ANNUAL PERFORMANCE ANALYSIS

JULY 2014 • JUNE 2015

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES
Serving the Counties of Henrico, Charles City, and New Kent
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MANAGEMENT SUMMARY

Henrico Area Mental Health & Developmental Services (HAMHDS) is pleased to present the Annual Report for Fiscal Year ’15, highlighting our major initiatives this past year to improve the quality of care for individuals with mental health, substance use/addiction issues and intellectual/developmental disabilities. One of the most significant accomplishments for the agency has been an increased focus on the physical health needs of the individuals we serve. There is growing evidence that individuals with serious mental illness die, on average, 25 years younger than the general population. We are committed to assuring access to quality healthcare and promoting better health outcomes for the people we serve. Initiatives include: adding LPN’s who check-in individuals prior to psychiatry appointments and record vitals and changes in health and medication status; the creation of a Clinical Nurse Supervisor position; implementation of the Nutrition and Exercise for Wellness and Recovery curriculum; in partnership with The Daily Planet, co-location of a Primary Care Nurse Practitioner at our eastern Henrico facility 16 hours per week; partnering with three managed care organizations (MCO’s) involved in the Commonwealth Coordinated Care Program; and completing screenings for the Governor’s Access Plan (GAP) enabling eligible individuals access to health insurance.

We continue to strengthen a robust emergency response system. We remain committed to improving the experience and outcomes for individuals with mental illness, substance use disorders and intellectual/developmental disabilities when they interact with the criminal justice system, and expanding our role supporting public safety agencies in the community. The Crisis Intervention Team (CIT) has trained over 1,400 first responders, representatives from other agencies and jurisdictions across the commonwealth in the 40 hour training. The Crisis Receiving Center (CRC) has expanded the hours of operation, offering a safe and appropriate location for emergency mental health evaluations and triage to occur. Eighteen hundred individuals have been seen at the CRC. Jail diversion efforts have been enhanced to divert, coordinate and clinically manage the needs of individuals who have a mental illness, resulting in expanded treatment options in the jail setting, positive outcomes upon release and reducing incarceration costs while keeping our community safe.

We celebrate continued progress in assisting individuals with intellectual/developmental disabilities to live “a life like ours” successfully and fully integrated in our community.

In the year ahead we will have a strategic focus on improving the infrastructure needed to support our staff as they strive to meet more complicated demands for data and more varied reimbursement systems. We will prepare for communication strategies that will be needed in the years ahead. We will strengthen existing partnerships and develop new ones. We will promote wellness and recovery in all service areas.

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

Lindsey N. Johnson  Laura S. Totty
Board Chair        Executive Director
STRATEGIC GOALS AND STRATEGIC PLANNING

Summary of Agency Strategic Initiatives
During FY15 cross functional workgroups continued their work on the following Agency Strategic Initiatives:

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

Agency Workgroup:
An agency workgroup also pursued the following:

- Maintaining and supporting a high performance organization

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

Create a Wellness/Recovery Focused Culture
Physical Environment:
- Scheduled consult with VCU School of Design – begins August 2015
- Obtaining client art work – plan to display many pieces in the 4 major sites (RMP, East, Woodman, PF) - RMP will have 40 pieces by August 15, 2015 – Art showing of these pieces on September 25, 2015

Staff Trained in “WE” Model of Service Delivery:
- Trauma informed training part 2 – 2/5/15 (previously scheduled)
- My Side of the Story Brown bag series – every other month, clients from a designated program come and share their experiences, they include what worked, how services might be improved.
- AMT approved all admin staff with f/f contact with clients, mandatory MH 1st aid training in the first year, all other admin staff and all ID staff this training is optional
- Researching recovery/person-centered/trauma-informed service delivery system, all members reviewing the SAMHSA Manual on Trauma-informed care in Behavioral Health Services

Wellness Promotion:
- Contacted Sports Backers to investigate promoting wellness in the workplace
- Listing of naturally occurring wellness activities that staff have started on their own
- Have trained 1 additional MH 1st aid trainer and have scheduled 2 more to get trained
- Have applied for the In Shape grant which will provide a staff person whose position will be solely focused on health and wellness for the clients/staff of the agency

Goals/Action Plans for upcoming year:
- Work with VCU School of Design for interior designs of Woodman Road lobby
- Continue art work project and identify additional site after RMP
- Complete MH 1st Aid Training in FY16
- Continue Wellness promotion implementing In Shape grant

Department of Justice (DOJ)/ Centers for Medicare/Medicaid Services Transformation Team
- Converted Person Centered Planning forms into current EHR for implementation
- Gathered information as requested for the state on Supports Intensity Scale Validation to assist with Waiver re-design information
- Participated in the Eligibility Pilot for Waiver by using the old and new tool for annual re-determinations
- Completed provider Self-Assessment Survey for compliance with CMS Final Rule on integration
- Participated in 2 DOJ audits of Case Management services
- Participated in a Department of Licensing Pilot to assess compliance with DOJ requirements
- Restructured to separate Residential services from Intake and Housing to meet CMS Final Rule requirements
Goals/Action Plans for upcoming year:
DOJ settlement agreement transformation team will continue to:
- Monitor HSRI recommendation status
- Monitor the Waiver re-design details
- Prepare for Virginia’s ID Waiver Transition Plan in response to the Centers for Medicaid and Medicare (CMS) final rule
- Provide updates to Leadership Group as needed
- Identify the state definition of developmental disability and related conditions
- Determine the numbers of individuals fitting the definition on waiting lists and on DD, EDCD and Tech Waivers who reside in CCC, Henrico and NKC
- Identify resources needed to provide Case Management services
- Prepare for assuming point of entry role for all IDD
- Prepare for CSB Case Management involvement to include individuals on the Waivers and the Waiver Waiting List for IDD
- Prepare for conflict free Case Management requirements under the CMS final rule
- Prepare for residential and day services integrated activities requirements
- Continue to comply with current guidance around settlement agreement requirements

Explore Electronic Health Records Systems:
- Formed a Workgroup of 20 staff from across all parts of the Agency
- Evaluated the current system (Cerner)
- Listed pros and cons of the current functionality
- The Workgroup attended five demonstrations from nationally known Electronic Health Record Systems
- Wrote a recommendation to be presented to the Agency Leadership Group in FY 2016: “To seek approval from the County to move from the Cerner system to another EHR system through an RFP process.”
- to be presented in FY 2016

Goals/Action Plans for upcoming year:
- Present recommendation to Agency Leadership Group, “To seek approval from the County to move from the Cerner system to another EHR system through an RFP process.”
- Present the approved recommendation to County Finance, County IT and the County Manager to acquire a new EHR System for their approval and guidance through the county CIP and RFP processes.

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

Over the last year HAMHDS has worked in partnership with three managed care organizations (MCO’s) involved in the Commonwealth Coordinated Care Program. This Program is designed for individuals who are eligible for Medicaid and Medicare insurance. The MCO’s involved in this project have stressed the need for integrated primary and behavioral health care for their members. HAMHDS currently serves about 100 individuals who are participating in this program. Two of the MCO’s have introduced an Enhance Care Coordination level of service that specifically targets individuals with co-morbid chronic health conditions and severe and persistent mental illness.

In addition to our work with the three MCO’s, HAMHDS has developed a partnership with The Daily Planet to provide primary care medical services at our East Center location. The Daily Planet has placed a nurse practitioner at this site two days a week. The co-location of medical and behavioral health services makes medical care more accessible for some individuals who may have been reluctant to go to a primary care physician’s office. The co-location of services also facilitates better coordination of care between HAMHDS staff and The Daily Planet’s nurse practitioner.

During the first 9 months of this project:
- The nurse practitioner treated 239 individuals;
- The number of individuals participating in Adult Recovery Services with primary care physicians rose from 65% to 89%; and,
- Individuals seeing the nurse practitioner reported a significant reduction in use of Emergency Rooms for treatment.
Goals/Action Plans for upcoming year:
- We will work on continuing to strengthen our partnership with the MCO’s offering Enhanced Care Coordination services and plan to implement this service during the 2nd quarter of the fiscal year.
- We continue to explore opportunities to secure funding to expand the hours The Daily Planet nurse practitioner provides services to HAMHDS client.

Maintaining and supporting a high performance organization:
- Workgroup created to research and review recommendations for HPO training
- The County of Henrico, Human Resources’ Organizational Learning and Talent Development Program offers training on High Performance Organizations. Staff encouraged to participate in this training opportunity.
- Completed a survey of all staff in order to evaluate the current status of our work environment. Results were presented to Leadership Group and analyzed. Results indicated that while there are areas for improvement, the overall Agency Culture is strong and effective work practices are in place to move the agency forward.
- Areas of concentration will be training around the HPO concepts and improving the competencies of our supervisory group to maintain consistency in the areas of leadership, performance management and ongoing supervision.
- Contacted and explored training for all staff with two different vendors in the area of High Performance Organizations and determined neither was feasible due to speaker requirements of number of staff to be trained and funding

Goals/Action Plans for upcoming year:
- To explore and develop training plan using in-house resources, local guest speakers and innovative ways of providing information for all staff around our High Performance culture and improvement of consistency amongst supervisors

FY15 PROGRAM ACCOMPLISHMENTS

**Administration**
- Reorganized credentialing responsibilities to Human Resources
- Evaluated, automated and streamlined credentialing processes
- Implemented electronic PIV submission
- Began quarterly Performance Contract reporting (from semi-annually)
- Ran SAM exclusions monthly to meet Magellan requirements
- Tracked part time personnel to ensure compliance with Affordable Care Act requirements
- Implemented Evening Security Officer oversight at Richmond Medical Park
- Coordinated new ID Card Scanner Project with the County
- Coordinated carpet renovation for Building B at Woodman Road Facility with the County
- Relocated Physical location of Access Center to the East Center
- Developed measures for accuracy and volume of automated claims submissions to the EDI Clearinghouse
- Modified the EHR system to:
  - provide credentialing modifiers for the Magellan system
  - track authorization and establish billing for the new GAP program
- Implemented encrypted email
- Converted to Office 365 email
- Implemented Cerner’s Ultra Sensitive Exchange which will allow some records to be electronically exchanged in a secure environment
- Attested to Stage one, Year two of Meaningful Use for 6 prescribers and Stage one, Year one for 2 prescribers
- Implemented posting client payments at point of receipt (the front desk)
- Restructured Front end business support, resulting in transferring one Office Assistant IV position to Reimbursement
- Installed Regional Child Crisis Telehealth equipment

**Clinical and Prevention Services**
- Re-structured Adult Recovery Services Program to prepare for anticipated legislative requirements and to provide greater oversight and support of PACT and ICT teams
- Re-structured weekly management teams to increase efficiency and to include Program Coordinator from Provide Forge office on monthly basis
- Implemented speaker series for monthly Clinical and Prevention Management Team meetings
- Participated in Zero Suicide Academy
Adult Substance Abuse/ Adult Mental Health Services

- Expanded jail diversion resources through the addition of a full time case manager to the jail staff; this allows for intervention along intercept 2 and increased resources at intercept 5. A full time case manager was added to the jail team with the specific goal of expanding services for inmates with serious mental illness who were re-entering the community. This service has proven to be very successful with a noted reduction in recidivism for individuals receiving this service. The program was recognized this year by NACo for an achievement award. The re-entry program has focused on intercept 5. Plans are currently underway to apply for funding to expand diversion services focused on intercept 2.
- Coordinate Moral Reconation Therapy (MRT) with criminal justice partners. Jail staff received training in MRT and began offering the service to clients in early 2015. Thus far about 20 inmates have participated in the West Jail have participated in the group. Plans are to expand the group to the East Center in FY16.
- Assessed county need for increased heroin treatment programs. We have experienced a decrease in demand for heroin treatment programs during the current fiscal year. We have taken steps to better coordinate services with detox centers through the use of a voucher program for detox services. This has increased client engagement in services.
- Revamped group programming in SA:
  - added seeking safety for men (recognizing that many of the men we serve have experienced trauma)
  - Offer motivational enhancement groups
- Initiated a voucher program for those seeking methadone treatment - increased engagement in services
- Continue to provide Building Blocks monthly
- Received a NACo award for walk-in expansion
- Strengthened partnership with Henrico Drug Court and District 32 probation and parole
- Assisted clients with obtaining GAP insurance
- Provided training on SA and MH to CIT, CASA, Sheriff's Citizen Academy
- Providing Mental Health 1st Aid training to all new recruits for the Sheriff's department
- Continue to provide childcare for clients attending groups
- NACo award for coping skills groups in jail
- NACo award for jail diversion program
- Linked with Community Partners (HCCP, Drug Court, Sheriff's Dept., Police, Commonwealth Attorney) to provide Lunch and Learn series on the opiate epidemic in our community
- Enhanced relationships with the courts - met with judges in both general district and circuit court

Adult Recovery Services

- Partnered with Daily Planet to integrate healthcare at our East Center. Primary Care is provided by a Family Care Nurse Practitioner. The Nurse Practitioner began working 8 hours a week in September 2014. Within 2 months, demand for services necessitated that we expand services to 16 hours per week. In the 9 months the program has been in operation about 200 individual clients have been seen for approximately 650 patient visits.
- Exploring telepsychiatry: successfully applied for state funding for telepsychiatry services. We are currently in the planning stage for implementation of this service. We anticipate increased access to psychiatry services for Providence Forge and the jails, as well as increased coordination with the magistrate offices in Charles City and New Kent Counties.
- Continue to explore opportunities to increase wellness programming for our clients. This has become an increased focus through the Commonwealth Coordinated Care (CCC) project for individuals who are dually eligible for Medicaid and Medicare. Within the CCC program there is the opportunity to provide Enhanced Care Coordination which more specifically focuses on individuals with mental illness and co-occurring physical health problems. Plans are currently underway, in coordination with Anthem and Beacon Health Services to provide Enhance Care Coordination.
- Initiated health programming for clients within individual program areas:
  - a walking group at our East PACT program
  - individual educational services for clients with diabetes
- Restructured program to better to implement conflict free case management and to enhance opportunities for program development
- Continued to demonstrate the effectiveness of case management services with 92% of clients experienced a reduction in their hospitalization rates or remained at 0 hospitalizations
- Implemented Young Adult Services Program serving youth between 16 and 25 years of age who are experiencing their first psychotic episode
- Increased focus on clients’ medical issues through wellness activities (walking group, Yoga at Lakeside Center)
- Continued LPN monitoring of clients’ medical conditions at check in for psychiatry appointments; linking clients with medical providers.
- Assisted 15 clients in gaining paid employment.
Emergency Services
Crisis Intervention Team (CIT):
- Continue to refine and support Henrico’s Crisis Receiving Center. Successfully applied for state funding to expand our services at the Crisis Receiving Center. This will allow us to provide on-site coverage for 18 hours per day and secures funding for our full time peer counselor who is housed at the Crisis Receiving Center.
- Continue outreach and advanced CIT initiatives. CIT classes are offered monthly to police, fire and EMS staff. In this fiscal year we have trained over 300 individuals, and also expanded our number of CIT trainers. We have successfully implemented Advanced CIT training classes.
- Continued to provide coordination and staff to maintain monthly CIT classes, 40 hour trainings
- Trained over 1400 persons since the inception of Henrico CIT
- Trained 19 first responders as trainers through train the training class
- Received permission from the Federal Government to redirect funds (from conference) to develop Advanced Training Program for CIT Responders for fiscal year 2015
- Applied for and received Mentorship Funding through DBHDS and DCJS to provide mentorship to several area CIT programs (including Goochland/Powhatan, Fairfax, Eastern Shore, Cross Roads, and several others).
- Continue to provide outreach to the community through our STAR team (our Police division has developed a designated mental health team of 4 personnel to work specifically with persons with mental illness)
- Commitment from New Kent and Charles City Sheriff to train 100% of deputies through our 40 hour training and the development of a regional CIT group to develop enhanced systems in both jurisdictions

Crisis Receiving Center (CRC) / Emergency Services Program (ESP):
- Continue to support our CRC through coordination, staffing, and leadership. We served over 600 persons last fiscal year. We have served over 1700 persons since the beginning in December in 2013.
- Provided tours and technical assistance to several CIT programs in their efforts to obtain funding for crisis receiving center.
- Applied for and received expansion funding that will allow us to operate CRC 18 hours a day (up from 12) and increase clinical and peer specialist support to begin August of 2015
- CRC expansion will also allow New Kent and Charles City Sheriff’s Deputies access to the CRC
- Successfully implemented the new mental health laws that promote assurance of safety net for all persons in crisis through mandated coordination with law enforcement, mental health, private and state hospitals.
- ESP took over role of access at Woodman Road for all walk in clients.
- Continued high volume of assessments both voluntary and involuntary (1634 for this fiscal year-second highest year on record)

Access:
- Moved access to East Center in October of 2014
- Took over role of crisis services in East Center at same time
- There was an increase in the number of calls of 13% in 2014 over the average of the previous last three years.
- Approved additional FT staff for Access

Youth & Family
- Continue implementation of High-Fidelity Wraparound Intensive Care Coordination Services in Henrico. Successfully applied for DBHDS funding to implement High Fidelity Wraparound Services through a partnership with several regional partners. In spite of some staffing issues during the course of the fiscal year, this program proved to be very successful and was recognized at the state CSA conference for being an effective private/public partnership. By June, 2015, Henrico served 25 youth in High Fidelity Wraparound Services (better known to the community as Intensive Care Coordination); this number far exceeded our projected goal of 14 by the end of grant year two (9/30/15). This was possible because of the public/private partnership and the private providers stepping in to cover while we were down staff; we continued to refer and case manage cases throughout the year.
- Continue implementation of evidence-based SA Groups across sites through increased education and partnership with stakeholders. Expanded our partnership with court services with the updating and implementation of the Court Alternative Program Substance Abuse psycho-educational groups in September, 2014. Sixty-one clients, along with a significant family member, completed one of the four session groups. Provision of the CAP-SA groups on-site allows for a smoother continuum of care for adolescents with substance abuse issues, with more rapid referral to treatment as needed.
- Improve staff skills at assessment and identification of trauma through increased training and implementation of a structured trauma assessment instrument
- Six of our staff completed training and consultation in trauma-focused Cognitive Behavioral Therapy; two of those staff are finalizing their work to be certified in this model of treatment. The Child Team has implemented a structured trauma assessment tool for children entering treatment who have experienced trauma.
- Implemented VICAP-like assessments for eligible referrals seeking intensive in-home, day treatment, or mental health support services through CSA funding
- Provided Behavioral Health Clinical Assessments for CSA clients who do not have Medicaid. To date, demand for this service has been limited and we have provided three of these assessments for Henrico CSA and three for New Kent CSA.
- Completed 886 VICAP Assessments
- Restructured the CAP-SA groups and served over 50 individuals/families in this program
- Expanded capacity for provision of MST services to court-involved youth through new MOA with Court Services Unit

Prevention
- Increased awareness of community issues of mental illness by providing mental health first aid training. During the course of the fiscal year we have provided Mental Health First Aid training to 158 individuals, 111 adults and 47 youth. Mental Health First Aid training is valued training for non-clinical staff who works with individuals with mental illness, such as HAMHDS administrative staff and jail staff. Mental Health First Aid has become part of the standard orientation training for jail staff, and recently the Agency Management Team has decided that all administrative staff who have direct contact with clients will be required to complete Mental Health First Aid during this first year of employment.
- Collaborated with schools and community to promote wellness through prevention of violence (i.e., bullying, relationship violence, etc.) and substance use. During the last year, Prevention staff taught Safe Dates groups for all of the 9th grade students at Tucker High School. This curriculum is focused specifically on reducing dating violence. Prevention staff has also worked in conjunction with the Generating Recovery of Academic Direction (GRAD) Program in Eastern Henrico. Support to this program has included staff workshops and direct service to the students.
- Worked with youth, families and schools to enhance early academic success and promote resilience through life skills development. Two of the ways that the Prevention Program addresses Life Skill Development is through the Al’s Pals curriculum and the Life Skills Training Curriculum provided at the Connect Programs. At the end of the fiscal year, eighteen 1st and 2nd graders who had participated in the program throughout the school year were administered the Al’s Pals post-test. 100% of responses reflected unfavorable attitudes toward “kids” drinking alcohol and smoking. The sample of 3rd, 5th, and 7th graders receiving the Life Skills Training curriculum that were pre-tested in the fall were post-tested after completion of the LST curriculum. Two youth left the program and did not complete the curriculum, leaving a sample of 48. Among the ES participants, there was a decrease of 7% in favorable responses to ATOD use. “Not Sure” responses also decreased by 8%. Among the MS group favorable responses increased slightly from 35% to 37%.
- Suicide Prevention PSA featured in Regal Cinemas @ Virginia Commons. The Suicide Prevention PSA shown from 12/12/14 through 1/8/15 ran 3,600 times on the big screen and 10,800 times in the lobby of Regal Cinemas Virginia Center 20. The total impressions were 86,227. The PSA idea, concept and development were done totally by Henrico Prevention staff.
- 5/21/15 Little Black Dress play held @ Henrico Theatre focused on raising awareness regarding depression and suicide. Multiple community partners (suicide prevention resources) participated: American Foundation for Prevention of Suicide, The Jason Foundation, NAMI Youth Move, Full Circle Support Group, Safe Harbor.
- Partnership with VCU Occupational Therapy Dept.- cohort of interns implement projects with Connect youth annually
- Annual College Tour- 50 youth visited Georgetown University and Smithsonian during spring break
- Newport News Senior Olympics 2015- (service learning) Connect youth assist with event @ Christopher Newport College on 5/16/15
- Youth Ambassadors attend Annual Youth Alcohol & Drug Abuse Prevention Project (YADAPP) Leadership Conference @ Longwood University in July 2014
- Two Connect Youth to attend the Y-Street Leadership Team Training in Richmond 6/23-6/26/15
- Connect - 1 Henrico HS graduate received academic scholarship to University of Tenn.; 2 rising 11th graders will take advanced placement courses in the VCU Engineering Program next year

Community Support Services
- Sponsored an activity for National Developmental Disability Month in March, 2015 which was open to the public and reported in the Henrico Citizen newspaper
- Monitored Department of Justice (DOJ) and Waiver Re-Design processes and requirements

Intake/Eligibility and Housing
- Participated in the Eligibility Pilot for Waiver by using the old and new tool for annual re-determinations and submissions for the Waiver waiting list
- Restructured to separate Residential services from Intake and Housing to meet CMS Final Rule requirements
• Updated Voucher administrative preferences to serve Agency clients only, opened the waiting list, and put 300 clients on the list for the first time in 9 years

Residential
• Completed provider Self-Assessment Survey for compliance with CMS Final Rule on integration
• Participated in a Department of Licensing Pilot to assess compliance with DOJ requirements
• Restructured to separate Residential services from Intake and Housing to meet CMS Final Rule requirements

Parent Infant Program
• Collaborated with area Neonatal Intensive Care Units to streamline evaluation process so that premature infants can access services earlier
• Partnered with Essex Village to provide a weekly play group for developmentally delayed children receiving early intervention services and typically developing peers

Case Management Services
• Converted Person Centered Planning forms into Anasazi for implementation
• Gathered and continue to gather information as requested for the state on Supports Intensity Scale Validation to assist with Waiver re-design information
• Participated in the Eligibility Pilot for Waiver by using the old and new tool for annual re-determinations
• Participated in 2 DOJ audits of Case Management services
• Participated in a Department of Licensing Pilot to assess compliance with DOJ requirements
• Continued to participate in National Core Indicators
• Case Management Services staff participated on state and regional workgroups related to quality management and waiver Re-Design
• Restructured to accommodate changes to Supports Intensity Scale assessment process

Day Services and Employment
• Converted Person Centered Planning forms into Anasazi for implementation
• Completed provider Self-Assessment Survey for compliance with CMS Final Rule on integration
• Successfully held training for VAN GO transportation drivers on diversity awareness in November 2014 – presented by 2 Day Services staff
• Assisted individuals in attending the General Assembly and speaking to their legislators
• Hosted a review by the Disability Law Center who toured and spent 3 days within our programs
• Staff were represented on several State Advisory Boards including the Employment First Advisory Group and the Community Engagement Advisory Group, both for the Dept. of Behavioral Health and Developmental Services.
## AGENCY OUTCOMES AND PERFORMANCE IMPROVEMENT MEASURES

### ADMINISTRATIVE OUTCOMES

<table>
<thead>
<tr>
<th>Efficiency Objective</th>
<th>Results</th>
<th>Performance Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency Objective: There is to be no greater than 10% of Accounts with outstanding balances in the 121+ day bucket.</td>
<td>20%</td>
<td>The target goal of 10% was not met, however, AR in the 121+ day bucket at the end of 4th quarter made up 20% of the total AR and compared to 30% in the 3rd Q, a significant decrease of 10%.</td>
</tr>
</tbody>
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Recommendations/Action taken: Goals established for FY15 were difficult to reach due to regulatory changes and manage care implementations. In FY16 the program focus will be on improving collections.

<table>
<thead>
<tr>
<th>Efficiency Objective</th>
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</tr>
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<tbody>
<tr>
<td>Efficiency Objective: No services 2 or more months should be in the Third Party Suspense; total dollars no more than $6,543.</td>
<td>$44,815.13</td>
<td>Total AR in suspense for end of the FY 2015 is $44,815.13 which is a 29% increase over our baseline but a 54% decrease as compared to 2014 Annual Results. The total number of suspense that was two months old or older was $14,624.45 which is a 39% increase over our baseline but a 53% decrease compared to the 2014 Annual Results.</td>
</tr>
</tbody>
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Recommendations/Action taken: We continue to improve business process to meet the goals as we continue process improvement necessary to reduce the amount of suspense on a monthly basis. In FY16 the program focus will be on improving collections.

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</thead>
<tbody>
<tr>
<td>Efficiency Objective: To monitor accuracy and volume of claims submitted for adjudication to Medicaid, Medicaid Managed Care, Medicare and Commercial Insurances. (GEDI 3%, Payer Errors 5%, Trizetto 5% or less)</td>
<td>GEDI 1.80%, Payer Errors 1.55%, Trizetto 3.06%</td>
<td>GEDI errors annual average of 1.80% is below the targeted goal of 3%. Payer errors are at 1.55% annually, also significantly below the goal of 5%. In comparison to the overall GEDI for all sites, we continue to remain below the 5% average at 3.06%.</td>
</tr>
</tbody>
</table>

Recommendations/Action taken: Overall, in comparison to the goals, we submitted an average of 540 additional claims per month. We will continue to address payer errors as they arise by actively working the rejections report in Gateway to remain on this trajectory.

### ADULT SUBSTANCE ABUSE OUTCOMES

<table>
<thead>
<tr>
<th>Access Objective</th>
<th>Results</th>
<th>Performance Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Objective: Clients admitted to the program will be seen within 14 calendar days for the next available appointment following the walk in intake.</td>
<td>100%</td>
<td>The team met this objective the entire year. Highest wait to second appointment was 14 days, lowest was 6. While there is some fluctuation within the 14 calendar days, staff watch this number closely and attempt to reduce the wait to the second appointment whenever possible.</td>
</tr>
</tbody>
</table>

Recommendations/Action taken: SA staff recognize the need to not only initiate services when services are requested, but understand that to fully engage clients in treatment, clients need to be seen quickly for their follow up appointment.

<table>
<thead>
<tr>
<th>Effectiveness Objective</th>
<th>Results</th>
<th>Performance Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness Objective: 60% of clients opened to this service will receive 4 hours of service (group and individual combined) within the first 30 days of service.</td>
<td>55%</td>
<td>The annual trend is improvement in the engagement of clients. While the objective of 60% was not met, the trend is definitely headed in that direction. This is a measure that will be continued in the next year.</td>
</tr>
</tbody>
</table>

Recommendations/Action taken: We understand the importance of a strong therapeutic relationship and how that correlates with positive client treatment outcomes. We have diligently worked to improve our engagement with clients and have been successful in improving the rate of engagement by 10% from the lowest month measured (45%) to the most recent month (55%).

<table>
<thead>
<tr>
<th>Effectiveness Objective</th>
<th>Results</th>
<th>Performance Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness Objective: 30% of clients admitted to services will be retained in services for a minimum of 6 mos.</td>
<td>18%</td>
<td></td>
</tr>
</tbody>
</table>
**Recommendations/Action taken:** There are many factors that affect retention in substance use disorder treatment. Barriers to sustained treatment include: lack of transportation, incarceration, relapse, lack of motivation, etc. Because some of our programming is less than 6 months in length in some areas, we will alter our definition to more appropriately match the services we provide.

**Performance Improvements:** The overall retention rate has decreased during the year, thus not meeting the objective. We have worked diligently to increase retention. Some of the strategies tried included: increasing the methadone stipend, actively outreaching clients who don’t show for appointment, and expanding group programming.

**Objectives for the Coming Year**

Access - Clients admitted to the program will be seen within 14 calendar days for the next available appointment following the walk in intake.

Effectiveness - 60% of clients opened to this service will receive 4 hours of service within the first 30 days of service.

Effectiveness - 30% of clients admitted to services will be retained in services for a minimum of 6 months.

Satisfaction - 80% of clients surveyed in September and March will rate their overall satisfaction with the session as satisfied utilizing the SRS.

<table>
<thead>
<tr>
<th>ADULT MENTAL HEALTH OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Objective:</strong> Clients will be scheduled for a follow up appointment within 14 calendar days of call to central access.</td>
</tr>
<tr>
<td><strong>Recommendations/Action taken:</strong> The requests for service far exceed the capacity. However, despite this, the agency strives to look for innovative ways of managing the needs of the citizens. Currently, the agency is investigating alternatives to our current intake structure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHARLES CITY/NEW KENT OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Objective:</strong> Clients will be seen for initial appointment within 10 days of contacting Access.</td>
</tr>
<tr>
<td><strong>Recommendations/Action taken:</strong> PF is currently experiencing is heavy caseloads. If staff are out for vacation or training, they will put opened clients in the intake slots in order to meet client needs. Another issue is client “no show” and then rescheduling the intake appointment, sometimes 2-3 times. Exploring changes to allow easier access.</td>
</tr>
<tr>
<td><strong>Effectiveness Objective:</strong> Staff will engage clients and address their needs appropriately as evidenced by an increase in planned discharges.</td>
</tr>
<tr>
<td><strong>Recommendations/Action taken:</strong> Staff need to be more cognizant of discussing discharge planning when a client initially starts treatment. Many of the closings due to “noncompliance” or “against agency advice” may be due to a client feeling better and not feeling the need to return.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENCY SERVICES OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Objective:</strong> Persons not open to the agency hospitalized through the civil involuntary admissions will attend a non-emergency discharge appointment within 7 days of their discharge 75% of the time.</td>
</tr>
</tbody>
</table>

PAGE 10
**Recommendations/Action taken:** ESP staff will continue to explore process to enhance our engagement of persons hospitalized as part of a larger hospital initiative to reduce suicide attempts (Zero Suicide). This may include more formalized outreach and flexible access processes in ESP and the agency at large.

**Performance Improvements:** For the year ESP meet the outcome objective. The average number of days from request to appointment was 4.

<table>
<thead>
<tr>
<th>Effectiveness Objective: ESP will respond to request for face to face assessment within one hour 100% of the time.</th>
<th>Results: 99%</th>
</tr>
</thead>
</table>

| Recommendations/Action taken: While there remains frustration among stakeholders in the civil commitment/ emergency process this data is useful to demonstrate delays are related to bed searches and medical issues not the response time of ESP staff. | Performance Improvements: Just missed target of 100%, 125 of 126 times. ESP staff is efficient and does prioritize emergency requests from law enforcement and emergency rooms. |

**Objectives for the Coming Year:**
Access - Persons not open to the agency hospitalized through the civil involuntary admissions will attend a non-emergency discharge appointment within 7 days of their discharge 75% of the time.
Efficiency - 90% of persons (not currently open to the agency) not hospitalized will be contacted by phone within 5 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.

**ACCESS OUTCOMES**

<table>
<thead>
<tr>
<th>Access Objective: Direct calls to Access will be answered first time 90% of the time.</th>
<th>Results: 89.6%</th>
</tr>
</thead>
</table>

| Recommendations/Action taken: The staff were able to meet the standard for the first time this year. There has been a sustained effort to ensure adequate staffing of three persons in access to meet this demand. This effort has resulted in fewer call backs. | Performance Improvements: Despite significant higher call volume the percentage of calls answered on the first time benchmark was almost met. The access supervisor has hired new relief staff and is in process of training to fill scheduling needs to support even better response. |

**Objectives for the Coming Year**
Access - 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.

**LAKESIDE CENTER OUTCOMES**

<table>
<thead>
<tr>
<th>Access Objective: 100% of consumers referred to the program will be admitted within 10 days from receipt of the referral.</th>
<th>Results: 45%</th>
</tr>
</thead>
</table>

| Recommendations/Action taken: More appointments were offered weekly by one staff (3) than when two non-licensed staff (2) were conducting initial appointments. Two additional extraneous factors that contributed to being unable to meet our objective were the reschedule of appointments after having scheduled them within 10 days and the date of appointment chosen by the SAI. In FY16 we have revised this objective to a target of admission within 15 days of the referral. | Performance Improvements: Despite good intentions, we fell quite short of our target for the year as we were only successful in admitting 45% of those referred within 10 days or less. A common occurrence over the course of the year that often led to delayed access to services was an influx of referrals around the same timeframe and/or insufficient resources to meet the demand. In the first, second, and third quarters, we were not fully staffed, therefore less appointment slots could be offered. |

| Effectiveness Objective: The “dead referral” rate will not exceed 15% (consumer who did not attend at all within 30 days). | Results: 17% |

| Recommendations/Action taken: Despite communication with the SAI about the positive impact of a program tour prior to referring an individual to services, the tours did not occur 100% of the time. Efforts will continue to be made to have program tours be a part of the total referral process. This will especially be a significant factor as we begin to accept direct program referrals in the coming year. | Performance Improvements: For FY15, we fell 2% of our targeted “dead referral” rate at 17% (11/64) for the year. This percentage was identical to FY14. In FY15, we believed that a 15% “dead referral” rate would be achievable due to an expectation, versus a recommendation, that prospective members tour the program prior to a referral being made. |
### Effectiveness Objective:
85% of sampled consumers that attend curriculum based groups will respond with an 8-10 rating to all survey questions.

**Results:** no meaningful data

**Recommendations/Action taken:** For FY15, we decided to give a pre-test and a post-test to a small sample of members who were known to attend groups regularly to see if their scores would improve from pre-test to post-test. Unfortunately, upon review of the 11 surveys, the data was determined to be meaningless. All respondents’ answers on the post-test were lower than answers on the pre-test and there were several pre-tests that contained all 10’s.

**Performance Improvements:** This objective will be discontinued in FY16. In future years, we hope to develop more reliable and valid instruments/practices to effectively measure group effectiveness.

### Efficiency Objective:
There will be improved coordination of care with other providers over the last 12 months as evidenced by a score of 90% on the record review.

**Results:** 95%

**Recommendations/Action taken:** We plan to utilize two scoring methods: one being an “all or nothing” scoring method, and the other being a strengths-based method that will reflect a percentage of the total months in which a contact was present. In other words, if one contact is missing from 24 months (2 years), the resulting score would be 96% (23/24) versus a zero (calculated in the “all or nothing” scoring method). Both methods should prove to be helpful in different capacities.

**Performance Improvements:** For the year, we were able to achieve an overall score of 95% (21/22) and in every quarter except the fourth, we were able to achieve a 100% score! In FY16, we will attempt to achieve an 85% score on the coordination of care with the SAI over the last 2 years. This should prove to be a challenge given that there were five records that were missing an SAI contact between one and two years.

### Satisfaction Objective:
90% of consumers will respond with an 8-10 rating to all survey questions.

**Results:** 80%

**Recommendations/Action taken:** Noteworthy recommendations about how to improve the program include: peace and quiet time, more exercise groups, differing levels of groups, groups separated by gender, more variety of groups, computer skills training, and more hands on activities. Suggestions to keep program fresh were: the need for audio/video equipment in group facilitation, offering more groups related to tranquility and/or exercise, better integration of members into the program, stepping up efforts in providing 1:1 time for members, increasing focus on computer skill and other skill development, and a variety of other program enhancements, such as remedial education.

**Performance Improvements:** Despite an increased sample size of 55, which was up 17% from FY14 and up 7% from FY13, we were only able to achieve a score of 80% this year. Consideration was given to alternative means of obtaining member feedback as the paper and pencil method does not appear to provide a true gauge of how we are doing. For FY16, this objective will be modified to “90% of consumers surveyed will report being satisfied with services” and the method for obtaining the results will be via 1:1 verbal survey using a random sample of five members per individual staff caseload.

### 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:** 87%

**Recommendations/Action taken:** The question that received the lowest score on one survey was: “how would you rate information received from Lakeside Center regarding various announcements, such as holiday closings, special events, social outings, etc.” In our effort to better communicate with the Stakeholders over the next year, we will ensure that each group home receives a LSC newsletter, which provides information about outings, events, holidays, lunch menu, and other tidbits of information.

**Performance Improvements:** We fell just short of the target with an overall average score of 87%. One noticeable difference between FY14 & FY15 was the response rate in FY14 was 15% higher than this year.

### Objectives for the Coming Year

- **Access:** 100% of consumers referred to the program will be admitted within 15 days from receipt of the referral.
- **Effectiveness:** The “dead referral” rate will not exceed 15% (consumer who did not attend at all within 30 days).
- **Effectiveness:** There will be an overall reduction in LSC suspensions as a result of alternative intervention.
- **Efficiency:** Coordination of care with SAI over the last 2 years will be documented in the record at least 85% of the time.
- **Satisfaction:** 90% of consumers surveyed will report being “satisfied” with services.
- **Satisfaction:** 100% of stakeholders will respond with an 8-10 rating to all survey questions.
## MH CASE MANAGEMENT OUTCOMES

<table>
<thead>
<tr>
<th><strong>Access Objective:</strong></th>
<th>100% of non-crisis clients will be seen within 7 business days of the initial attempt to access services.</th>
<th><strong>Results:</strong></th>
<th>met objective 5 of 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations/Action taken:</strong></td>
<td>Team supervisors have completed intakes throughout the year to assist their teams in meeting client demand for services. This has helped in keeping wait times as short as possible and better meeting client’s needs.</td>
<td><strong>Performance Improvements:</strong></td>
<td>The objective was met for 5 of the 12 months. Staffing vacancies/turnover was the major factor negatively impacting wait times to intake appointments.</td>
</tr>
<tr>
<td><strong>Effectiveness Objective:</strong></td>
<td>Newly opened clients will demonstrate an 80% reduction in hospitalization rate or remain hospitalization free from their baseline (measured from 3 months prior to initiation of service to 3 months after initiation of service) as compared with their hospitalization rate from months 4-9.</td>
<td><strong>Results:</strong></td>
<td>92% of clients experienced a reduction in their hospitalization rates or remained at 0 hospitalizations</td>
</tr>
<tr>
<td><strong>Recommendations/Action taken:</strong></td>
<td>During the period that we examined 203 clients were opened to the Case Management and Assessment Unit. 87 clients remained active in case management services for at least 9 months. Of these 87, 80 clients experienced a reduction in hospitalizations or remained at 0 hospitalizations. Only 7 clients experienced an increase in their rate of hospitalization. During the entire reporting period, these clients experienced 58 hospitalizations during their baseline period (3 months prior to treatment + 3 months post treatment) and only 9 hospitalizations in months 4-9 post treatment.</td>
<td><strong>Performance Improvements:</strong></td>
<td>These results demonstrate a clear reduction in hospitalization rates of clients that remain in case management services for at least 9 months which is quite encouraging. There continues to be a large number of clients that terminate case management services prior to the 9 month mark (57%), which is down slightly from the previous year results of 59%. The discharge reasons of the closed cases will be examined in the upcoming year to determine any trends and to potentially utilize in program development.</td>
</tr>
<tr>
<td><strong>Efficiency Objective:</strong></td>
<td>50% of newly opened case management clients will receive a minimum of 5 hours of case management services within the first 90 days of service</td>
<td><strong>Results:</strong></td>
<td>44%</td>
</tr>
<tr>
<td><strong>Recommendations/Action taken:</strong></td>
<td>During periods of staff vacancies, remaining team members carry higher client caseloads making it difficult to provide the level of service needed to meet this objective. Team supervisors will work closely with staff into the next fiscal year to maximize engagement services for newly opened clients in hopes of retaining clients and fully meeting clients’ treatment and recovery goals.</td>
<td><strong>Performance Improvements:</strong></td>
<td>During the reporting period 44% of newly opened clients received 5 or more hours of case management services within the first 90 days of service, falling a bit short of meeting the stated objective of 50%. Staffing vacancies on the 3 case management teams throughout the year is a likely contributor to not meeting this objective.</td>
</tr>
<tr>
<td><strong>Satisfaction Objective:</strong></td>
<td>90% of clients will respond with the two highest ratings to all questions on the satisfaction survey.</td>
<td><strong>Results:</strong></td>
<td>97%</td>
</tr>
<tr>
<td><strong>Recommendations/Action taken:</strong></td>
<td>Teams will continue to strive to gain higher return rates of surveys so that we will have a broader view of clients’ satisfaction with services.</td>
<td><strong>Performance Improvements:</strong></td>
<td>Of the surveys returned the client satisfaction and feedback continues to be quite positive – With 97% of client responses giving one of the top 2 ratings. The return rate of surveys is at 26% up slightly from last year at 24%.</td>
</tr>
<tr>
<td><strong>Satisfaction Objective:</strong></td>
<td>90% of those responding to the survey will respond with the two highest ratings to all questions on the stakeholder satisfaction survey.</td>
<td><strong>Results:</strong></td>
<td>94%</td>
</tr>
<tr>
<td><strong>Recommendations/Action taken:</strong></td>
<td>Agency Prescribers and staff from Psychosocial Rehabilitation and Mental Health Skills Building were surveyed and results were quite positive. There were 86 surveys returned and out a total of 344 questions asked 323 questions received one of the top 2 ratings on the survey or 94%.</td>
<td><strong>Performance Improvements:</strong></td>
<td>There was much useful feedback provided that will be shared with case management staff in individual supervision in order to continue to improve services and collaboration between service providers.</td>
</tr>
</tbody>
</table>
## Objectives for the Coming Year

Access - Non crisis clients will be seen within 7 business days of initial attempt to access services.

Effectiveness - Newly opened clients will demonstrate an 80% reduction in hospitalization rate or will maintain 0 hospitalizations. Efficiency - At least 50% of newly opened case management clients will receive a minimum of 3 hours of case management services within the first 90 days of service.

Satisfaction - 90% of client responses will be one of the two highest ratings to questions on the satisfaction survey.

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.

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### MH PACT OUTCOMES

**Access Objective:** There will be an increase in 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.

**Results:** 78%

**Recommendations/Action taken:** Both teams were able to successful get over three fourths of their clients to attend appointments with a community health provider. This data does not include the numerous appointments attended with the agency psychiatrist whom might also address some issues with the client, nor does it include the clients who are being taken to appointments by family members, Medicaid transportation, or even the ones who are able to drive themselves.

**Performance Improvements:** The East PACT team had only 3 clients on the entire team who were not seen by a health care provider during FY15. For the following year our goal will continue addressing this area of concern and set the goal to 75% of the client on the PACT/ICT team will attend an appointment with a health care provider during FY16.

**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.

**Results:** West ICT 410 hospital bed days/43 crisis stabilization bed days (.10), East PACT 247 hospital bed days/47 crisis stabilization bed days (.19) (baseline = .25)

**Recommendations/Action taken:** The data does suggest that it might be possible for staff to intervene earlier to avoid having to be admitted on an involuntary basis, and it is important to note that 65 of those inpatient bed days were clients whom went to the hospital on a voluntary status. Continue to work on this goal to avoid using inpatient bed days unless all other options have been attempted and provide education to clients on the availability of the CSU when in crisis to avoid having to be inpatient.

**Performance Improvements:** Results were lower than expected and implies that CSU is not being utilized as much as we had hoped. In looking at the data and the specific cases it would be difficult to have made another decision based on the acuity the of clients mental status.

**Efficiency Objective:** 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:** 100%

**Recommendations/Action taken:** Based on the total admissions for both teams this outcome is something that has been met consistently. Using an EHR has greatly improved this process and made it easier to monitor the status of completion.

**Performance Improvements:** All paperwork is being completed within the 30 days of opening a new client. Having an EHR allows for easier monitoring and collection of the necessary information.

**Satisfaction Objective:** 100% of consumers will rate their satisfaction with PACT and ICT services a “4” or higher on the PACT/ICT Consumer Satisfaction Survey.

**Results:** 86%

**Recommendations/Action taken:** Satisfaction declined for all questions compared to last year, the largest being a 16-point decrease in # 5, “My primary worker helps me make the most of my personal strengths as we work toward my personal recovery.” ICT and PACT Team Leaders will strategize ways to help program staff assist clients in making the most of personal strengths in working toward recovery.

**Performance Improvements:** Cumulatively, the West ICT and East PACT Teams had 26 clients complete the survey. The percentage rating their satisfaction at 4 or higher, overall out of 130 total responses, for a satisfaction figure of 86% overall.
**Satisfaction Objective:** Local hospital social work staff will rate their satisfaction with PACT/ICT Team staff at “4” or higher on the PACT other stakeholder satisfaction survey

| Results: no responses |

**Recommendations/Action taken:** Plan was to increase to surveying local hospital social work staff in December and June and have staff increase outreach to social workers to stimulate additional responses. We were unsuccessful in obtaining any surveys from local hospitals during our clients inpatient stays.

**Performance Improvements:** This outcome has proven that we are not able to get the results that we are looking for. Data is hard to gather and the hospitals are not that willing to participate. For FY16 we have decided to remove this outcome measure and look to solicit the help of family members to help us evaluate our services.

---

**Objectives for the Coming Year**

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

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

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

**Satisfaction** – Consumer’s families/identified primary support system will complete a service satisfaction survey to rate the services being provided to their family members.

**Satisfaction** – Consumers will rate their satisfaction with PACT and ICT services a “4” or higher on the PACT/ICT Consumer Satisfaction Survey.

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**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 FY15. We did have one male resident successfully move to a lower level of care home, his bed will not be filled reducing the number of residents from six to five. This now leaves only one shared bedroom.

**Performance Improvements:** In FY16, we will continue this measure.

**Effectiveness Objective:** 80% of residents will demonstrate increased independence with caring for their personal hygiene as evidenced of needing less prompts/direction to brushing their teeth and wearing clean clothes that fits, matches, and are weather appropriate.

| Results: 50% |

**Recommendations/Action taken:** There were many factors throughout the year that contributed to us not consistently meeting this objective. A busted pipe caused significant damage to the home and required a lengthy time to repair. Additional factors that contribute to us not meeting this objective consistently include: the small sample size, the chronicity of the population served as well as one resident having a progressive neurological condition.

**Performance Improvements:** We are pleased that we met this objective during the fourth quarter. The dedication of the group home supervisor and the residential staff are evident in their daily work with the residents. This objective will continue for the next reporting year.

**Effectiveness Objective:** 100% of residents will participate in at least one community activity a quarter that will promote community integration and further development of social skills.

| Results: 100% |

**Recommendations/Action taken:** Community activities were planned by residents and staff: NAMI banquet and picnic, the recovery luncheon, community parks, the State Fair of VA, cultural festivals, movies, shopping and eating at various food establishments. This objective will be slightly modified for the next reporting year and will focus more on skill building.

**Performance Improvements:** We are pleased that we met this objective throughout the year and provided residents with opportunities for community integration.
Efficiency Objective: There will be improved coordination of care between staff and the resident’s SAI as evidenced of monthly documentation 90% of the time.

Results: 100%

Recommendations/Action taken: Improved communication has assured that the residents’ needs were met. This objective will be modified for the next reporting year to measure the communication between residential staff and the resident’s day treatment program staff.

Performance Improvements: Significant compliance was noted in communication resulting in better coordination of care for our clients.

Satisfaction Objective: 85% of consumers will respond with an 8-10 rating to all survey questions.

Results: 67%

Recommendations/Action taken: While the results of the consumer satisfaction survey initially appear low, all questions that were not rated with an eight and above were rated with a seven which on the scale indicates a “good” rating. We did receive a helpful comment. This person felt that her ideas and opinions were heard but that staff were not quick enough in responding, especially when problem solving conflict with other residents. This comment was discussed with the group home supervisor to explore ways of improving staff’s response time to handling conflicts among residents.

Performance Improvements: This objective will be modified for the next reporting year; rather than conducting a survey, a focus group with the residents will occur first followed by a follow-up discussion and survey questionnaire.

Satisfaction Objective: 85% of family stakeholders will respond with an 8-10 rating to all survey questions.

Results: 100%

Recommendations/Action taken: This objective will be modified for the next reporting year. The objective will measure the satisfaction of the staff assigned to the resident in their day treatment program.

Performance Improvements: Out of the five surveys sent, four were returned all with ratings of 8-10. We are pleased that this objective was met as residential staff, especially the group home supervisor, works hard in maintaining communication and a relationship with family members and/or guardians.

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 - Four out of five residents will demonstrate increased independence with caring for their morning and evening routine as evidenced of needing less prompts/direction to brushing their teeth and wearing clean clothes that fits, matches, and are weather appropriate.

Effectiveness - Residents will score an average of three on a scale of 1-5 on the community activity sheet that measures appropriate social behavior when on community outings in order to further promote community integration and reinforce social skills developed.

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

Satisfaction - Four out of five stakeholders (stakeholder is defined as the staff assigned to the resident in their day treatment program) will respond with an 8-10 rating to all survey questions.

MH SKILLS BUILDING OUTCOMES

Access Objective: MHSS will open consumers within 7 days of case manager being notified of opening.

Results: met objective 8 of 24 openings

Recommendations/Action taken: These results cannot be compared to last year’s results as our goal last year was to open consumers up within 30 days of referral and not within seven days. As a result of not achieving this goal for the year, but having more recent success in the quarter, this objective will be modified. The objective will read, “MHSS will open 90% of referrals within 7 days of referral from case manager.”

Performance Improvements: Twenty-four consumers were opened this past fiscal year with 8 of these referrals being opened within 7 days. As a result, 33% of consumers were opened within 7 days of referral. The average wait period for the year was 16.9 days.

Effectiveness Objective: Of consumers currently enrolled in MHSS, 15 will be discharged successfully in the next year.

Results: 3 successful discharges
Recommendations/Action taken: Last year MHSS became viewed as a time limited service in which consumers were expected to graduate, and so many consumers did indeed graduate inflating the results. Due to change in expectations, this objective will be measured differently next fiscal year; the new measure will focus on the ratio of successful discharges to total discharges. Since 3 discharges out of 14 discharges were considered successful, the new objective will be to have 25% of discharges considered successful.

Performance Improvements: A total of 14 consumers were discharged from MHSS with 3 of these discharges considered successful. The remaining 11 consumers were discharged for an assortment of reasons to include: client decision/against advice (4 consumers), change in client need/transfer (1 consumer), non-compliance with treatment (4 consumers), incarceration (1 consumer), and client chose another treatment provider (1 consumer).

**Efficiency Objective:** MHSS staff will document monthly collateral contacts with case managers 90% of the time.

Results: 84%

Recommendations/Action taken: MHSS supervisors will continue to try and keep this trend moving forward by reminding all staff via e-mail and in team meetings to be sure everyone completes their monthly collateral contacts. In addition this goal will be measured differently with the focus being on collateral contacts being completed 90% of the time as opposed to collateral contacts being completed all three times on 90% of the consumers.

Performance Improvements: This objective was not achieved for this fiscal year where charts only had all three contacts per quarter documented 84% of the time; however, this was a 4.4% increase over last year’s fiscal result which was only 79.6%.

**Satisfaction Objective:** 90% of clients will respond positively to each survey question.

Results: 70%

Recommendations/Action taken: We successfully graduated 16 consumers last year and an additional 3 more this year so far. As a result, the sample may be skewed toward more negative results as we lose our more motivated consumers. Also, some of our consumers are not happy with our service becoming more time limited in nature, and staff members have had to continue having tough conversations with consumers.

Performance Improvements: 70% of client survey responses were in the excellent range (8-10) which did not exceed this objective which was 10% lower than last year’s results. MHSS will continue to focus on skills building with the hope that satisfaction regarding goal progression will be gained.

**Satisfaction Objective:** 80% of primary case managers responses to the survey questions will be 8 or above.

Results: 90%

Recommendations/Action taken: MHSS has continued to do an excellent job collaborating and communicating with its primary stakeholder (case managers). Case managers view MHSS as a recovery focused service which has helped shared consumers improve. MHSS is viewed as responding in a timely manner, as being responsive, and as having monthly contact regarding shared consumers.

Performance Improvements: This year’s result was just 0.6% lower than last year’s result which was 90.6%. These results were shared with staff.

**Objectives for the Coming Year**

Access - MHSS will open 90% of referrals within 7 days of referral from case manager.

Effectiveness - 25% of all consumers discharged from MHSS will be considered “successful.”

Efficiency - MHSS staff will document monthly collateral contacts 90% of the time.

Satisfaction - 90% of consumers will respond positively to each survey question as evidenced by a score of 8 or higher for every question.

Satisfaction - 80% of ARS case manager responses will be in the excellent range (8-10).

**MH VOCATIONAL OUTCOMES**

Access Objective: Increase the number of participants that have received employment services by 10.

Results: 11

Recommendations/Action taken: A new referral process is forthcoming that does not require those seeking vocational services to be currently receiving agency case management services. The vocational team will continue to meet with DARS and assist individuals in accessing needed resources that may be offered, once eligible.

Performance Improvements: This goal was reached for the year. It will be increased to 15 for the upcoming year.
<table>
<thead>
<tr>
<th>Effectiveness Objective:</th>
<th>Twenty-four (24) additional assigned-program participants will become hired during evaluation period.</th>
<th>Results: 15</th>
<th>Performance Improvements: The realization that only two-thirds of the goals for program hires is disappointing. However, it is believed that the goal can be reached. The vocational team will continue to review and increase employer contacts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations/Action taken:</td>
<td>“Cold-calling” and more job development contacts will increase the likelihood of gaining employment. Staff is involved with the application process. It has been discovered that many clients struggled with required “assessments” that have been added to many employer applications. Staff realizes the need for engagement with this portion of job development &amp; will review completed application, when at all possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiency Objective:</td>
<td>Full time job coaches will meet 40% productivity</td>
<td>Results: 38%</td>
<td>Performance Improvements: The annual results fell just short of the desired goal by 2%.</td>
</tr>
<tr>
<td>Recommendations/Action taken:</td>
<td>The team has discussed the lower trends in the 2nd and 4th quarters. We are committed to schedule more job development and follow along during October-December, which seems to be a time of lower trends. This is possibly due to the holidays and time off for staff. In addition the case management teams will be visited more often with the goal of increasing vocational referrals and answering questions, especially from newer staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction Objective:</td>
<td>90% of responding program participants will score a rating of at least “8” satisfaction level on a scale of 0 to 10.</td>
<td>Results: 89%</td>
<td>Performance Improvements: The annual results were very close to the 90% desired. Next year the team will move to a more “focus group” approach and hopefully that will provide more comments and or solutions to employment concerns and progress.</td>
</tr>
<tr>
<td>Recommendations/Action taken:</td>
<td>The interactions with program participants seemed very honest and insightful. The comments about transportation were true and definitely impact employment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction Objective:</td>
<td>90% of responding employers will score a rating of at least “8” satisfaction level on a scale of 0 to 10</td>
<td>Results: 95%</td>
<td>Performance Improvements: The 90% goal was achieved. However, the program will move to a focus group approach to measuring stakeholder satisfaction for the next year.</td>
</tr>
<tr>
<td>Recommendations/Action taken:</td>
<td>The information that was received from telephone calls seems to lack substance and lacked a sense of personal connection with the responding employers. The focus groups will be planned around the convenience of participating employers.</td>
<td></td>
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</tr>
</tbody>
</table>

**Objectives for the Coming Year**

**Access** - Increase the number of participants that have received employment services by fifteen.

**Effectiveness** - Staff will assist program participants with obtaining twenty-two additional jobs during the evaluation period.

**Efficiency** - Full time job coaches will reach at least fifty direct service hours monthly.

**Satisfaction** - 90% of responding program participants will score a rating of at least “8” on a scale of 0 to 10.

**Satisfaction** - 90% of responding employers will score a rating of at least “8” satisfaction on a scale of 0 to 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.

<p>| Recommendations/Action taken: | Registration for the Connect program continues to be offered at each program site. The majority of admissions occur at the beginning and end of the school year (i.e., summer program). Access to the program is determined based on site capacity. As space permits, youth can begin participation in the Connect program following registration, staff approval, and parental preference regarding start date. | Results: 100% | Performance Improvements: There were 67 new admissions to the Connect program in FY15, representing a 58% increase in admissions over the prior year. The new participants comprised approximately 44% (43.79) of the total Connect program census. All 67 admissions were approved within 5 business days. |</p>
<table>
<thead>
<tr>
<th>Effectiveness Objective:</th>
<th>Results:</th>
</tr>
</thead>
<tbody>
<tr>
<td>95% of CONNECT of 1st – 3rd grade participants shall be reading on or above grade level.</td>
<td>80% reading on or above grade level</td>
</tr>
</tbody>
</table>

**Recommendations/Action taken:** This year the Connect program experienced significant staff shortages that impacted programming. The progress made in reading outcomes can be attributed to staff and interns from area colleges working with participants on basic reading skills and creative language arts activities, close collaboration and follow-up with teachers by Connect staff, on-site tutorials provided by teachers at some Connect sites, and Connect staff facilitating greater parental engagement with the schools. Prevention Services is also working closely with Human Resources to find creative solutions to improve recruitment of dedicated and qualified part-time staff to support Connect programming.

**Performance Improvements:** Although the 95% objective was not achieved, there was significant progress made in reading over the course of the school year. The number of youth reading below grade level was reduced from 17 (three of which receive modified instruction) to 10. 80% of the 1st-3rd graders who participated in Connect throughout the school year are now reading on or above grade level compared to 66% at the beginning of the school year.

<table>
<thead>
<tr>
<th>Effectiveness Objective:</th>
<th>Results:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>slight decrease in favorable attitudes obtained</td>
</tr>
</tbody>
</table>

**Recommendations/Action taken:** The Prevention Services staff continues to develop creative substance use prevention activities to supplement the evidence-based curriculums in an effort to enhance positive outcomes. Other substance use prevention activities include training in prevention science, leadership development, jobs skills training and cultural enrichment. Research shows that a combination of these activities is more likely to reduce substance use and other risk factors, and promote healthy behaviors/lifestyles in youth.

**Performance Improvements:** 1st and 2nd graders sustained 100% unfavorable attitudes toward “kids” drinking alcohol and smoking. 3rd and 5th graders showed slight decreases in favorable attitudes, and the 7th grade group favorable attitudes remained virtually unchanged–65% showed unfavorable attitudes on posttest.

<table>
<thead>
<tr>
<th>Efficiency Objective:</th>
<th>Results:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Henrico Too Smart 2 Start Community Coalition shall implement community-level prevention strategies as measured by the delivery of 2 events annually.</td>
<td>4 events</td>
</tr>
</tbody>
</table>

**Recommendations/Action taken:** Substance use and mental illness are connected to suicide risk and completed suicides. Based on that fact, this fiscal year Prevention Services took on an additional area of focus- raising awareness regarding suicide prevention as part of a regional initiative funded by the Dept. of Behavioral Health & Developmental Services.

**Performance Improvements:** Prevention Services exceeded its objective for FY15 by implemented four community-level activities: 1) Rx Drug Take Back in collaboration with Henrico Police Dept., 2) A suicide public service announcement shown at Regal Cinema theatre, 3) It takes a Village Community Forum, 4) the production of The Little Black Dress raising awareness about depression.

<table>
<thead>
<tr>
<th>Satisfaction Objective:</th>
<th>Results:</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% of CONNECT participants (3rd grade and above) shall give a response of 1 (i.e., agree) on the consumer satisfaction survey</td>
<td>84%</td>
</tr>
</tbody>
</table>

**Recommendations/Action taken:** In general, Participant Satisfaction Survey comments reflect that most participants establish close bonds with staff and enjoy the specialty programs, recreational activities, fieldtrips, and the opportunity for summer employment. Staff turnover continued this year in all 5 of the Connect programs. Staffing continues to be supplemented by college/university interns, teachers and parent volunteers. Quality service and program stability (i.e., staffing) remain paramount goals for the Connect programs as recruitment continues to focus on staff and volunteers with the dedication and skill to work effectively in the communities served by the Connect program.

**Performance Improvements:** The mean survey results 84% for this school year fell slightly short of the objective of 85% of youth served agreeing that the Connect program is beneficial to them. The majority of the participants reported enjoying the program, appreciating staff interaction with them, and acknowledged both academic and social-emotional benefits from the program. Older youth, Teen Job Prep Program and Youth Ambassadors, reported valuing the job skills and work opportunities, as well as learning leadership skills. The partnership with the Central Virginia Food Bank Kids Café was particularly important to some youth who noted that the program serving food was something they like about Connect.
**Satisfaction Objective:** 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree) on the satisfaction survey

| Results: | parents 98%, community 99% |

**Recommendations/Action taken:** Both parents and other community stakeholders offered similar feedback, requesting expansion of the program in staffing, space and scope of services. Parents’ comments reflect their perception of Connect as having a positive role in their child’s education, social-emotional development, and good citizenship that contributes to their community. Likewise, community stakeholders agree that Connect is a great resource for the child and the community.

**Performance Improvements:** The objective of 95% of community stakeholders reporting that the Connect program is beneficial was exceeded. The annual results reflected an average of 98% of parents and 99% of other community stakeholders commented positively about the program.

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**Objectives for the Coming Year**

Access - Consumers will be approved for admission into the CONNECT program within 5 business days of request for services.

Effectiveness - 95% of CONNECT of 1st – 3rd grade participants shall be reading on or above grade level.

Effectiveness - Students will show a decrease in favorable attitudes towards Alcohol, Tobacco and other Drugs (ATOD) as demonstrated by the evaluation outcomes of evidence-based curriculums implemented in the community.

Efficiency - Prevention Services shall implement environmental approaches, in collaboration with community partners, to address substance use prevention and mental wellness as measured by the delivery of 2 community-level activities annually.

Satisfaction - 85% of CONNECT participants (3rd grade and above) shall give a response of 1 (i.e., agree) on the consumer satisfaction survey.

Satisfaction - 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree) on the satisfaction survey.

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**YOUTH & FAMILY OUTCOMES**

**Access Objective:** 100% of Youth & Family services non-crisis consumers will be seen within 10 business days of their initial attempt to access services

| Results: | met 3 of 12 months |

**Recommendations/Action taken:** Tracking this objective over time has been helpful in clarifying the impact of multiple contractual and community demands on program capacity and overall access to outpatient services for children and adolescents. While HAMHDS Youth & Family Services staff is able to provide rapid response for court-ordered evaluations, school-contracted substance abuse evaluations, and Medicaid-contracted independent clinical assessments, those commitments diminish our capacity to respond to non-crisis outpatient consumers. Multiple staff vacancies and leaves have also impacted both capacity and planning efforts.

**Performance Improvements:** Youth & Family Services Outpatient teams met their Access goal of seeing non-crisis consumers within 10 days of first contact for three months during this fiscal year, or 25% of the time. Y&FS staff opened 735 cases, averaging 61.25 cases per month. Youth & Family Services Supervisors and staff have continued to explore strategies for maximizing access to services across populations.

**Effectiveness Objective:** MST Team will increase the percentage of youth in the program who remain in their current placement [in home and community] to program target of 90%

| Results: | 74.32% |

**Recommendations/Action taken:** Actions taken to improve this outcome measurement include doing community stakeholder education, making family stabilization a priority in the team, educating stakeholders about making appropriate referrals and advocating to the judges about alternatives to detention such as crisis planning and supervision and monitoring plans.

**Performance Improvements:** MST staff continues to work with community agencies to identify alternatives to placement outside of the home. Engagement and buy-in from probation staff continues to be strong and there has been a continued wait list for services during this past year.

**Effectiveness Objective:** Clients in the Court Alternative Program-SA (CAP-SA) educational group will demonstrate an increase in SA knowledge through their participation in the four week program; Baseline: 90% feel supported by family; 50% feelings contributed to use; 85% they would likely have more problems if they continued to use.

| Results: | 79% feel supported by family; 49% feelings contributed to use; 76% they would likely have more problems if they continued to use. |
**Recommendations/Action taken:** It would be good to track in the future as the CAP SA program continues the number of clients that must return and finish more intensive services such as our Path group for SA treatment. This could add to the information about the success of the educational group. The group facilitators will continue to find ways to strengthen the messages regarding the relationship of feelings and on-going use/abuse of substances, and that the continued use/abuse of substances will lead to more problems for the client.

**Performance Improvements:** A majority of the clients were able to feel supported by their families by the end of the CAP SA psycho-educational group, they were also able to see that more trouble would come from continued use and almost half of the clients saw that their feelings contributed to their use of substances. These numbers support that some of the key issues were addressed and important information passed on to the clients to enable them to make a better decision about their use.

**Effectiveness Objective:** 90% of participants in the Incredible Years Parenting Group will report positive gain in 50% of items on the IY Parenting Scale.

**Results:** 100%

**Recommendations/Action taken:** This past year we have undergone several staffing changes and the demands on our programs have grown significantly, particularly in the case management arena. Due to staff turnover and attrition we currently have only one trained facilitator to provide the IY group. In the next fiscal year we will assess the continued sustainability of the IY parenting program as well as assess the referral and attendance of the group which has been declining in the past 4 years.

**Performance Improvements:** The outcomes from 2nd quarter, although a very small sample size, show that the IY parenting program has a positive impact on parents.

**Objectives for the Coming Year**
- **Access** - Y&FS non-crisis consumers will be seen within 14 calendar days of initial attempt to access services.
- **Effectiveness** - Reoffending rates will remain at or below 10% for MST clients during the course of treatment.
- **Effectiveness** - Youth & Family Services staff will conduct a face to face visit with client/families receiving targeted case management services every 30 days at least 85% of the time.
- **Effectiveness** - Youth & Family Services Outpatient clinicians will see their clients within 14 days of their Initial session 90% of the time.

**CSS CASE MANAGEMENT OUTCOMES**

<table>
<thead>
<tr>
<th>Access Objective: 100% of individuals will be seen within 20 days of assignment to “Eligibility Complete” unit</th>
<th>Results: 77%</th>
</tr>
</thead>
</table>

**Recommendations/Action taken:** Reasons for delayed meetings included individual preference to delay the meeting, illness on the part of the individual, family or Case Manager, and delays in assigning and moving the chart. New processes were established to reduce eliminate the need for the Case Manager to have the physical chart before contacting the individual to set up the meeting. This seems to help address the issues involved in moving the charts from one location to another but does not address illnesses or requests for delays of meetings. Processes designed to eliminate delays in chart assignment, notification to Case Manager of assignment and notification to individual of assigned Case Manager will continue to be implemented.

**Performance Improvements:** There were a total of 110 individuals assigned to the Community Support Teams in FY15. Of those 30 were Waiver transfers from other community services boards to the Teams and 1 individual had a Money Follows the Person grant. 45 individuals were assigned to start as Periodic Survey. The Periodic Survey individuals do not receive a face to face meeting once assigned to the Community Support Teams. The first face to face meeting for individuals who have Waiver or a Money Follows the Person grant occur prior to the effective transfer date. 77% (26 of 34) of the individuals who met the target group for being seen within 20 days had the first face to face within 20 days.

**Objectives for the Coming Year**
- **Access** - Individuals will be seen within 20 days of assignment to “Eligibility Complete” unit.
- **Effectiveness** - For individuals 18 and over interest in employment will be discussed at the time of the annual meeting.

**CSS DAY SERVICES OUTCOMES**

| Access Objective: 100% of Individuals referred to one of the Day Services programs will be contacted by the Training Specialist within 10 days of assignment from the Program Supervisor. | Results: 82% |
Recommendations/Action taken: 9 of 11 referrals were referred to a Training Specialist who contacted the individual or family within ten days. Five individuals chose to come into the Day Services programs after their assessments were complete. One chose to return to Supported Employment and one choose to go into Group SE. Three referrals are still awaiting their scheduled assessments due to a combination of scheduling and transportation issues. One chose another day provider because we did not have an opening in the program she wanted.

Performance Improvements: We are generally successful in contacting individuals or families within the 10 business days. The outcome will be changed next year to reflect days, not just business days.

<table>
<thead>
<tr>
<th>Effectiveness Objective: 55% of the individuals will participate in at least one activity that meets the community inclusion criteria per quarter.</th>
<th>Results: 59.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations/Action taken: This was a positive move towards more community engagement activities. Each program area emphasized finding activities that individuals would enjoy and linking with community resources. Our efforts have been successful in providing opportunities for individuals to meet people and build relationships and to provide opportunities for members of our community to understand individuals with disabilities.</td>
<td>Performance Improvements: Over the year, we met this outcome three of the four quarters, missing the third quarter with only 52%. Our overall average was 59.5% of the individuals we serve were able to participate in a community inclusion activity – meaning the activity was in a naturally occurring setting with less than 3 individuals with disabilities. The Program-by-program breakdown is as follows: LEP – 33.5 (0 of 4 quarters); STEP – 89% (4 of 4 quarters); Hermitage workshop – 56% (2 of 4 quarters).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effectiveness Objective: 5 individuals who attend the workshop will participate in individual or group supported employment activities by the end of the year.</th>
<th>Results: 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations/Action taken: The Employment Resource Program assists individuals who are in the workshop program at Hermitage Enterprises identify and seek more integrated community employment making minimum wage or above. This program will continue as an integral part of our Employment Services.</td>
<td>Performance Improvements: Our goal was to assist 5 individuals and in actuality we assisted 7 individuals move to more integrated employment opportunities. 3 of the individuals have been placed in jobs on group sites on either a part time or full time schedule. 1 is working part-time as an office assistant at Hermitage, making minimum wage. The other 3 are currently working with Employment Specialists and are actively seeking employment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Efficiency Objective: Utilization Peer Review scores on the DATA section will reflect an average of 95% compliance for all waiver charts.</th>
<th>Results: 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations/Action taken: Most of the areas of missing data were signatures. There were a few cases of missed details such as changing sheets at the start of the new annual year to ensure we were collecting the appropriate data. With the small sample size, the figures are representative for the individual programs with no significant deviance between programs. The billing of the 3rd unit in several programs continues to be a challenge. We are re-evaluating our data keeping systems in light of the recent changes in regulations and person centered processes.</td>
<td>Performance Improvements: There were 19 waiver charts reviewed this year, with 18 of them requiring data to be compiled, representing 20% of all waiver charts. Of those 18 charts, there were 152 data elements that were evaluated for compliance. We reached compliance on 144 of those elements for a rate of 94.7%, essentially meeting this outcome. We will continue to monitor an outcome about documentation due to these changes.</td>
</tr>
</tbody>
</table>

| 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 in their program. | Results: 85% |
Recommendations/Action taken: We used a personal interview to determine the satisfaction of those we serve. A face to face interview was completed with 82 of the 101 individuals enrolled in one of the programs at Hermitage and Cypress. Most comments indicated they wanted variety in both work and recreation and many wanted to go out to restaurants or shopping more. We will take the comments and continue to incorporate suggestions from the individuals into our planning including the expansion of both our employment and community based opportunities.

Performance Improvements: There were 10 individuals who did not respond to the survey or whose responses could not be categorized by the interviewer. Of the 71 responses we recorded, 85% expressed satisfaction all or most of the time.

Satisfaction Objective: 90% of the Business customers and Community Partners for whom we volunteer will respond with a 4 or 5 on a satisfaction survey.

Results: 100%

Recommendations/Action taken: We mailed out 14 surveys to business customers of the workshops at Hermitage and Cypress and received 8 back for a return rate of 57%.

Performance Improvements: Of those returned all rated our service as better than average to above average, meeting the outcome criteria. There were 7 other questions on the survey from responsive to needs to interactions with the driver. All responses were positive. We will continue the emphasis on customer service to continue to increase our customer satisfaction.

Objectives for the Coming Year
Access: 100% of the individuals referred to a Day Service program will be contacted within 20 days to discuss/schedule an assessment or visit.
Effectiveness - Billing: 95% of the billing documentation will match the information keyed and billed in Anasazi.
Effectiveness - Non-waiver Programs: 80% of those in the non-waiver programs of STEP, Cypress and Hermitage will have an employment goal in their ISP.
Effectiveness - Waiver Programs: 80% of the individuals in a waiver program at Hermitage, Cypress, STEP or LEP will have an outcome related to community integration in their ISP.
Efficiency - Utilization Peer Review: Scores on the new PCP plans including the new plan for supports will reflect an average of 95% compliance for all waiver charts.
Satisfaction - Customer: 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.
Satisfaction - Families and Caregivers: 90% of the Families and Caregivers will respond with a 4 or 5 on a satisfaction survey.

CSS INDIVIDUAL SUPPORTED EMPLOYMENT OUTCOMES

Access Objective: 100% of individuals will be seen by the employment specialist within 10 days of assignment from the supervisor.

Results: 75%

Recommendations/Action taken: This outcome was successful in helping the Employment Specialist understand the importance of quickly making contact and begin working with the individuals on their job quest as quickly as possible. We will continue this outcome into the coming year.

Performance Improvements: We received a total of 16 referrals from Support Coordinators or DARS this fiscal year. We were able to meet with 12 of the individuals within 10 days of the Employment Specialist receiving the referrals. Of the four we did not meet within 10 days we met within an average of 21 days. Many of those individuals were contacted via telephone within the 10 days but appointments could not be arranged due to scheduling.

Effectiveness Objective: 100% of the individuals assigned a job coach from the ERP will begin the assessment process within 30 days of the referral.

Results: 100%

Recommendations/Action taken: This outcome has allowed us to establish a procedure for accepting and working with individuals who want to leave the facility program and move into Supported Employment. This will provide us with the necessary resources to continue to assist in expanding our Employment First efforts in coming years.

Performance Improvements: Three individuals were referred from the ERP program in the Hermitage Workshop program and all three began working with their job coach within the first 30 days after a referral was received.
### Effectiveness Objective
Group SE: 100% of the new enclaves/crews developed for group employment will incorporate an hourly pay rate of minimum wage or above for the consumers.

<table>
<thead>
<tr>
<th>Results</th>
<th>Policy established</th>
</tr>
</thead>
</table>

**Recommendations/Action taken:** No enclaves were developed in this fiscal year. However, having this outcome to pay minimum wage or above at all group employment sites did allow us to establish a policy around only working with employers, cementing our efforts towards Employment First.

**Performance Improvements:** This policy did help when one business approached us about reverting back to piece rated work after they had changed to an hourly, minimum wage standard. We were able to ensure that the consumers were paid appropriately for the work they performed.

### Efficiency Objective
Job coaches will present or meet with one new non-traditional business once per quarter to promote the hiring of individuals with disabilities.

<table>
<thead>
<tr>
<th>Results</th>
<th>Met 3 of 4 quarters</th>
</tr>
</thead>
</table>

**Recommendations/Action taken:** The staff was able to identify employers willing to hire individuals with disabilities in jobs beyond the basic work done in grocery stores or fast food restaurants. Continuing to expand our business networks will allow individuals to find the job of their choice, not just any job that is available.

**Performance Improvements:** This outcome to present and work with at least one non-traditional business or job types per quarter was met 3 of the 4 quarters this year. A total of 5 presentations were made to such varying companies as Hancock Fabrics and Colonial Scientific Management.

### Satisfaction Objective
90% of individuals in both Group and Individual Supported Employment services will express satisfaction with supports provided by their Training/Employment Specialist.

<table>
<thead>
<tr>
<th>Results</th>
<th>98%</th>
</tr>
</thead>
</table>

**Recommendations/Action taken:** Comments were positive with many thanking their employment specialist and some indicated they may want a change of jobs soon but feel their employment specialist listens to them. We received approx. 40% of the surveys back. We will continue to emphasis excellence in customer service.

**Performance Improvements:** For the Community Employment services, 98% expressed satisfaction with their services (48 of 49). 15 individuals in Group SE responded to the survey, with 14 indicating they liked their work most or all of the time and 1 stating they liked it some of the time. This is a 93% positive response rate. For Individual SE, 34 individuals responded and ALL expressed satisfaction with their employment specialist.

### Satisfaction Objective
90% of the referral sources (Case Managers and DARS Counselors) will express satisfaction with the work of the Training/Employment Specialist with a response of 4 or 5 (on a 5pt. scale) on a survey.

<table>
<thead>
<tr>
<th>Results</th>
<th>80%</th>
</tr>
</thead>
</table>

**Recommendations/Action taken:** Concerns were in the area of communication. At team meetings, the importance of communication was discussed and staff was able to brainstorm ways they could make improvements in this area.

**Performance Improvements:** We received a total of 10 responses back from our DARS counselors and our Agency Case Managers. 4 indicated their consumers were in Group SE and 6 in Individual SE. 2 surveys rated their satisfaction a 3 (satisfied) or 2 (unsatisfied) on the scale of 1 to 5. 8 surveys rated their satisfaction 5 – Very Satisfied.

### Objectives for the Coming Year
- **Access -** Individuals will be seen by the employment specialist within 10 days of assignment from the supervisor.
- **Effectiveness -** 90% of the individuals in job development will be placed in an integrated job of their choice within 4 months of their start date.
- **Efficiency -** Documentation of all services and plans will meet an overall 94% compliance in the Utilization Review.
- **Satisfaction -** 90% of individuals in both Group and Individual Supported Employment services will express satisfaction with supports provided by their Training/Employment Specialist.
- **Satisfaction -** 90% of the Businesses/Employers for both Group and Individual SE will express satisfaction with the services offered by the program by answering with a 4 or 5 on a 5 pt. scale.

### CSS INTAKE OUTCOMES
- **Access Objective:** 100% of individuals referred to the agency for services will have a face to face intake meeting within 10 days of the first contact.

<table>
<thead>
<tr>
<th>Results</th>
<th>Met 4 of 12 months</th>
</tr>
</thead>
</table>

Recommendations/Action taken: In October one of the two staff who complete the intakes left the agency. Initially, the Program Coordinator increased intake slots to make up for the vacancy but could not maintain that schedule with other job responsibilities. During the 3rd quarter intake slots were limited to 2-3 a week and resulted in longer wait times from the initial call to the first appointment. Emergencies/crisis were managed in a timely manner during these quarters. Hiring and training has now occurred and we should be able to catch up during the 1st quarter of FY16.

Performance Improvements: The objective was met for 4 of the 12 months. Staffing vacancies/turnover was the major factor negatively impacting wait times to intake appointments. The ID intake completed 117 intakes during FY15.

Access Objective: Individuals currently residing at NVTC, SEVTC and CVTC will be tracked as they successfully discharge to the community or transfer to another facility by 6/30/20.

Results: 1 discharge

Recommendations/Action taken: We will continue to support the individuals as they work through the transition process to the community or other facilities in the future.

Performance Improvements: During FY15, one individual transitioned from CVTC into the community. This individual has made a smooth transition and is doing well in her program. Another individual has started the pre-discharge process by family members looking at options. This family member has looked at numerous group homes and day support programs and is interested in ICF options. As of yet he has not chosen a provider.

Objectives for the Coming Year
Access - Individuals referred to the agency for services will have a face to face intake meeting within 10 days of the first contact.
Access - Individuals currently residing at NVTC, SEVTC and CVTC will be tracked as they successfully discharge to the community or transfer to another facility by 6/30/20.

CSS RESIDENTIAL OUTCOMES

Efficiency Objective: 90% residents will participate in at least 2 community inclusion activities of choice per month.

Results: 94%

Recommendations/Action taken: Staff has been identified for the upcoming year to work with the residents to expand their focus to more “out-of-the-box” activities that they may enjoy. There are residents that continue to choose to participate in those comfortable and routine activities and those choices are respected and supported.

Performance Improvements: The residents continue to benefit from inclusion in their communities and this outcome has assisted many of them to experience some new/different activities.

Objectives for the Coming Year
Effectiveness - 90% residents will participate in at least 2 community inclusion activities of choice per month.

PARENT INFANT PROGRAM OUTCOMES

Access Objective: The Infant and Toddler Connection of Henrico Area will meet or exceed the December 1 child count, the Part C state office determine this to be 44.

Results: 50

Recommendations/Action taken: This year we created additional evaluation teams specifically for our 0-1 babies. We combined intake and assessment appointments together to avoid families having to attend 2 separate appointments. We worked closely with the NICU’s in the area to gather recent assessments and reports that would assist our evaluation teams in determining eligibility. We have conducted monthly orientations at the NICU for parents. We continue to look for various child-find activities.

Performance Improvements: The Infant and Toddler Connection of Henrico Area met the December 1st child count (50 children). This is the largest number of 0-1 infants that we have ever had in the system.

Access Objective: The Infant and Toddler Connection of Henrico Area will conduct 5 child find activities this fiscal year.

Results: 10
**Recommendations/Action taken:** This year’s child find outcome has not only increased PIP’s child count, but it has helped our system establish and build relationships in the community. These relationships have created a more streamlined process for the families referred to our system.

**Performance Improvements:** PIP will continue this outcome in the up and coming year.

**Efficiency Objective:** 100% of children discharged from Early Intervention Services will have all of their transition steps and services completed on their IFSP.

**Results:** 99%

**Recommendations/Action taken:** The program attributes this year’s results to the restructuring of the discharge process (transition steps and services are reviewed by supervisor prior to discharge). Infant Toddler Connection of Henrico Area has maintained full compliance around the transition.

**Performance Improvements:** Of the 308 children discharged from Early Intervention services this year, 304 of the children had 100% of their transition steps and services on their IFSP completed.

## Objectives for the Coming Year

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

**Efficiency -** The Infant and Toddler Connection of Henrico Area will conduct 10 child find activities this fiscal year.

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

HAMHDS has exceeded targets in the majority of the OSHHR measures. As of June, HAMHDS has exceeded the targets of all seven Developmental Quality Measures, the Training Center Measure and the Bed Utilization Measures. For the Behavioral Health Quality Measures, two of the five targets were met. The MH Engagement and SA Engagement and Retention targets did not meet established targets. Our research into these measures showed consumers remained engaged each month after admission but total services hours did not meet the OSHHR benchmarks of 5 hours in the 90 days following a MH admission or 2 hours in the 30 days following an SA admission. SA Retention was difficult to meet due to shorter treatment program durations running less than the OSHHR measure of 6 months. These targets were challenging state wide and lead to changes in the measures for FY16. HAMHDS by the end of the year moved closer to meeting the benchmark for state hospital bed utilization at Central State.
Several revisions were approved by the Secretary of Health and Human Services’ Outcomes Committee for the FY16 OSHHR Dashboard:

- Delete the employment status of adults admitted to the mental health services measure
- Intensity of engagement in adult mental health case management, decrease the benchmark from 5 to 3 hours
- Intensity of engagement in adult substance abuse outpatient services, decrease the benchmark from 1 & 2 additional hours to 45 minutes & 1.5 additional hours
- Intensity of engagement in child mental health outpatient services, change from outpatient to only case management services and change 2 hours within 30 days to 2 hours in 60 days
- Retention in community substance abuse services for 6 months (adult and youth), remove residential Detox and possibly only compute using substance abuse outpatient services
- Add another “Retention in community substance abuse services (adult and youth)”, measure for retention for 3 months
- Delete the developmental services transformation measure

POST DISCHARGE 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, 2014 through March 31, 2015.

During this fiscal year, ten separate services were tracked. A total of 212 surveys were mailed and 30 were returned. The response rate for programs ranged from 0% to 28.6% with an average response rate for all of the CARF services of 14%, up from the response rate of 9% for FY14. Individual comments are forwarded to the respective program.
SATISFACTION

Agency Satisfaction Survey
HAMHDS directly conducted Consumer and Stakeholder satisfaction surveys in CARF programs. Results below indicate all responders report at least a 67% satisfaction rate with services, with the majority of responses indicating at least a 85% rating. Three programs demonstrated an increase in consumer satisfaction ratings, and five programs demonstrated an increase in stakeholder satisfaction.

Recovery Oriented System Indicators (ROSI) Survey
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) annually administers the Recovery Oriented System Indicators (ROSI) Survey. 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 eight 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.
FY16 ADMINISTRATIVE AND PROGRAM INITIATIVES

Administrative
- Begin receiving insurance payment by electronic funds transfers
- Automate a new Inspection & Drill System
- Coordinate carpet renovation for Building A at Woodman Road Facility with the County
- Convert from ICD9 coding platform to ICD10/DSM5
- Implement Patient Portal in Cerner
- Coordinate with County IT/Communications to convert to VOIP at 6 locations
- Expand Business Support at Providence Forge
- Restructure Reimbursement to align with managed care model
- Analyze and restructure Front End Financial Team responsibilities to align with location traffic and volume
- Coordinate with County IT on updating the Agency Website
- Coordinate an Agency wide workgroup to implement a Telehealth strategy and equipment with State Grant funding.
- Evaluate and streamline Onboarding processes to include:
  - Adding QMHP/QIDP Qualifications guidance to Supervisory Tools
  - Improving the Directory accuracy
  - Assessing Administrative Orientation day
Clinical and Prevention Services
- Implement policies and procedures to reduce the risk of suicide and suicide attempts among clients
- Implement Enhanced Care Coordination and explore other opportunities to expand wellness programming for clients
- Participate in Regional Initiative to expand crisis services to youth and their families
- Participate in Regional Initiative to expand peer services
- Develop strategies to meet increasing regulatory and insurance requirements

Adult Substance Abuse/ Adult Mental Health Services
- Pursue opportunities to expand jail diversion services, specifically at Intercept 2 and 3
- Expand MRT groups to Jail East’s RISE Program
- Expand consumer/peer involvement in program planning and service delivery

Adult Recovery Services
- Fully define new program structure and explore opportunities this presents
- Implement Telepsychiatric services
- Implement Enhanced Care Coordination services to increase focus on clients’ medical conditions
- Explore opportunities to expand in-house medical services through expansion of current program with The Daily Planet

Emergency Services
Crisis Intervention Team (CIT):
- Continue mentorship initiative for programs listed above
- Train New Kent and CC Deputies and develop regional CIT group to address crisis services
- Implement advanced training services (first training is July 31, 2015)
- Continue training of all first responders with the goal of training 100% of Henrico Police Division (should be reached by end of 2015)

Crisis Receiving Center (CRC) / Emergency Services Program (ESP):
- Implement CRC expansion through additional hiring and redeployment of ESP staff
- Incorporate NK and CC law enforcement into CRC processes
- Enhance night coverage for ESP to ensure adequate phone and face to face coverage for crisis response

Access
- Through Access Workgroup develop process of increased efficiency

Youth & Family
- Explore opportunities to better coordinate assessment services across Youth and Family Programs
- Evaluate use of existing resources and services to maximize capacity to meeting increased community demand for case management service

Prevention
- Increase community members’ knowledge of how to respond to youth and adults experiencing symptoms of mental illness by providing Mental Health First Aid training
- Work collaboratively with schools and community to promote wellness through prevention of at-risk behaviors, with particular focus on substance use and violence.
- Work with youth, families and schools to enhance early academic success and promote resilience through life skills development.
- Administer Youth Substance Use Survey to students in HCPS in the 2016 school year
- Continue participation in regional Suicide Prevention Activities.

Community Support Services
Intake/Eligibility
- Prepare for DD single point of entry and eligibility determination

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

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

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

Day Services and Employment

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

QUALITY HEALTH INFORMATION

Outcomes

Record reviews were completed on approximately 20% of Medicaid charts and 10% of non-Medicaid charts; 863 Quality reviews and 468 Administrative reviews were done in FY 2015. Nearly all of the ID programs were 90%+ compliant with standards reviewed with only two programs falling slightly below 90%. Almost half of the MH/SA programs were 90%+ compliant with standards reviewed. Three out of four case management programs improved from FY14 and for the first time physician's documentation was reviewed for all MH/SA clients who received psychiatric services. Administration (Financial & HIM combined) was 90%+ compliant in both divisions.

FY16 Objectives for the Coming Year

• Continue improvements of the Utilization Review process
• Identify and report trends to program managers & AMT
• Update reviews for CMHRS programs mid-year to reflect new regulations
• Evaluate adding PIP to the agency record review process
• Continue training to ensure documentation meets all requirements

FY 2015 CSS RECORD REVIEW RESULTS SUMMARY

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2015</th>
<th>FY 2014</th>
<th>FY 2013</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTH 1 WAIVER</td>
<td>92%</td>
<td>93%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>EAST 1 WAIVER</td>
<td>92%</td>
<td>96%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>EAST 2 WAIVER</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>WEST 1 WAIVER</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>WEST 2 WAIVER</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>NORTH 1 SPO</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td></td>
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<tr>
<td>EAST 1 SPO</td>
<td>93%</td>
<td>91%</td>
<td>96%</td>
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<tr>
<td>EAST 2 SPO</td>
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<td>98%</td>
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<tr>
<td>WEST 1 SPO</td>
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<td>96%</td>
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<td>96%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>HERMITAGE VOC</td>
<td>90%</td>
<td>95%</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>CYPRESS VOC</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>ENCLAVES</td>
<td>93%</td>
<td>94%</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>LEP</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>STEP</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td></td>
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<tr>
<td>SUPPORTED EMPLOYMENT</td>
<td>89%</td>
<td>95%</td>
<td>95%</td>
<td>down 6% from FY14</td>
</tr>
<tr>
<td>RESIDENTIAL</td>
<td>90%</td>
<td>95%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>ID ADMINISTRATIVE</td>
<td>97%</td>
<td>95%</td>
<td>92%</td>
<td></td>
</tr>
</tbody>
</table>

Percentage represents compliance with standards reviewed

Represent area in compliance 90% or better

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)
EXTERNAL AGENCY REVIEWS

Outcomes
Over the last year the agency experienced a significant increase (48%) in external audits/program reviews. There were 36 desk audits and 8 onsite reviews throughout the year. Programs reviewed included Administration (3), Clinical and Prevention Services (13) and Community Support Services (25), all divisions, (3).

External reviewers included; DMAS (department of medical assistance), DBHDS (Virginia Department of Behavioral Health and Developmental Services), CMS (Center for Medicare and Medicaid), HHS (Department of Health and Human Services), Anthem, Virginia Supportive Housing, DOJ (Department of Justice), Office of Special Education, VDH (Virginia Department of Health), Disability Law Center, VHDA (Virginia Housing Development Authority), County Auditors, HUD (Department of Housing and Urban Development).

Types of reviews include; follow up after inpatient stay, falls plan, mortality reviews, SIS (supports intensity scale), employment, Shelter plus care policies-ensure compliance, services received, meaningful use, accommodation/accessibility, evaluator workforce and pre-screener qualifications, risk adjustment/medical record review, financial and compliance, CM documentation, employment records, communications audit, service package validation, medical records request, licensure review, visit to clients about their rights, sheltered workshop/day program visit. All audits were completed on time.
FY16 Objectives for the coming year:

- Continue to meet audit deadlines
- Explore additional venues other than secure email exchange to send electronically health information records more efficiently

<table>
<thead>
<tr>
<th>Total number of Reviews:</th>
<th>FY15</th>
<th>FY14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin:</td>
<td>44</td>
<td>23</td>
</tr>
<tr>
<td>C&amp;P:</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>CSS:</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>Across All Divisions:</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td># of Desk Reviews:</td>
<td>36</td>
<td>14</td>
</tr>
<tr>
<td># of Onsite reviews:</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

RISK MANAGEMENT / INCIDENTS AND COMPLAINTS

The Risk Management Committee summarized the following areas of identified risks for FY15.

Service Delivery: Continued implementation of requirements and recommendations from the Department of Justice related to ID services and case management. Clinical services have begun the process of implementation of Medicaid standards as written in Medicaid manual effective July 1st. Addition of a program serving young adults with mental illness. Continued partnership with the Daily Planet to provide medical services to clients. Exploring additional options related to medical services to minimize the use of the 911 system. Reorganization of programs under Adult Recovery Services and ID services.

Computer Resources: Committee was formed to explore other options to use for the agency related to the Electronic Health Record. A proposal will be presented to Leadership group in early FY16. Related to the Mental Health initiative purchased and installed equipment for telepsychiatry services. Also a committee is looking into options for a telehealth program.

Confidentiality: We continue to review confidentiality policies and move toward compliance with developing a full electronic health record. Policies have been developed around use of encryption options, electronics for communication (i.e. Texting and social media).

Financial: All business support staff have continued to work collaboratively in implementing the ongoing changes related to Magellan and CCC to maintain program financial stability. In addition, a committee from across the agency has been working to gain education and develop process related to the conversion from DSM IV/ICD9 to DSMV and/or ICD10.

Critical Incidents: The Critical Incident continues to meet quarterly to review incidents and shares reports with the Risk Management committee. One area that the committee has been focusing on this year is related to suicides. They have been looking at trends and to make sure appropriate support is available to the individual and staff. In addition, the agency has complied to increased submission requirements around deaths of consumers, specifically individuals with ID.

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

Emergency/Disaster Response and Recovery: Supervisors review disaster plans at a minimum yearly with staff during meetings. All program (day services and group homes) sites maintain a supply of emergency food, water and other emergency supplies.

Health and Safety: Implementation of an on-line drill recording system went into effect this fiscal year. This program allows for all drills and safety checklists to be completed on line and monitored by the facilities staff. Continue to provide Mental Health First Aid to county employees and the general public. Henrico CIT continues to train emergency personnel throughout the county and surrounding areas.

Regulatory Compliance: Staff completed required trainings. Chart reviews were completed and entered into Chart Tracker.
Media Relations and Social Media: Four press releases occurred in the FY15 including the announcement of the new Executive Director, March is Developmental Disabilities Month, Henrico 2 Smart to Start Coalition’s It takes a village Community Forum and inviting the community to the Little Black Dress dramatic production promoting awareness of depression and suicide. The agency works closely with the Henrico County Public Relations and Media Services for press releases and the development of community awareness and educational videos such as Hermitage Enterprises Staffing and Labor Services, Too Smart 2 Start, People in Crisis, Breaking the Stigma of Mental Illness and other Prevention Videos. These productions can be viewed online on the Public Relations Media Services internet and programs are often selected to be viewed on the County’s community TV channel HCTV. The Agency does use Social Media to provide information to the community on Facebook including; Hermitage Enterprises, Too Smart 2 Start Coalition, Youth-Ambassadors and henricoconnect.wordpress.com. Prevention Services is approved to text participants as they are not providing treatment services and therefore no health information is involved. Staff strongly adheres to the Agency’s social media policies and procedures.

FY16 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.

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Total FY2013-2014</th>
<th>Total FY2014-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault by client</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Behavioral incident</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Biohazard incident/bomb threat</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Communicable Disease</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>County vehicle</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Death-accidental</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Death-likely homicide</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Death-likely suicide</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Death-natural causes</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>Fall-withinjury requiring medical attention</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Fall-without injury</td>
<td>38</td>
<td>73</td>
</tr>
<tr>
<td>Fire</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Illness (e.g. seizure, diabetic reaction)</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Lic/Illicit drugs or weapons</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Med incident-med error requiring medical attention</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Med incident-med error with NO adverse reaction</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Peer-to-Peer Aggression* no longer a category in 11/12</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Property damage</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Property/loss/theft</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Self-injurious behavior</td>
<td>2</td>
<td>3</td>
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<td>Serious injury</td>
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<td>0</td>
</tr>
<tr>
<td>Sexual incident</td>
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<td>1</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Threats/violence</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Violent crime by client</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>193</td>
<td>257</td>
</tr>
</tbody>
</table>

Review of FY1314 compared to FY1415: Of Note:
The Incident Review Committee reviewed year-end FY2014 to FY2015. Assaults appear to have increased. The committee discussed the option staff have to choose “Assault” or “Behavioral”. When looking over the years at both Assault and Behavioral together, the numbers are similar. The agency is serving more complex clients and behavioral incidents continue to reflect this complexity. Julie will be reviewing the Assaults and Behavioral Issues, as well Threats/Violence and report back next Incident Review Committee meeting.

Committee reviewed data on all falls. One client accounts for 20% of all falls. Falls for this person seem to occur in different areas. No trends or actionable items noted. The remainder falls were reviewed in detail by age, location, and individual. No significant trends or issues noted.
In response to an increased number of suicides and attempts over the last year, the agency is adopting a model of “Zero Suicide” which includes policies and procedures to reduce or eliminate suicides and attempts. The agency continues to provide education and training to support staff in their duties.

### Brief Description of “Other” for Fiscal Year 2014/15

| 1. | elopement | CM&A West |
| 2. | County vehicle accident report | ICT |
| 3. | Victim of assault/theft (aggressor not client) | LSCCr |
| 4. | Client brought knife to program | Hermitage |
| 5. | Minor sprain | ID Community Support |
| 6. | Assault (client not aggressor) | PIP – Woodman Lobby |
| 7. | Minor burn | LSCCr |
| 8. | Minor employee wound | FACT |
| 9. | Minor sprain | Group Home Sherbrook (Clt on Community Outing) |
| 10. | Choking | Hermitage |
| 11. | Fall: ice (not client) | Hermitage parking lot |
| 12. | Minor burn | LSCCr |
| 13. | Fall: ice (staff) | NH OP East Ctrl lot |
| 14. | Fall: ice (staff) | CM & A East Ctrl Lot |
| 15. | Fall: ice (not client) | Woodman Lot |
| 16. | Irritated eyes | Hermitage |
| 17. | Report of assault (not HAMHDS) | Community Support |
| 18. | Missing meds (not an error) | Group Home Green Run |
| 19. | Minor bump to face | LSCCr |
| 20. | Minor cut | Cypress |
| 21. | Mis-taken meds (not an error; not suicide attempt; not OD) | CM&A |
| 22. | Minor cut | Group Home Walton Farms |
| 23. | Minor scrape and bruise | Group Home Green Run |
| 24. | Minor burn | Group Home Walton Farms |

### STAFF TRAINING

#### Outcomes

Agency employees have the opportunity to obtain training through the County of Henrico Employee Development and Training, Human Resources Department and with Henrico Area Mental Health & Developmental Services. The County of Henrico offers a wide variety of innovative training programs such as the Emerging Leaders Certification Program, Customer Service Certification Program, Leadership Development Program and a training series called the Role of the Supervisor for newly promoted and newly hired supervisors. In partnership with several technology-training providers, the County offers a wide variety of technology courses to help County employees enhance their technological skills. Online learning is also available to employees and offers a wide variety of courses and topics to meet their needs. An electronic employee course profile is maintained in the County wide Oracle e-Business Suite Human Resources system for all classroom and online courses completed through the County of Henrico.

Henrico Area Mental Health & Developmental Services maintains a group of 27 staff trainers that provide training in a variety of areas such as First Aid & CPR, Prevention of Violence, Therapeutic Options, Prevention of Infectious Diseases, Cultural Competency and training of the agency’s electronic health system, Cerner. Additionally professional training is offered throughout the year. Examples of professional training provided includes; Ethics, Boundaries and Social Media, Motivational Interviewing, Beyond CBT: Alternative Therapeutic Approaches, Functioning with Disabilities, Use of Self, Working with Dually Diagnosed ID/MH Individuals, Suicide Assessment and Management, Opiates 101, Foundation of Disaster Mental Health, Voices from a Teen Male Perspective, Working with Deaf and Hard of Hearing Individuals, Interacting with Individuals with Autism, Diversity Issues in Aging, Introduction to Autism, Finding Balance in Work and Play and Sex Trafficking. In total about 89 classroom style training sessions were offered. Staff have the opportunity to registering for training provided directly by the agency through the use of an internal web-based system known as MyTraining.

During the year, on-line training courses were also available on the Agency Intranet in Information Security Awareness, Fraud Awareness, Code of Ethics, Health Information Management Confidentiality and Privacy, Prevention of Violence
Refresher, Pharmacy Services; Fraud, Waste & Abuse, Medication Refresher, Safety/Hazard Communication, Regulated Medical Waste, Professional Ethics Training and Fire Suppression. On-line competency based training is provided for all staff annually in the areas of Human Rights and the Reporting of Critical Incidents. The online courses were reviewed and updated to meet new state requirements and internal procedures. Several Agency staff are certified to teach the Mental Health First Aid course. These successful courses were offered to staff within the agency and throughout the County of Henrico.

Agency trainers meet twice a year to review training needs and plan the training schedule for the next year. Yearly trainers are recognized for their contributions to the agency through a celebratory lunch. A few of the staff trainers were re-certified in Therapeutic Options. Additional staff was identified to become certified American Red Cross Trainers in First Aid/CPR and will take the course in FY15.

**FY16 Objectives for the coming year**
- Add two American Red Cross First Aid/CPR Trainers
- Add additional Cultural Competence/Awareness Instructors
- Provide refresher training for American Red Cross First Aid/CPR Trainers
- Add an online course for Prevention of Infectious Diseases
- Add two new Therapeutic Option trainers

**INFORMATION TECHNOLOGY**

**Outcomes**
The Information Technology Plan is reviewed periodically to assess the progress of projects and update their timelines as needed. For FY15 some major accomplishments included the implementation of Office 365 and updating all desktops and laptops to Windows 7, implement encrypted email using the product MOVEIT, installing new Anasazi/Cerner database servers and upgrade to SQL version 2008, attesting to Meaningful Use Stage 1, year 2 for 6 eligible prescribers and stage 1, year 1 for 2 providers, and bring into production the newly developed facility inspection and drill system (FIDS) system.

**FY16 Objectives for the coming year**
Our goals for FY16 are to implement telehealth at the major agency sites including possible remote connections, begin using the ultra sensitive exchange portal to send and receive patient records electronically with other providers, install a patient portal to securely communicate electronically with patients and allow patients to communicate back through the Anasazi/Cerner software, work with County IT to update the agency internet site as part of the entire county website redesign, complete conversion from icd9/dsm4 to icd10/dsm5.

**CULTURAL AWARENESS AND COMPETENCY**

**Outcomes**

**CACC Meetings**
Meetings were held every 6 weeks to continue development through implementation of the Cultural Awareness & Competency Committee FY 2015 Plan. Meetings have been rotating between locations. Meetings were held at Woodman, Hermitage, and East locations in this fiscal year.

New chair and co-chair of the Cultural Awareness & Competency Committee were appointed as of July, 2014.

Notable topics discussed at meetings include: Possible interest in offering CACC 102 Training: “Understanding My Community” and/or CACC 101 Training: “Understanding Me Helps Me Understand Others” more often based upon feedback from staff; possible interest in changing time of cookout next year based upon feedback from staff; interest in increasing the Cultural Awareness & Competency Committee’s Tool Kit of resources; community resources regarding cultural competence are shared.

Conference call participation began being offered in May, 2015 to promote more availability for meetings. This has been used successfully, and will continue to be offered to members.

**The following Brown Bags and trainings were offered to staff in this fiscal year:**
- July 31, 2014 at Woodman. CACC 102 Training: “Understanding My Community”.
• August 5, 2014 at Woodman - Supporting Access to Latino Families. Speaker was Tanya Gonzalez with the Office of Multicultural Affairs. Colaborando Juntos presents a workshop of ensuring access to services for Latino families.
• September 15, 2014 at Woodman- Working with Interpreters. Asia Cozette, translator/interpreter with In Other Words, LLC was guest speaker.
• October 22, 2015 at Woodman- Orientation on Islam and Muslims. Speaker was Malik Khan with the Asian American Society of Central VA. This was a presentation regarding key elements to assist in understanding Islam.
• November 12, 2014 at Richmond Medical Park- The Opioid Subculture: The Ethos of Opioid Addicts.
• December 14, 2014 at East- The Opioid Subculture: The Ethos of Opioid Addicts.
• February 4, 2015 at Woodman; February 26, 2015 at East- Eyes on the Prize: No Easy Walk. Showed a PBS documentary that depicts major civil rights movement events in three American cities.
• February 12, 2015 at East- Ethnic Notions. Showed a 1987 documentary film directed by Marlon Riggs and narrated by Ester Rolle that examines anti-black stereotypes that shaped popular culture from the ante-bellum period until the advent of the Civil Rights Movement of the 1960s.
• February 19, 2015 at Woodman- Journey to South Africa with Robin Edwards. Robin (HAMHDS staff member) shared her photos and details of a recent trip she had taken to South Africa.
• February 24, 2015 at Woodman- The Question of Race. Showed a video about biases, followed by an open discussion forum.
• February 26, 2015 at East- Eyes on the Prize: No Easy Walk. A PBS documentary was shown that depicts major civil rights movement events in three American cities.
• March 4, 2015 at Woodman- CACC 101 Training: “Understanding Me Helps Me Understand Others”.
• March 26, 2015 at Woodman - Functioning with Disabilities. This was an experiential training in which participants were “provided” with physical disabilities and asked to complete tasks. Processed with group after tasks were completed regarding difficulties/feelings experienced and insight gained.
• March 30, 2015 at Woodman- Women’s History Presentation and Bingo.
• April 21, 2015 at Woodman- Everything’s a Process: Gaining Insight into How We Think. This was an experiential training meant to provide insight into brain development and the functioning of those with developmental delays and exceptions.
• April 29, 2015 at Providence Forge- Presentation on Cultural Diversity. This was a discussion regarding worldly cultural differences and similarities.
• May 11, 2015 at Woodman- Stories of refugee resettlement challenges and mental health issues in Henrico County and surrounding areas. VCU professor Hyojin Im was guest speaker.
• June 11, 2015 at Woodman- CACC 102 Training: “Understanding My Community”.
• June 15, 2015 at Woodman- Presentation on Cultural Diversity. A discussion was held regarding global cultural similarities and differences.
• June 18, 2015 at East- Showing of DVD “Breaking the Silence- Lesbian, Gay, Bisexual, Transgender, and Queer Foster Youth Tell Their Stories”.
• Three additional Cultural Awareness & Competency Committee members were trained to lead CACC 101 Trainings: “Understanding Me Helps Me Understand Others”.
• Two additional Cultural Awareness & Competency Committee members were trained to provide orientation to new employees.
• Orientations began being offered on a monthly basis during this fiscal year, as needed based upon hiring. Cultural Awareness & Competency Committee continued to provide orientation to CACC with this change. The power point is updated prior to each orientation offered to provide relevant information regarding trainings and brown bags being offered. New employees were oriented to the Cultural Awareness & Competency Committee mission and annual plan at each orientation.
• All staff is required to attend at least one cultural or linguistic training per fiscal year. This is evident based upon yearly staff acknowledgement form submitted by each employee and is maintained in his/her HR record.

Translation/Interpretation 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.
• Key forms (i.e. Human Rights brochure, Code of Ethics, authorization of release) have been translated into Spanish, for use with consumers. These are available to staff via the intranet, staff provides these to consumers upon intake when applicable. One HAMHDS staff is a qualified bilingual interpreter. She is at Hermitage Enterprises location.

Provision of Culturally Relevant Information to Staff
• Education regarding HAMHDS’s values and commitment to cultural competency, as well as the Cultural Awareness & Competency Committee mission and CLAS standards, is provided at each orientation by the Cultural Awareness & Competency Committee member to new employees, at least bi-monthly.
• Cultural sensitivity and awareness trainings are offered by the Cultural Awareness & Competency Committee members within the CACC 101 Training: “Understanding Me Helps Me Understand Others” and CACC 102 Training: “Understanding My Community” classes at least annually. Examples of curriculum include, the Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS), Intercultural Communication, Personal Cultural Assessment and Demographic changes in the communities we serve.
• All HAMHDS staff is notified of CACC trainings via email, flyers and intranet postings.
• The Cultural Awareness & Competency Committee folder is maintained on the Public Drive and available to staff at any time. This folder includes the Cultural Awareness & Competency Committee meeting minutes, training materials, etc.
• The Cultural Awareness & Competency Committee Annual Report is provided to all agency staff via email and as posted on the Public Drive, which includes recent local demographics/statistics, as well as those served by HAMHDS.
• Information regarding offerings by the Cultural Awareness & Competency Committee is posted within the agency newsletter, Quality Matters.
• The Cultural Awareness & Competency Committee email address (diversity@henrico.us) continues to be maintained for staff to submit comments and questions. (Committee plans to promote more consistent knowledge and use regarding address in upcoming fiscal year.)
• Diversity bulletin boards are maintained at Woodman, East, Hermitage, and Lakeside Center to provide education and information regarding culturally relevant monthly celebrations, though this has been reported as inconsistent within this fiscal year. The Cultural Awareness & Competency Committee will work to provide greater consistency and punctuality regarding maintenance of these in the upcoming fiscal year. Multicultural calendars were purchased for 2015 by the agency and posted on these boards.
• Photos of appointed CSB members are posted on the agency’s intranet and at the entrance hall of Woodman. AMT updates these and the Cultural Awareness & Competency Committee supports maintenance to reflect diversity among the community represented.

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

Community Partnerships
• One HAMHDS staff is a member of Virginia Department of Behavioral Health and Developmental Services’ Steering Committee with the Office of Cultural and Linguistic Competence. HAMDHS staff Pat Hill was appointed to the Statewide Cultural and Linguistic Competency Committee in 2014, and she remains a member. She works on the Community Engagement subcommittee that plans the National Minority Mental Health Media Contest. HAMHDS
Prevention staff help promote the contest. (Of note, Prevention participants won 3rd place for their submission in June, 2014.)

- One HAMHDS staff, Mary Beth Schutte, 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, 2014 entitled “The Champion’s Toolbox: Resources on Safety, Wellness and Advocacy for Aging with Lifelong Disabilities”. A conference was held at the Double Tree Hilton in Midlothian in June, 2015 entitled “Mental Health Challenges and Possible Solutions in Aging with Lifelong Disabilities”.
- There is continued partnership with community providers including Colaborandos Juntos, the Virginia Asian Foundation, and community language interpretation/translation providers.
- Multiple community providers have been brought in to provide culturally competent trainings/brown bags to HAMHDS staff. See above for details.
- Consumer artwork is displayed at Woodman, Hermitage, and Cypress Enterprises. A current HAMDHS committee is working to add more consumer artwork in more locations. This is supported by the Cultural Awareness & Competency Committee.
- Staff attended the 4th annual Building Bridges conference in October, 2014 entitled Embracing Cultural Differences in Community Living: An Institute in Building Culturally Sensitive Collaboration. Cultural Awareness & Competency Committee member Yvonne Russell was a presenter at this conference as well.
- HAMHDS has continued to work with the VA Department of Health and Office of Cultural Awareness and Competence Program to assist in linking refugees in Henrico County with services/resources. HAMHDS staff is member of the Richmond Refugee Mental Health Council that discusses progress with program.

Accessibility to Services
- Agency phone greeting has not yet been provided in Spanish, but this is scheduled to occur with the introduction of a new phone system in fiscal year 2015-2016.
- See above regarding translation/interpretation services available for staff’s use with consumers to promote access to services.
- Wheelchairs are available at Woodman and East for use with consumers when appropriate.
- Elevator access is available at Woodman to reach second floor adult services.
- Doors at Woodman can be automatically opened with use of button for individuals with handicap.
- A welcome environment for children is provided within the children’s area in the lobbies of Woodman and East.

FY16 Objectives for the Coming Year
The Cultural Competency Committee will develop and implement the FY16 Cultural Competency Plan and when finalized it will be posted to the Agency Intranet.

DEMOGRAPHICS

Counties of Henrico, New Kent and Charles City
According to the US Census Bureau, quick facts for 2014, there are about 321,924 people in Henrico County, 59.3% White/Caucasian, 30.1% Black/African American, .4% were Alaskan Native, American Indian, 7.9% Asian, .1%, Native Hawaiian and Other Pacific Islander persons, 2.2% Multi-racial, 5.4% of Hispanic or Latino Origin. Language other than English spoken at home is 14.2%. Median household income is $61,048. Persons below poverty level are 10.7%.

In New Kent County there are approximately 20,021 people, 81.9% are White/Caucasian, 13.7% Black/African American, 1% Alaskan Native, American Indian, 1.1% Asian, 2.3%, Multi-racial and 2.6% Hispanic or Latino Origin. Language other than English spoken at home is 2.8%. Median household income is $70,618. Persons below poverty level are 5.9%.

In Charles City there are about 7,023 people, 42.1% White/Caucasian, 47.5% Black/African American, 7.2% American Indian and Alaska Native, .4% Asian, 1% Native Hawaiian and Other Pacific Islander persons, 2.7% Multi-racial, and 1.7% Hispanic or Latino Origin. Language other than English spoken at home is 2.0%. Median household income is $48,428. Persons below poverty level are 11.8%.
### Counties of Henrico, New Kent and Charles City

<table>
<thead>
<tr>
<th>Race &amp; Ethnicity</th>
<th>FY15 Henrico</th>
<th>FY15 New Kent</th>
<th>FY15 Charles City</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>59.3%</td>
<td>81.9%</td>
<td>42.1%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>30.1%</td>
<td>13.7%</td>
<td>47.5%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander, Multi-Racial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*(Pac. Island 0.1%)</td>
<td>*(Pac. Island 0.0%)</td>
<td>*(Multi-racial 2.3%)</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>0.4%</td>
<td>1.0%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>7.9%</td>
<td>1.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>For persons served who identify themselves as Hispanic</td>
<td>5.4%</td>
<td>2.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Language other than English spoken at home</td>
<td>14.2%</td>
<td>2.8%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

*Source US Census Bureau, quickfacts.census.gov*

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

<table>
<thead>
<tr>
<th>Order/Frequency</th>
<th>Seen within Agency</th>
<th>Within Henrico County</th>
<th>State of Virginia**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>English</td>
<td>English</td>
<td>English</td>
</tr>
<tr>
<td>2.</td>
<td>Spanish</td>
<td>Spanish</td>
<td>Spanish</td>
</tr>
<tr>
<td>3.</td>
<td>Arabic</td>
<td>Arabic</td>
<td>Korean</td>
</tr>
<tr>
<td>4.</td>
<td>Chinese</td>
<td>Chinese</td>
<td>Vietnamese</td>
</tr>
<tr>
<td>5.</td>
<td>American Sign Language</td>
<td>Vietnamese</td>
<td>Urdu</td>
</tr>
<tr>
<td>6.</td>
<td>Vietnamese</td>
<td>Hindi</td>
<td>Arabic</td>
</tr>
<tr>
<td>7.</td>
<td>Korean and Russian * (same amount of Korean and Russian languages seen)?</td>
<td>African languages</td>
<td>French</td>
</tr>
</tbody>
</table>

**State languages are from the Center for Public Education

### HAMHDS

Henrico Area Mental Health & Developmental Services, HAMHDS, values a diverse workforce that is representative of the person served. As of 6/30/15 of the approximately 9,766, 46% of consumers served were White/Caucasian and 44% were Black/African-American. The remaining 10% were: Alaskan Native, American Indian, Asian/Pacific Islander, and Multi-racial. Of all consumers served 5% percent identified themselves as Hispanic.

As of 6/30/15, of the approximately 345 HAMHDS permanent employees 54.50% self-identify as White/Caucasian, 42.31% Black/African-American, 0.29% Alaskan Native, American Indian, 1.45% Asian/Pacific Islander, 0.85% Multi-racial, and 0.87% identified themselves as Hispanic.

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

<table>
<thead>
<tr>
<th>Race &amp; Ethnicity</th>
<th>FY15 Persons Served</th>
<th>FY14 Persons Served</th>
<th>FY13 Persons Served</th>
<th>FY15 HAMHDS Employees (345)</th>
<th>FY14 HAMHDS Employees (335)</th>
<th>FY13 HAMHDS Employees (304)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>46%</td>
<td>49%</td>
<td>50%</td>
<td>54.50%</td>
<td>55.82%</td>
<td>56.91%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>43%</td>
<td>41%</td>
<td>39%</td>
<td>42.31%</td>
<td>41.19%</td>
<td>40.46%</td>
</tr>
<tr>
<td>Alaskan Native, American Indian, Asian/Pacific Islander, Multi-Racial</td>
<td>11%</td>
<td>10%</td>
<td>11%</td>
<td>2.32%</td>
<td>1.49%</td>
<td>1.65%</td>
</tr>
<tr>
<td>For persons served who identify themselves as Hispanic</td>
<td>5%</td>
<td>4%</td>
<td>6%</td>
<td>0.87%</td>
<td>0.99%</td>
<td>1%</td>
</tr>
</tbody>
</table>
DEMOGRAPHICS

Total Consumers Served by Program Area

Seven (7) percent of individuals served were ages 0 – 2; 21% were ages 3 – 17; 69% were ages 18- 64; and 3% were ages 65+.

Consumers Served by Gender

Fifty-three (55) percent of individuals served in the Mental Health program area were male, and 45% served were female. In the Developmental Disability program area, 60% of individuals served were male, and 40% served were female. In the Substance Abuse program area, 67% of individuals served were male, and 33% served were female.

Distribution by Race and Ethnicity

Of the unduplicated count of 9,818 consumers served, 43% (4,211) consumers served identified themselves as Black/African American. 46% (4,553) White/Caucasian, 11% (1,054) Alaskan Native, American Indian, Asian, Pacific Islander, Multi-Racial.
BUDGET

Revenue

FY2015 per the Year End Performance Contract Report

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
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<tbody>
<tr>
<td>State Funds</td>
<td>$7,293,864</td>
</tr>
<tr>
<td>Local Funds</td>
<td>$13,995,632</td>
</tr>
<tr>
<td>Federal Funds</td>
<td>$1,859,928</td>
</tr>
<tr>
<td>Medicaid Fees</td>
<td>$8,641,486</td>
</tr>
<tr>
<td>Other Fees</td>
<td>$2,415,978</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$33,878,274</strong></td>
</tr>
</tbody>
</table>

Expenses

FY2015 per the Year End Performance Contract Report

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td>$15,194,802</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>$11,738,146</td>
</tr>
<tr>
<td>Developmental Services</td>
<td>$2,410,862</td>
</tr>
<tr>
<td>Administrative Services</td>
<td>$2,423,238</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$31,223,195</strong></td>
</tr>
</tbody>
</table>