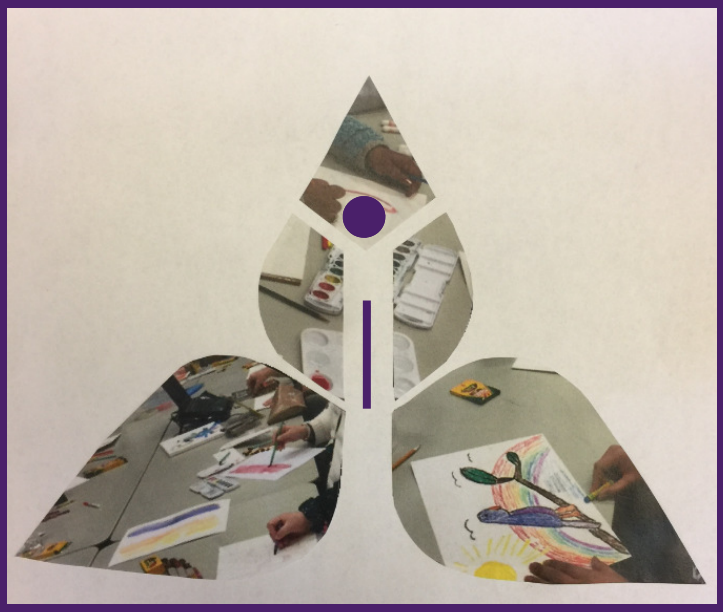
HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

ANNUAL PERFORMANCE ANALYSIS 2016 - 2017



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MANAGEMENT SUMMARY

Henrico Area Mental Health & Developmental Services (HAMHDS) is pleased to present its Fiscal Year 2016-17 Annual Report, highlighting major initiatives to improve the quality of care for individuals with mental health, substance use disorders and developmental disabilities. A great deal has been accomplished thanks to the hard work of HAMHDS staff, partnerships with many community organizations and support of our stakeholders.

In July 2016, we became the single point of entry for individuals with developmental disabilities seeking waiver services and began providing case management services to these individuals. Case management, day support and residential services staff planned for and implemented the new waiver services for individuals with intellectual and developmental disabilities. The new waiver services have enabled us to expand our community partnerships.

In April 2017, same day access for behavioral health services was implemented. Individuals seeking services can walk into our two main sites and are seen by a licensed therapist, evaluated and linked to ongoing services. Initial data shows an increase in the number of individuals seen as well as a higher percentage of persons who attend their second appointment.

Throughout FY 2017, HAMHDS staff was heavily engaged in the search for a new electronic health record system. A selection team, representing all of the agency programs, defined the requirements that a 21st century system should have to most effectively and efficiently serve our needs. The team regularly engaged all staff, seeking input and advice. All vendors' proposals were evaluated and discussed in detail. The agency is excited about the implementation of a new system which will begin in 2018.

Our comprehensive emergency response system remains strong. We are committed to improving the experience and outcomes for individuals in a psychiatric crisis or when they interact with the criminal justice system. Since 2008, Henrico's Crisis Intervention Team (CIT) staff has offered the CIT Basic class to over 1,670 first responders from Henrico's Police Division, Sheriff's Office, Division of Fire and HAMHDS, along with personnel from over 36 other agencies from throughout the Commonwealth. Additionally, 200 students were trained in the 2017 CIT Refresher classes. The Jail Diversion Team has been successful in diverting, coordinating and clinically managing the needs of individuals who have a mental illness. The team completed 486 assessments and worked closely with the sheriff, commonwealth's attorney and judges to divert individuals from jail.

The agency's focus on wellness and recovery is steadfast. We received a grant that allowed for the expansion of integrated primary health care. We are committed to assuring access to quality health care and promoting better health outcomes for the people we serve.

The agency received its sixth, three-year Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. This tremendous accomplishment speaks to the high quality, innovative services provided by our talented and dedicated staff.

Finally the HAMHDS 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 support allow critical community services to be in place that promote recovery, resiliency and inclusion.

Brenda A. Brown	Laura S. Totty
Board Chair	Executive Director

STRATEGIC GOALS AND STRATEGIC PLANNING

Summary of Agency Strategic Initiatives
During FY17 cross functional workgroups continued their work on the below strategic initiatives.

1. Procure and Implement a new Electronic Health Record
2. Provide same day access to services
3. Assure the provision of high quality services for individuals with Developmental Disabilities

Agency Workgroup:
An agency workgroup also pursued the following:

- Maintaining and supporting a high performance organization

The following information lists the strategic initiatives, FY17 accomplishments and action plans for FY18.

1. Explore Electronic Health Records Systems (EHRS)

FY17 Accomplishments
- August – January, the EHRS Selection Team worked with the consulting firm, Barry Dunn, to write the Request for Proposal (RFP). Insight and feedback was received from all staff through meetings with the consultants.
- In January 2017 the RFP was released and responses were received February 25, 2017
- In late March and early April, 3 top vendors were asked to demonstrate their software over a 2 day period. All Staff were invited, many attended and gave feedback.
- In April and May site visits and references calls were made related to the top 2 vendors.
- The best and final offers were received by both vendors on June 30, 2017.
- After evaluation of the offers, including significant increases in pricing, it was decided that we would reject the proposals because of insufficient funding. The Agency will release a new Request for Proposal in FY 2018.

Goals/Action Plans for upcoming year:
- EHRS Selection Team will select a new electronic health record system and complete contract negotiations
- Begin planning the implementation of the new electronic health record system with the new vendor

2. Provide Same Day Access to Services

HAMHDS Staff worked throughout the year to develop a process for Same Day Access to services. This work was led by a Rapid Cycle Change Team (RCCT) with consultation from MTM Consulting Group. The goal of Same Day Access is to facilitate easy, convenient access to services. This implementation process required close examination of our business processes, efficiency in service delivery—particularly our admission process, and, clarification of admission and discharge criteria. Ultimately the RCCT elected to operate our Same Day Access services at our East Center and Woodman Road locations. Same Day Access Services are available 5 days a week with some early morning and some late afternoon/early evening appointments available.

FY17 Accomplishments
- Implemented Same Day Access on 4/20/17.
- Allocated 6 FTE's of clinical staff and 1.5 FTE's of supervisory staff to this initiative.
- Significantly reconfigured our Administrative Process including centralizing our call center, and streamlining the admission and financial screening process.
- 627 received Same Day Access services between 4/20/17 and 6/30/17.
- Average time for clients from walking in the front door, completing the admission process, and leaving with a scheduled follow up appointment is 1 hour and 50 minutes.

Goals/Action Plans for upcoming year:
- Develop and implement protocols to support individuals who are seen in Same Day Access who are at high risk for hospitalization or harm to self or others.
- Continue to refine process for assessing risk of suicide through assessment and screening tools

- Develop strategies for efficiently staffing Same Day Access team to accommodate a great deal of variability in demand for services.

3. Assure the Provision of High Quality Services for Individuals with Developmental Disabilities

HAMHDS Staff HAMHDS Staff worked throughout the year to develop subgroups to address the focus areas of community outreach, navigating internal/external resource services, and training and education.

FY17 Accomplishments:
- Established contacts with Developmental Disabilities community agencies.
- Built and developed relationships with community partners.
- Initiated a resource directory file with a variety of options to offer individuals and family members
- Partnered with Department of Aging and Rehabilitation Services
- Developed partnership with Compass Counseling Services of Virginia
- Coordinated 2 Autism 101 trainings (Woodman Rd and East Center)
- Brown bag training "A Life Like Yours- Family's Journey"
- Member received 4 months training on Mental Health Approaches to Intellectual/Developmental Disability
- Coordinating a provider fair with community partners

Goals/Action Plans for upcoming year:
- Offer a variety of year-long Lunch and Learn meetings for agency programs/staff
- Coordinate 2 trainings for all agency staff.
- Coordinate certification training(s) on Autism Spectrum Disorder
- Maintain subgroups: Community Outreach, Navigating Internal/External Resource Services, Training and Education to address focus areas.
- Complete and post DD Resource Directory for agency staff.

Maintaining and supporting a high performance organization (HPO)
A small workgroup continued awareness and education on embedding HPO concepts.

FY17 Accomplishments:
- Workgroup took information from leadership group and developed a plan of action to provide additional training to members of the supervisory groups.
- Developed an on-line training on Holding Effective Staff Meetings. This is on the Agency Intranet Professional Training Page and all supervisors have been asked to review within the calendar year.
- Developed and held a 4 hour training for all Managers and Supervisors exploring the topics of General Supervision, Emotional Intelligence, Conflict Management and Change Management.
- Developed a training on Facilitation which will be conducted with Division Managers and Supervisors in FY 2018
- Developed a series of "brown bag" short trainings highlighting topics to follow up to the four hour training. Four of these sessions will be offered in FY 2018, with the first one scheduled for November, 2017.

Goals/Action Plans for upcoming year:
- Conduct the trainings for supervisors on facilitation and four independent HPO topics.

FY17 PROGRAM ACCOMPLISHMENTS

Administration
- Completed the Woodman lobby redesign, incorporating wellness and trauma informed concepts
- Continued to update 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
- Restructured Business Support in order to implement the Same Day Access Initiative. This included establishing a Call Center at Richmond Medical Park as well as redefining work responsibilities for front desk staff.
- Enhanced technology accessibility by adding computers in conference rooms, expanding public WiFi hotspots to more sites and providing second monitors to improve efficiency for staff.
- Worked with clinical staff and the county to credential, finance, establish new positions to hire physicians.
- Created a new process to resolve credit balances in a timely fashion
- Completed carpet replacement project by installing new carpet in Woodman Existing building, 2nd Floor and Lobby

- Coordinated an Agency-wide workgroup to evaluate and enhance the content and improve accuracy of information on the Internet Website
- Submitted the CIP to build a new East Center facility which was approved by the Board of Supervisors.
- Established the volunteer and internship process and ensured it runs smoothly.
- Completed the design and implemented the administrative initiatives related to implementing the DOJ Final Rule
- Created and implemented a solution to capture incremental data for ID Day Services to meet DOJ documentation rules.
- Reviewed contracts with management and Attorney for signature and began planning billing modalities redesign and changes in processes for the CCC Plus (Managed Care) State Initiative
- Expanded the use of Telehealth in practice
  - Built the billing modalities for telepsychiatry
  - Added 2 morel Telehealth conference rooms with additional State Grant funding
  - Completed training and training materials to staff
- Implemented electronic lab order process in Cerner to meet Meaningful Use measures and attested to Stage 2 for 3 prescribers.
- Began managing the newly awarded SAMHSA grant (Integrating primary health care) which includes using four websites to report outcomes, financial reports and drawing down funds. Renovating exam space was also done for this initiative.

Quality Assurance

- Celebrated achieving the 6th consecutive three-year CARF accreditation, 9 programs received accreditation.
- 44 external audits occurred, 109 client charts viewed for external desk reviews, 100% of reviews were completed within the specified timeframes.
- New Human Rights regulations implemented to include updated staff training and policies and procedures.
- DD private providers received agency training, including the reporting of Critical and Human Rights incidents/complaints in iRIS.
- Medical Records responded to 1,176 requests for records/information and 9 subpoenas for records in calendar year 2016 (January 1 – December 31).
- Approximately 550 quality record reviews and 100 Administrative Reviews were completed in FY 2017.
- Processed 56 Human Rights/Privacy Reports in a timely manner representing a 47% increase from FY16.
- Freedom of Information Act (FOIA) lead named within QA, staff training occurred and 3 FOIA requests processed within required timeframes.

Clinical and Prevention Services

Same Day Access (SDA)

- Initiated SDA on April 20th with significant increase in the number of persons seen as well as a higher percentage of persons who attend their second appointment

Adult Substance Abuse/ Adult Mental Health Services

- Implementation of treatment groups for ORBIT participants – 2X a week
- Obtained a contract for the purchase of Suboxone for pregnant women and women with substance exposed infants
- Recovery Event for the Community in September – joint effort with Henrico Drug Court
- Partnered with Health Brigade to provide free HIV testing
- Expansion of Dual Diagnosis group, collaboratively provided by partnership between Adult Recovery Services (ARS) and Substance Use Disorders (SUD) – alternating east and west groups
- Continuation of a DBT skills only group for ARS, collaboratively provided by partnership between ARS and MH
- Initiated MH Outpatient Behavioral Activation Group
- Entered into a partnership with Virginia Center for Addiction Medicine
- Overall expanded our Substance Use Disorders (SUD) group complement again, adding Outreach Program (ORP) Maintenance Group and a Motivational Enhancement Group
- Increased collaboration between outpatient SUD services and those being released from the jail Recovery in a Safe Environment (RISE) program
- Participating in county wide Heroin Task Force – assisted in the development of the http://bouncebackhc.com site, provided all initial content for site.
- Provided training at all Crisis Intervention Team (CIT) academies
- Developed 2 hours Substance Use training for CIT refresher
- Outreach system for the mothers of substance exposed infants expanded to include Telehealth while they are still in the hospital
- Provided REVIVE training for clients with substance use disorders

- Provided 1 community REVIVE training
- Provide staff for hostage negotiation for the county
- Successfully transitioned from walkin for SUD services only to agency wide same day access
- Participated in prescribers in training on Medication Assisted Treatment (MAT)

Jails:
- Implementing jail diversion program – developed excellent partnerships with Commonwealth Attorney's office, judges, beginning to work with some defense attorneys and magistrates
- Excellent sustained relationship with Sheriff
- Additional staff trained in Moral Reconation Therapy (MRT) and MRT groups initiated at the east jail (already had them at west jail)
- Provided MH 1st Aid training to 3 Sheriff academies, 2 more additional staff trained in MH 1st aid
- Utilized peer services
- Extensive use of telehealth
- Staff were more actively involved in medication management due to limited psychiatry time
- Developed new partnership with GOODWILL, their staff provide groups at the jail
- Received NACO award for MRT groups in the jail

Courts:
- Completed 292 evaluations, 96 were competency/sanity evaluations/restoration

Adult Recovery Services
- Case Management & Assessment teams received excellent consumer satisfaction ratings on their surveys this past year, with approval ratings of 96% from clients served by the teams and 97% from other stakeholders
- In conjunction with Collaborative Services, began implementation of the Independent Placement and Support (IPS) Vocational Services model, and the vocational specialists on the PACT and ICT teams completed the IPS certification curriculum. Vocational Services staff have begun attending CM&A team meetings periodically.
- In partnership with The Daily Planet, expanded primary health care services to the Woodman Road office, using a grant from SAMHSA
- Used new technology to successfully implement telepsychiatry for ICT clients
- CM&A facilitated an increased number of psycho-educational groups over the past year including 2 Co-occurring MH and SUD groups, 2 WRAP groups, a DBT skills group, 2 Skills for Success Communication groups, and 2 Illness Management and Recovery Groups

Lakeside Center
- On averaged served 56 members a day.
- Continued to support members' recovery and six members graduated from the program.
- Supported members' goal for obtaining employment, volunteering, and/or returning to school. We have 13 members employed, 5 that volunteer, and three are taking college courses.
- Promoted health and wellness by providing a variety of groups. 12 members received a certification for successfully completing a nutrition course sponsored by the 4-H Extension Office. Partnered with other community providers and an instructor taught yoga classes.
- Better access of technology (internet) to enhance psycho-educational group.
- Continued to serve as an educational site for Bon Secours Nursing Students.
- Continued to have a Certified ServSafe Employee/Trainer.
- Continued to provide tours for County CIT Training.

Mental Health Support Services (MHSS)
- Total number of consumers served in FY17 was 84.
- Provided on-going facilitation of a Volunteer Committee, which is a NACO Awarded program, empowering consumers to be leaders and volunteers in the community. While not an all-inclusive list some sites visited include: the Glen Allen Cultural Arts Center, Virginia Supportive Housing, Richmond Public Schools, Meals on Wheels, VA Hospital, VCU Health Systems and various nursing home. "Guitars for a Cause" is an outgrowth of the volunteer committee. It includes several consumers who play the guitar. The goal of the group is to "bring music to people in need," and so they go to several nursing homes and play for the residents.
- MHSS had 16 successful discharges, individuals served graduated from services as a result of learning the skills they needed to learn. In addition, 54% of all discharges were considered "successful," compared to 33% in the previous year.
- MHSS added a second peer-led program, Recovery Among Friends Support Group. That meets twice a month.

MH Residential

- In promoting recovery, Walton Farms now has three out of five residents that successfully completed the Home Safety Program, increasing their independent living skills, and are now able to stay home unsupervised for a period of up to seven hours.
- Continued focus on promoting health/wellness resulting in a resident's decreased blood glucose levels.
- Supporting residents' talents, two residents' artwork is hung at Woodman.

Vocational Services

- Provided vocational services to 32 consumers.
- Successfully obtained 18 new job placements.
- Provided vocational services to residents at Danray and all five residents are employed.
- Continued close relationship with Department for Aging and Rehabilitative Services (DARS).
- Continue to support and expand the Consumer Work Program, currently 13 consumers employed.
- Vocational supervisor and job coaches were trained in the IPS (Individual Placement and Support) Evidenced Based Model for Supportive Employment. Vocational supervisor received additional training as an IPS Supervisor.
- One job coach began his WISA training (Work Incentive Specialist Advocate), through Cornell University. His training will be completed this fiscal year.

Emergency Services

- 1,630 Emergency Evaluations/Preadmission Screening Assessments Completed
- Clinicians responded to an average of 4,350 Crisis Calls per month
- Established protocol and continue to manage new procedures for certifying new preadmission screeners for HAMHDS and assist Human Rights in assuring compliance with requirements
- Implemented group supervision for certified prescreeners outside of the crisis unit to obtain necessary supervision and continued training
- Participated in Regional Initiatives to decrease utilization of state hospital beds, including bed purchase plan at Poplar Springs Hospital and mobile crisis stabilization
- Began use of telehealth technology to complete assessments quickly when clients are in crisis at locations where travel time is prohibitive to a timely response
- Conducted all walk in intake appointments, facilitated hospital discharge appointments until the beginning of Same Day Access
- Helped support the promotion of the Same Day Access Program by supporting SDA clinicians with consultation and assessment of individuals who present to SDA with more urgent needs
- Began implementing plan to improve collaboration with other HAMHDS programs
- Improved collaboration process with jail mental health clinicians to increase fluid facilitation of hospitalization process for citizens being released from jail who need inpatient treatment
- Established regular meetings with Parham Doctor's Hospital Behavioral Health Unit director to address issues and improve communication and collaboration between Emergency Services clinicians and behavioral health nursing staff
- Facilitated better working relationships with Sheriff's Office by co-attending meetings and conference
- Expanded Anthem Bridge program participation to include St. Mary's Hospital in addition to Parham Doctor's Hospital

Crisis Intervention Team (CIT):

- NAMI-CVA awards received for Marty Shephard, HAMHDS Controller (MH Services Award), Rachel Shrewsbury, Henrico Police (Officer of the Year), CVACIT (Distinguished Community Partner)
- Helped organize and attended Virginia CIT conference in Blacksburg, VA
- Governor McAuliffe recognized Nicki Moon, HAMHDS Clinical Supervisor, and Cindy Wood, Henrico Police Lieutenant, for work with VACIT
- VACIT Deputy Sheriff of the Year award received by Captain Earl Williams, Henrico Police
- In March 2017, began offering 8 hour CIT refresher courses for those who have been through the 40 hour CIT class
- Continue to offer 40 hour CIT Basic Course 6 times a year, Mental Health First Aid for Public Safety classes, as well as other trainings
- Police are 100% CIT trained
- Members of the CIT Steering Committee attended the Institute for Behavioral Healthcare Improvement (IBHI) conference and toured comprehensive facility in Bexar County San Antonio, TX
- Emergency Services Clinicians staff the Crisis Receiving Center (CRC) which is supported by the CIT program; clinicians have assisted 3193 citizens since the inception of the CRC

Youth & Family

- Continued our partnership with Juvenile Court Services, serving 50 youth and their families in Court Alternative Program Substance Abuse (CAP-SA) psycho-educational groups and will expand services to by adding full time clinician on site beginning in July, 2017
- Continued Partnership with Henrico County Schools providing assessments and educational groups to over 50 youth.
- Continued to expand our role as Children's Services Act (CSA) case managers for youth receiving residential or community-based services providing CSA case management to 53 youth during fiscal year
- Served 55 Henrico/New Kent/ Charles City youth in Crisis Response & Stabilization Services (CReST) a regional program for youth in Crisis.
- Served 59 Henrico/New Kent/ Charles City youth through the Regional Child Crisis Stabilization at St Joseph's Villa
- Increased number of youth served with case management services by 10% over previous year.
- Hired new Child Psychiatrist
- Initiated Juvenile Drug Court, in partnership with The Commonwealth Attorney's Office, Juvenile Court Services, Henrico Juvenile Courts and other county agencies.
- Provided Multisystemic Therapy (MST) services to 33 Henrico at risk youth and successfully negotiated contact with state wide Department of Juvenile Justice managed care organizations.
- Implemented pilot same day access for youth beginning in December of 2016 resulting in an increase of 25% more youth receiving initial assessments between January and June of 2017 compared with previous year during same time period.

Prevention

- A Community Needs Assessment was conducted by Prevention Services to identify community needs and resources related to prevention of substance use, with a particular focus on youth ages 12-17. The comprehensive community assessment included youth and parent surveys, focus groups, key informant interviews, and data from state agencies. The results of the needs assessment were used to develop a plan to address substance use prevention in the locales served by HAMHDS, beginning in the fiscal year 2017-2018.
- As part of a statewide initiative to raise awareness and reduce sales of tobacco products to minors, Henrico County Prevention Services is partnering with DBHDS in the Counter Act Initiative. Two hundred nine (209) audits of tobacco product vendors were conducted across Henrico, Charles City and New Kent. Additionally, information from the Department of Alcohol Beverage Control regarding preventing alcohol sales to minors and trainings offered to vendors were distributed at the time of audits.
- 2nd Annual Hip Hop Wellness Poetry Slam was hosted by the Youth Ambassadors Leadership Group. The idea for the wellness-focused event was developed by the Youth Ambassadors while attending the Annual Youth Alcohol and Drug Abuse Prevention Project Conference (YADAPP) @ Longwood University. Youth participants in the event represented Henrico middle and high schools from across the county who performed spoken-word entries focused on bullying, substance use and suicide prevention.
- The Ask the Question (#ATQ16) suicide prevention campaign encouraged people to speak up if someone close to them appears in distress. Asking the critical question "Are you thinking about suicide?" can save lives. The campaign used social media and advertisements on GRTC buses to spread the campaign message throughout communities and direct people to appropriate resources.

<u>Community Support Services</u>

Intake/Eligibility and Case Management

- Since becoming the central access point for individuals with Developmental Disabilities on July 1, 2016, face to face intakes have increased this year by about 50%; intake total for FY17 was 277 (113 individuals had DD diagnosis, not ID), FY16 = 141
- In addition, the team completed another 72 "paper" intakes for individuals who needed to be opened in our EHR system but would continue to receive case management services from a private DD case manager.

Housing

- During second half of fiscal year, began receiving referrals for individuals who had been awarded Department of Justice (DOJ) vouchers. Thus far have received five referrals and one has gone under lease (one declined, and others in process).

Community Support Teams

- All Case Managers completed additional Modules and received training on new services implemented in FY17 as well as services scheduled for implementation in FY18.
- Began use of the Waiver Authorization Management System (WAMS) in September 2016 and received training in the spring of 2017.

- Implemented the new Waiver Slot Allocation process (Waiver Slot Allocation Committee) which involved a new priority system for all individuals on the DD Waiver Waiting List, assessment to attach numerical scores to situations and implementation of new forms to document need to take to committee members.
- Implemented new processes for SIS scheduling, change requests and verifications.
- Participated in DBHDS and internal Waiver Re-design training.
- CMs assisted individuals to apply for special housing Vouchers.
- Participated in Guardianship Panel and obtained Public Guardianship for nine individuals in need.

Developmental Disability Case Management
- Established contract with two Private Providers- Catholic Charities and Waiver Services
- Since the new WSAC process 11 DD individuals were offered a waiver slot
- Provided on-going training to Private Providers; began quarterly supervision meetings; provided monthly/bimonthly Question & Answer updates for staff
- Created a DD resource list that will eventually be posted and shared with all Henrico MHDS employees to utilize

Employment and Day Services
- Agency received our THREE YEAR CARF Accreditation – including all programs in Employment and Day Services
- Employment Resource Program (ERP) continues going strong with new jobs such as Bojangles, K-2
- Developed 4 new volunteer sites for ERP participants to gain work skills
- Began an Aging services initiative to better serve individuals who are experiencing Alzheimer's and/or Dementia
- Licensed for and began implementation of two new Community based waiver services as part of the Waiver Redesign requiring more community based activities along with maintenance of lower ratios within Hermitage and Cypress.
- Assisted 10- 12 individuals who were laid off due to the Martin's closings to move to other jobs or activities of their choice.
- Maintained all 4 Group SE sites with no job losses and increased capacity at two despite several management changes.
- Cypress Enterprises added two new volunteer sites, including participating in the Oyster Shell recycling program with the VCU Rice Center.
- We have been begun work with a collaboration between the Department for Aging and Rehabilitative Services (DARS) and the Henrico Schools to increase options for Transition Students
- Jackie Fuller, Hermitage Training Assistant, won the VaACCSES Statewide Staff recognition award in Fall 2016.
- As part of the Waiver redesign all Employment and Day Staff (and Residential) received training and met all state DBHDS competencies to continue the work we do

Residential
- Planted gardens and donated part of harvest to Lamb's Basket, community food bank.
- Residents participated in chair Zumba and Yoga classes with personal trainer
- Resident earned award for Scout of the Year through VENTURES
- Resident attended the Southern Women's Show
- Resident learning technology (cellphone) and the art of the selfie and texting
- Attended Nascar and Bluegrass Concert
- 5 of 19 residents loss 12+ pounds during the weight loss challenge

Parent Infant Program
- The Parent Infant Program (PIP) collaborated with Dr. Oswald from Commonwealth Autism. PIP therapists were trained to conduct the Autism Diagnostic Observation Schedule (ADOS), (a highly recognized evaluative measure for diagnosing Autism Spectrum Disorder). An ADOS clinic was created through this collaboration. Our ADOS clinic will help to relieve the wait time for families accessing services.

FY18 ADMINISTRATIVE AND PROGRAM INITIATIVES

Administrative
- Planning and preparing for the EHR implementation
  - Plan system set up, including program, security and billing & authorization modalities
  - Create the Data Conversion
  - Map the systems interfaces and extracts
  - Create Forms
  - Create Testing scenarios
  - Plan training strategy and training materials

- Expand the use of Telehealth and integrate the use of Jabber
- Renovate a kitchen and bathrooms in the group homes and Hermitage
- Update agency job descriptions
- Work with the County to be one of the first Agencies to implement P cards (county credit cards) which will include writing procedures and training staff.
- Work with the County and Architects to plan and begin to build the new East Center facility.
- Implement CCC Plus
  - Work with the MCOs to establish a smooth credentialing process with each of them.
  - Build and test billing modalities
  - Create new ways to ensure that eligibility is verified as clients come in the front door
  - Create forms and system sweeps for Authorizations
- Working with other Cerner boards, plan, promote and implement WaMS reporting and extract to the State
- Implement the human resources, facilities and financial reporting aspects of the Permanent Housing Support Initiative

Quality Assurance

- Assist the agency in meeting requirements for the Medicaid managed care program, CCC plus.
- Continue to collaborate with the six new Managed Care organizations.
- Continue to research, interpret and comply with regulatory requirements.

Clinical and Prevention Services

Same Day Access:

- Continue to expand and refine same day access to be able to meet the needs of our residents and community

Adult Substance Abuse/ Adult Mental Health Services:

- Develop an enhanced substance use disorders (SUD) outpatient program for women with dependent children and pregnant women
- Investigate substance use disorders and intensive outpatient services
- Provide 4 community REVIVE trainings
- Develop additional community partnerships for the purchase of Suboxone
- Investigate the possibility of an Office-based Opioid Treatment (OBOT) partnership with a community partner
- Provide 3 SUD trainings to agency staff
- Have peer ready to bill for services by having completed internship hours during this year
- Demonstrate a reduction of substance use in those who have completed treatment
- Demonstrate continued positive outcomes in Behavioral Activation groups

Jails:

- Work to increase the linkage between jail and outpatient services
- Increase jail diversion numbers by 20% over previous year

Courts:

- Continue to be responsive to judges and requests of the courts

Adult Recovery Services:

- In the coming year, implement a new permanent supportive housing program to serve 30 clients
- Following the recent efforts toward improving health and wellness, teams are forming new groups for physical activity, e.g., the walking group, and planning educational groups, e.g., a healthy food preparation class.

Collaborative Services:

- Fully implement the Individual Placement and Support (IPS) Evidenced Based Practice for Supportive Employment.

Emergency Services:

- Establish a workgroup which meets regularly to analyze processes within Emergency Services Program with the goal of improving efficiency, communication, collaboration with and offer improved customer service both internally and with community stakeholders

- Begin tracking patient acceptance rates for private hospitals in Region IV to utilize this information to inform and impact admission rates for local hospitals and hopefully, decrease state hospital admissions
- Develop, in collaboration with other Boards, consistent practices among Region IV CSB's when responding to hospital requests
- Establish workgroup to examine ES 24 hour schedule for efficiency and effectiveness improvements
- Develop brochure for clients and families explaining ECO/TDO processes

Crisis Intervention Team (CIT):

- Exploring options for other services on the crisis intervention continuum with visits to other sites regarding Psychiatric Emergency Centers.
- Continue CIT and Mental Health First Aid-Public Safety trainings
- Continue outreach and advanced CIT initiatives

Youth & Family:

- Better integration and clinical focus of case management services for youth
- Enhance service coordination with Juvenile Court Services
- Develop integrated and evidence based substance use services to our youth through partnership with our community agencies and stakeholders
- Expand the Juvenile Drug Court
- Improve focus on integrated health care through better coordination with pedestrians and primary care providers

Community Support Services

Intake/Eligibility

- Streamlining DD single point of entry and eligibility determination

Residential

- Implement Home and Community-Based Services (HCBS) requirements modify documentation and train staff.

Parent Infant Program

- Implement the Fidelity Assessment process to ensure evidence based practice for Early Intervention therapy provider

ID Case Management Services

- Continue to implement the changing requirements generated by the Department of Justice Settlement Agreement and the DD Waiver Re-design.
- Incorporate changes to the Medicaid system affecting individuals served including Commonwealth Coordinated Care (CCC) Plus Managed Care implementation, Elderly or Disabled with Consumer Direction Waiver and Technology Waiver transition to CCC Plus Waiver and changes to authorization under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for certain services for children receiving Developmental Disability Waiver

DD Case Management Services

- Cultivate and develop the Developmental Disabilities Services provided to Henrico residents by Henrico DD unit and Private Providers
- Implement the DD waiver Re-Design and the DOJ Settlement Agreement requirements
- Learn and apply CCC Plus, CCC Plus Waiver and EPSDT authorization changes to children utilizing a Developmental Disability Waiver.

Day Services and Employment

- Employment Resources Program continues to enhance skills that lead to employment for those in our center based program
- Community Engagement and Community Coaching continues to assist individuals in being more consistent and accepted community members.
- Emphasis on helping our older citizens who have signs of Alzheimer's and Dementia be active and maintain skills.
- Continue employment options including those who are transitioning from school and those who are looking for advancement.

AGENCY OUTCOMES AND PERFORMANCE IMPROVEMENT MEASURES

ADMINISTATIVE OUTCOMES

Efficiency Objective: To improve the collection rate of net charges for Unit 1200 to 85% by June 30, 2017. There is to be no greater than 15% of services billed out of Unit 1200 pending adjudication.	**Results:** 72%, not met
Recommendations/Action taken: Unit 1200's average collection rate for services provided in FY17 total 42%. The average net charges pending adjudication for FY17 was 58%. In comparison to the overall collection rate for services provided in FY16 collections is up 9%. The Reimbursement Department had the opportunity during FY17 to address several issues that hindered collection to include the correction of systems set up issues, correcting the billing for purchased medications and the implementation of focused training sessions with each analyst.	**Performance Improvements:** The overall goal of a collection rate of 85% was not obtained during FY17. Although the specific goal was not achieved during FY17, the knowledge gained through tracking this outcome has positioned us for greater success in this area in FY18.

Efficiency Objective: Court staff will receive the court orders within 4 weeks of the scheduled evaluation; increase their customer satisfaction to at least 9 on a ten-point scale.	**Results:** 99%, met
Recommendations/Action taken: The goal of customer satisfaction of at least a 9 on a ten-point scale was met and exceeded. Court staff report that they are receiving the court orders timely. Two out of the 3 staff give their satisfaction as 10. This is a huge improvement from the starting point of a 3. The process in place will continue to be followed and the supervisor will regularly communicate with court staff about their satisfaction.	**Performance Improvements:** As changes or issues arise business staff, business supervisor and court staff will communicate to update and keep the process running smoothly.
Objectives for the Coming Year Efficiency - To ensure that 96% of clients meet with a screener in 15 minutes or less Efficiency – To ensure that 100% of the ID Private Provider logs received in the month are keyed by the keying deadline each month.	

ADULT SUBSTANCE ABUSE OUTCOMES

Access Objective: 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.	**Results:** The objective was met all 9 out of 9 months. There is no data for the last quarter due to the initiation of agency wide same day access.
Recommendations/Action taken: The agency underwent a restructuring of access to services which resulted in a new same day access process. As of April 2017, anyone who seeks services from the clinical and prevention unit can walk into the agency 5 days a week and receive an intake assessment. Services are available upon request.	**Performance Improvements:** Utilize same day access format in order to maintain the most responsiveness possible on an outpatient basis. Clients are seen at the time of request for services.

Effectiveness Objective: 60% of clients opened to this service will be retained in services for a minimum of 3 months (demonstrating a service provided each of those 3 months)	**Results:** Retention for 3 months in services ranged from a low of 37% to a high of 63%, not met
Recommendations/Action taken: Continue to actively outreach clients who have missed appointments and invite them back to services. Look to incorporate peer recovery specialist in the process of outreaching clients.	**Performance Improvements:** Look to enhance transportation and day care options for clients so that those are not obstacles to treatment.

Effectiveness Objective: 26% of clients admitted to services will be retained in services for a minimum of 6 months (demonstrating a service provided each of those 6 months)	**Results:** Retention in services for a minimum of 6 months, with a service each of those 6 months ranges from a low of 13% to a high of 31%, not met
Recommendations/Action taken: No action will be taken	**Performance Improvements:** We strive to keep clients

at this time as this is an outcome that has been dropped by the state.	engaged in services for the timeframe that is appropriate for them. For some, that is longer than 6 months but for many that is less than 6 months.

Consumer Satisfaction Objective: 80% of clients surveyed in September and April will rate their overall satisfaction with services. (4 or 5 rating)	**Results:** 99% in September, 98% in April, met
Recommendations/Action taken: Results shared with staff and stakeholders.	**Performance Improvements:** No specific performance improvements made as a result of this objective.

Objectives for the Coming Year
Access - Clients will be scheduled for their second appointment after same day access within 14 calendar days of their SDA intake.
Efficiency – 60% of clients opened to this service will be retained in services for a minimum of 3 months (demonstrating a service provided each of those 3 months)
Effectiveness – Clients discharged from services will demonstrate a reduction in use in 70% of planned discharges (discharges where clients are involved in the development of the discharge plan).
Consumer Satisfaction - 90% of clients surveyed in February 2018 will rate their satisfaction with services as positive as represented by a 4 or 5 rating.

ADULT MENTAL HEALTH OUTCOMES

Access Objective: Clients will be scheduled for a follow-up appointment within14 days of call to central access.	**Results:** The objective was met 2 of 9 months of recorded data.
Recommendations/Action taken: As a result of not being able to accomplish this objective, the agency undertook a new initiative, Same Day Access. In April 2017, anyone who seeks services from the clinical and prevention unit can walk in to the agency 5 days a week for assessment.	**Performance Improvements:** Utilize same day access format in order to maintain the most responsiveness possible on an outpatient basis. Clients are seen at the time of request.
Consumer Satisfaction Objective: 80% of clients surveyed in September and March will rate their overall satisfaction with services at a 4 or 5 on the survey.	**Results:** 99% in October, 97% in April, met
Recommendations/Action taken: Share results with staff and stakeholders.	**Performance Improvements:** Continue to provide services as currently designed.

Objectives for the Coming Year
Access - Clients will be scheduled for their second appointment after same day access within 14 calendar days of their SDA intake.
Consumer Satisfaction - Client satisfaction will be surveyed during the month of February 2018. Positive results will be considered a rating of a 4 or 5 on the questions asked. At minimum of 90% of all responses to the survey will be rated as positive.

CHARLES CITY/NEW KENT OUTCOMES

Access Objective: Clients will be seen for initial appointment within 10 days of contacting Access.	**Results:** 7.8 days, met
Recommendations/Action taken: PF met this goal.	**Performance Improvements:** Use information learned during tracking of this goal to continue to meet objective.

Consumer Satisfaction Objective: 80% of clients surveyed in October and April will rate their overall satisfaction with the session as satisfied utilizing the SRS. Satisfied is defined as 8 or above.	**Results:** 90.5%, met
Recommendations/Action taken: Overall, satisfaction from clients was consistent.	**Performance Improvements:** Overall, most clients appear to be satisfied with the services they received.

Objectives for the Coming Year
Access – Clients will Clients will be seen for initial appointment within 10 days of contacting Call Center
Satisfaction – 80 % of clients surveyed in each quarter will rate their overall satisfaction with the session as satisfied utilizing the SRS. Satisfied is defined as 8 or above.

EMERGENCY SERVICES OUTCOMES

Access Objective: Persons not open to the agency	**Results:** 74%, not met

hospitalized through the civil involuntary admissions will attend a non-emergency discharge appointment within 7 days of their discharge 75% of the time	
Recommendations/Action taken: Due to Same Day Access program assuming the role of discharge appointments, consider whether that program should assume the tracking and follow up for clients being discharged from hospitals. ES will continue to track those who are LIPOS funded and who are treated at CSU.	**Performance Improvements:** Arrange follow up phone calls to any individuals given an appointment following discharge from LIPOS funded or CSU stay who do not come to an appointment to reschedule and improve engagement in services.

Efficiency Objective: 90% of persons (not currently open to the agency) not hospitalized will be contacted by phone within 5 business days of their assessment if follow up is indicated in assessment. If the phone call is not completed a letter will be sent within 5 days. Excluded are persons who live in a group home or are assessed in jail or detention.	**Results:** 87%, not met
Recommendations/Action taken: During the first 3 quarters, we exceeded our objective for an average of 96% for that time period. Due to not meeting the 5 day timeframe sometimes, we did not meet the objective for the year. We will consider modifying the timeframe to follow up within 7days to allow for times of high volume and acuity so that we can continue to respond to present crises while following up with those served as well.	**Performance Improvements:** Supervisors will run a report of prescreenings completed first thing in the morning and complete this task daily except under extraordinary circumstances. Program manager will monitor this daily as well to ensure that we are reviewing prescreenings quickly. 100% of prescreenings will continue to be reviewed and outreach will be attempted on all those identified that outreach is appropriate.

Objectives for the Coming Year:
Access – Continue to provide hospital liaison services to link individuals to agency services to provide seamless access.
Efficiency – Run reports daily and review prescreenings daily.
Effectiveness – Clinicians will attempt to obtain accurate contact information for follow up.
Consumer Satisfaction –ES Workgroup will complete a brochure for clients and families explaining the TDO process.
Stakeholder Satisfaction- Program Manager will arrange meetings with stakeholders to discuss how to improve processes to support good communication and collaboration.

ACCESS OUTCOMES

Access Objective: Access staff will include 3 key elements: reason for request of services, lethality screening, SA, diagnosis if known, past treatment including hospitalizations and any medications in 90% of the Central Access forms. Excluded are Central Access for CAP SA and Building Block Referrals.	**Results:** 92%, met
Recommendations/Action taken: Measure discontinued. The agency has made a significant shift in how services are accessed, mental health and substance use services are accessed through same day access.	**Performance Improvements:** During the 2 quarters where data was collected, the outcome was met. The Central Access form used to collect this outcome data was discontinued when the Agency initiated Same Day Access Program.

Objectives for the Coming Year:
Access – 80% of clients referred to services will show for their second appointment
Effectiveness – 80% of clients will score a total of 20 or better on the SDA Satisfaction Survey

LAKESIDE CENTER OUTCOMES

Access Objective: 100% of consumers referred to the program will be admitted within 10 days from receipt of the referral.	**Results:** 100%, met
Recommendations/Action taken: For the FY17 Quarter there were a total of 25 admissions to the program (excluding Central State Hospital referrals as defined above) which averaged ten days from referral to admission therefore meeting the defined objective above. Upon examining the average admission data, several factors	**Performance Improvements:** The varied factors contributing to admission delays are detailed in the 4th Quarter narrative above. Though our current processes, including the hiring of a clinician, has resulted in more timely access to services, referral sources should continue to be encouraged to have consumers tour Lakeside Center,

existed which contributed to the delay of admission. One pertains to the current agency referral process. Specifically the "Referral Date" which starts the 10 day window, is the date the referral source starts the form but it may be several days later before it is completed, final approved, and sent to the program supervisor for review. When there is a delay in receiving the referral from the time it was initiated it makes it extremely difficult to meet the objective. During the 4th Quarter, a Clinician position was added to the program for the first time and among the job description responsibilities for this position is to conduct all orientations/openings to the Lakeside Center Psychosocial Program. This has already proven to increase the timeliness and efficiency of admissions.	to determine interest, prior to referral, and complete/final approve referrals the same day so as to maximize our available response time.

Effectiveness Objective: The "dead referral" rate will not exceed 10% (consumer who did not attend at all within 30 days).	**Results:** 24%, not met
Recommendations/Action taken: Our internal efforts to curb the "dead referral" rate remain related to our request for individuals to tour the program before a referral is made. Previous outcomes have shown that doing so significantly increased the ratio of referrals to admissions and reduced the "dead referral" rate. Results shared in Team Meeting and in ARS Supervisors Meeting to illustrate the importance of program tours in reducing the rate.	**Performance Improvements:** The rate of "dead referrals" improved or maintained improvement each of the four FY17 Quarters. Multiple external variables outside of our control continue to impact the "dead referral" rate. Moving forward we will close referrals which have not resulted in admission by 30 days as updated clinical information may be warranted.

Effectiveness Objective: As a result of alternate intervention, LSC suspensions will occur in less than 10% of incidents.	**Results:** 2/5 or 40%, not met
Recommendations/Action taken: For FY17 we had five behavioral incidents with two resulting in suspension. While we didn't achieve our goal it should be noted that there were only a few number of incidents that occurred throughout the reporting period, and even if one resulted in a suspension we would not have met our objective. In response to the incidents of inappropriate sexual behavior we have locked the back hall bathroom and kitchen doors for increased security.	**Performance Improvements:** Continue to educate program members on program rules and appropriate boundaries.

Efficiency Objective: 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.	**Results:** 62%, not met
Recommendations/Action taken: For FY17, the outcome measure was revised to include Care Coordination with the SAI and <u>other healthcare providers</u> 100% of the time. This revision reflects best practice for continuity of care, which includes collateral contact with additional agency providers, private providers, family members, and/or ALF administrators. Though we did not achieve our goal of 100% each quarter, it should be noted that we made improvements throughout the year with the last quarter's results at 100%.	**Performance Improvements:** Continue to stress to staff the importance of documentation related to collateral contacts for all service providers involved in providing care to shared consumers.

Satisfaction Objective: 90% of consumers surveyed will report being "satisfied" with services.	**Results:** 92%, met
Recommendations/Action taken: Achieving a score of 92%, our overall results for FY17 surpassed our target of 90% a significant improvement on FY16 when, by comparison, we were only able to achieve a score of 81%. This year all 17 members (21% of census) that were	**Performance Improvements:** Given the consumer comments made that more reminders from staff could be helpful with further engagement staff will be encouraged to increase same. Some potentially viable comments about how to improve the program included: more exercise and

randomly selected agreed to participate. Again, by comparison, in FY16 there were 32 members randomly selected but only 8 participants. So, our response rate was also significantly better than in FY16. The scores would appear to parallel our thoughts about episodes of care. Those who have been attending the shortest amount of time are typically those who are beginning to learn about their illness, are acclimating to a day program or have been mandated to attend. Those who have been attending for the longest period continue to attend because of their continued need for support which may not evolve, while those in the 5-10 year period of attendance are more likely those who have been maximizing the benefit of the program while actively working on their recovery.	medically related groups; more "fun" groups'; and the use of outside professional speakers. Several of these have already been implemented including a fitness class, and two series of nutrition classes scheduled for both the 3rd Quarter and 4th Quarter FY18.

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:** 94%, not met
Recommendations/Action taken: In FY17, a total of 18 stakeholders (family members and ALF's) surveys were conducted. This included a 10 of 10 response rate (100%) from family members and 7 of 8 response rate (88%) from ALF's. No action required, however, wording of survey questions 3 and 4, will be changed in order to obtain a more accurate measurement of satisfaction.	**Performance Improvements:** When measured separately, family members provided a score of 90% or better on their survey questions and ALF managers provided a score of 100% on all of their survey questions. The combined survey score was 94%.

Objectives for the Coming Year

Access - Consumers referred to the program will be admitted within an average of 10 days from receipt of the referral.
Effectiveness - Consumers will be administered both pre- and post-surveys to determine the retention of information disseminated in their daily groups.
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 - Stakeholder Satisfaction- 90% of Case Managers will respond with an 8-10 rating to all survey questions in both the first and third quarters and 90% of consumers surveyed will report being "satisfied" with services as evidenced by an 8-10 rating to all survey questions.

MH CASE MANAGEMENT OUTCOMES

Access Objective: Non crisis clients will be seen within 7 business days of initial attempt to access services.	**Results:** 6.2 days, met
Recommendations/Action taken: In the fourth quarter of FY17 on 4/20/17, the agency moved to a same day access model of services thus eliminating wait times for clients seeking mental health case management services. This initiative has been received well by agency clients and has allowed individuals to seek services without the need of an appointment and when they are in most need.	**Performance Improvements:** To best meet client needs, the agency has instituted a same day access model of care that will remain in effect throughout FY18. We remain committed to this model and will monitor wait times for second appointments in the upcoming year to ensure that ongoing services are provided in a seamless fashion.

Effectiveness Objective: Newly opened clients will demonstrate an 80% reduction in hospitalization rate or will maintain 0 hospitalizations. The baseline (measured from 3 months prior to initiation of service to 3 months after initiation of service) will be compared with their hospitalization rate from months 4-9.	**Results:** 90%, met
Recommendations/Action taken: One of the primary goals of case management services is to assist clients with obtaining all the needed supports to be successful in the community and to avoid the costly and often disruptive nature of inpatient psychiatric hospitalizations. These results indicate that remaining in agency services can very strongly reduce the likelihood of experiencing psychiatric hospitalizations. Teams and supervisors will continue to	**Performance Improvements:** A total of 246 clients were opened to case management this period. At nine months post admission to services 121 cases remained active and 108 of them experienced a reduction in hospitalizations or remained at zero hospitalizations. The results also demonstrate that there is a significant percentage of clients (49%) that discontinue services prior to the nine month mark in services which will be a focus in the upcoming

focus efforts on client engagement in services as a part of the overall services provided.	year.

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: Team supervisors have worked closely with case management staff to discuss various ways to engage consumers and to discuss and strategize outreach efforts to maintain client engagement which has yielded some positive client outcomes. Staff discharge clients that chose to decline services and offer the opportunity to return for services via same day access.	**Performance Improvements:** Client engagement in services will remain a focus in the upcoming year across the three case management teams as we have found this to be a critical component in a client's success in their recovery from their serious mental illness.

Consumer Satisfaction Objective: 90% of client responses will be one of the two highest ratings to questions on the satisfaction survey.	**Results:** 96%, met
Recommendations/Action taken: Specific team and individual staff feedback was shared with team supervisors whom in turn shared with individual staff in clinical supervision. In addition to inquiring about client satisfaction with case management services provided consumers were also asked about their interest in a variety of group psycho educational group topics - This feedback was used in planning for upcoming education group offerings.	**Performance Improvements:** This marks the largest number of client satisfaction surveys collected to date. The return rate climbed from 38% last year to 46% this year. The exceedingly positive results remain very encouraging. Teams have found that a client's experience in agency services is central to a client's engagement and often to yielding positive clinical outcomes – Staff will continue to strive to meet or exceed these results in upcoming surveys.

Stakeholder Satisfaction Objective: 90% of HAMHDS prescribers' and ARS Collaborative Services providers' responses will be 1 of 2 highest ratings to questions on satisfaction survey rating CMs and clinicians within CM&A	**Results:** 97%, met
Recommendations/Action taken: Overall results were shared with all Case Management and Assessment staff and individual and team results were shared with team supervisors to share with individual team members during clinical supervision meetings. There was some really good feedback provided that highlighted some very positive collaboration between providers. This partnership and collaboration will remain at the forefront in the upcoming year.	**Performance Improvements:** At total of 67 surveys were collected from agency prescribers, mental health skills building, psychosocial, and residential staff. Collaboration with stakeholders is a key and core component of effective case management services and will remain at the forefront of services provided. Teams will utilize feedback provided to enhance and inform service delivery to maximize client outcomes.

Objectives for the Coming Year

Access - Non crisis clients will be seen within 7 business days of their same day access appointment for ongoing case management and assessment services.

Effectiveness - At least Newly opened clients will demonstrate an 80% reduction in hospitalization rate or will maintain 0 hospitalizations. The baseline (measured from 3 months prior to initiation of service to 3 months after initiation of service) will be compared with their hospitalization rate from months 4-9.

Efficiency - At least 75% of cases will have a minimum of one face to face contact with their case manager every 45 days to maintain engagement in services.

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

Access Objective: Consumers referred for InSTRIDE will be contacted, on average, for an assessment within 7 days of notification of the referral.	**Results:** 3.6 days, met
Recommendations/Action taken: There were 17 new referrals this fiscal year that were opened to the program.	**Performance Improvements:** The ability to exceed this standard continues to be in large part to the flexibility and

The individuals were seen and assessed within an average of 3.6 days. This is a decrease from the previous fiscal years average of 4.4 days and is well below the expectations of 7 days.	willingness of the clinical supervisor and clinician to meet with individuals in the residence, community, and inpatient settings. This allows for a quick turnaround time for assessments and increased access to the program.

Effectiveness Objective: There will be a decrease in the number of hospitalizations from InSTRIDE recipients as compared to the previous year. (per consumer report)	**Results:** 14 to 12, met
Recommendations/Action taken: The improvement in the number of hospitalization continues to demonstrate the ability of the team to work to maintain the individuals in the least restrictive environment. This is done through consistently providing education, support and encouragement as the individuals navigate the system while being new to their mental illness.	**Performance Improvements:** 12 out of the 34 consumers were hospitalized this fiscal year. This is a decrease from the 14 hospitalizations last year. There was also a decrease in bed days from the 1st quarter to the 2nd quarter. The improvement in the number of hospitalization continues to demonstrate the ability of the team to work to maintain the individuals in the least restrictive environment. This is done through consistently providing education, support and encouragement as the individuals navigate the system while being new to their mental illness.

Effectiveness Objective: 100% of consumers will participate at least quarterly in activities within their community such as vocational, educational, or recreational.	**Results:** 85.75%, not met
Recommendations/Action taken: During the next fiscal year team will provide additional opportunities to assist our individuals with community engagement. We will also make more effort in involving their identified family which may also foster a desire to increase socialization.	**Performance Improvements:** There was an overall decrease in engagement this fiscal year. It is important to note that the significant decline in the 4th quarter may be in part to 4 individuals being opened during the last 2 weeks of the quarter and not being in position yet to participate in community based activities.

Efficiency Objective: Program orientation packets, initial assessment, and initial individual service plans will be completed within 30 days on all new referrals to InSTRIDE.	**Results:** 100%, met
Recommendations/Action taken: This objective was met with 100% accuracy as it was last fiscal year. Both the clinical supervisor and the clinician have worked diligently to ensure paperwork is completed by the set deadlines. The team has also been supportive in achieving this objective as they are willing to assist with obtaining information and completing the necessary paperwork with the individual in the event it could not completed during the assessment.	**Performance Improvements:** We will continue to monitor this objective.

Consumer 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 survey questions had 89.5% responses indicating satisfaction, the remaining questions had 86% or lower, not met
Recommendations/Action taken: There was a decrease in the ratings for questions 12-15; which are related to the individual being able to take care of their own needs, do things they want to do and doing things that are meaningful to them. As 100% of our program participants reside with family, it often times presents a challenge for them to make decisions independent of others. This can be developmentally appropriate as the young adult population tends to struggle with exerting independence at this time in their life. For our individuals this can be a little more challenging as their family is working to make sure they are safe and have the ability to function being new to their mental illness. As we enter the next fiscal year the goal will be to provide more support and education to family members so they may be better able to assist our individuals with navigating their independence.	**Performance Improvements:** Just as last fiscal year there were a variety of satisfaction levels from the individuals that completed the survey. The highest rated question continues to be #1. *I like the services I received here.* This is directly related to the hard work the team provides to ensure each individual is receiving the best possible service. They do an excellent job in advocating for the program participants and assisting in learning and understanding about their mental illness. There was also a significant improvement in the question that ranked the lowest last fiscal year #4 *I deal more effectively with daily problems.* Last fiscal year rating was 55% with an increase to 78.5%. Again this is due to the education, modeling and support from the team; assisting each individual with improved functioning in the community.

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:** average rating 2.8%, not met
Recommendations/Action taken: Due to transition with prescribers we were not able to collect surveys throughout the fiscal year. 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:** Out of the 23 surveys collected 1st quarter, there still was a slight improvement from last fiscal year with an average rating of 2.8% 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

Access Objective: There will be an increase in access to health care services experienced by persons receiving PACT/ICT services. Benchmark = 80%	**Results: 64**%, not met
Recommendations/Action taken: An average of 64% of clients accessed healthcare with facilitation by ICT/PACT staff. This is a decrease from FY 2016 which had result of 80%, but 2 quarters of data were irretrievable due to staff change at East PACT. With inclusion of those two quarters, it is expected that the average would be at or near last year's result of 80%. Teams will continue to encourage clients to outreach healthcare when appropriate. Teams will also try to increase use of Daily Planet care through agency which will improve care coordination for consumers.	**Performance Improvements:** The number of clients accessing routine and urgent health care is expected to climb for FY 2017-2018 due to utilization of Daily Planet primary care at HAMHDS sites. Both teams have also been understaffed due to vacancies. When at full capacity, we expect to be able to follow up with clients' healthcare needs more aggressively.

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 = .13	**Results:** .11, met
Recommendations/Action taken: There does not appear to be significant utilization of CSU. There are multiple possible reasons for this. This outcome will be discontinued for next fiscal year.	**Performance Improvements:** Next year's outcome will measure voluntary hospitalizations in attempt to more accurately capture the number of consumers who seek care before they no longer have capacity to consent to care. We theorize that it is more recovery focused and more empowering for people to make these decisions about their treatment while they have capacity to do so.

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:** 56%, not met
Recommendations/Action taken: Last year there was a change made to the East PACT team's process for new referrals. The West was already using a process whereby	**Performance Improvements:** Both teams had 56% compliance with completing opening documents within the 30 day window. While this is a slight improvement over

the supervisor opened all new referrals and completed the paperwork with the client. This had resulted in considerable success in completion of opening paperwork. However, there were significant supervisory staffing changes during this FY for both teams, and the process appears to have suffered.	previous year, there is room for continued improvement. Both ICT and PACT supervisors will monitor opening paperwork deadlines and revisit the process if needed. This outcome is an important marker for our efficiency, and serves the consumer by engaging them in services and identifying treatment needs quickly.

Satisfaction Objective: 72% of consumers will rate their satisfaction with PACT and ICT services a "4" or higher on the PACT/ICT Consumer Satisfaction Survey.	**Results:** 81%, met
Recommendations/Action taken: Last year's Annual Outcome Report suggested collecting surveys at psychiatric appointments. East and West teams will implement this strategy in hopes of achieving greater sample size.	**Performance Improvements:** West ICT did not have data to analyze due to staff turnover and inaccessibility of data. East PACT had an increase in satisfaction from 72% to 81% for this FY. For the upcoming fiscal year we have left this measure as a reflection of consumer's satisfaction with their services.

Stakeholder Satisfaction Objective: 90% of 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.	**Results:** 61%, not met
Recommendations/Action taken: Both teams have brainstormed for ways to increase sample size on this outcome, and have implemented several ideas but with little improvement.	**Performance Improvements:** Teams should continue to attempt to increase sample size. For next FY we have left this measure.

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 more voluntary hospitalization bed days vs. involuntary hospitalization bed days utilized by PACT and ICT service recipients.

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

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:** No vacancies
Recommendations/Action taken: There were no vacancies during this reporting period.	**Performance Improvements:** NA

Effectiveness Objective: There will be improved relationships between the residents as evidenced by a decrease in peer complaints.	**Results:** 62% reduction, met
Recommendations/Action taken: This is a new outcome for residential services. Our first quarter information was used as baseline information for the remaining three quarters. The three preceding quarters showed a decrease in complaints compared to the first quarter. The annual result showed a 62% decrease in resident to resident complaints. The complaints mainly centered on one resident and included behaviors, such as asking others for cigarettes, being rude, or invading others' personal space. All of these issues were addressed on the person's individual service plan with mixed results.	**Performance Improvements:** The majority of complaints centered on one resident. The issues identified were addressed on the person's individual service plan with mixed results. Throughout the reporting period staff provided guidance, direction, and support to the individual to decrease problematic behaviors.

Throughout the reporting period staff provided guidance, direction, and support to the individual to decrease problematic behaviors.	

Effectiveness Objective: 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.	**Results:** 4.6 hours, not met
Recommendations/Action taken: 3 residents that completed the Home Safety Evaluation Checklist were intermittently able to stay home unsupervised. 1 resident did well until the 3rd quarter when she stole cigarettes from 2 fellow residents when home unsupervised. This resident went into the staff area and took the file cabinet key to where the residents' cigarettes are stored. All keys are now locked in a combination lock box so they are inaccessible to the residents. This resident was re-evaluated after 30 days and was able to resume staying home with no other incident. We also learned that due to staffs' schedule it was difficult to have a full 7 hours when the residents could stay home unsupervised. We did have one steady resident who was able to stay home unsupervised two days a week. Staff will continue to promote independence and all three residents will continue to be evaluated for safety and ability to remain home unsupervised.	**Performance Improvements:** 2/4 quarters, 3/5 residents stayed home unsupervised for an average of 4.6 hours, objective not met. The ability to stay home was fluid and often based on whether they were experiencing symptoms of their illness or exhibiting unsafe behaviors. To ensure the safety of the residents when home unsupervised the following procedure was implemented: 1. Staff provided the residents with ESP and the on-call supervisor phone number with instructions to call the on-call supervisor once in a four hour period to check-in or in any time of need. 2. Staff placed all keys in a lock box to have them inaccessible to the residents.

Efficiency Objective: 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.	**Results:** 95%, met
Recommendations/Action taken: Staff received positive feedback for their effort in keeping them abreast of the person's progress, needs, issues, etc. Toward the end of the reporting period some family members no longer felt a need to be contacted monthly. Staff will maintain regular contact with family/legal guardian.	**Performance Improvements:** During this reporting period staff was successful in maintaining monthly contact with the family/legal guardian 95% of the time. No improvements were needed.

Consumer Satisfaction Objective: Four out of five residents will respond with an 8-10 rating to focus group survey questions.	**Results:** 3/5, not met
Recommendations/Action taken: A focus group was conducted during the first quarter with the residents to gather their input and information on how services can be improved. A follow-up satisfaction survey based on the focus group was administered during the third quarter. The questions measured the following: comfort level of living at Walton Farms, satisfaction with the community outings, relationship with fellow housemates, satisfaction with the sharing of household chores, and level of help received from Walton Farms' staff. We met the objective of 4/5 residents rating each question with an eight or above, with the exception of question three which measured the satisfaction level of the relationship they have with one another, three residents rated a 10 with two rating a 7. In general the residents interact well with another but there were times when conflicts occurred. The conflicts mainly involve the same resident. Staff intervened and provided the appropriate supports during times of conflict among the residents. The questions for the next consumer satisfaction survey will be based from the focus group.	**Performance Improvements:** In an effort to improve the residents' satisfaction with living at Walton Farm we tracked the number of resident to resident complaints as stated under objective two. The goal of objective two was to improve relationships among the residents, which is the area that was rated the lowest on the satisfaction survey.

Stakeholder Satisfaction Objective: 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.	**Results:** 3/3, met
Recommendations/Action taken: During the first quarter a letter along with a satisfaction survey was sent to family members/legal guardian of those living at Walton Farms group home. The purpose of the initial survey was to gather information that could be used to improve services and communication. During the third quarter a follow-up satisfaction survey was mailed with 3/5 returned. The three returned rated their satisfaction level with a nine or ten on all survey questions.	**Performance Improvements:** The questions addressed the following: satisfaction of communication between them and residential staff, the responsiveness of residential staff to their questions or concerns, satisfaction level of residential services, and would they recommend the program to others, which all stated yes. The stakeholder satisfaction for the next reporting period will include the residents' primary case manager.

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 - The residents' health and wellness will improve as evidenced by their weight loss
Efficiency - There will be improved coordination of the residents' health care needs as evidenced by residential staff communicating weekly updates to the Group Home Supervisor.
Consumer Satisfaction - Four out of five residents will respond with an 8-10 rating to focus group survey questions.
Stakeholder Satisfaction- The residents' Case Manager will respond with an 8-10 rating on all survey questions.

MH SKILLS BUILDING OUTCOMES

Access Objective: MHSS will open 80% of referrals within 7 days of referral from case manager.	**Results:** 45%, not met
Recommendations/Action taken: MHSS opened 20 consumers this past fiscal year with 9 consumers being opened within 7 days of referral which means that 45% of referrals were opened within 7 days compared to 44% for FY16. We continue to believe that it is best practice for MHSS specialists to attend the initial assessments, so that that coordination of care with case management is initiated.	**Performance Improvements:** MHSS specialist will continue to keep their outlook schedules current so that referring case manager can quickly schedule initial assessments.

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:** 50%, met
Recommendations/Action taken: In this past fiscal year, a total of 32 consumers were discharged from MHSS with 16 of these discharges considered successful which means that 50% of the consumers discharged from MHSS this past year completed treatment with no referral being made. Since this objective was achieved for this fiscal year and for the previous year (33%), this objective will again be tracked and measured for the next fiscal year with target measure being increased to 50%.	**Performance Improvements:** Use information learned during tracking of this goal to continue to meet objective.

Efficiency Objective: MHSS staff will document monthly collateral contacts 90% of the time.	**Results:** 91%, met
Recommendations/Action taken: For a second consecutive year, this objective was achieved. MHSS supervisors provided monthly prompts to staff to complete collateral contact notes. These prompts helped us achieve this goal. Since this goal was met, MHSS supervisors will no longer send monthly reminders to staff; however, MHSS supervisor will continue to track collateral contacts.	**Performance Improvements:** Continue to monitor to ensure appropriate documentation occurs.

Satisfaction Objective: 90% of consumers will respond positively to each survey question as evidenced by a score	**Results:** 78%, not met

of 8 or higher for every question.	
Recommendations/Action taken: These improvements in outcomes could be attributable to staff becoming more recovery oriented in their clinical work. MHSS has been focused on empowering consumers to be volunteers, and encouraged consumers to develop their own peer led support group.	**Performance Improvements:** While this objective was not achieved this year, overall results did exceed last year's results by seven percentage point (78% versus 71%), and in terms of consumers' self-perception of progress where results increased by 5 percentage points (56% versus 51%). To continue to work with staff on promoting consumer recovery.

Satisfaction Objective: 80% of ARS case manager responses will be in the excellent range (8-10).	**Results:** 87%, met
Recommendations/Action taken: We continue to exceed our goal. 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. MHSS is viewed as responding in a timely manner (100%), being collaborative (97%), having monthly contact (95%), being recovery-focused (87%) and consumer improvement (54%). While this is a decrease from last year, case manager comments were all positive, and did not provide explanation as to the decrease in rating.	**Performance Improvements:** This objective was achieved. 87% of case manager responses on the stakeholder survey were an 8 or higher. Thirty-nine surveys were returned this year which interestingly enough was the exact same number returned last year. MHSS supervisors will request feedback from case managers in order to obtain helpful information that can be used to improve services.

Objectives for the Coming Year
Access - MHSS will open 80% of referrals within 7 days of referral from case manager.
Effectiveness - 50% of all consumers, who have weight loss as a goal, will have lost some weight.
Effectiveness - 50% 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.
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 18.	**Results:** increased by 22, met
Recommendations/Action taken: The goal of eighteen was surpassed as twenty-two participants were enrolled in vocational services this reporting period. Information will continue to be shared with the vocational team. Vocational staff will continue to participate in case management team meetings where vocational questions will be answered and updates on employed clients will be provided.	**Performance Improvements:** The team will continue to work towards increasing the number of clients that receive vocational services through outreach to both staff and clients.

Effectiveness Objective: Staff will assist program participants with obtaining twenty-two additional jobs during the evaluation period.	**Results:** 23, met
Recommendations/Action taken: Slower numbers were noted in the 1st and 3rd quarters, while the 4th quarter demonstrated a significant increase. Staff will continue to be creative with job development techniques and encourage clients to complete applications in a timely manner.	**Performance Improvements:** Staff will continue to meet with perspective employers and clients. Also, staff will increase involvement with job fairs. In addition, program participants and potential clients are encouraged to attend weekly Job Club meetings.

Efficiency Objective: Full time job coaches will reach at least fifty direct service hours monthly.	**Results:** 46%, not met
Recommendations/Action taken: The program fell slightly short with this goal. We will continue to strive for increasing staff presence in the community and less time in the office. Although the agency has moved away from measuring	**Performance Improvements:** Staff will use the scheduler to ensure better time management. Job training has been on the decline due to employers being reluctant to have non-employers in buildings. Staff has been counseled on

direct service as a goal, the team agrees in maintaining records of time spent in this area of vocational services.	increasing job development through more cold calling and employer research as recommended by the IPS model.

Satisfaction Objective: 90% of responding program participants will score a rating of at least "8" satisfaction level on a scale of 0 to10.	**Results:** 91%, met
Recommendations/Action taken: The survey method of customer satisfaction tends to have attracted more feedback that the previously used focus group. We will continue to use the anonymous survey and look at ways to improve upon the process. Some of the comments are listed below: • more community events (movies, job fairs, dinners) • changing locations (east vs. west)	**Performance Improvements:** Staff will continue to engage clients in conversations that will address satisfaction with both their employment experiences and staff as a whole. We continue to look at ways that would improve on program effectiveness. The current survey will be revised to ask more effective questions. Also, we will reschedule if weather affects attendance in the future.

Satisfaction Objective: 90% of responding employers will score a rating of at least "8" satisfaction level on a scale of 0 to 10.	**Results:** 96%, met
Recommendations/Action taken: We have struggled with finding ways to attract employers as their opinions are valuable. Recent Employer Recognition events have bolstered some feedback. We understand there is a delicate balance between the information that we seek and not infringing upon their professional and personal time.	**Performance Improvements:** We will continue to solicit feedback for employers in order to improve our image and increase job opportunities for those that we serve. The survey format will be changed in upcoming year to include more questions that would provide program improvement ideas.

Objectives for the Coming Year:
Access - Each full time job coach will develop twenty-four new employer contacts monthly.
Effectiveness - time job coaches will average at least fifty direct service hours monthly
Efficiency – increase the number of participants that received employment services by eighteen.
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
Recommendations/Action taken: There were a total of 63 new admissions for FY17. Youth continue to be admitted to the program based on capacity	**Performance Improvements:** During the past year there was no waiting period for any Connect sites and youth were approved at the time of registration. Community-based access facilitated youth starting participation in the program immediately. Prevention Services met this objective for the year

Effectiveness Objective: 95% of CONNECT of 1st – 3rd grade participants shall be reading on or above grade level.	**Results:** 64%, not met
Recommendations/Action taken: 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 the overall educational experience. Additionally, a variety of community partners also provide enrichment activities that support Connect objectives. Research confirms that reading skills are paramount to academic success and instrumental in reducing multiple risk factors. Prevention Services is committed to continuing its focus on reading skills and overall academic success in its efforts to promote the healthy social-emotional development of youth.	**Performance Improvements:** The Connect program made marginal progress toward achieving its academic goal. Several factors impacted this Connect program outcome. The challenge of part-time staff shortages in Connect continues, and the turn-over among part-time staff remained high. One program transitioned back to an apartment community setting and experienced numerous staffing challenges. Additionally, Connect experienced a large influx of new admissions of which more than half were early elementary age. New mandates from DBHDS also competed with Connect programming. Interns from area colleges and universities, supervised by Prevention staff, continued to supplement staffing

	shortages.

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
Recommendations/Action taken: HCPS currently administers the Life Skills Training (LST) curriculum in all middle school PE classes. Connect will discontinue the curriculum for MS youth in FY18 and focus its efforts on LST with the elementary youth.	**Performance Improvements:** Improve fidelity of implementation.

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 a media campaign and merchant education activities annually.	**Results:** 96%, met
Recommendations/Action taken: Continue to monitor MH/SU issues that compromise community wellness and collaborate with community partners to develop/implement strategies to address identified issues.	**Performance Improvements:** Continue raising community awareness and capacity building with community to promote prevention and behavioral health wellness.

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:** 85.5%, met
Recommendations/Action taken: Satisfaction Surveys are conducted in the fall and spring with Connect Program participants 3rd grade and above at the four existing sites. This year one program transitioned from a school site back into an apartment community setting.	**Performance Improvements:** Favorable participant rating of Connect's benefits rose from 76% to 85.51% from fall to spring. The fall response may in part be attributed to the large number of new admissions this year. Approximately 15% (14.5) of youth were unsure and none disagreed that the program is beneficial. Favorable comments focused on positive relationships with staff, skill building, and other enrichment opportunities afforded by Connect. Participants' critical comments primarily focused on the meals, the desire for more fieldtrips and the lack of certain amenities (more computers, the space).

Satisfaction Objective: 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree) on the satisfaction survey	**Results:** 96%, met
Recommendations/Action taken: Engage more community stakeholders in the evaluation of the Connect program. Integrate parent and community feedback into program planning, where feasible.	**Performance Improvements:** Continue to expand Connect activities to engage the larger community where fiscally feasible.

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 - 90% 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 minimum of 2; community-level events, social norms 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:** 100%, met
Recommendations/Action taken: The agency has made a significant shift in how services are accessed, all Youth and Family Services are accessed through same day access.	**Performance Improvements:** No wait for clients to access Youth and Family Services.

Effectiveness Objective: Youth &Family Services Outpatient clinicians will see their clients within 14 days of their Initial session 90% of the time.	**Results:** 100%, met
Recommendations/Action taken: The agency has made a significant shift in how services are accessed; all Youth and Family Services are accessed through same day access.	**Performance Improvements:** No wait for clients to access Youth and Family Services.

Efficiency Objective: 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.	**Results:** 61%, met
Recommendations/Action taken: Same day access has helped to identify clients for case management services and assign them to the correct subunit from intake. Clinical staff are being clearer about what is a case management service and separating that out from their therapy sessions.	**Performance Improvements:** Over the reporting year, the engagement percentages have increased from 51% to 61%, meeting our goal. We will continue with our current plan of action as there has been a steady increase in engagement.

Effectiveness Objective: Reoffending rates will remain at or below 10% for MST clients during treatment.	**Results:** 61%, met
Recommendations/Action taken: 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 well, as well as a renewed focus on linking youth with prosocial activities (for the year 68% of clients were linked with prosocial activities or peers at time of discharge).	**Performance Improvements:** The overall reoffending rate for FY17 was below the target goal of 10%. Program census increased as the year progressed as well, with caseloads being full at the end of the fiscal year. The increase in caseloads was a result of an intensified partnership with the court services unit. The increased communication and collaboration with CSU staff likely had a positive impact on keeping youth and families together in the community.

Objectives for the Coming Year
Effectiveness - Youth &Family Services Outpatient clinicians will see their clients within 10 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

Access Objective: For individuals 18 and over interest in employment will be discussed at the time of the annual meeting 90% of the time	**Results:** 99%. met
Recommendations/Action taken: After the end of the second quarter discussion with case managers included the age range for employment discussions and circumstances when those discussions might not happen.	**Performance Improvements:** Continue current practice to encourage employment. . 429 of 432 met the measure.

Effectiveness Objective: Discussions about community engagement opportunities will occur at the time of the annual meeting 100% of the time	**Results:** 100%, met
Recommendations/Action taken: None	**Performance Improvements:** Next year's outcomes to include community engagement and coaching opportunities specific to those DD Waiver services as a

	part of the Waiver Re-design.

Effectiveness Objective: 86% Individuals receiving enhanced developmental case management services will receive at least one face-to-face contact per month.	**Results:** 82%, not met
Recommendations/Action taken: Began receiving reports on Enhanced Case Management status each month.	**Performance Improvements:** 563 of 684 met the measure. Carry over this outcome to next year and continue to review reports and discuss with case managers to insure that individuals are in the correct status for Enhanced Case Management..

Effectiveness Objective: 84% 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.	**Results:** 64%, not met
Recommendations/Action taken: Staff were reminded to use only "Consumer Residence" as the location code when a face to face contact is done in the individual's home.	**Performance Improvements:** 361 of 563 met this measure. Carry over this outcome and share reports and codes used with case management staff each quarter for individuals who meet enhanced case management criteria.

Effectiveness Objective: 99% of Multi Service Progress Notes will be final approved within 5 days of opening.	**Results: 85**%, not met
Recommendations/Action taken: Supervisors run reports and share with case management staff.	**Performance Improvements:** 14,303 of 16,840 met this measure. Reports will be run monthly and results shared with staff.

Objectives for the Coming Year 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

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: 96**%, not met
Recommendations/Action taken: Of the 24 referrals we received this year, all but one was contacted for an assessment within the 20 days. The one that was not, was contacted within 30 days. There are no recommendations for changing our process at this time.	**Performance Improvements:** 23 of 24 met this measure. Supervisors will continue to work with Case Managers to discuss possible referrals and identify needs prior to the actual referral. This will ensure they are being referred for the right program and that we can provide a tour if possible prior to a decision on whether to send the referral. Once referrals are received, the person or their family will be contacted to set assessment dates.

Effectiveness Objective: For OES: 90% of non-waiver individuals will have an employment goal in their ISP	**Results:** 68%, not met
Recommendations/Action taken: We will continue to monitor those who are not waiver, who are in the center-based programs and ensure that if they want to work, they have the opportunity to work. There were no differences between the programs, so the data is presented in a congregate manner.	**Performance Improvements:** While we did not meet our desired percentage, it was clear in reviewing plans that individuals are working when they want and if they want. We have more individuals interested in community outings and in retirement activities than we anticipated. We are developing a program that will concentrate on retirement and we will also be increasing the access to community integration activities across all programs.

Effectiveness Objective: For COI: 50% of the waiver individuals will have an employment goal in their ISP.	**Results:** 40%, not met

Recommendations/Action taken: Those individuals who want to explore work have an outcome in their plans. Those who did not are usually of retirement age and have indicated they would like to retire or those who have shown no interest in working. The LEP area had a much higher percentage of those not interested in working (almost 90%), while those in the Vocational and STEP program had a much lower percentage not interested in work (closer to 50%).	**Performance Improvements:** Those who are on waiver who want to work or explore work was a little lower than anticipated, but with the large number of individuals who are in their 50's and 60's, their interests have become more focused on community and on retirement. In response, we are developing a retirement focused program and will be concentrating on increasing options for community integration in all programs.

Efficiency Objective: 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.	**Results:** 80%, not met
Recommendations/Action taken: We have continued to refine and learn how to improve documentation for our Waiver programs. The staff has shown steady improvement in our note taking. Further training will be occurring which the supervisors will attend. Then training with staff will continue.	**Performance Improvements:** While we did not meet our goal of 95%, there has been a steady improvement in the quality of the notes as we have implemented the new services under the waiver. For the next year, we will incorporate reviews into our regularly scheduled utilization reviews and continue efforts to receive training from the State and pass on that training to staff.

Consumer 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:** 95%, met
Recommendations/Action taken: With the majority in all programs with strong positive responses, we will continue to add community activities and explore more work options, which are the two things the majority said they would like to see more of or that they enjoy the most.	**Performance Improvements:** Based on the responses to the surveys, we will continue to listen to consumer suggestions at meetings and to expand the options we offer in both community activities and in work within and outside the center.

Stakeholder Satisfaction Objective: 90% of the Case Managers will respond positively to their satisfaction on a survey.	**Results:** 86%, not met
Recommendations/Action taken: Based on responses, it is clear that some case managers are not fully familiar with what we do so we will continue to work with case managers to help them understand the various services we provide and communicate with them quickly and in detail.	**Performance Improvements:** 6 of 7 met this measure. With an 86% satisfaction rate, it is clear we are meeting the needs of most consumers. We will continue to look at the types of activities we do in the center when there is no work. We will work to find activities that the individuals want to do and will therefore keep them engaged and active. Find more community based activities and evaluate how we can increase/enhance these activities for all. In addition, it is important to continue to explore and build our work options for all individuals.

Objectives for the Coming Year

Access - All programs: 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: Increase the number of community activities by 30% from the first quarter to the fourth quarter.
Effectiveness - For COI: Will increase the number of community activity hours to no less than 50% of the authorized hours for the Community Engagement/Coaching services by the end of the year.
Effectiveness - For Older Adults/Dementia Care: Two new activities will be developed and introduced (either community or center based) to the older adults in the LEP area each quarter.
Efficiency - For OES: 95% of the elements reviewed will be met for the data collection section of the quality review.
Efficiency - For COI: 95% of the elements reviewed will be met for the data collection section of the quality review for all individuals enrolled in waiver services.
Efficiency - For Older Adults/Dementia Care: LEP staff will receive training on older adults or dementia care each quarter to enhance their knowledge and skills in these areas.
Consumer Satisfaction - 90% of the individuals served will respond with a positive response (always or almost always) when asked if they are satisfied with the activities they have been offered

Stakeholder Satisfaction - 90% of the Caregivers/Family members will respond with a positive response to the question about satisfaction with the programs offered through Employment and Day Services

CSS GROUP AND INDIVIDUAL SUPPORTED EMPLOYMENT OUTCOMES

Access Objective: 100% of individuals will be contacted by the employment specialist within 10 days of assignment from the supervisor.	**Results: 67**%, not met
Recommendations/Action taken: There were 15 referrals that resulted in individuals choosing our services. Of those 15, we were able to contact 10 or 67% within a 10 day period of time. We will continue to reach out to individuals and try to set up our first contact within those 10 days.	**Performance Improvements:** Staff will be reminded on different options to connect with individuals if they are not able to reach them right away. At a minimum, continual efforts to reach the individual will demonstrate responsiveness and our willingness to work with them on their job search.

Effectiveness Objective: Development and implement 6 informational sessions for consumers regarding alternative work options and /or exposure to non-traditional jobs. Note: non- traditional means not in food service, janitorial or retail.	**Results:** 3 sessions held, not met
Recommendations/Action taken: This outcome was developed to assist individuals who had struggled with finding employment; the intention was to broaden their thinking around job placement and assist them in locating a job of their choice. Of the initial targeted individuals, they either got jobs or chose to discontinue the job search process.	**Performance Improvements:** 50% of the sessions held; all participants who were targeted either got jobs or dropped out of job search. Efforts will continue to be made in expanding the knowledge of individuals around the types of work that might be open to them. Staff have received training on customized employment and may use some of these techniques. Job fairs, employment discussions and other person-centered discussions will also be used to help expand opportunities for the people we serve.

Efficiency Objective: 30% of those who attend the informational sessions will find a job by June 30, 2017.	**Results:** 60%, met
Recommendations/Action taken: While there were only 3 sessions rather than 6, the five individuals who were targeted made some improvements. 3 of 5 or 60% got jobs. Of the two that did not, one choose not to pursue work and the other decided that these classroom type activities were not for her.	**Performance Improvements:** Employment specialists will be offered opportunities for training to enhance their tool boxes on helping individuals get and prepare for jobs.

Consumer 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:** 100%, met
Recommendations/Action taken: No suggestions were made for improvement in either Group or Individual Supported Employment. Staff were seen in a positive light.	**Performance Improvements:** We will continue to look at ways to be more effective in job development and in providing efficient services. Based on feedback from our consumers, we should do more of what we already do.

Stakeholder Satisfaction Objective: 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.	**Results:** 100%, met
Recommendations/Action taken: Satisfaction was high despite the small number of responses. We will continue to provide excellent customer service.	**Performance Improvements:** Improvement suggestion was to expand options. Ensuring person-centered job development will be a focus over the next year, as well as continued efforts in providing best practices in both Group and Individual Supported Employment.

Objectives for the Coming Year Access - Individuals will be contacted by the employment specialist within 10 days of assignment from the supervisor. Effectiveness - Find jobs of choice for 90% of the targeted demographic (young adults ages 18 to 25) within 6 months of first appointment. Efficiency - Hold at least one outreach event for the target demographic (young adults ages 18 to 25) in coordination with

schools and /or DARS to educate about competitive integrated employment and market our provider services. Consumer Satisfaction - 90% of the individuals served will respond with a positive response (always or almost always) when asked if they are satisfied with the activities they have been offered. Stakeholder Satisfaction - 90% of the Caregivers/Family members will respond with a positive response to the question about satisfaction with the Group or Individual Supported Employment Services.

CSS INTAKE OUTCOMES

Access Objective: 100% 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: Staff will continue to offer 6-7 slots per week and monitor the intake phone line when not doing intakes.	**Performance Improvements:** Only met criteria in October and November 2016. No recommended changes at this time since there is still an element that is beyond our control with the DDCM providers. During this past year we have not had a chance to see what our current slots vs. incoming individuals would truly look like.

Access Objective: Individuals currently residing at SEVTC (1) and CVTC (3) will be tracked as they successfully discharge to the community or transfer to another facility by 6/30/20.	**Results:** 1 discharge, met
Recommendations/Action taken: During this annual year, one individual transitioned into the community from CVTC and another transitioned to SEVTC, as the family has refused community placement.	**Performance Improvements:** Discontinued as an outcome measure in 2018.

Objectives for the Coming Year: 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

Effectiveness Objective: 90% residents will participate in at least 2 community inclusion activities of choice per month	**Results:** 91%, met
Recommendations/Action taken: Recommend to continue this outcome and maintain current outcome percentage. Several of our residents are dealing with aging symptoms (forms of dementia and other ailments) that cause them to be less eager occasionally to participate in community activities, will continue to encourage residents to participate in activities of their choice in their community.	**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.

Effectiveness Objective: 50% of the overall 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.	**Results:** 26%, not met
Recommendations/Action taken: This outcome will be discontinued do to very few of the residents were willing to fully participate.	**Performance Improvements:** As for the weight loss over the course of the year there was 12/19 (63%) whose weight had decreased this year. The HAMHDS group homes had 26% (5/19) of its residents to lose 12 pounds between June 2016 and June 2017.

Effectiveness Objective: HAMHDS Residential clients will be supported in improving their health by measuring metabolic labs and recording positive changes for 100% of residents each quarter.	**Results:** 68%, not met
Recommendations/Action taken: Collection of data occurred at physician visits. It was determined that this goal was outside of the control of the Residential program's control with limited data collection and scope of data available during reporting periods.	**Performance Improvements:** By the end of March 2017, the residential program had 68% of the clients who had a decrease in their blood pressure. No client had a significant decrease in their blood pressure readings. Most of the decreases were one point lower that their starting systolic blood pressure reading.

Objectives for the Coming Year:
Effectiveness - 90% residents will participate in at least 2 community inclusion activities of choice per month. Effectiveness - 60% of the residents will connect/join a volunteer organization of their choice during the 1st quarter of this outcome year. Effectiveness - 30% of residents will participate in a volunteer activity the 2nd, 3rd and 4th quarter.

PARENT INFANT PROGRAM OUTCOMES

Access Objective: The Infant and Toddler Connection of Henrico will meet or exceed the December 1 child count of 44 determined by the Part C office.	**Results:** 56, met
Recommendations/Action taken: The infant program attributes this accomplishment to the ongoing collaborations with NICU and community partners. In the up and coming year, we will specifically target the Henrico Doctor's NICU to expand the relationship. Additionally, we plan to implement standard processes for all NICU referrals to the system.	**Performance Improvements:** The Infant and Toddler Connection of Henrico Area exceeded its child count. 56 infants between 0-1 were in the system on December 1st.

Effectiveness Objective: 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.	**Resul1ts:** 3 transitions, met
Recommendations/Action taken: The collaboration between PIP and Part B services has improved this year. Conferences have allowed parents the opportunity to meet with Part B to ask questions regarding their child's transition. We are looking at having 4 conferences. We will work with the schools to provide parents the opportunities to meet with families individually.	**Performance Improvements:** Goal was met by 3rd quarter. PIP will provide 4 transition conferences as well as collaborate with the schools to schedule individual conferences as requested by the family.

Efficiency Objective: 100% of children will be discharged from ITOTS no later than 1 day before their third birthday.	**Results:** 100%, met
Recommendations/Action taken: We contribute this success to a new procedure that was implemented. A report is run in ITOT's biweekly and the names of children that are aging out are given to the Service Coordinators. The Service Coordinators submit the ITOT's forms to be discharged prior to the child's 3rd birthday.	**Performance Improvements**: Discharges occur before the children's 3rd birthday, families are linked to appropriate services as needed timely.

Objectives for the Coming Year
Access - The Parent Infant Program will increase the 0-1 child count (baseline 60). Effectiveness - Individuals receiving targeted case management services will receive at least one face-to-face contact per month. Efficiency - The Infant and Toddler Connection of Henrico Area will conduct 3 individual transition conference meetings in collaboration with Henrico Part B Preschool Special Education Program this fiscal year.

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

Performance targets are set by the DBHDS and the Secretary for all 40 of the State's Community Service Boards. The data used is submitted monthly by CSBs as outlined in the State's performance contract with CSBs. HAMHDS met 9 of the established targets. Two of the five Behavioral Health Quality targets were met. MH Engagement, SA Engagement, and SA Retention did not meet established targets. Continued research into these measures showed consumers remained engaged each month after admission but total services hours did not meet the established benchmarks of 4 hours in the 90 days following a MH admission or 2.25 hours in the 30 days following an SA admission.

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

Behavioral Health Quality Measures AIM IS TO BE ABOVE TARGET	target	FY16Q3	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
Intensity of engagement in adult mental health case management	68%	72%	77%	79%	77%	81%	78%
Intensity of engagement in adult substance abuse outpatient services	63%	78%	77%	77%	76%	77%	78%
Intensity of engagement in child mental health case management	73%	45%	45%	51%	53%	56%	61%
Retention in community substance abuse services (adult and youth) **3 months**	60%	52%	52%	51%	50%	50%	50%
Retention in community substance abuse services (adult and youth) **6 months**	26%	20%	21%	22%	22%	23%	22%
Bed Utilization Measures AIM IS TO BE BELOW TARGET							
Adult Civil TDO Admissions per 100k pop	5	2	4	6	6	3	9
Adult Forensic TDO Admissions Per 100k pop	1	1	0	1	1	1	1
Hospital Bed Utilization per 100k pop – Civil TDO Admissions	294	60	153	170	166	161	279
Hospital Bed Utilization per 100k pop – Forensic TDO	51	44	43	59	83	44	52
Hospital Bed Utilization per 100k pop – Civil Legal Status	1070	431	610	575	516	492	662
Hospital Bed Utilization per 100k pop – Forensic Legal Status	606	372	408	467	395	422	468
State Hospital Measure AIM IS TO BE BELOW TARGET							
Forensic state hospital bed utilization (Central)	31%	33%	34%	34%	34%	35%	35%
Developmental Quality Measures AIM IS TO BE ABOVE TARGET							
Percent receiving face-to-face Developmental Case Management services	90%	73%	81%	62%	70%	61%	74%
Percent receiving in-home Developmental Case Management services	90%	93%	84%	75%	78%	79%	85%
Health and Well Being Goal Measure	84%	95%	95%	94%	94%	98%	86%
Community Inclusion Goal Measure	84%	94%	94%	93%	94%	98%	85%
Choice and Self-Determination Goal Measure	84%	94%	94%	94%	95%	99%	86%
Living Arrangement Stability Measure	84%	97%	96%	95%	95%	99%	86%
Day Activity Stability Measure	84%	97%	96%	94%	94%	98%	86%
Training Center Measure AIM IS TO BE BELOW TARGET							
Training Center Census	-1.0%	-2.1%	-2.2%	-0.9%	-3.0%	-1.0%	-2.0%

SA Retention was difficult to meet due to shorter treatment program durations. Five of the seven Developmental Quality targets were met. These targets were challenging state wide. Delivering Enhanced Case Management face-to-face and in-home services were difficult to meet with increased caseloads and increased documentation requirements. 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 may be adopted and become a program outcome so that trends and development areas be identified and pursued. For the coming year DBHDS announced the collection of new data and measures for FY18; the VACSB and DBHDS Quality and Outcomes Committee approved these measures.

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, 2016 through March 31, 2017.

During this fiscal year, ten separate services were tracked. A total of 284 surveys were mailed and 22 were returned. The response rate for programs ranged from 0% to 29% with an average response rate for all of the CARF services of 8%, up from the response rate of 7% for FY16. Individual comments are forwarded to the respective program.

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

FY2017 ANNUAL POST DISCHARGE REPORT

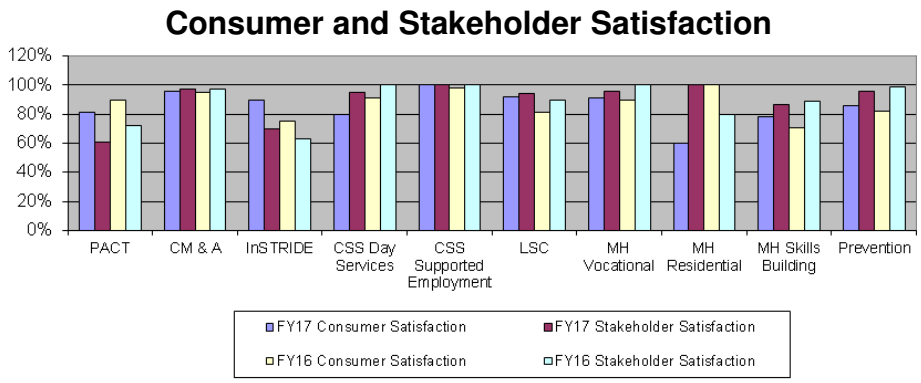
Unit	SubUnit	HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Discharges by Program (Apr 2016 - Mar 2017)																
1300	HCE1,HCPF,HCW1&2	CM&A	MH Case Management	10	8	22	9	21	17	16	15	12	15	20	21	186
1301	HACF,HACW,HYAR	PACT	Assertive Community Treatment	3	2	4	1	1	0	1	1	1	1	1	3	19
1302	HDLH	MH Day Support	MH Community Integration	4	2	2	0	3	0	2	0	4	0	4	2	23
1303	HRTO	MH Residential	MH Community Housing	0	0	0	0	0	0	0	0	0	0	0	0	0
1304	HSEL	MH Vocational	MH Community Employment	1	0	1	4	0	0	1	0	2	0	1	2	12
1306	HSSW, HSSE, HSSP	MH Supported Svcs	MH Supported Living	1	1	1	3	1	5	0	1	4	3	1	1	22
2001	RDST,RDEP,RDNW	LEP	ID Community Integration	0	0	0	0	0	1	1	0	2	0	0	0	4
2002	RSEU	ID Supp Employ	ID Community Employment	0	0	0	1	1	3	0	0	2	0	1	1	9
2007, 2008	RDSH, RDSC, RDSP, RDHE, RDCY	Sheltered Employ	ID Organizational Employment	1	0	2	0	2	1	0	0	0	1	0	0	7
2008	RSGE, RSGH, RSGW, RDEN	ID Group Supp Empl	ID Community Employment	0	0	0	0	0	2	0	0	0	0	0	0	2
Total				**20**	**13**	**32**	**18**	**29**	**29**	**21**	**17**	**27**	**20**	**28**	**30**	**284**

Unit	SubUnit	HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Response Rate%
Survey Response Rates (Apr 2016 - Mar 2017)																	
1300	HCE1,HCPF,HCW1&2	CM&A	MH Case Management	2				1		1		1		2	3	10	5%
1301	HACF,HACW,HYAR	PACT	Assertive Community Treatment		1											1	5%
1302	HDLH	MH Day Support	MH Community Integration	2						1					1	4	17%
1303	HRTO	MH Residential	MH Community Housing													0	0%
1304	HSEL	MH Vocational	MH Community Employment	1												1	8%
1306	HSSW, HSSE, HSSP	MH Supported Svcs	MH Supported Living				1		1					1		3	14%
2001	RDST,RDEP,RDNW	LEP	ID Community Integration													0	0%
2002	RSEU	ID Supp Employ	ID Community Employment									1				1	11%
2007, 2008	RDSH, RDSC, RDSP, RDHE, RDCY	Sheltered Employ	ID Organizational Employment	1		1										2	29%
2008	RSGE, RSGH, RSGW, RDEN	ID Group Supp Empl	ID Community Employment													0	0%
Total				**6**	**1**	**1**	**1**	**1**	**1**	**2**	**0**	**2**	**0**	**3**	**4**	**22**	**8%**
Response Rate				**30%**	**8%**	**3%**	**6%**	**3%**	**3%**	**10%**	**0%**	**7%**	**0%**	**11%**	**13%**	**8%**	

SATISFACTION

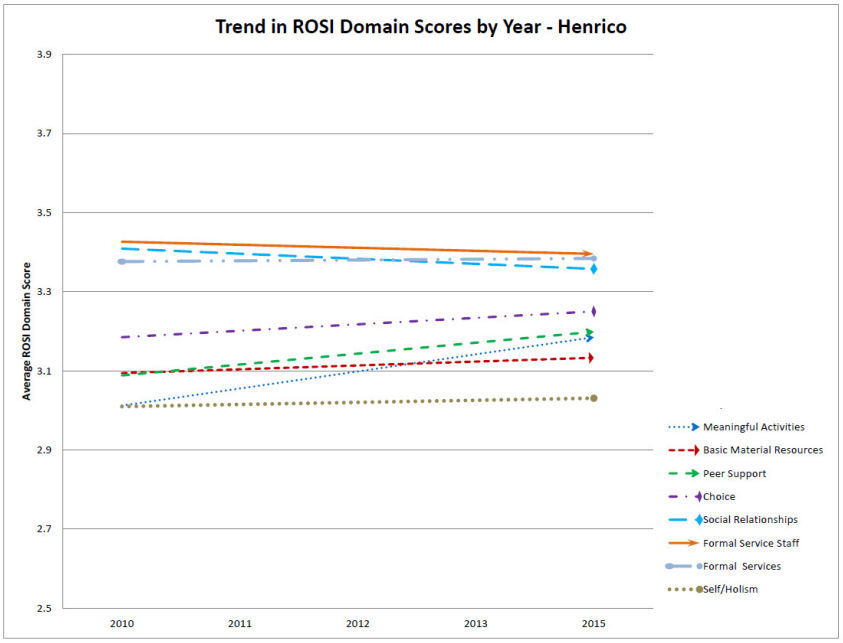
Agency Satisfaction Survey

HAMHDS directly conducted Consumer and Stakeholder satisfaction surveys in CARF programs. Results below indicate all responders report a satisfaction rate with services between 61% to 100%, with the majority of responses indicating at or above 86%. Seven programs demonstrated an increase in consumer satisfaction ratings, and three programs demonstrated an increase in stakeholder satisfaction.



Recovery Oriented System Indicators (ROSI) Survey

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) 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

Approximately 550 quality record reviews and 100 Administrative Reviews were completed in FY 2017. MH/SA reviews included 7% Medicaid cases and 3% non-Medicaid cases. Half of the MH/SA programs had 90% or greater compliance with standards reviewed (ESP, Youth & Family, Outpatient, Skills-Building & Residential). This was a decrease from last year with several programs falling in compliance (Case Management, Day Program & Physician); two programs (PACT/ICT) had no change from last year. ID reviews included 20% waiver cases and 10% non-waiver cases. Day and Employment Programs maintained 90%+ compliance. Residential fell below 90% this year and Case Management did not participate in formal quality reviews in order to complete targeted staff reviews throughout the year. Administration (Financial & Medical Records combined) maintained 90%+ compliance.

FY18 Objectives for the Coming Year

- Continue improvements of the Utilization Review process
- Identify and report trends to program managers & AMT
- Resume ID case management reviews
- Begin reviews for DD case management and Same Day Access
- Continue training to ensure documentation meets all requirements

FY 2017 CSS RECORD REVIEW RESULTS SUMMARY

Percentage represents compliance with standards reviewed
Target for All Programs is 90%

	FY2017	FY2016	FY 2015	Comments
NORTH 1 WAIVER	na	81%	92%	Program is doing targeted staff reviews in FY17 in place of formal quality reviews.
EAST 1 WAIVER	na	86%	92%	
EAST 2 WAIVER	na	85%	95%	
WEST 1 WAIVER	na	96%	98%	
WEST 2 WAIVER	na	91%	94%	
NORTH 1 SPO	na	89%	87%	
EAST 1 SPO	na	79%	92%	
EAST 2 SPO	na	91%	93%	
WEST 1 SPO	na	98%	97%	
WEST 2 SPO	na	85%	95%	
HERMITAGE VOC	92%	94%	96%	maintaining 90+ compliance
CYPRESS VOC	96%	97%	98%	maintaining 90+ compliance
ENCLAVES	94%	94%	93%	maintaining 90+ compliance
LEP	95%	99%	98%	maintaining 90+ compliance
STEP	95%	98%	97%	maintaining 90+ compliance
SUPPORTED EMPLOYMENT	95%	91%	89%	maintaining 90+ compliance
RESIDENTIAL	83%	90%	90%	↓ 7 percentage points from FY16
ID ADMINISTRATIVE	91%	97%	97%	

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 2017 MH/SA RECORD REVIEW RESULTS SUMMARY

Percentage represents compliance with standards reviewed
Target for All Programs is 90%

	FY2017	FY2016	FY2015	Comments
ESP/OUTPATIENT	95%	91%	96%	
ESP/PRESCREENING	96%	98%	96%	Results now include prescreenings completed by non-ESP staff to meet new requirement that at least 5% of a certified prescreener's emergency evaluations are reviewed annually.
YOUTH & FAMILY	90%			Results not separated by East & West starting this year as it was not meaningful to program to separate.
MHOP EAST/WEST	96%	95%	94%	maintaining 90+ compliance
MHOP/SA/YOUTH PF	91%	95%	93%	maintaining 90+ compliance
SA EAST	93%	90%	85%	maintaining 90+ compliance
SA RMP	91%	95%	92%	maintaining 90+ compliance
LAKESIDE CENTER	85%	93%	91%	↓ 8 percentage points from FY16
LAKESIDE CTR VOC	92%	93%	88%	maintaining 90+ compliance
PACT EAST	87%	87%	91%	no change from FY16
PACT WEST	83%	83%	87%	no change from FY16
CM&A EAST	86%	83%	84%	↑ 3 percentage points from FY16
CM&A WEST 1	84%	86%	89%	↓ slightly from FY16
CM&A WEST 2	87%	91%	88%	↓ slightly from FY16
CM&A PF	89%	91%	87%	↓ slightly from FY16
MH SUPPORTED SVS WEST	95%	97%	97%	maintaining 90+ compliance
MH SUPPORTED SVS EAST/PF	93%	91%	88%	maintaining 90+ compliance
MH RESIDENTIAL	96%	93%	91%	maintaining 90+ compliance
PHYSICIAN	86%	88%	86%	↓ slightly from FY16
MH ADMINISTRATIVE	95%	95%	91%	maintaining 90+ compliance

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

The agency continued to experience a significant number of external audits/program reviews, 109 client records were reviewed. Licensure Mortality Reviews and requests from Magellan increased from the previous year. The agency explored efaxing in addition to secure email exchange to send electronically health information records more efficiently. The agency issued two more Adobe Pro software licenses convert EHR documents into electronic files. Reviews were sent by secure email exchange-Cisco, fax and mail. 100% of reviews were completed within the specified timeframes.

	FY17	FY16	FY15
Total number of Reviews:	**44**	**75**	**44**
Admin:	1	2	3
C&P:	14	29	13
CSS:	26	33	25
Across All Divisions:	3	11	3
# of Desk Reviews	39	64	36
# of Onsite Reviews	5	11	8
# of C&P client records reviewed	33	-	-
# of CSS client records reviewed	76	-	-

- FY17 reflected a number of risk assessments from insurance companies which reduced this year
- Mortality reviews were received individually last year and this year some requests included 1-4 records in one request.
- Scanner purchased last year has an increase in use and other teams were trained on how to use the scanner.
- At the request of Leadership began tracking the number of records reviewed this FY
- Reviews were sent by secure email exchange-Cisco, fax and mail.
- To increase efficiency E-Fax and Adobe Plus software added to selected QA computers.
- 100% of reviews were completed within the specified timeframes.
- 14 charts for VHDA included C&P/CSS
- Received 8 requests for medical requests regarding services we do not provide such as immunizations, colorectal cancer, etc.

External reviewers included: DMAS (Department of Medical Assistance), DBHDS (Virginia Department of Behavioral Health and Developmental Services), HHS (Department of Health and Human Services), Anthem, DOJ (Department of Justice), VHDA (Virginia Housing Development Authority), National Core Indicators Survey (NCI), Va Premier, Magellan, Beacon, Delmarva, CARF, CIOX health, Aetna, BC/BS, CMS

Types of reviews include: Mortality reviews, SIS (Supports Intensity Scale), Risk adjustment, Prescribers review, Background requests, Community Engagement and Community Coaching Services, HEDIS, Risk adjustment, Crisis Services, Foster care medical records (immunization hx/well child visits), Medical records (labs, BMI, weight, HBP, Colorectal Cancer, Seizure protocol), Comprehensive Diabetes Care , Provider Quality Review and Improvement, Meaningful use

FY18 Objectives for the coming year:

- Meet new MCO reporting requirements
- Meet all audit deadlines
- Develop guidelines for length of time copies of reviews/audits are kept
- Continue to look at new methods to track audits

RISK MANAGEMENT / INCIDENTS AND COMPLAINTS

FY17 Accessibility Plan Annual Summary:

During FY17, the Risk Management Committee completed an agency wide self-assessment of their facilities to identify areas that may need modifications and changes. Identified areas were added to the FY17 Accessibility Plan of Correction. In FY17, the following accessibility projects were completed to include: ESP rooms were renovated to become more trauma informed; Woodman's lobby was redesigned based on the concept of a trauma informed and person centered culture; handicapped door installed at Hermitage main entrance; Hermitage carpets in the changing room were removed and replaced with tile; motion detector lights and new lights fixtures in the kitchen was installed at Allenshaw; solar path lighting was installed at Gayton to increase visibility; four bathrooms were redesigned at RMP to meet ADA requirements. AEDs were added to RMP, East Center, Hermitage and Lakeside Center. The County of Henrico in correlation with HAMHDS are in the early stages of constructing a new East Center on Nine Mile Road with a 2019 completion date. The agency continued initiatives of the Wellness Committee, to include weekly yoga for staff at Woodman and additional art

was created by staff and persons served was displayed at additional agency locations. The committee also promoted the QUIT now program. The Wellness Committee is now a standing committee within the agency. Employment First initiatives continued to follow and support supported employment opportunities. Staff participated on state wide committees related to employment first initiatives. The agency continues to support the Network of Care, the Cultural Awareness and Competency Committee and the planning and procurement of a new electronic health record. 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 throughout the year (i.e. meeting sites; meeting times; "jigs" for work programs; etc.).

FY17 Risk Management Summary:

The Risk Management Committee summarized the following areas of identified risks for FY17.

Service Delivery: Added safety training to acknowledgement form to ensure staff complete training within the first 15 day of employment. Agency orientation revised to include agency tours of a day program and a group home. Prepared for and completed a successful CARF survey in October 2016. Implemented strategic initiative of same day access to behavioral health and substance use services effective April 2017. Implemented SAMSHA grant to increase access to medical services by partnering with the daily planet and providing coordinated health care, (health and mental health). Increased supervisory access to chart review outcomes in chart tracker, supervisors are able to access information directly in the chart tracker system.

Computer Resources: Agency replaced and repaired desk top computers, laptops, signature pads, keyboards, phones, fax machines, printers as needed. Two new areas were equipped with teleconference equipment, at the Woodman and East Center locations. The agency added computers to additional conference rooms and expanded WiFi in additional sites. Reviewed and implement technology plan.

Confidentiality: Agency provided training regarding the Freedom of Information Act, FOIA to all staff. Identified a FOIA liaison for the agency at the request of the County of Henrico.
Financial: Implemented recommendations to reduce risks. Reviewed and updated business process manual.

Critical Incidents: The Risk Management Committee reviewed quarterly reports from the incident review committee. Reportable incident reports are forwarded to DBHDS through CHRIS and Magellan.

Vehicle Safety and Maintenance: Several agency vehicles were replaced during the year due to high mileage or maintenance issues. The County of Henrico, Central Auto Maintenance, expanded our ability to wash over sized vehicles at the Woodman road depot. New staff that drive county vehicles attend a three hour defensive driving class. Defensive driving classes are held twice a month for all new and current county employees. The course is required within the first 90 days of employment and every three years thereafter through an online course.

Emergency/Disaster Response and Recovery: Leadership group completed their annual review of their emergency disaster response and recovery plan through a table top exercise in September 2016. During the winter of 2016 an emergency meeting was called to prepare for an upcoming snow storm and to ensure all facilities had needed supplies and preparations plans were in place.

Health and Safety: Agency Management Team completed Critical Incident Response Training offered by the County of Henrico on August 4, 2016 in preparation of the roll-out of this training for all Henrico County Employees. Active shooter training occurred in the Fall of 2016 and embedded in the annual safety training that was rolled in March 2017. Egress signs were reviewed and updated at all locations in March 2017. Annual update of disaster and planning binder (all important agency contact numbers) occurred in August 2016. Annual facility inspection walk-throughs occurred in the summer of 2016 and June 2017 to ensure safety and maintenance needs are being met and address any necessary repairs. Training occurred with the supervisory and leadership group regarding the employee health services and the new service called "Company Nurse" for workplace injuries. Company Nurse labels were added to employee work phones to increase access to service. Wallet cards were also made available regarding Company Nurse Services. HAMHDS added additional card readers to the Woodman Road office increasing office safety. New safe areas signs were designed, made and displayed throughout agency. CPR face shield key chains are provided to all staff that successfully completes the agency's American Red Cross CPR class. The County of Henrico signed a new contract for the disposal of regulated waste. The pick -up locations for the agency includes the Woodman and East Center locations.

Regulatory Compliance: HAMHDS received its sixth CARF accreditation survey for eight programs. It was a very successful review and the strengths identified by the four national surveyors are posted on the agency's website. The agency received 52 separate reviews for services; either through desk audits or onsite audits. The regular chart reviews conducted by staff assist in maintaining regulatory compliance.

Media Relations and Social Media: The press releases for FY17 include; the public event of the showing of Chasing the Dragon in September 2016, Prevention Services Ask The Question, suicide prevention campaign which launched in October 2016, awards won by Henrico Crisis Intervention Team in April 2017, Ambassadors Poetry Slam in April 2017, CARF three year accreditation awarded in December 2016, and public classes regarding treating Opioid overdoses with Naloxone education in June 2017. Henrico County Public Relations and Media Services reviews and releases requests to the media. The agency uses a variety of social media venues to include Facebook pages for Hermitage Enterprises and Too Smart 2 Start Coalitions Youth Ambassadors. Prevention Services hosts their own website at http://henricoprevention.org, this website also lists their twitter address on Suicide Prevention at #ATQ17. The Henrico Heroin Task Force which HAMHDS is an active member launched Bounce Back from Addition this year at http://www.bounceback .

FY18 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

Review of FY16 compared to FY17

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 notably fewer suicide attempts this year. The agency introduced a new Suicide Risk Assessment and implemented enhanced safety planning. This will be an area we continue to monitor. The agency continues to serve more complex clients and behavioral incidents continue to reflect this complexity. Falls without injury significantly decreased this year while falls with injury increase considerably. Lastly there was an increase in assaults by clients. The agency continues to provide education and training to support staff in their duties.

Incident Type *	FY1516	FY1617
Assault by client	7	10
Behavioral incident	20	29
Biohazard incident/bomb threats	0	0
Communicable Disease	0	0
County vehicle*	7	8
Death-accidental	4	3
Death-likely homicide	0	0
Death-likely suicide	4	5
Death-natural causes	33	21
Fall- with injury requiring med. Attn	5	12
Fall- without injury	45	40
Fire	1	1
Illness (e.g. seizure, diabetic reaction)	21	26
Licit/Illicit drugs or weapons	0	0
Med incident- req. med. Attn	0	0
Med incident- NO adverse reaction	22	22
Other	16	24
Property damage	3	4
Property loss/theft	8	4
Self-injurious behavior	7	11
Serious injury	2	1
Sexual incident	3	2
Suicide attempt	30	25
Threats/violence	2	1
Violent crime by client	0	0
Totals	**240**	**249**
Restraints	**1**	**1**

Brief Description of "Other"	FY1617
Suspicious Package	2
Overdose	3
Biohazard Exposure	1
Choke	2
Picked up wrong client	1
Lost ID	1
911 call	2
Injury – no medical attention	6
Medication	3
Care Van	1
Assault	2
Total	**24**

STAFF TRAINING

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. Additional training opportunities occur through conferences, outside workshops and training offered statewide and regionally.

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 37 staff trainers that provide training in a variety of areas such as First Aid & CPR, Prevention of Violence, Therapeutic Options, Cultural Competency, Brown Bags, Wellness series; My side of the Story, MH First Aid, EHR and other Professional training

Approximately 78 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:
Wellness Series: My Side of the Story: Adolescent unit, Black Lives Matter Open Forum Discussion, Waiver Redesign & Documentation, HAMHDS Peer Recovery Specialists, Critical Incident Training by County Manager – Video, Understanding Me Helps Me Understand Others, The Effects of Zika in Our Community, Wellness Series: InStride Young Adult Program, Safety Training, Disaster Table Top Training, Risk Assessment, Advocate for the Aging, Individual Placement & Support Training, ASIST:Applied Suicide Intervention Skills Training, Virginia Relay, Brown Bag - Let's Paint!....Create!, My Side of the Story: Residents of ID Group Home, Financial Consents, Breaking the Silence, Valuing Dignity During the TDO Process, Black History Bingo, Afro Art-Painting black art, Learning About Cultures, Black History Famous Faces, The story of Ella Baker, Music Over the Ages, 13th Amendment Part 1, 13th Amendment Part 2, Valuing Dignity During the TDO Process , The Aging Population: Are You In The Know?, Wellness Series: INShape Program, Autism 101, Resilience – SCAN, CAN, The Syracuse Eight, My Side of the Story; CM&A, Side By Side (Formerly ROSMY), A Life Like Yours: One Family’s Journey, Key Principles and Considerations for Thorough Risk Assessments, Ethical Considerations in Documentation

Over the past year:
- New Red Cross purchases included; CPR key chains, Combination Training packs, new face shields/lung bags, Training device replacement pads
- Certified 2 new Therapeutic Options trainers
- Added Safety Training, Agency staff meeting Training, Columbia-suicide Severity Rating scale, Healthkeepers Model of Care
- Certified 2 Red Cross Trainers

FY18 Objectives for the coming year
- Certify 3 new TO trainers
- Recertify 1 TO trainers

INFORMATION TECHNOLOGY

The Information Technology Plan is reviewed periodically to assess the progress of projects and update their timelines as needed. accomplishments and initiatives of the past year and update accordingly. For FY17 the team was a part of the agency wide initiative to search for a new electronic health record system working with a consultant the agency team wrote and submitted an RFP for a new EHRS. The RFP was issued and vendors evaluated. Other major agency wide accomplishments Involving the team was the implementation of Same Day Access and the SAMSHA Grant implementation which expanded primary health care to include the Woodman clinic. The Promotion to implement the Progress Note re-write was another major accomplishment and was a major change across all teams within the entire agency.

To assist with training in-house training videos were created as new way to assist staff in learning and referencing the new information. Additional accomplishments include:

- Implemented solution to capture incremental data for ID to meet DOJ requirements including adding outside DD providers to the Cerner system.
- implemented measures to meet meaningful use stage 2 requirements such as labs, patient portal secure messaging, uploading client CCD's and successfully attested to meaningful use stage 2.
- migrated "P" drive to new server
- improved and updated chart tracker summary report and sampling
- updated agency website in accordance with county wide website revision
- Added computers to additional conference rooms and expand public WiFi in additional sites.
- Added the ability to bill for telehealth services to the billing tables.
- Deploy second monitors to mobility users.

FY18 Objectives for the coming year

- Participate on Agency team to select an EHRS and begin implementation.
- Install and train staff on windows 10 being installed on new computer installs
- Enhance and expand the use of telehealth
- Promoting Cerner system for state reporting changes
- Work with the program groups, reimbursement and quality assurance on what changes need to be made to billing tables and forms for the implementation of CCC+.
- Define and implement Jabber, including training staff to use with proficiency.
- update agency intranet site once we get go ahead from County IT on the use of SharePoint.

CULTURAL AWARENESS AND COMPETENCY

In FY17 the CACC committee continued to promote more staff involvement in presenting brown bags and ideas for cultural and linguistic events and activities. The quote bubble: "CACC wants to hear from you…" remained posted on all of the cultural bulletin boards throughout the agency and was sent out via email to solicit ideas from staff. There has been more staff interest and involvement despite low usage of the CACC email address..

Brown Bags, Trainings, & Orientations offered

The following Brown Bags and trainings were offered by CACC to staff during the 2017 fiscal year:

- July 29, 2016 at Woodman. "Black Lives Matter Open Forum Discussion", staff discussed the effects of social issues on employee and client populations.
- August 29, 2016 at East Center. "HAMHDS Peer Recovery Specialists", presented by the agency's Peer Counselors. This helped staff to explore the history of the peer support movement and discuss how agency Peer Recovery Specialists provide services here at HAMHDS.
- September 28, 2016 at Woodman. "Zika in Our Community", presented by HAMHDS consumers with special guest Jasmine Johnson, Director of the Medical Reserve Corp for the Chickahominy Health District. This was an informational brown bag regarding the effects of the Zika virus within Henrico County and surrounding areas.
- November 8, 2016 at Woodman. "Plans and Resources for the Aging Population within Henrico County", with special guest Jelisa Turner, Advocate for the Aging with Henrico County. Jelisa discussed the county's mission to assist the aging population in navigating county resources, and help shape the direction of county services for the aging population to best meet their needs.
- December 14, 2016 at Woodman. "Virginia Relay: Are You Connected?", with special guests Frazelle Hampton and Paul Stuessy from Hamilton Relay. Attendees were educated about how to connect to those who are deaf or hearing impaired, with use of Virginia Relay communication device utilized at HAMHDS.
- January 27, 2017 at Woodman. "Breaking the Silence: Lesbian, Gay, Bisexual, Transgender, and Queer Foster Youth Tell Their Stories", a video was shown to staff members followed by a discussion.
- February 2017- Black History Month was celebrated at multiple HAMHDS locations, with the following events being offered:
- Weekly trivia was held via email. Staff members replied with their responses and a winner with the correct trivia answer was drawn each week, with a prize given.
- February 10, 2017 - Black History Bingo at Lakeside Center, staff members and consumers participated.
- February 14, 2017 – Afro Art at Woodman. Staff members were provided with painting materials and a muse of a picture of an African-American female bust.
- February 21, 2017 – "Famous Faces" at Woodman presented by Administrative staff at All Admin meeting.

- February 22, 2017 – “The Story of Ella Baker” at East Center presented by HAMHDS staff. A discussion was held about this little known person and her story of being a major contributor to the Civil Rights Movement.
- February 23, 2017 – “Music over the Ages” at Woodman presented by CACC and Prevention staff. Music created by African-Americans over the decades was explored and discussed.
- February 27, 2017 – “13th Amendment: Part One” at Woodman. The first half of the documentary entitled “13th” was shown, followed by a discussion.
- February 28, 2017 – “13th Amendment: Part Two” at Woodman. The second half of the documentary entitled “13th” was shown, was shown, followed by a discussion.
- March 16, 2017 at Richmond Medical Park. “The Aging Population: Are you in the Know?” with special guest Megan Stucke from Bon Secours. A discussion was held regarding ways to identify and assess for early signs of Dementia/Alzheimer’s, clinical tools for use, community resources, and potential common themes/stressors within the aging population.
- March 21, 2017 at East Center. “CACC 101: Understanding Me Helps Me Understand Others”. This 3-and-a-half-hour training assists staff members in further developing self-awareness and cultural sensitivity.
- April 27, 2017 at Woodman. “CACC 102: Cultural Aspects of Our Community”. This 3-and-a-half-hour training assists staff members in learning more about the cultural demographics of Henrico County and the surrounding areas.
- May 8, 2017 at Woodman. “The Syracuse Eight”, with special guest Clarence McGill, a member of the Richmond Chapter of Coming to the Table, a national nonprofit organization dedicated to racial healing and conciliation. He discussed his experience with other players on the Syracuse University football team about 50 years ago in which they boycotted spring practice as a way to bring light to racism within the Athletics department.
- May 18, 2017 at Woodman. “Side By Side” with special guest Charles Dyson from Side By Side (formerly ROSMY). Staff was educated on the use of correct terminology among the LGBTQ community, current trends, mental health issues they are seeing, barriers to health care/medical treatment, and how to promote resilience and protective factors.
- June 27, 2017 at Woodman. “Childhood in Translation”. Chapters of the documentary with this title were shown and a discussion held regarding content, including the importance of the use of professional interpreters and the effects of family members being used as interpreters.
- Orientations are offered on an as needed based upon hiring new staff. Cultural Awareness & Competency Committee members continued to provide orientation to new employees during the agency orientation. The PowerPoint presentation is updated prior to each agency orientation offered to provide relevant information about upcoming trainings and brown bags. New employees also receive information regarding the Cultural Awareness & Competency Committee mission and annual plan. Staff are provided with information on how to contact committee members and are encouraged to participate creatively and collaboratively to help bring new culturally relevant ideas to the agency.
- All staff members are required to attend at least one cultural or linguistic training per fiscal year. This is evident based upon the annual staff acknowledgement form submitted by each employee and is maintained in his/her agency human resource personnel file.

Language Access Services

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.

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 is posted at Woodman, East, Providence Forge, and Richmond Medical Park locations, noting that interpretation services are available to consumers at no cost to them.

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 addresses these documents with clients at intake. The Human Rights brochure and Code of Ethics are provided to clients at that time.

Two HAMHDS staff members are qualified bilingual interpreters. One is located at the Hermitage Enterprises location. The second is located at Richmond Medical Park. Both are qualified to provide interpretation services for Spanish.

A Language Access Sub-committee was developed with 5 staff members, including 1 CACC member. The following objectives were addressed:

- "I Speak…" sheets that allow consumers to identify what language they primarily speak during initial interaction with staff were laminated and provided to front desk staff at Woodman, Richmond Medical Park, East, and Providence Forge. These were also provided to Same-Day Access staff to assist in identifying and preparing for use of interpretation services with consumers. On these sheets, the consumer points to the sentence that begins, "I speak [identified language]," in their own language, and the card identifies the language next to this sentence, in English.
- A Word document was developed with directions about how to access the phone interpreter services with Cyracom. It was noted that this would be helpful for Case Managers and Clinicians who may need to access this information while not in the office. The sub-committee recommended that this be posted as a view-only link on the employee intranet. This will be addressed in the next fiscal year's CACC Annual Plan.
- The appropriate contact person and information were identified with Network of Care Collaboration was held with the contact person and it was reported that webinars and/or brown bag trainings via web-based conference could be provided free of charge to HAMHDS staff regarding Network of Care, including how this resource could best be used with consumers and how to appropriately navigate the site. This will be addressed in next fiscal year's CACC Annual Plan. A flier was obtained regarding Network of Care and information identified in this flier was posted in the agency newsletter, Quality Matters, to better inform staff members about this resource.
- A list of all interpreters and translators with whom HAMHDS is contracted was obtained, and contact was attempted with all to acquire information regarding certification to provide interpretation/translation services, language(s) spoken, rates for service, and updated contact information. A Word document was created to comprehensively provide this information to staff. The sub-committee recommended that this be posted as a view-only link on the employee intranet under a new requested tab entitled "Language Access", and that an email noting this addition be sent to all staff. This will be addressed in the next fiscal year's CACC Annual Plan.
- Contact was made with HAMHDS staff members and the list of those who are willing to assist with interpretation services if a professional interpreter is not available or during emergency, was updated. There are currently 2 staff members who are willing to assist, with the languages of Spanish and Tagalog.
- The signage at Richmond Medical Park, Woodman, East, and Providence Forge, that notes availability of interpretation services to consumers at no cost to them, was analyzed and compared. The sub-committee recommended that the signage at these locations be the same. It was also recommended that the current most used languages within the county be identified to determine what languages should be on the signs at this time, and that the signage be updated to reflect this. The sub-committee recommended that the language/terminology used on the signage also be updated to reflect heightened knowledge and understanding of language access services, since they were first posted. This will be addressed within the next fiscal year's CACC Annual Plan.

Use of Interpreters Within the Agency Based on FY17 Actual Budgetary Expenses

During FY17 HAMHDS utilized interpreter and translation services in the amount of $85,796. CyraCom, a provider of language interpreter services in healthcare was also used for a variety of language via phone in the amount of $3,670.

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 agency orientation of new staff by the Cultural Awareness & Competency Committee members, at least bi-monthly.
- Cultural sensitivity and awareness trainings were 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. Both were provided twice during this fiscal year.
- All HAMHDS staff was notified of CACC trainings via email and intranet postings. Trainings were posted on the agency intranet so employees can review and sign up for the trainings. Information regarding trainings was often also posted in the agency newsletter, Quality Matters.

Community Partnerships

- One HAMHDS staff is a member of Virginia Department of Behavioral Health and Developmental Services' Cultural and Linguistic Competence Advisory Committee with the Office of Health Equity Advancement.
- 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 2016 entitled "The Champion's Toolbox: Home is Where the Heart is". Four HAMHDS employees attended the training. Their annual conference was held at the Double Tree by Hilton in Midlothian in June 2017 entitled "A Balanced Life: Making Meaningful Connections". HAMHDS employees attended.
- Multiple community providers were invited to provide culturally competent trainings/brown bags to HAMHDS staff. See above for details.
- The agency's Health and Wellness Committee continued 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 them throughout various locations within the agency. Art was displayed at Woodman and Lakeside Center in FY17. This work was supported by the Cultural Awareness & Competency Committee. The agency decided to continue this workgroup as a standing committee to promote health and wellness initiatives on behalf of the agency.
- As small subcommittee of the Health and Wellness group was developed to direct the redesign of the main lobby at Woodman to create a more trauma informed environment for our consumers and visitors. A member of AMT served on the subcommittee as well as representation from the agency's Parent Infant programs, Youth and Family programs, and Substance Abuse programs. The lobby at Woodman received new light fixtures, paint, carpet, furniture, new plants, and a soothing wall fountain. New furniture that complements the lobby was also added in the waiting area of the atrium, on the second floor, and in building A.
- HAMHDS staff attended the 3rd Statewide Refugee Mental Health Summit at Embassy Suites in Richmond, Virginia. The theme for the event was "Social Determinants of Mental Health".
- A HAMDS staff member was appointed to the Statewide Cultural and Linguistic Competency Committee in 2014, and remains an active member. Information from the Statewide Cultural and Linguistic Competency Committee is channeled to agency employees; such as information on bilingual trainings, Native American Heritage, a new crisis service provider who joined LifeLine that specializes in services for the deaf and hard of hearing population, a webinar pertaining to providing service to the Latino population, the NAACP forum regarding substance abuse, as well as several symposiums and summits.
- HAMHDS has continued to work with the VA Department of Health and DBHDS Office of Health Equity Advancement to assist in linking refugees in Henrico County with services/resources. HAMHDS staff is a member of the Richmond Refugee Mental Health Council that monitors progress with the program.

Accessibility to Services

- Spanish greetings were added to the agency's after-hours messages in FY17. When callers dial the agency's phone numbers at Woodman, East Center, Richmond Medial Park, and Providence Forge after hours, they have the opportunity to dial "1" to hear the greetings in Spanish.
- See above regarding translation/interpretation services available for staff's use with consumers to promote access to services. CACC developed a Language Access Sub-committee to continue to research and expand these services. Objectives addressed are listed above, and will continue to be addressed in the next fiscal year.
- Wheelchairs are available at Woodman and East for use with consumers as needed.
- An elevator is available at Woodman for second floor access to adult services.
- Doors at Woodman and East Center can be automatically opened with use of push button for individuals with disabilities. An automatic door opener was added to one door at Hermitage Enterprises in FY17.

FY18 Objectives for the Coming Year

- The Cultural Competency Committee will develop and implement the FY18 Cultural Competency Plan and when finalized it will be posted to the Agency Intranet.

DEMOGRAPHICS

The US Census Bureau data reported below was last updated in July 1, 2016.

According to the US Census Bureau, quick facts for 2016, there are about 326,501 people in Henrico County, 58.3% White/Caucasian, 30.4% Black/African American, 0.3% were Alaskan Native, American Indian, 8.5% Asian, 0.1%, Native Hawaiian and Other Pacific Islander persons, 2.3% Multi-racial, 5.3% of Hispanic or Latino Origin. Language other than English spoken at home is 14.8%. Median household income is $61,934 based on data averaged between 2011-2015. Persons below poverty level are 9.3%. Persons with disabilities under the age of 65 is 6.8% based on data averaged between 2011-2015.

In New Kent County there are approximately 21,147 people, 82.0% are White/Caucasian, 13.2% Black/African American, 1.1% Alaskan Native, American Indian, 1.1% Asian, 2.5% Multi-racial and 2.9% Hispanic or Latino Origin, Language other than English spoken at home is 3.1%. Median household income is $73,041 based on data averaged between 2011-2015. Persons below poverty level are 6.7%. Persons with disabilities under the age of 65 is 6.8% based on data averaged between 2011-2015.

In Charles City there are about 7,071 people, 42.8% White/Caucasian, 46.5% Black/African American, 7.0% American Indian and Alaska Native, 0.6% Asian, 0.5% Native Hawaiian and Other Pacific Islander persons, 3.2% Multi-racial, and 2.17% Hispanic or Latino Origin. Language other than English spoken at home is 2.0%. Median household income is $49,563 based on data averaged between 2011-2015. Persons below poverty level are 11.6%. Persons with disabilities under the age of 65 is 10.7% based on data averaged between 2011-2015.

Counties of Henrico, New Kent and Charles City

Two year Race & Ethnicity Comparison

Race & Ethnicity	FY17 Henrico	FY16 Henrico	FY17 New Kent	FY16 New Kent	FY17 Charles City	FY16 Charles City
White/Caucasian	58.3%	58.9%	82.0%	81.9%	42.8%	42.6%
Black/African American	30.4%	30.2%	13.2%	13.5%	46.5%	46.8%
Alaskan Native, American Indian, Asian/Pacific Islander, Multi-Racial	11.2% *(Alask/Amer Ind 0.3%) *(Asian 8.5%) *(Pac. Island 0.1%) *(Multi-racial 2.3%)	10.9% *(Alask/Amer Ind. 0.4%) *(Asian 8.2%) *(Pac. Island 0.1%) *(Multi-racial 2.3%)	4.7% *(Alask/Amer Ind. 1.1%) *(Asian 1.1%) *(Pac. Island 0.0%) *(Multi-racial 2.5%)	4.6% *(Alask/Amer Ind. 1.0%) *(Asian 1.2%) *(Pac. Island 0.0%) *(Multi-racial 2.4%)	10.8% *(Alask/Amer Ind. 7.0%) *(Asian 0.5%) *(Pac. Island 0.1%) *(Multi-racial 3.2%)	10.8% *(Alask/Amer Ind. 7.3%) *(Asian 0.6%) *(Pac. Island 0.1%) *(Multi-racial 2.8%)
For persons served who identify themselves as Hispanic	5.3%	5.5%	2.9%	2.6%	2.1%	1.8%

*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.	Other	Other / Asian	Korean
4.	Arabic	Arabic	Vietnamese
5.	Chinese	Chinese	Chinese
6.	Farsi	Vietnamese	Arabic
7.	Vietnamese and nonverbal	Hindi	Tagalog

HAMHDS

Henrico Area Mental Health & Developmental Services, HAMHDS, values a diverse workforce that is representative of the person served. As of 6/30/17 of the approximately 10,014, 47% of consumers served were White/Caucasian and 43% were Black/African-American. The remaining 10% were: Alaskan Native, American Indian, Asian/Pacific Islander, and Multi-racial. Of all consumers served 4% percent identified themselves as Hispanic.

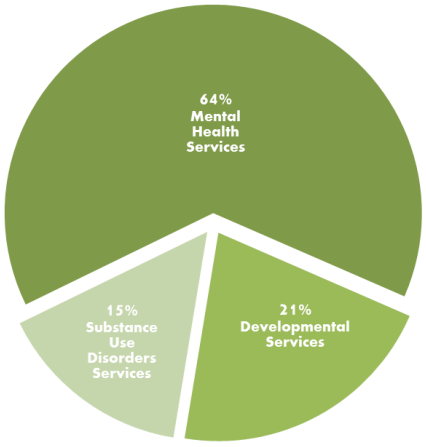
As of 6/30/17, of the approximately 358 HAMHDS permanent employees 53.34% self-identify as White/Caucasian, 43.58% Black/African-American, 1.68% identified themselves as either Alaskan Native, American Indian, Asian/Pacific Islander, or Multi-Racial, and 1.40% identified themselves as Hispanic.

Three Year Comparison of Person Served to HAMHDS Employees

Race & Ethnicity	FY17 Persons Served	FY16 Persons Served	FY15 Persons Served	FY17 HAMHDS Employees (358)	FY16 HAMHDS Employees (358)	FY15 HAMHDS Employees (345)
White/Caucasian	47%	45%	46%	53.34%	52.79%	54.50%
Black/African American	43%	44%	44%	43.58%	44.41%	42.31%
Alaskan Native, American Indian, Asian/Pacific Islander, Multi-Racial	10%	11%	10%	1.68%	1.69%	2.32%
Persons served who identify themselves as Hispanic	4%	5%	5%	1.40%	1.11%	0.87%

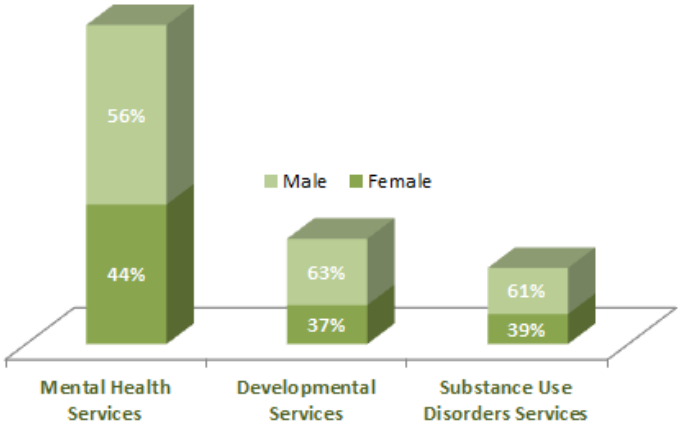
Total Consumers Served by Program Area

10,014 individuals were served in FY17, 64% received Mental Health Services, 21% Developmental Services and 15% Substance Use Disorders Services. Eight (8) percent of individuals served were ages 0 – 2; 17% were ages 3 – 17; 72% were ages 18- 64; and 3% were ages 65+.



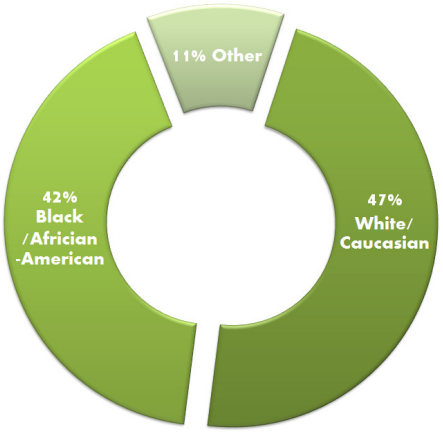
Consumers Served by Gender

Fifty-six (56) percent of individuals served in Mental Health Services were male, and 44% served were female. In Developmental Services, 63% of individuals served were male, and 37% served were female. In Substance Use Disorders Services, 61% of individuals served were male, and 39% served were female.



Distribution by Race and Ethnicity

47% served identified themselves as White/Caucasian, 42% Black/African American, 11% Alaskan Native, American Indian, Asian, Pacific Islander, Multi-Racial.



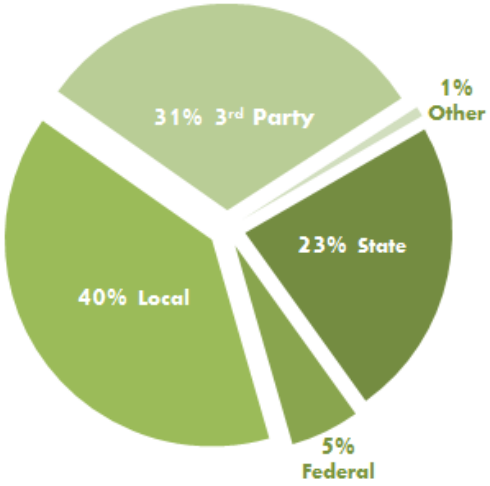
BUDGET

Revenue

FY2017 per the Year End Performance Contract Report

Revenue by Source

Local Funds	$ 14,308,417
3rd Party Fees	$ 11,352,926
State Funds	$ 8,551,193
Federal Funds	$ 1,974,019
Other Funds	$ 285,546
Total	**$ 36,472,101**



Expenses

FY2017 per the Year End Performance Contract Report

Expenses by Disability

Mental Health Services	$ 17,389,374
Developmental Services	$ 13,278,822
Administrative Services	$ 2,812,182
Substance Abuse Services	$ 2,508,142
Total	**$ 35,988,520**