origin, Language other than English spoken at home is 14.5%. Median household income is $61,438. Persons below poverty level are 11.0%.

In New Kent County there are approximately 20,392 people, 81.9% are White/Caucasian, 13.5% Black/African American, 1.0% Alaskan Native, American Indian, 1.2% Asian, 2.4% Multi-racial and 2.6% Hispanic or Latino Origin, Language other than English spoken at home is 2.3%. Median household income is $73,030. Persons below poverty level are 6.2%.

In Charles City there are about 7,040 people, 42.6% White/Caucasian, 46.8% Black/African American, 7.3% American Indian and Alaska Native, 0.6% Asian, 0.1% Native Hawaiian and Other Pacific Islander persons, 2.7% Multi-racial, and 1.7% Hispanic or Latino Origin. Language other than English spoken at home is 2.1%. Median household income is $48,088. Persons below poverty level are 13.1%.

**Counties of Henrico, New Kent and Charles City**

**Two year Race & Ethnicity Comparison**

| Race & Ethnicity | FY16 Henrico | FY15 Henrico | FY16 New Kent | FY15 New Kent | FY16 Charles City | FY15 Charles City |
|---|---|---|---|---|---|---|
| White/Caucasian | 58.9% | 59.3% | 81.9% | 81.9% | 42.6% | 42.1% |
| Black/African American | 30.2% | 30.1% | 13.5% | 13.7% | 46.8% | 47.5% |
| Alaskan Native, American Indian, Asian/Pacific Islander, Multi-Racial | 10.9%* *(Alask/Amer Ind. 0.4%) *(Asian 8.2%) *(Pac. Island 0.1%) *(Multi-racial 2.3%) | 10.6%* *(Alask/Amer Ind. 0.4%) *(Asian 7.9%) *(Pac. Island 0.1%) *(Multi-racial 2.2%) | 4.6%* *(Alask/Amer Ind. 1.0%) *(Asian 1.2%) *(Pac. Island 0.0%) *(Multi-racial 2.4%) | 4.4%* *(Alask/Amer Ind. 1.0%) *(Asian 1.1%) *(Pac. Island 0.0%) *(Multi-racial 2.3%) | 10.8%* *(Alask/Amer Ind. 7.3%) *(Asian 0.6%) *(Pac. Island 0.1%) *(Multi-racial 2.8%) | 10.4%* *(Alask/Amer Ind. 7.2%) *(Asian 0.4%) *(Pac. Island 0.1%) *(Multi-racial 2.7%) |
| For persons served who identify themselves as Hispanic | 5.5% | 5.3% | 2.6% | 2.4% | 1.8% | 1.7% |

*Source US Census Bureau, quick facts.census.gov

**Language Comparison with County of Henrico and State of Virginia**

| Order/ Frequency | Seen within Agency | Within Henrico County | State of Virginia** |
|---|---|---|---|
| 1. | English | English | English |
| 2. | Spanish | Spanish | Spanish |
| 3. | Arabic | Asian Languages | Korean |
| 4. | Chinese | Arabic | Vietnamese |
| 5. | Vietnamese | Chinese | Chinese |
| 6. | American Sign Language | Vietnamese | Tagalog |
| 7. | Farsi/Persian | Indic Languages | French |

**HAMHDS**

Henrico Area Mental Health & Developmental Services, HAMHDS, values a diverse workforce that is representative of the person served. As of 6/30/16 of the approximately 10,740 persons served, 45% of consumers served were White/Caucasian and 44% were Black/African-American. The remaining 11% were: Alaskan Native, American Indian, Asian/Pacific Islander, and Multi-racial. Of all consumers served 5% percent identified themselves as Hispanic.
As of 6/30/16, of the approximately 358 HAMHDS permanent employees 52.79% self-identify as White/Caucasian, 44.41% Black/African-American, 0.30% Alaskan Native, American Indian, 1.69% Asian/Pacific Islander, Multi-Racial, and 1.11% identified themselves as Hispanic.

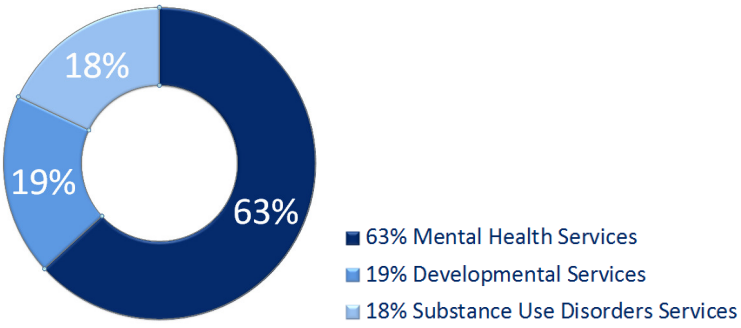
**Three Year Comparison of Person Served to HAMHDS Employees**

| Race & Ethnicity | FY16 Persons Served | FY15 Persons Served | FY14 Persons Served | FY16 HAMHDS Employees (358) | FY15 HAMHDS Employees (345) | FY14 HAMHDS Employees (335) |
|---|---|---|---|---|---|---|
| White/Caucasian | 45% | 46% | 49% | 52.79% | 54.50% | 55.82% |
| Black/African American | 44% | 44% | 41% | 44.41% | 42.31% | 41.19% |
| Alaskan Native, American Indian, Asian/Pacific Islander, Multi-Racial | 11% | 10% | 10% | 1.69% | 2.32% | 1.49% |
| Persons served who identify themselves as Hispanic | 5% | 5% | 4% | 1.11% | 0.87% | 0.99% |

# DEMOGRAPHICS

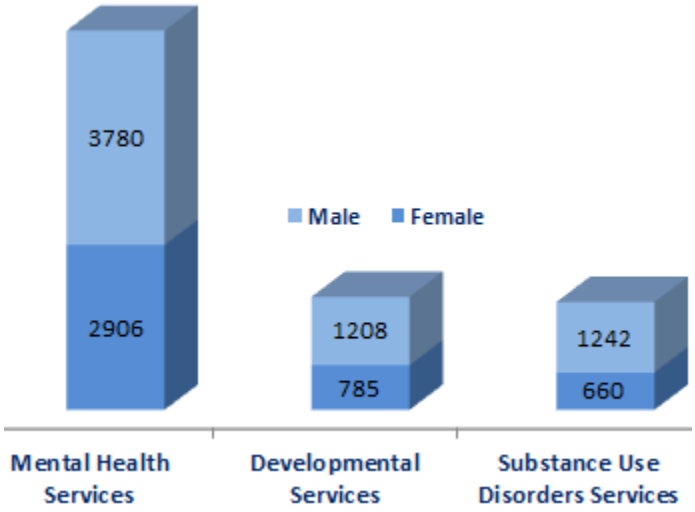
## Total Consumers Served by Program Area

Eight (8) percent of individuals served were ages 0 – 2; 20% were ages 3 – 17; 69% were ages 18- 64; and 3% were ages 65+.



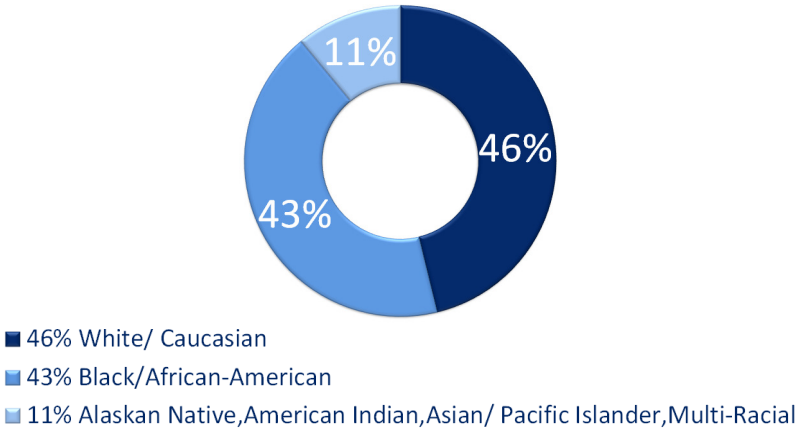

## Consumers Served by Gender

Fifty-seven (57) percent of individuals served in Mental Health Services were male, and 43% served were female. In Developmental Services, 61% of individuals served were male, and 39% served were female. In Substance Use Disorders Services, 65% of individuals served were male, and 35% served were female.




## Distribution by Race and Ethnicity

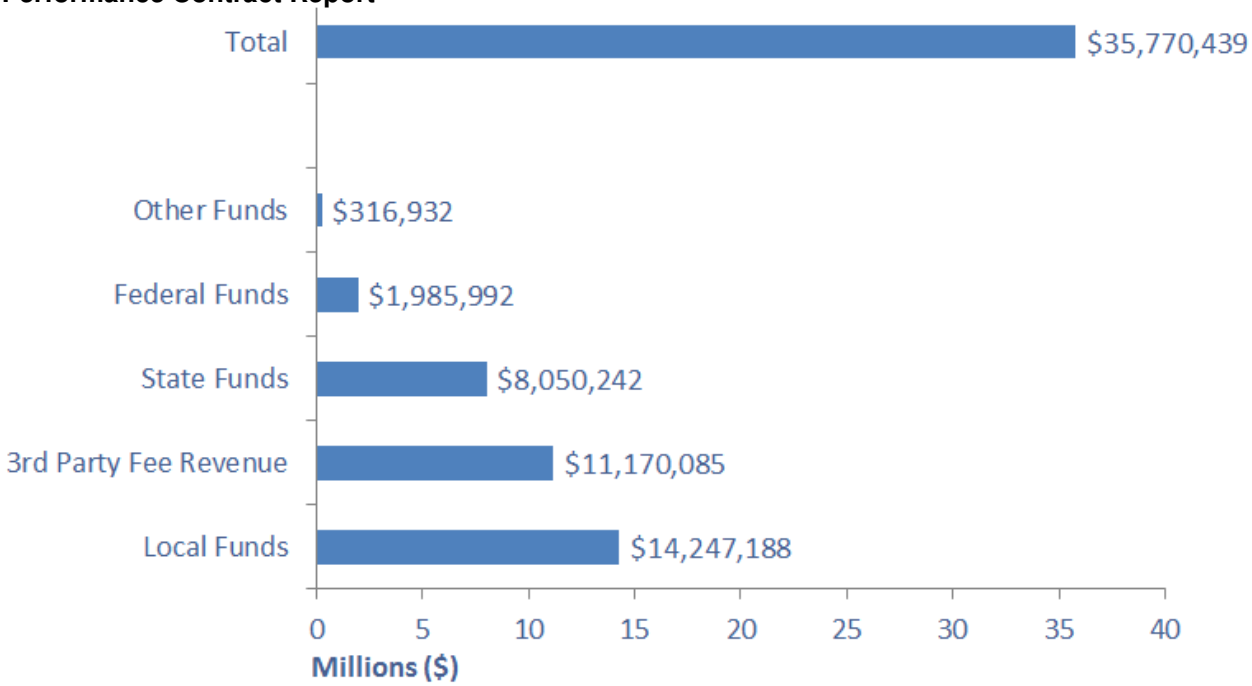
Of the unduplicated count of 9,933 consumers served, 43% (4,4252) consumers served identified themselves as Black/African American. 46% (4,588) White/Caucasian, 11% (1,093) Alaskan Native, American Indian, Asian, Pacific Islander, Multi-Racial.



# BUDGET

## Revenue

**FY2016 per the Year End Performance Contract Report**




## Expenses

**FY2016 per the Year End Performance Contract Report**

| | |
|---|---|
| Mental Health Services | $16,363,625 |
| Substance Use Disorders Services | $2,396,291 |
| Developmental Services | $12,297,130 |
| Administrative Services | $2,661,554 |
| **Total** | **$33,718,600** |