FY23 Performance Analysis

MANAGEMENT SUMMARY

Henrico Area Mental Health & Developmental Services (HAMHDS) is proud to present our Fiscal Year 2023 Annual Report. This year's report is designed to showcase how we continue to rise to meet the challenges in our communities and the resiliency of individuals and families we serve. The report highlights a few of our major initiatives that strengthen the quality of care for individuals with mental illness, substance use disorders, and developmental disabilities. Our dedicated staff continue to focus on the mission of the agency and work diligently to achieve outstanding results in partnership with our many community partners, stakeholders, and individuals in service. It has been an exciting year with many accomplishments.

We received a Behavioral Health Equity Grant from the Department of Behavioral Health Services. Our focus was the LGBTQIA+ community. With extensive community partners we held a community forum and resource fair, conducted a six-week Youth Empowerment series, established a lending library, provided staff training and produced a series of 9 short videos. The videos, *~~In~~Visible:* Behavioral Health Equity in Henrico County, cover a variety of topics including: The Burden of Education, Expanding the Acronym, Strengths in the Queer Community, Sexuality vs Gender, Reclaiming Queer, How to Handle Pronouns, Intersectionality and Culture and Advice for Parents of Queer Transgender Children.

The Henrico Area Community Services Board established the Mary Ann Bergeron Hall of Fame Award. This award, to be given annually, recognizes individuals who have made significant contributions through service and commitment to the Board. Two ceremonies were held this fiscal year. George Hettrick and Nita Grignol were the recipients in July 2022 and Dale McMahon and Steve Hixon were the recipients in June 2023. The hall of fame is named in honor of Mary Ann Bergeron, the founding executive director of the Virginia Association of Community Services Boards, who served the association from 1989 to 2014.

The agency began working on four strategic initiatives. They include recruitment and retention of our work force, transformation of youth services, expanding crisis services, and redesigning day services for individuals with developmental disabilities.

We successfully prepared for the eighth CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation and celebrated 22 years of being CARF accredited. It confirms adherence to over 2,100 professional standards and a commitment to delivering programs and services that are measurable, accountable, and of the highest quality.

We expanded our community-based services in several areas to better serve the community:
- Collaborated with St. Joseph's Villa to create a Crisis Receiving Center for youth where individuals will have an alternative to emergency room care. Renovations of the existing structure are underway with a target opening date in early 2024.
- Increased community-based response to traumatic events in communities. A clinician is designated to address issues around violence and traumatic events that have occurred in the community.
- Increased community-based crisis response to youth with substance use disorders. We successfully implemented the youth crisis response clinician role. This resulted in increased coordination with police for youth threat assessments.
- Increased community-based outreach to individuals with substance use disorders (SUD). A mobile clinician used information from the Addiction Task Force and Overdose Map to identify "hot spot" areas within the community. They reached out to hotels and organizations within these areas and provided REVIVE training and information about how to access services. The clinician partnered with the Health Department to provide onsite services in an apartment complex.
- Increased school-based services to youth and their families. Through a grant, we fully implemented school-based clinic and family support services at the Academy at Virginia Randolph. This program is recognized by Henrico County Public Schools as a successful strategy for eliminating barriers to treatment for youth and an opportunity for enhanced coordination between schools and our agency. Henrico County Public Schools are actively exploring opportunities to expand this program to other schools.
- Continue to build community resources for individuals with serious mental illness. Our new Peer Specialist focusing on community inclusion successfully implemented strategies to increase awareness and access to community events for individuals with serious mental illness.

• Increased co-response with police to individuals experiencing behavioral health crises. The emergency services team is providing co-response with police four days a week during daytime hours. We quickly saw positive results from this co-response model and were able to divert numerous individuals from hospitalization. We anticipate that this program will continue to grow.
• Enhanced coordination with regional crisis programs (Call Center, REACH, CReST). We partner closely with the regional teams on a regular basis. Representatives from the regional teams presented to the County's Marcus Alert Task Force to further enhance coordination and to assist in preparation for implementation of Marcus Alert in July 2024.
• Henrico refined its plan to build a Continuum of Care Facility that will include a detox center and a 23-hour adult crisis center. It is targeted to open in 2025.

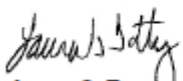
The agency earned two Achievement Awards from the National Association of Counties, including one for a program that supports individuals who are seeking treatment for substance use disorder. Established in 2021, the Community Based Housing for Individuals in the Recovery Process (CHIRP) program establishes safety and other standards for recovery homes and covers the costs of two weeks of treatment when an individual is placed in a certified home. So far, 84% of CHIRP's participants have successfully completed their stays. HAMHDS also earned a NACo award for its community inclusion specialist, which supports individuals with serious mental illness. The position, established in 2021, promotes recovery and healthy living by helping individuals participate in events and build connections with partners throughout the community.

The agency implemented a new electronic health record, Credible, which went live on July 1, 2022. This was a major accomplishment of a former strategic initiative and a joint project with Henrico County IT and HAMHDS. A very committed implementation team helped prepare the agency for this major transition followed by the administrative team providing Credible and Cerner training to new staff throughout the year. Many thanks to the Credible Post Go-Live cross-functional workgroup that continues to maximize the use of our new system with the vision of increasing efficiency and effectiveness.

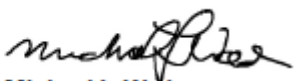
Administrative and Quality Assurance staff teamed up with Henrico County IT to develop and implement, within four months, our new learning management system, Relias. This implementation allowed us to move to an all-electronic training record, upload historical training records, develop our own content and provide access to hundreds of competency-based trainings for professional and clinical development. Relias went live on March 1, 2023, in time for the agency's required annual training to be completed.

Agency employees are generous with their time and resources. Many employees support community events that raise awareness of mental health, substance use, developmental disabilities and early intervention services. The agency supported the Henrico Christmas Mother with food, gifts and $1,530, and the Henrico Community Food Bank by donating 1,397 items of food. It is these dedicated and talented individuals who tirelessly work to improve the lives of others that make this agency successful.

The Board and staff are grateful to the Boards of Supervisors of Henrico, Charles City and New Kent counties for their ongoing support of our mission. Their commitment and support allow critical community services to be in place that promote wellness, recovery, perseverance and inclusion for the individuals we serve, their families, and the community.



Laura S. Totty
Executive Director



Michael L. Wade
Chairperson

VISION & VALUES

OUR VISION: We strive for inclusive, healthy, safe communities where individuals and families live meaningful lives.

OUR VALUES: Promote Dignity, Build Partnerships, Celebrate Perseverance, Embrace Diversity and Cultivate Quality

OUR LEADERSHIP STATEMENT: The success of our organization depends on the contributions of everyone having an opportunity to listen, learn and lead.

BUDGET

FY23 Revenues			FY23 Expenses		
State Funds	$12,611,656	26%	Mental Health Services	$23,625,798	52%
Federal Funds	$2,191,795	5%	Substance Use Disorder Services	$3,632,413	8%
Local Funds	$19,532,861	41%	Developmental Services	$15,168,963	34%
Fee Revenues	$13,522,022	28%	Administrative Services	$2,623,509	6%
Other Funds	$32,337	0%			
Total Revenues	$ 47,890,671		Total Expenses	$45,050,683	

STRATEGIC GOALS AND STRATEGIC PLANNING

During FY23 cross functional workgroups completed their work on the 2022-2025 strategic initiatives. The strategic initiatives for 2022-2023 were as follows.

1) To improve the recruitment and retention of our workforce

Overview:
As of July 25, 2022, HAMHDS had about 62 vacant positions. In FY22 this number peaked at about 99-103 vacancies. There are 366 F/T, 11 P/T (together makes 377 permanent staff) and 51 temporary/hourly staff (417 staff with hourly staff). The current turnover rate for the agency is about 16.4% for permanent positions only. The impact of these vacancies creates a burden on the existing workforce to meet the needs of the persons served. It also impacts the moral and wellbeing of staff which threatens the workforce. Additionally, area community service boards are increasing their salaries which makes our region increasingly competitive.

Plans and accomplishments of the committee:

- *Identifying ways to make our positions more attractive in the County job postings by stating the perks we offer such as the County qualifying for the public student loan forgiveness program, reimbursement for license and certification, employee recognition, public celebration of employee milestones, etc.*
- *Decreased recruitment timeframe. We now are posting positions quicker, as we were part of a pilot program to post directly. This has dramatically improved the recruitment process from months to days. (Once approved by the county, we create the posting, approve and post in Oracle for applicants to apply, this used to be done by HR).*
- *Planning to send out a job satisfaction assessment (called Stay Interview process) to all staff on 7.3.23 and in the future to new staff at their 6 month and 12 month anniversary. The emphasis is on retaining and enhancing what we are doing well to build on creating a better work/life balance.*
- *Recommending offering exit interviews (with Executive Director and internal HR Manager) next fiscal year, currently finalizing process.*
- *Worked with leadership to add a mid-week casual dress day to improve staff well-being and to allow greater flexibility for staff to be active.*

2) To Transformation of Youth Services

Overview:
There is an increase in demands for children services. COVID has impacted the youth in our communities and there is a call to address the youth violence and safety from our communities and schools. A comprehensive multi departmental approach is needed to include education, prevention, jail diversion and expansion of services.

Plans and accomplishments of the committee:

- *Youth and Caregiver Surveys have begun to be distributed to the public to ascertain experiences with mental health and developmental services across our catchment area, enhancing relationships and capacity building with community partners across the schools and human services sectors.*

- *Focus groups are being built and developed to gather more detailed information that was identified in the survey related to experience with mental health and developmental services.*
- *Building on those public and private partnerships across the child service continuum and identifying how we leverage those partnerships to ensure we are aware of availability for services and resources in the community.*
- *Provider Resource Fair planning has begun for child serving staff to take place in early 2024, to strengthen relationships and knowledge of the available services offered by private providers.*
- *The new Community Partner tab on the Prevention Services page was identified as a great location for partner resources, but there may still be some opportunities to support a hub of external private providers within Henrico County website and having community navigators or newly hired Resource Coordinator in the agency to help facilitate development of this listing.*

3) Crisis Services

Overview:
The Department of Behavioral Health and Developmental Services is identifying strategies to meet the crisis services across the state. This includes the implementation of the Marcus Alert, discussions of regional services and a crisis model for individuals with developmental disabilities. There is a lack of private and state hospital beds available to meet the public need which results in individuals waiting in emergency rooms, waiting for services for long hours. A continuum of services is needed to address the mental health crisis in our communities.

Plans and accomplishments of the committee:

- *Group discussions occurred regarding the current state of Crisis, including barriers to services such as delays in bed placements, access to mobile crisis services, and housing disparities. Discussions also occurred related to implementation of 988 (National Suicide Prevention Hotline started July 2022), Marcus Alert protocols (state-wide alert system will triage behavioral responses to regional crisis centers and mobile crisis teams due February 2024), 23-hour Crisis Center for Youth at St. Joseph's Villa, and a 23-hour Crisis Center for Adults (planning with County's detox center).*
- *The Emergency Services Program (ESP) and Medical Unit Pilot Program began where an individual under an Emergency Custody Order (ECO)between the hours of 7am-12pm can be brought to Woodman office for a prescreening, appropriate medical screening, and possible intervention to attempt to divert some individuals from having to go to the emergency room or Temporary Detention Order (TDO) be admitted to a Behavioral Health Unit (BHU)*
- *The groundbreaking ceremony for the 23-hour Crisis Center for Youth at St. Joseph's Villa took place in late April 2023. The expected opening date will be Spring 2024.*
- *In addition to our Youth Mobile Crisis Clinician, other ESP clinicians are partnering with Henrico Police daily from 9am-3pm to ride with police officers while responding to mental health phone calls and/or providing follow up with community members. We are calling this our Mobile Response Team (MRT) and will be part of the Marcus Alert implementation.*

4) Re-design of Day Services for individuals with developmental disabilities

Overview:
Over the last several years there has been a movement for all individuals with developmental disabilities to experience employment. The traditional workshops are dwindling within the state as programs lose their ability to pay sub-minimum wages through the department of labor certificate. Although the premise is that everyone can be gainfully employed that is not the reality. Regulatory requirements are requiring the elimination of workshops across the state. A continuum of services is needed to meet the wide range of abilities of individuals with developmental disabilities, this includes both community and day service options.

Plans and accomplishments of the committee:

- *Announced to stakeholders that the Department of Labor special certificate to pay sub-minimum wages will be ending September 30, 2023.*
- *Engaged in conversations and meetings with the Department of Aging and Rehabilitative Services regarding participation in a grant.*

- *Met with families in February 2023 for a kickoff meeting, virtual and in-person options, with over 90% of families represented. Since then, have surveyed individuals and families to see their interest with approximately 10% interested in community employment, additional 27% possibly interested, and the remainder not interested in seeking community employment opportunities. There are some who may be interested in work groups in community settings but not individual employment.*
- *Began implementation of a Job Seeker Alliance for those who have expressed interest in possibly working in a competitive integrated environment. This group, which is led by Day Services staff, will explore work options, teach work stamina and engage in activities such as short-term work crews or volunteering that may help the individual in making choices that are right for them.*
- *Working with individuals on what they would like to see in the day program to enhance the activities and options. Survey provided individuals interest and staff have identified "clubs" we will hold from July thru September. Will hold at least 5 clubs per week with individuals getting to choose what they would like to participate in.*
- *Group Supported Employment sites will be transitioned to Individual SE sites, replacing full time job coaches with more traditional periodic follow-along services by the end of Sept 2023. This will free up 3 staff to support the changes in the day program, including an increase in community engagement opportunities.*

Financial and Workforce Impact

HAMHDS has identified the workforce needed to support the above strategic initiatives. It includes cross functional workgroups with staff across the organization and in varied positions. Workgroups may also include other stakeholders from the County of Henrico and community partners. Financially, the organization is positioned to allocate the resources to meet the initiatives and will seek additional funding, as needed, and as available from the County of Henrico, VA DBHDS, and DARS.

FY22 ACCOMPLISHMENTS/ FY23 GOALS

Medical Accomplishments

- Added 1 full-time triple boarded adult psychiatrist to increase capacity to provide supervision and evaluate medically complex psychiatric presentations.
- Added 2 full-time medical assistants, 1 at each primary office, to assist with gathering records for new intakes coming through Same Day Access services to ensure the most comprehensive evaluation possible in this setting.
- Medical Assistants assist with keeping the clinic flow with check-ins and vitals when nursing staff are not available.
- Medical Unit developed their mission statement: *To provide compassionate and individualized evidence-based treatment to those residing in Henrico, Charles City, and New Kent who experience mental health, developmental, or substance use challenges.*
- Medical Unit staff or a representative are always available for consultation for emergency or crisis medication questions.
- Medical Unit staff work collaboratively to accommodate individuals' needs in a timely manner. (i.e. missed or late injection, medication refills etc.)
- The Medical Unit participated with Emergency Services on a pilot for hospital diversion.
- The Medical Unit continues to host medical students, nurse practitioner students, and psychiatry residents for clinical psychiatry rotations. A new affiliation agreement is in place to host physician assistant students.
- The Medical Unit has worked closely with IT and Credible to improve usability of the electronic health record and address prescribing and documentation issues. We continue to work toward finding and developing a more efficient documentation process within the Credible framework.
- The Medical Unit has worked to become more cohesive and collaborative internally and with the agency.
- Community involvement
    - MD participates in Pathway Clinic in Petersburg to increase access to MH treatment 1 Saturday every 2-3 months.

    - MD volunteers teaching a mission class and at Golden Club
    - MD active in the Shiite Muslim community
    - MD participates in the National Social Welfare Board for Mental Health
- Professional involvement
    - MD contributed to Virginia Mental Health Access Program (VMAP) State Guidebook for pediatricians.
    - MD teaches for VMAP REACH and Project ECHO, offering pediatric mental health training to improve access to mental health care for children across Virginia.
    - MD testified before the Virginia Senate Subcommittee on mental health issues and access for diverse and marginalized populations.
    - MD attended Zoom meeting with HCA Regional Director in Memphis to address HCA policies that have been problematic for HAMHDS clients.
    - MD continues consultation to the Office of the Inspector General
    - MD continues consultation to local FBI and ATF regarding prevention of Mass Events
    - MD has met with the Lieutenant Governor and the Commissioner of Mental Health to help them better understand some of the issues confronting individuals with mental health challenges in the commonwealth, especially for underserved populations.
    - MD contributing editor for Journal of Clinical Psychiatry
    - MD member of the Guidance Workgroup for DSM 6
    - MD Co-author of APA Guidelines for the Treatment of First Episode Psychosis.
    - MD 2022 NIMH Award for top 50 most influential Psychiatrists in the US
    - MD 2022 NAMI Service Award
    - MD presided over and contributed to multiple psychiatric and professional meetings across the US.
    - MD gave presentations to multiple grand rounds at University of Wisconsin, Johns Hopkins, and University of Maryland psychiatry departments.
    - MD continued working in the field and 24 hours on call to CIT officers to assist with assessment and disposition of mental health calls.
- Over 130 years of clinical experience combined for HAMHDS's MDs.
- The Medical Unit Program Manager coordinated the Agency food drive, which led to 1,397 items donated, and earned the Agency 2nd place in the County competition.
- PA earned their Equine Therapy Certification and plans to begin team building sessions and aspires to offer this as a service through our agency.

Medical Goals

- Continue promotion of and participation in educational opportunities for current evidence-based practice and new and developing treatments.
- Continue building internal and intra-agency team cohesion and build and strengthen external collaborations.
- Continue to explore options to improve documentation efficiency in Credible.

Administration Accomplishments

Facilities staff assisted with the purchase and installation of cubicles in Woodman A building.

Partnered with County IT for purchase and installation of telehealth equipment in Woodman Conference Room C. Evaluation & Reporting/AMT Support team received training from County IT on how to use the equipment and provided support to users.

Human Resources participated in a pilot program with County Human Resources where the HR manager was responsible for creating, approving and posting/re-posting all MH/DS open positions in Oracle, this substantially reduced the time some positions were vacant.

Human Resources staff represented the agency at job fairs at Virginia Union University, Virginia State University and Brightview.

Human Resources contracted with Indeed to provide greater visibility to difficult-to-fill position postings.

Admin staff participated in the Relias implementation as our training platform. Three staff conducted staff and supervisor Relias trainings before and after go-live. Training history records were imported into Relias. Relias went live on March 1 in time for required annual trainings to be completed in Relias. 4,376 courses were assigned, 4,316 were completed on time, 45 were completed late and 15 are overdue. 98.63% compliance and 99.66% total completion!

Human Resources worked with the Relias implementation team to purchase QR scanners and assign each staff a QR code. Staff attending a training may be checked in electronically and their attendance recorded in Relias.

An Admin manager provided in-person support when HAMHDS began the Mobile Office-Based Addiction Treatment unit in partnership with the Richmond and Henrico Health District. The van provides on-site services at the Henrico Arms apartment complex.

The Facilities team completed 137 facility projects and 1,162 KACE tickets at 17 different sites.

Financial Management staff processed 7,384 accounts payable invoices totaling $ 8,157,561.

Financial Management implemented Webgrants and successfully requested reimbursement from DBHDS for our Federal grants using Webgrants.

Financial Management implemented MHDSInvoices@henrico.us and MHDSmileage@henrico.us to streamline receipt and processing of accounts payable invoices and mileage reimbursements.

One Admin manager was a mentor in Leadership Henrico during FY23. Three Admin managers and one supervisor have completed training to be mentors in FY24.

The agency went live in Credible on July 1. Superusers from Admin were available at main sites to support staff after go-live. Admin staff created an encounter form and front desk reports within a couple of days of being in Credible and used those reports to make reminder calls.

Business Support tested and implemented automated reminder calls for prescribers through Credible.

Admin representatives participated in the Credible Post Go-Live meetings every two weeks and participated in Enhanced Support Services calls with Credible each week from December through June.

The Evaluation and Reporting/AMT Support team provided Credible and Cerner training to new staff throughout the year. Team members took minutes at all Leadership Group meetings in FY23, eliminating the need to rotate responsibility to take minutes between the divisions.

Reimbursement staff developed processes to request authorizations and notify staff of expiring or missing authorizations. 53,694 claims were submitted to insurance companies from Credible.

Admin staff assisted Youth & Family with submitting a SAMHSA grant application in partnership with Henrico Public Schools.

The agency received a three-year reaccreditation from CARF. Admin staff supported the CARF survey by inspecting our facilities, updating egress plans, checking first aid kits, ensuring drills have been carried out, and presenting financial and IT information to the surveyors during the survey.

Admin provided a co-chair and several members of the Recruitment and Retention strategic planning committee.

Two Admin staff participated on the CARE Committee in FY23.

Admin staff participated on the VACSB Finance Director Council, the VACSB Human Resources Directors Council and the Virginia Association of Reimbursement Officers during FY23.

Administration Goals

- Partner with IT to replace computers in conference rooms.
- Partner with IT to place FLIR cameras at Hermitage Enterprises and Richmond Medical Park office.
- Continue participation on the Credible Post Go-Live Committee. Partner with IT to improve processes and efficiency in Credible.
- Conduct monthly Revenue/Accounts Receivable meetings with managers and supervisors to increase understanding of revenue impacts throughout the agency.
- Provide a listing of grants/funding applied for and received during FY24 on the P: drive.
- Reduce the percentage of outstanding A/R over 90 days compared to total A/R by 1% each quarter (FY24 Admin outcome)

Administration Outcomes

MEASURABLE OBJECTIVE Effectiveness Reduce the percentage of outstanding accounts receivable balances over 90 days old by 1% per quarter.	Year end results:	Q1 68% Q2 69.5% Q3 72% Q4 65% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The percentage of outstanding receivables improved in the 4th quarter, (65%) down from the 3rd quarter (72%) but increases in the percentage of outstanding accounts receivable balances over 90 days old were experienced in all other quarters. We encountered many issues with billing FY23 services from the new Credible EHR. We met weekly with Credible and we met monthly with the C&P and DS management teams to discuss barriers to timely billing. The billing issues in Credible improved greatly in the 4th quarter. We submitted 43,088 insurance claims in the 4th quarter out of a total 53,694 insurance claims submitted throughout FY23. We did not meet this goal overall but made progress throughout this fiscal year. Admin will continue this goal in FY24.

Quality Assurance Accomplishments

- Developed and Implemented a CARF plan that resulted in a successful CARF Re-survey November 2023
- Assisted with new EHR implementation, Credible
- QA staff member of the EHR post implementation workgroup
- Collaborated with County IT to improve iRIS incident reporting system
- Completed four look behinds every quarter
- Updated annual training PowerPoints in preparation for Relias
- Worked with Facilities and County IT to update FIDS
- Began meeting quarterly with facilities
- Completed review of ACT records
- Led scanning workgroup and agency scanning began in July 2022
- Co-lead Relias workgroups with agency Human Resource staff with a successful implementation in four months; Go live date occurred March 1, 2023
- Collaborated with Health Services Advisory Group to coordinated round 4 and round 5 with Developmental Disabilities Division
- Assisted with the coordination and upload of information in CONNECT for our annual unannounced licensure visit

- Assisted in the coordination of 76 external reviews such TMACT Fidelity Review (Tool for Measurement of ACT), Health Services Advisory Group (HSAG) Round 4 and 5, DBHDS Office of Quality Improvement Support Coordinator Quality (SCQR) Reviews
- Participated in the following strategic initiative workgroups: Recruitment and Retention, Crisis
- Collaborated with agency staff to develop and print the agency's annual report
- A member of QA applied to be a CARF surveyor and successfully completed requirements to become a CARF administrative surveyor
- Member of QA team along with an Admin staff became the two agency certified Relias administrators
- Editor of the agency monthly newsletter, HAMHDS Happenings
- QA staff are a member of the VACSB Quality Leadership (QL) Council, VACSB Executive QL Council, member of the Region IV QA Council and member of the DBHDS MART group
- Updated agency policies and procedures

Quality Assurance Goals

- Redesign of incident reporting system
- Supplemental Reviews
- Training on Data Analysis
- Moving to Credible for Chart Reviews

Quality Assurance Outcomes

MEASURABLE OBJECTIVE Efficiency Report incidents within required timeframe, 24 hours	Year end results:	5 late reports, one more than last year Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	A total of 208 reports were made into CHRIS for FY23. 8 were late, of which we received 7 CAPs. 7 times the Office of Licensure sited us for reporting Level II or Level III serious incidents beyond the 24 hrs reporting period. The incidents occurred in different services, a 2 were under the same license but the agency determined these were not systemic problems based on the number of reports completed timely. Staff were retrained on regulation 160.D. Continued education provided; Agency leadership team discussed expectations and policy was reviewed.

MEASURABLE OBJECTIVE Efficiency QA staff to complete 4 Quality Look Behind reviews each quarter (16)	Year end results:	18 Met Actions during the year produced the desired results	Recommendations, actions taken, performance improvements:	A total of 18 reviews were completed. QA completed its goal of 4 look behinds each quarter. QA was able to examine 5 reviews in 2 of the 4 quarters, exceeding expectations. QA monitored the agency's response and to ensure action plans are continuing to be implemented, none have been found to need to be revised and resubmitted to OL.

Developmental Services Accomplishments

- Completed successful licensure review of case management, residential, and day programs.
- Assisted with payment for 29 individuals to attend camp in summer of 2023.

Intake, Eligibility and Housing

- Program Manager, with support from other agency staff completed 3 presentations about Developmental Services to school related programs during this fiscal year.
- DD Intake staff successfully transitioned to Credible with very minimal downtime in July.

- DD Intake staff received training in DocuSign from the county which has greatly improved access to getting signatures following intakes and increasing the timeliness of intake completion.
- Henrico's HCVP opened the waitlist in March 2023 for the first time in 9 years.
- One of the case management positions was upgraded to a Senior Management Specialist to better oversee the day-to-day functions of the program.
- Henrico's HCVP branched into two additional voucher types: FYI- Foster Youth Initiative and Homeless 78 vouchers.
- PSH Admin Case Manager was trained in the new DBHDS PSH database and has consistently maintained Henrico's data without errors during this year.
- PSH Admin Case Manager has transitioned a primary paper chart to almost all electronic during this fiscal year.

Residential Services

- Filled vacant Group Home Supervisor positions at two locations.
- Returned to pre-COVID protocols allowing community visits and family visits in the home.
- Identified a vendor to add a chair lift at the Gayton Home.
- Completed a CARF survey with no recommendations.
- Obtained OBRA funding to replace the bus at Sherbrooke with a new minivan.
- Gayton group bus replaced with a new van.
- Filled five client vacancies in the group homes.
- Two staff agreed to become CPR and TO instructors for the agency.

Employment and Day Services

- Began implementation of ending 14C services and developed a committee for the strategic plan.
- Completed a CARF survey with no recommendations.
- Applied and were awarded money for the Department of Aging and Rehabilitation EPIC grant to assist with staffing to place 14C individuals.
- Applied and were awarded money from Department of Aging and Rehabilitation for infrastructure items to support 14C closure.
- Successfully transitioned two group sites to supportive employment sites due to individuals becoming more independent.

DD Case Management

- Continuation of Credible implementation. Senior Developmental Services Supervisor working with IT building reports to assist case management supervisors and staff.
- Participated in two HSAG reviews and two SCQR reviews from DBHDS.
- Received 4 new Community Living Waiver slots for distribution.
- Staff completed 10 Career Development Program applications,
- The team took on 30 new cases from transfers only, by transferring approximately 50 cases out of the area and servicing approximately 80 new transfer cases.

Parent Infant Program

- The PIP program served a record number of babies this past year.
- The PIP Program Manager, along with representatives from VCU and another system, presented on Infant Services at an international conference in Chicago.

- Began utilization and expansion of Trac-It, the electronic health record of the State's Part-C program. Started a work group to continue implementation.
- Therapists provided training about child development to community day care providers that assisted them with the training hours needed to maintain their childcare educational requirements.

Developmental Services Goals

- Continue working with IT to develop reporting from Credible.
- Advertise, recruit, onboard and train key vacancies in the Developmental Services Division.
- Will adhere to all CAP's and QIP's from any DOJ sanctioned review with the goal of assisting the State become compliant with the DOJ settlement by December 2023.

Employment and Day Services:

- Continue working on the agency strategic plan initiative "Re-design of Day Services for individuals with developmental disabilities.
- Participate in the DARS EPIC grant to assist 14C transition and future vocational goals youth transitioning out of high school.
- Develop and implement group and individual community activities.

Case Management

- Will implement Credible reports to ensure timely and accurate submission of quarterlies, DOJ, and CCS data.

Housing

- Continue to monitor new Foster Youth Initiative and Homeless Vouchers.

Infant

- Fully implement Early Intervention electronic case management record system.
- Partner with a childcare center within our locality to provide annual screenings.
- Reimplement graduation program for Early Intervention.
- Increase provider availability to address the increased child count by adding at least 1-2 new provider agencies.

Residential

- Continue to meet HCBS and CARF requirements.
- Develop and implement plan to transition Sherbrooke house to a 5-bed residence.
- Keep all beds occupied and fill any vacancies within 60 days.
- Improve and maintain funds ledger and inventory tracking for individuals.

Developmental Services Outcomes

DD CASE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Efficiency 90% of Multi Service Progress Notes will be final approved within 5 days of opening	Year end results:	ID = 50.32% DD = 82.35% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	FY23 has been very unstable with staffing, EHR transition, and staff burnout due to excessive caseload size. We were unable to meet our 90% objective for the year. As the fiscal year came to an end, there were many accomplishments with the Credible process and staff comfortability. We have improved our staff retention with staff salary increases

				and 3 new FT CM positions. The higher starting salary will improve the ability to secure qualified staff. We continue to review trends, train, improve our process where we can, and continue to push for 5-day compliance. Supervisors will continue to work with IT to identify and establish reports that will give the necessary tools to assist in reaching our objective.

MEASURABLE OBJECTIVE Effectiveness 90% of DD Waiver charts reviewed will have a VIC completed accurately, thoroughly at the time of the annual and when a change occurs	Year end results:	89.58% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The objective was slightly missed at 89.58% for the year. There had been a lot of transition during this year that impacted the review being completed and having the VIC available for review in a timely manner. We are pushing for Case Managers to quickly file their documents as soon as they are completed so the chart room personnel can upload documents immediately. Case Managers are receiving a copy of their reviews and being retrained on any deficiencies.

MEASURABLE OBJECTIVE Efficiency 90% of Person-Centered Reviews will be completed and final approved within 30 days from due date noted by EHR report.	Year end results:	ID 63.34% Not met DD 90.49% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	FY23 has been very unstable with staffing, EHR transition, and staff burnout due to excessive caseload size. DD was successful in meeting their objective for the fiscal year, but ID fell short from meeting their objective. Improvements were seen, but not enough to meet the objective for the year. As the fiscal year came to an end, there were many accomplishments with the Credible process and staff becoming more comfortable. We have improved our staff retention with staff salary increases and 3 added new FT CM positions that we continue to interview for. The higher starting salary will improve the ability to secure qualified staff for the PT CM vacancies. We continue to review trends, train, improve our process where we can, and continue to push for 30-day compliance. Supervisors will continue to work with IT to identify and establish reports that will give the necessary tools to monitor quarterlies in real time and assist in reaching our objective.

MEASURABLE OBJECTIVE Efficiency 100% of the quarterly supervision meetings by the Developmental Disability supervisor will be conducted with the DD	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Objective was met during FY23. There were no areas of improvement noted for the entire fiscal year. Ongoing quarterly supervision meetings were successful and beneficial in overseeing the work of the Private Providers and ensuring that they are following agency regulations.

Contracted Private Providers for the fiscal year.				

MEASURABLE OBJECTIVE Effectiveness 90% of individuals receiving enhanced case management services will receive at least one face to face contact every 30 days	Year end results:	ID = 64.31% Not met DD = 62.5% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Individuals were still listed as ECM even after they came off and some came off, but the ECM program was not updated until later. In switching to the new electronic health record, the process was to remove from ECM was 2 steps and in most cases only 1 step was completed. Each quarter an attempt was made to correct the problem, but the necessity to go through the Episodes as well as the program tab was only discovered after the FY23 ended.

MEASURABLE OBJECTIVE Effectiveness 90% of individuals receiving enhanced case management services, who received face to face contact every 30 days, will also receive one of those contacts every other month in their residence.	Year end results:	ID = 77.00% Not met DD = 80.09%Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Individuals were still listed as ECM even after they came off and some came off, but the ECM program was not updated until later. In switching to the new electronic health record, the process was to remove from ECM was 2 steps and in most cases only 1 step was completed. Each quarter an attempt was made to correct the problem, but the necessity to go through the Episodes as well as the program tab was only discovered after the FY23 ended.

DS HERMITAGE AND CYPRESS DAY SERVICES OUTCOMES

MEASURABLE OBJECTIVE Access 100% of the individuals referred to a Day Service program will be contacted for at tour, followed by setting up a 60 day assessment within 20 days of the tour. Baseline 2022: 100%	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This year, we used a new process for assessing an individual who wanted to attend Hermitage or Cypress Enterprises. Each person/family had a tour, followed by a 60-day assessment period. This allowed the individual and family to truly experience the programs and to try different pods if they were available. This allowed the staff to work with the individual and family to problem solve any concerns and to ensure we were able to fully support the needs of the individual. Each quarter, we tweaked the process thanks to feedback from families and staff. Next year, we will incorporate meetings into the process at or near the start date of the assessment and again at the end of the assessment.

MEASURABLE OBJECTIVE Effectiveness For COI: Increase number of individuals to 25 who are enrolled in and receiving	Year end results:	16 Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Over the course of the fiscal year, we encouraged individuals to add the Community Engagement service to their plans. This service would ensure multiple community activities at a 1 staff to 3 individual ratio and would allow for specialized billing through the Medicaid Waiver. Despite efforts, we increased from 10 individuals to 16 individuals, which did not

community engagement services through the waiver.				meet the goal. Many felt they did not need community engagement, because outings that occur during the group day service was satisfactory to the individual. We will continue this goal into the new year, with the hope that we enhance the individualized opportunity and that we continue to increase the revenue for the programs.

MEASURABLE OBJECTIVE Effectiveness For OES: In order to meet requirements for HCBS and increasing community integration, 75 % of all who attend Hermitage and Cypress will participate in at least one community outing each quarter.	Year end results:	4 of 4 quarters, average 92% Met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Through the course of Fiscal year 2022-23; community activities were and continue to be an integral part of the Day Services opportunities for individuals who attend Hermitage and Cypress. An overall average of 92.5% of individuals participated in at least one activity per quarter, with only a small number not participating. Most who did not participate did so of their own choice. Since we met this outcome, we will continue to look at ways to expand options in the community by measuring how many times everyone goes on a community activity rather than overall program numbers.

MEASURABLE OBJECTIVE Efficiency For OES and COI: 90% of the documentation written in Credible and reviewed at Utilization Reviews will meet HCBS and DMAS criteria.	Year end results:	98.3% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	For the year, a total of 25 charts were reviewed for the data portion of the quality review form. 98.3% of the elements were within the framework for compliance. There were no large areas needing improvement, however, it was clear in the reviews that staff needed to be more consistent in how the notes were written. Further training will be held to ensure that all notes meet the consistency requirements. In addition, the chart reviews for next year will look for more specific items, to ensure that all regulations have been met.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of all individuals who attend the Hermitage or Cypress programs will express satisfaction for their services in the annual survey with a 4 or 5 on 5-point scale	Year end results:	54 of 69, 78% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The programs at Hermitage and Cypress Enterprises are undergoing changes due to the elimination of the 14c DOL certificate, which allows work paid at less than minimum wage. Due to that, we have been exploring other options within the program and within the community. Change is difficult but especially for some of the individuals who attend. Almost always was the rating received when asked if their staff person showed respect for almost 100% of the surveys. Most noted that they liked coming. Several noted that they missed work and that they missed seeing their friends from other pods as two areas of concern. Those who want, are being offered community employment options. With Covid restrictions lowering, more activities and options are being made available for inter-pod

				interactions. We will continue to monitor feedback and gain input as changes are developed and made.

MEASURABLE OBJECTIVE Stakeholder Satisfaction For OES and COI: Will host 2 caregiver/stakeholder meetings regarding future of day services and get feedback. Written survey for feedback will also be used. 75% of families, stakeholders or other invited parties will participate in either the meeting or the survey.	Year end results:	More than 75% of enrollees had family represented to provide feedback. Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	One large meeting and another smaller meeting was held. Feedback was received during the meeting and also in written format following the meeting. More than 75% of the individuals had family or caregivers present to provide feedback. Feedback received was positive and supportive of the efforts being made to enhance the programs. The largest concern was transportation and families were assured we were working on the issues. Families were confident that changes would assist their family member and while disappointed that work would be a very limited option, that they were happy we were working to enhance daily activities. The newsletter was noted as being a very good source of information for the families and those will continue.

DS GROUP AND INDIVIDUAL SUPPORTED EMPLOYMENT OUTCOMES

MEASURABLE OBJECTIVE Access 90% of the individuals referred to an Employment program will be contacted within 10 days of assignment to an Employment Specialist.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Over the course of the year, we had 6 referrals. All individuals were contacted within 10 days. We receive referrals from the Department of Aging and Rehabilitation Services and from our internal DD Case Managers. Once received, staff are assigned by the Program Supervisor and the Employment Specialist has 10 days to connect with the individual. We met this outcome at 100%. No changes are needed at the is time.

MEASURABLE OBJECTIVE Effectiveness 90% of individuals will remain employed each quarter thru the fiscal year.	Year end results:	4 of 4 quarters at more than 90% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This outcome targeted our retention rate for individuals employed. Our goal was 90% was stay employed each quarter. Several individuals lost their job due to layoffs; several were not working but were looking for work and one individual retired. Employment Specialists participated with each individual when changes occurred by assisting with job development or entered a discussion of their future. One chose to go work for another provider in their group site while another went back to DARS for further assistance. There were no actions needed for improvement during the year. We will not continue this outcome next year, but will target job development for those leaving the workshop over the next year.

MEASURABLE OBJECTIVE Efficiency 100% accurate reporting of services for LTESS, EES, and Waiver by ensuring there is a note for each billable service in Credible.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	For this outcome, the target was 100% accuracy in documentation for all funding sources. Quarterly, there were chart reviews completed on 25% of the records. In addition, each month, bills were reviewed to ensure that the notes reflected the amounts billed. There were no issues reported throughout the year. Since this year, we entered all data into a new electronic health record, reaching this outcome is a true milestone. Staff worked hard to learn the system and ensure billing was accurate.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of the individuals served will respond with a positive response when asked if they are satisfied with the services which they have received.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	All thirteen surveys returned expressed 100% satisfaction with supported employment services. This is a low return rate since we served approximately 90 individuals during the year. This rate is low despite handing them the survey directly during their annual meeting. We will try something different next year in an effort to gather more significant information from more individuals involved in the SE Program.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of the employers involved in Group and Individual Supported Employment will report satisfaction with services by answering Mostly or completely satisfied when asked.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This year, we surveyed caregivers and families of those in the Supported Employment services. We only received 6 surveys. But all 6 expressed complete satisfaction. Next year, we will be surveying the employers who have hired individuals through the SE program.

DS INTAKE OUTCOMES

MEASURABLE OBJECTIVE Access 90% of transfers to/from Henrico will be completed within the timeframe (90 days) as designated in the statewide transfer protocols.	Year end results:	61% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Measuring this element this year was an illustrative tool to document the complexity of transfers between CSB's. There is a reoccurring issue with transfers both going and coming where the letter gets sent but documentation does not follow in a timely manner. Other barriers included issues with diagnosis documentation and stability of supports. This is the first full year where the intake unit orchestrates both transfers in and out (before that time we were only doing those coming in). We did not meet the goal but discovered lots of great information in hopes to better the process on our end.

MEASURABLE OBJECTIVE Consumer satisfaction 90% of Individuals/families will report satisfaction with supports received during the intake process. Individuals/families will receive a short survey via mail following the intake. The survey will include feedback on ease of access, resource sharing and staff responsiveness.	Year end results:	0 Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	No surveys returned. Surveys have continued to be mailed to families once an intake has been completed. This has not been the best avenue for us to collect documented satisfaction with these families. We do however often receive phone calls where these families in conversation share positive feedback about the staff interaction and the information shared.

DS RESIDENTIAL OUTCOMES

MEASURABLE OBJECTIVE Access All vacancies in the program will be offered and accepted within 90 days.	Year end results:	3 vacancy/0 accepted Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The residential program staff vacancies have improved, but there are still four part-time positions. During this year, the residential program has completed numerous house tours of potential residents, and from these tours, we have been able to fill five vacancies, 50% of openings have been filled. The program still has three vacancies that we continue to try to fill. The agency Case Management teams have been informed of the openings.

MEASURABLE OBJECTIVE Effectiveness 35% of residents will participate in special individualized community inclusion events/activities (non- routine) each quarter.	Year end results:	10% or less Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Residents continued regular community participation, this outcome measures residents additional desired special events such as attending a NASCAR race or attending a show at the Altria Theater. The expected outcomes was not met this quarter. It was noted by supervisors that the biggest issue was that too many residents participated in activities. Since several new residents have moved into the homes, the program staff are still learning their likes and dislikes regarding community integrations, which has ended with residents refusing to get out of the vehicles, getting to the event and then stating they wanted to leave, or just not knowing what they wanted to do, so they say "no" to all activities.

MEASURABLE OBJECTIVE Efficiency 95% of employees will complete 2 High	Year end results:	97% Met Actions during the year did produce the	Recommendations, actions taken, performance improvements:	Actions taken, including all classifications of residential staff, were assigned training via the Relias training platform starting on March 1, 2023. There was one Residential staff member who completed the last of the assigned

Risk Trainings related to Congregate Living situations each quarter.		desired results		training after the assigned deadline but still within the 4th quarter.

MEASURABLE OBJECTIVE Efficiency 95% of employees will be current with all required training each quarter.	Year end results:	97% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Actions taken, including all classifications of residential staff, were assigned training via the Relias training platform starting on March 1, 2023. There was one Residential staff member who completed the last of the assigned training after the assigned deadline but still within the 4th quarter.

MEASURABLE OBJECTIVE Consumer Satisfaction 100% of residents will be satisfied with their services and achieve desired outcomes documented in their quarterly reviews	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The residential program will continue to work diligently with the residents to meet their TO/FOR outcomes and supports, which is a contributing factor to this outcome. This goal will continue next year with the current satisfaction rating captured in the residents quarterly reviews.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of residents' family/AR/guardians will be highly satisfied with their services and achieve desired outcomes via an annual survey	Year end results:	88% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Due to the limited response from the previous survey request last year, it was determined that family/AR/guardian satisfaction would be gathered from routine contact. We are in the process of finding a better way to gather the annual satisfaction of services since many people don't respond to surveys being mailed or emailed to them. One suggestion from Day Services' Program Manager is to have the survey done during residents annual ISP meetings.

PARENT INFANT PROGRAM OUTCOMES

MEASURABLE OBJECTIVE Efficiency 95% of all Targeted Case Management (TCM) contacts will be met every month.	Year end results:	51% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Going forward we will incorporate a new process to address TCM's. All of PIP therapists will be certified to assist with completing TCM's. When there are no-show evaluations or canceled appointments, they will use the report out of Credible to contact families for TCM's. We believe that this will assist us in meeting our outcomes despite our staffing shortages.

Clinical and Prevention Accomplishments

Expand community-based services:

- Increase community-based response to traumatic events in communities (Prevention)
  We created a new clinician position with the Prevention Program designated to address issues around violence and traumatic events that have occurred in the community. The Clinician successfully partnered with Henrico Police and community organizations to help support individuals and communities following shootings and other events. As part of these efforts, door hangers were created that have links to resource information.
- Increase community-based crisis response to youth and individuals with substance use disorder (ESP)
  There has been a sustained vacancy in our mobile substance use disorder Crisis Clinician position which has impaired our ability to implement this effort. We successfully implemented the youth crisis response clinician role. This resulted in increased coordination with police for youth threat assessments.
- Increase community-based outreach to individuals with substance use disorders (SUD)
  Our new Mobile OBAT Clinician successfully increased our support and services within the community. The clinician used information from the Addiction Task Force and Overdose Map to identify "hot spot" areas with the community. She reached out to hotels and organizations within these areas and provided REVIVE training and information about how to access services. The clinician partnered with the Health Department to provide onsite services in the Henrico Arms community for 4 hours each week. The clinician and clinical team use the Health Department's van as an on-site office.
- Increase school-based services to youth and their families (Y&F)
  Through a grant, we fully implemented school-based clinician and family support services at the Academy at Virginia Randolph. This program is recognized by the schools as a successful strategy for eliminating barriers to treatment for youth and an opportunity for enhanced coordination between schools and our agency. The schools are actively exploring opportunities to expand this program to other schools in the County.
- Continue to build community resources for individuals with SMI (Collaborative Services)
  Our new Peer Specialist focusing on community inclusion successfully implemented strategies to increase awareness and access to community events for individuals with serious mental illness. Among these accomplishments is a monthly calendar of events and support groups that are available in the community. This program was recognized with a National Association of Counties award this year.

Enhance Crisis Continuum of Services

- Implementation of 23-hour Center for Youth in Collaboration with St. Joseph's Villa. We successfully secured funding and broke ground on the new 23-hour Center for Youth. There are monthly planning meetings with St. Joseph's Villa. Renovation on the existing structure began in late Spring 2023 with a targeted opening date of Spring 2024.
- Increase co-response with police to individuals experiencing behavioral health crises (ESP)
- The emergency services team is providing co-response with police 4 days a week during daytime hours. We quickly saw positive results from this co-response model and were able to divert numerous individuals from hospitalization. We anticipate that this program will continue to grow.
- Enhance coordination with regional crisis programs (Call Center, REACH, CReST) (All programs)
- We partner closely with the regional teams on a regular basis. Representatives from the regional teams presented to the County's Marcus Alert Task Force to further enhance coordination and to assist in preparation for implementation of Marcus Alert in July 2024.

Enhance support to staff:

- Implement Career development plans for Clinicians.
- We successfully launched the Career Development Plan for clinicians. To date, 13 clinicians have submitted completed packers and were promoted to Clinician II.
- Increase training opportunities through regional trainings, use of Relias, and in-house training

- The implementation of Relias significantly increased staff's access to training. In addition, staff have been trained in several evidence-based treatments including:
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Trauma Focused Cognitive Behavioral Therapy
  - Parent Child Interaction Therapy
  - Adolescent Community Reinforcement Approach
  - Child-Adult Relationship Enhancement
  - Advanced Motivation Interviewing

Increase opportunities for interns

- We have designated an individual Program Manager within the Clinical and Prevention Division to coordinate our work with interns. This has resulted in better collaboration and coordination. We worked with VCU to provide internship opportunities to undergraduates to assist in preparing them for the work force post-graduation. We also partnered with the Regional Peer program to provide internship opportunities for individuals pursuing certification as Peer Specialists. We maintain relationships with multiple universities to provide graduate level internship opportunities.
- Increase clinical supervision opportunities--Ensure that adequate number of individuals are trained/qualified to provide clinical supervision
- We continue to partner license eligible clinicians with more seasoned staff to provide clinical supervision opportunities. Relias is assisting us in ensuring that licensed staff have the required training in order to provide clinical supervision.

Outpatient Services

- Obtained position for a SUD peer that works directly with the Henrico Fire Department providing overdose outreach.
- Successful community collaboration on abatement request for services for pregnant and parenting women
- Successful community collaboration on mobile Office Based Addiction Treatment (OBAT)
- Received award for permanent supportive housing for Pregnant and Postpartum Women (PPW)
- All SUD staff trained on Acu Wellness – this service has begun with individuals served and staff
- Several staff trained in Eye movement desensitization and reprocessing (EMDR), a new treatment that is now being provided
- NACO award for CHIRP (joint with CCP and Sheriff)
- Implement contingency management with OBAT
- Mobile OBAT site – joint partnership with Health Dept
- Award of 34,000 grant for PPW – training in Charles City for Charles City and New Kent providers
- Mobile door hangers (more than just outpatient)

Court Services

- New position – case manager for the team
- New supervisor
- Streamline referrals/orders – introduction of email for the clerks and for easy communication
- Multiple meetings with judges to introduce new supervisor and to work on processes
- Training provided to all restoration staff

Adult Recovery Services Case Management

- Continued successful partnership with two Managed Care Organizations (MCOs) with the goal to improve physical health outcomes of consumers served with serious mental illness. With one MCO, agency staff were able to get 98% of consumers connected and seen by their primary care physicians for annual physicals for ongoing care and preventive medical screenings.

- The vast majority of newly opened clients (89%) to the Mental Health Case Management and Assessment program demonstrated a reduction in psychiatric hospitalization rates.
- Agency clients report an extremely high level of satisfaction regarding services received within the Case Management and Assessment program, as reported on a recent survey, with 98% of responses being among the top two ratings.

InSTRIDE
- Continue to run the family support group
- Resumed community outings on the weekend
- Higher consumer participation in community outings
- Served 53 consumers, target is 55
- Hired a substance use clinician
- Serve the highest First Episode Psychosis (FEP) amongst the state
- Increased collaboration amongst the school system as we are serving an increased number of adolescents
- Continue to run the family support group
- Peer inclusion in the mobile OPIOD task force
- She serves the agency with DMAS and DBHDS in an FEP work group to enhance FEP across the state
- Clinician is part of the initiative to increase services to the adolescent homeless population across the region
- Vocational specialist was able to assist 20 consumers with obtaining employment

Lakeside Center
- Increased census and daily program attendance.
- Maintained strategies of cleaning, maintaining good hygiene, and other safety precautions as part of daily service provision to reduce risk of spreading illness and assisting members with maintaining wellness.
- Awarded the NACo Achievement Award for the peer recovery community inclusion specialist position.
- Received the DBHDS "Year of the Peer" micro-grant to support the community inclusion initiatives.
- Continued to assist individuals with accessing services to the program within an average of 10 days from the receipt of their referral.
- Received a rating of 8.7 or higher out of 10 from an annual satisfaction questionnaire for our members.
- Received a rating of 9 or higher out of 10 from an annual satisfaction questionnaire for members' families.
- Partnered with Bon Secours Memorial College of Nursing for students to shadow program staff and facilitate psychoeducational groups to members as part of their educational experience.
- Displayed support to agency by providing primary case management to over 15 program members.

MH Vocational Accomplishments
- Earned CARF 3-year reaccreditation.
- All Job Coaches are certified in Individual Placement and Support (IPS)
- 45 jobs were obtained surpassing last fiscal year of 35
- 13 persons remained employed 3months or longer.
- 10 successful discharges in which persons were closed while independently sustaining employment.
- Work Incentive Specialist obtained 5yr recertification.
- Obtained successful employment for a non-English speaking individual

InShape Program Accomplishments
- Program PGOIS were developed to allow charting independent of a case management ISP
- Program has increased participants and nearly operating and maximum guidelines for program effectiveness.
- Health Mentor has obtained InShape recertification.

MHSS/ MH Support Homes

- Program participants were able to show an increased understanding of nutrition and demonstrated learned skills through grocery shopping of appropriate food selections.
- Program participants showed an increased knowledge of physical health and understanding of medications.
- Independence has increased in community access and socialization with participants accessing Uber and Lyft as means for transportation.
- All individuals are working or engaged in a consistent structured activity.
- New bedroom, living room and dining furniture have been replaced at multiple homes.
- 1 person is preparing to move into their own apartment to live independently.

Emergency Services

- Completed 1,351 Preadmission screening evaluations in FY23 through May 2023
- Assessed 484 Individuals at our Crisis Receiving Center through April 2023
- Provided daily case management, advocacy, and supportive counseling for individuals boarding at ER's awaiting placement due to the statewide bed census crisis.
- Implemented Youth Mobile Crisis services and Adult SUD Mobile Crisis services
- Implemented an ECO pilot program where individuals are brought to the Woodman Road office to try to decrease ER visits, and in collaboration with the Medical Services Unit, provided crisis intervention services.
- Implemented a pilot co-response model program (Mobile Response Team or MRT) with police for mental health related 911 calls and for outreach visits utilizing current staffing.
- Tracked LIPOS funded individuals at private hospitals, and assisted in developing discharge plans for these individuals.
- Implemented the prescreening documentation process into the new EHR, Credible
- Continued representation on the interdisciplinary STAR (Services To Aid Recovery) team
- Offered an increased number of debriefings to community and agency members experiencing traumatic events.
- Trained clinicians, including those in other Agency programs, so that they could be certified as preadmission screeners.
- Continued providing outreach phone calls and letters for those clients not hospitalized during an emergency evaluation to link them with any resources needed.
- Provided co-leadership for workgroup on agency strategic initiative for expanding crisis services.
- Participated in interdisciplinary legal panels for basic CIT classes.
- Facilitated training and provided leadership for agency representatives on County Hostage Negotiations team.
- Planned and completed team retreat to work on team dynamics and expansion of crisis services.

Prevention Services

- Violence Prevention Coordinator position was created.
- CARF Accreditation, Fall 2022.
- Selected by DBHDS to participate in the Activate Your Wellness Media Campaign.
- Created and dissemination of the media campaign for conflict resolution. PSA airing on Mix 98, Q94, 103.7, 105.7 / 99.3 daily throughout the summer 2023.
- Strengthened relationships with internal and external partners:
    - Internal – Adult SUD & Youth and Family Services
    - External – Henrico Too Smart 2 Start, Police, Recreation & Parks, Libraries, and Schools
    - Community – 3C Church, Building Constructive Communities Foundation and Hour Little Daycare
- Train the Trainer – 3 staff have been trained in MHFA – Adult & Youth Curriculum, 1 staff trained in Strengthening Families Curriculum, 5 staff trained in the 5 Bridges of Wellness Curriculum.
- New evidenced based curriculum has been adopted – One Circle Foundation: Boys Council and Girls Circle.
- Prevention continues to partner with all Kroger Grocery stores in Henrico County to provide medi-bags with over the counter drug misuse prevention messaging.

- CONNECT Programming – 217 youth have been served throughout the summer and school year.
- Prevention has represented the agency at community events throughout the year (averaging 8-10 a month).

Clinical and Prevention Goals

Continue focus on building community-based services and programming:

- Fully develop plan for Marcus Alert implementation
- Develop mobile SUD services in Charles City and New Kent

Enhance continuum of crisis services:

- Support St. Joseph's Villa in opening of Youth 23-hour center
- Finalize plans for adult detoxification center and 23-hour program

Enhance services for pregnant and parenting women with substance use disorder:

- Implement permanent supportive housing program for PPW with SUD
- Seek Opioid Abatement funds and implement proposed programming

Enhance relationship with Charles City and New Kent Counties:

- Develop monthly reports for County Administrators
- Assist Charles City and New Kent with implementation of Families and Schools Together (FAST) Programming
- Seek opportunities to expand substance use programming

Create new substance use division:

- Develop transition plans for programs moving to new division
- Develop processes for coordination and referral between divisions
- Establish joint meetings for divisional staff to reduce siloing

Clinical and Prevention Outcomes

ADULT SUBSTANCE ABUSE OUTCOMES

MEASURABLE OBJECTIVE Access 100% of individuals admitted to the program will be scheduled within 14 calendar days for the next available appointment (group and individual sessions) following the same day access appointment	Year end results:	81% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Despite attempts to improve our ability to see individuals referred within 14 days of their same day access appointment, vacancies and FMLA leave negatively impacted the teams' ability to do so. However, 81% were seen within the 14 day goal. At the end of the quarter, only 1 vacancy remained so it is hoped that the number of people seen within 14 days will increase.

MEASURABLE OBJECTIVE Effectiveness Average length of stay will be 3 months or more for all individuals in the program. Aim is to	Year end results:	57% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	57% of individuals presenting for services remained in services for more than 90 days. This is an improvement over the retention rate from the previous year. We began contingency management as a means of attempting to improve retention in OBAT services. Given the results in the 4th quarter (62%), it appears that this may have had a positive impact on retention

increase retention over previous year, 53.5%				numbers. We will continue to utilize contingency management in our OBAT services.

MEASURABLE OBJECTIVE Effectiveness Of planned discharges, 70% will demonstrate a reduction in substance use or maintain abstinence during treatment. (Planned discharges are defined as those where the client is involved in the development of the discharge plan)	Year end results:	57% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The move to a new electronic health record this fiscal year has negatively impacted our outcome. During the first quarter, staff were learning the new EHR and as a result were not consistently entering the discharge drug usage frequencies appropriately. This skewed our results for the first quarter. If quarter one is removed, and use the results for quarters 2-4, we surpassed the objective. Changes were made and procedures put in place to accurately capture discharge use patterns during quarter 2.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of individuals surveyed in March will rate their overall satisfaction with services. (4 or 5 rating)	Year end results:	98% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Overwhelmingly, clients reported satisfaction with their substance use services. 147 surveys were completed during the month of February 2023. There were 578 opportunities for individuals to give a score of 4 or above and they did so 98% of the time. In addition, 141 individuals answered a question about their level of use since beginning services, 134 or 95% indicated that they have reduced their use since beginning treatment.

ADULT MENTAL HEALTH OUTCOMES

MEASURABLE OBJECTIVE Access 100% Individuals will be scheduled within 14 calendar days for the next available appointment following the same day access appointment.	Year end results:	58% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	58% of the individuals opened to MH Outpatient services were seen by their clinician within 14 days of presenting to Same Day Access. This team of clinicians has been plagued with ongoing vacancies. Additionally, in the fourth quarter, the team began to accept new individuals with insurance. For the first three quarters of the year, only those who did not have insurance and those at high risk of suicide were opened to services. The hope is that this percentage improves in the next year as the team recently hired a 5th clinician who will being providing services by the second quarter of 2024.

MEASURABLE OBJECTIVE Consumer Satisfaction 85% of individuals surveyed in March will rate their overall satisfaction	Year end results:	97% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Individuals that were surveyed as to their satisfaction with services, overwhelmingly reported being satisfied. 138 surveys were completed and 97% of the responses were positive. It is evident by the feedback that staff are providing a service that is welcomed and seen as valuable by our clients.

with services at a 4 or 5 on the survey				

PROVIDENCE FORGE OUTCOMES

MEASURABLE OBJECTIVE Access 100% individuals will be seen at their first appointment after SDA within 14 calendar days.	Year end results:	97.4% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	During the first three quarters of this year, PF was able to see 100% individuals at their first appointment after SDA within 14 calendar days. In the 4th quarter, two individuals were seen beyond 14 days. PF was successful with 77 out of 79 individuals. PF had staffing difficulties this year where we had a vacant clinician position for most of the year. Additionally, another clinician was out for medical issues. Overall, we were able to meet this goal. The last quarter there were extenuating circumstances with individuals that created a larger number of days not the availability of staff.

MEASURABLE OBJECTIVE Consumer Satisfaction 85% of individuals surveyed in March will rate their overall satisfaction with services at a 4 or 5 on the survey	Year end results:	87.5% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This was the first year using this satisfaction survey. Unforeseen circumstances such as not being fully staffed and one clinician being out on medical leave made it difficult to get many surveys. However, PF was still able to meet the standard with the number of surveys received. There were only 8 individuals surveyed. Of the 7 only one gave a 3 response on "How satisfied are you with the mental health therapy services you receive here" However, the comment made was "I don't know what I want".

CRISIS INTERVENTION TEAM OUTCOMES

MEASURABLE OBJECTIVE Effectiveness Peer Recovery Specialist will contact individuals who are experiencing a crisis and are being evaluated for hospitalization, follow up with these individuals, and attempt to engage in services. FY23 Goal: 30% of individuals who are being treated at the CITAC at Parham Doctor's Hospital will have contact with Peer Recovery Specialist.	Year end results:	39% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	596 preadmission screening evaluations were conducted at the CRC CITAC at Parham Doctor's Hospital this fiscal year. The peer recovery specialist (PRS) met with 39% of the individuals here experiencing a behavioral health crisis. Given that her schedule of 40 hours a week only 5 days a week, and that the CITAC is open and evaluations are completed 24 hours a days 7 days a week, the PRS is not there 2/3 of the time the CRC is open. Despite the difference in hours, on average, the PRS met with almost 40% of the individuals at the CRC. Some did stay for days awaiting placement but others had short stays in the CITAC. The PRS made a concerted effort to talk with everyone that could when she was working. Due to these efforts, she increased the number of individuals who had contact with the PRS. She attempted to engage and helped to answer questions and advocate for these individuals. We exceeded our goal this year and will take this into consideration when we set the goal for next year.

MEASURABLE	Year end	35%	Recommendations,	We met the objective this year. However, the

OBJECTIVE Effectiveness Law enforcement and emergency services clinicians will communicate and identify individuals who may be better served by receiving mental health treatment instead of or before legal charges are placed to divert individuals from jail when appropriate and possible. FY23 goal: 15%	results:	Met Actions during the year did produce the desired results	actions taken, performance improvements:	disclaimer is that this data was collected in a much different manner this year. Last year, it was collected off a report that police completed about arrest data. There was hesitation to report that they didn't charge when there were charges. This question was not on their supplemental CRC report this year. Therefore, this year the data was collected from this same report but we looked at the response for the type of incident and included situations where charges could have been brought. For calls that documented theft, disorderly conduct, domestic disturbances, panhandling, trespassing, loitering, public intoxication, weapons charges, threats, and drug activity. Therefore, while this information is encouraging for individuals receiving treatment instead of charges, due to the difficulty in gathering objective information, this outcome will not be utilized next fiscal year.

EMERGENCY SERVICES OUTCOMES

MEASURABLE OBJECTIVE Access Individuals who are treated in the Region IV Crisis Stabilization Unit or who are LIPOS funded during an inpatient treatment episode and plan to follow up with HAMHDS will be scheduled for an appointment within 7 days of discharge 90% of the time. Outreach efforts will be used 90% of the time for those who do not come to their appointments.	Year end results:	88% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	88% were scheduled for an appointment within 7 days of discharge. Only 50% of those requiring outreach received outreach calls. We came very close to our goal of 90% of individuals having an appointment within 7 days. Two that were scheduled out a bit farther than 7 days were during holiday time, and another one was scheduled within 8 days. Our outreach efforts have improved but still are not meeting our goal. We continue to work on processes to follow individuals more closely while they are receiving treatment at CSU and in private hospitals under LIPOS funding. At times, we are not notified when an individual is discharged quickly and we are working on establishing a consistent point of contact at each facility so that communication can improve. We did offer tele video Access appointments to a significant number of individuals while they were still at the treatment facility through collaboration with the Same Day Access program at HAMHDS. This improved the show rate for appointments and decreased the number of individuals requiring outreach due to not coming to their appointment. Only 4 of 24 (17%) individuals did not show for their first appointment. The other factor contributing to the difficulty in timely outreach efforts is the staffing shortage that the Emergency Services program has experienced most of this fiscal year. The hospital liaison responsible for tracking CSU admissions and treatment progress and for tracking those receiving LIPOS funding has

				planned a new system for tracking and follow up to improve our outreach and engagement.

MEASURABLE OBJECTIVE Effectiveness To increase the likelihood of intervention in the community and reducing ER utilization, we will try to conduct more prescreening evaluations in the community. Baseline gathered during FY22 was 29% of evaluations were completed in the community. The goal for FY 2023 will be 30% of total evaluations occurring on only those individuals who are not already in a hospital setting when request comes in will be completed in the community.	Year end results:	21% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	We did not meet our objective this FY. Staffing shortages and increasing numbers of requests from hospitals where individuals are already admitted have contributed. We do not have an accurate method of counting these and the numbers may be low as far as those that are already admitted to a hospital when they come to our attention. The last quarter of this fiscal year, we began a pilot program of a co-response team (a police officer and clinician) who respond out in the community to crisis situations and as follow up to crisis situations – called Mobile Response Team (MRT). This has increased our community response, but we do not usually complete a preadmission screening unless it is deemed necessary. We have not had a log or way to record these interactions except for ESP phone contacts which we use for brief contacts. There is no way to differentiate these from all other ESP phone contacts. Next FY, we plan to utilize a log to record activity for MRT community response. Also, we are working on a form which will be a brief crisis contact form where you may check whether it is face to face or telehealth and whether or not it is an MRT response. Hopefully these will improve the accuracy and helpfulness of our data.

MEASURABLE OBJECTIVE Effectiveness 35% of individuals on whom we complete a preadmission screening evaluation, will be diverted from hospitalization. An admission to CSU is considered a hospital diversion. We will also track voluntary hospitalization disposition as that is important information to include with diversion because that is less restrictive than involuntary	Year end results:	28% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	We did not meet our objective of diverting 35% of those individuals that we prescreen from hospitalization. The outcome of 28% diversion rate is fairly consistent throughout the months. The hospital bed census crisis has put a strain on the system and clinicians attempt other treatment options to intervene with individuals in crisis when they are safe. However, there are a substantial number of individuals who are placed under an Emergency Custody Order and are not willing to accept any treatment and they are a substantial risk to themselves and others. Clinicians are noticing that individuals evaluated are experiencing more severe symptoms than in past years. The team will continue to explore less restrictive options and attempt to increase the percentage of individuals diverted from hospitalization.

hospitalization which can result in state facility admission.				

MEASURABLE OBJECTIVE Efficiency 90% of persons (not currently open to the agency) not hospitalized will be contacted by phone within 7 days of their assessment if follow up is indicated in assessment. If the phone call is not able to be completed, a letter will be sent within 7 days. Excluded are persons who live in a group home or are assessed in or are returning to jail or detention, and those who are admitted to a medical unit.	Year end results:	67% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This year's results did not meet our expectations or goals. The system of assigning an individual to track these outreach attempts was not as effective as we hoped it would be. We have had staffing shortages and the hospital bed census crisis has created much case management that we are responsible for that take up much time. This FY will place a priority on gathering information needed for follow up and on updating spreadsheet so that clinicians can call sooner to follow up.

SAME DAY ACCESS OUTCOMES

MEASURABLE OBJECTIVE Access 100% of individuals who answer yes to one of the Crisis Risk Assessment Questions will be offered a referral to REACH.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Manually staff reported 26 individuals answered yes to one of the Crisis Risk Assessment questions and were offered REACH services, 12 declined a REACH referral. During FY22-23, a new electronic health record was implemented which had impacted programs' ability to extract data needed for reporting measures. It was learned in Q2 that this data was obtained from specific questions on the SDA CNA: "If ID, what is the date of the initial ID diagnosis" and "If DD, what is the date of the initial DD diagnosis?" At this time, the designed report does not provide accurate information regarding how many individuals have been diagnosed with ID/DD during SDA process. Above numbers and data were captured through Employee Activity Report search and does not accurately reflect the number of individuals diagnosed with ID/DD and completion of the Crisis Risk Tool and referral to REACH if needed. SDA supervisors and program manager will plan to work with IT further regarding accurate reporting and also remind clinical staff importance of form completion as part of State requirements.

MEASURABLE OBJECTIVE Efficiency 100% of individuals completing Same Day Access and being referred to SUD Services will have a completed TB Screening	Year end results:	73.5% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	In FY22-23, an average of 73.5% of TB screenings were completed. In the first quarter, 68% of TB screenings were completed; in the second quarter 72% were completed; in the third quarter 80% were completed, and in the fourth quarter 74% were completed. The varying completion rates throughout the year may be attributed to implementation of a new electronic health record and ability to capture date accurately. Of the screenings completed, it appears that TB screenings were completed on individuals with a SUD diagnosis and were either referred/not referred to the Health Department. Of the 653 individuals who received a TB screening, 1 individual was referred to Health Department for follow up. Clinicians will be reminded to complete TB screenings as appropriate and reminded of State mandate for completion and referrals to Health Dept as needed.

LAKESIDE CENTER OUTCOMES

MEASURABLE OBJECTIVE Access Individuals referred to the program will be admitted within an average of 10 days from receipt of the referral	Year end results:	Average 7 days Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Lakeside Center continues to prioritize easy access to services for its members. The LSC Supervisor and LSC clinician are both involved with coordinating with agency referral sources to ensure a quick and easy process to start services for members. Year end results were discussed in staff meeting on 8/1/2023 and can be found in meeting notes.

MEASURABLE OBJECTIVE Effectiveness 90 percent of current program members will demonstrate ability to avoid inpatient psychiatric hospitalization throughout the year.	Year end results:	90% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	90% of current members had avoided inpatient psychiatric hospitalizations in the past year. Program plans to amend objective for the next year due to other variables such as, medical hospitalizations and psychiatric inpatient hospitalizations for members who are no longer at the program. Year end results were discussed in staff meeting on 8/1/2023 and can be found in meeting notes.

MEASURABLE OBJECTIVE Efficiency 90 percent of Charts reviewed will demonstrate documented changes to Discharge /Graduation Goal in ISP in the past year.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	LSC staff have regular discussions about discharge planning in treatment plans and emphasizing the importance of objectives that are specific, measurable, attainable, relevant, and time bound. All charts reviewed had documented changes to the discharge/graduation goals in the ISP. LSC Staff continue to benefit from regular discussions about treatment planning during team meetings and in individual supervision. Year end results were discussed in staff meeting on 8/1/2023 and can be found in meeting notes.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of consumers surveyed will report being "satisfied" with services as evidenced by an average 8-10 rating to all survey questions	Year end results:	100% Question 1 average: 8.73 Question 2 average: 8.73 Question 3 average: 8.78 Question 4 average: 9.07 Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	All consumers reported being satisfied with services evidenced by an average score of 8 or higher on every survey question. In the next fiscal year, the program will try and capture feedback on the survey to incorporate into the program. Year end results were discussed in staff meeting on 8/1/2023 and can be found in meeting notes.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90 percent of Member Families/Significant Others surveyed will respond with an 8-10 rating to all survey questions	Year end results:	100% Question 1 avg: 10 Question 2 avg: 10 Question 3 avg: 9 Question 4 avg: 10 Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	All families/significant others reported being satisfied with an average of 9 out of 10 to all questions surveyed. In the next fiscal year, the program will attempt to capture feedback on the survey to incorporate into the program. The program will survey a different stakeholder in the next fiscal year.

MH CASE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Access On average non crisis individuals will be offered an appointment into ongoing case management and assessment services within 7 calendar days of their Same Day Access intake assessment.	Year end results:	13.3 days Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Workforce shortages/challenges across the Case Management teams continued to be a significant issue impacting wait times for individuals seeking agency case management services. To meet the individuals with the highest needs first, the agency did implement a triage system mid fiscal year, to offer first available appointments to these higher need individuals , which was helpful in meeting those client's needs, but did result in overall longer average wait times – We are hopeful that once all the vacant case management positions are filled that wait times will decrease and we will be able to meet the benchmark for this objective once again.

MEASURABLE OBJECTIVE Effectiveness Newly opened individuals will demonstrate an 80% reduction in hospitalization rate or will maintain 0 hospitalizations. The baseline (measured from 3 months prior	Year end results:	94% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	94% of newly opened individuals experienced a reduction in hospitalization rate or remained at zero hospitalizations. These results continue to speak to the efficacy of agency services in reducing the frequency of costly and at times disruptive inpatient psychiatric hospital admissions. The fourth quarter results also demonstrate a higher client retention rate within case management services at or past the 9 month mark, which is encouraging and demonstrates a higher client engagement rate, as compared to previous quarters, which

to initiation of service to 3 months after initiation of service) will be compared with their hospitalization rate from months 4-9.				is an indicator that case manager to client outreach efforts have been successful, which is also encouraging.

MEASURABLE OBJECTIVE Efficiency At least 55% of agency case management individuals will receive physical annually by a qualified medical provider to identify any health-related issues and develop a plan of care to meet those needs.	Year end results:	39% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	A total of 39% of individuals served in the Case Management and Assessment program of Henrico Mental Health received a physical in the past 12 months. Ensuring that individuals follow-up and follow through with their medical providers remains a focus within case management services to ensure that client's physical health needs are met in addition to their mental health needs. Staff vacancies across the case management teams, coupled with the initiation of a new electronic record that went live within the past12 months, both likely had a negative impact on meeting the benchmark for this outcome measure. Case management and supervisory staff will continue to monitor, encourage and link individuals to their medical providers and work to reduce any barriers individuals experience in accessing medical care.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of client responses will be one of the two highest ratings to questions on the satisfaction survey	Year end results:	98% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	During the month of April, case managers and agency staff offered and collected client satisfaction surveys to individuals that were seen face to face throughout the month. A total of 131 surveys were collected across the 4 main case management teams, with a total of 524 responses given to the 4 questions asked. Five hundred thirteen (513) of those responses were given one of the top 2 ratings or 97.90% of all the responses given. This meets and exceeds the target for this objective. The number of surveys collected this year did increase as compared to last year, when more services were provided virtually as a result of the COVID-19 pandemic, but the numbers of surveys collected has still not rebounded to pre-pandemic numbers. These results will be shared with team supervisors and staff along with client comments and feedback will be incorporated into how services are delivered, but overall speak to a high level of satisfaction regarding services received.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of HAMHDS	Year end results:	98% Met Actions during the year did produce the	Recommendations, actions taken, performance improvements:	During the month of June, a total of 28 surveys were collected and returned from agency prescribers and the staff from the agency's collaborative services teams (Lakeside Center staff and vocational services)

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		desired results		with a total of 112 individual responses given, rating the services and collaboration that they experienced with case management staff over the past year. One hundred ten (110) of the responses given were one of the top 2 ratings, or 98% of all responses, thus meeting and exceeding the benchmark for this objective. These results along with the comments provided were shared with team staff and supervisors. These results speak to a high level of collaboration occurring across teams which is fundamental and core to providing effective case management services.

IN-STRIDE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Access 100% of individuals referred for InSTRIDE will be opened, on average, for an assessment within 7 days of notification of the referral	Year end results:	85% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Two quarter of the year we were able to successfully open more than 80% of consumers referred to this program within the seven-day window. We will continue to work to meet expectation in providing alternatives to opening consumers within the seven-day window, i.e., if someone is hospitalized, we will see if they are appropriate to be opened in the hospital. At this time there are no identifiable areas to improve. We have two clinicians able to complete intakes twice per week and we will continue to respect consumer wishes if they prefer to meet for their second day appointment outside of the seven day window. Our objective will remain the same.

MEASURABLE OBJECTIVE Effectiveness More consumers than not will experience improvement regarding DLA-20 global scores.	Year end results:	No data Not met	Recommendations, actions taken, performance improvements:	The DLAs are completed twice a year. The team was unable to obtain this data. The agency transitioned to a new electronic health record in July 2022 and reporting capabilities and data validation were worked on throughout the year.

MEASURABLE OBJECTIVE Efficiency 70% of individuals will participate, at least quarterly, in activities within their community such as vocational, educational, or recreational activities to increase community integration and	Year end results:	75% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The team was able to accomplish their goal of 70% or more client participation at least quarterly n activities within their community. We were able to have more social outings to encourage peer interactions. These activities occurred at least once a month. These activities included movies, bowling, golfing, etc. and have been widely received by our consumers. We will continue to look to community resources in the community for our consumers to engage in as well as resources that we can provide our consumers. This will continue to be a goal in the next year.

functional improvement.				

MEASURABLE OBJECTIVE Consumer Satisfaction At least 85% of client responses on the client satisfaction survey will be one of the top 2 ratings.	Year end results:	72% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The team did not meet the goal of having responses in the top two for 85% of the consumer satisfaction survey. The main area that was scored lower was the community engagement. This area was lower due to several factors including distressing symptoms, lack of motivation and immigration challenges. We maintained consumers feeling like their and diagnosis knowledge increased. We will continue to maintain what we are doing and be open to suggestions from consumers about activities they may be more interested in doing with the team.

MEASURABLE OBJECTIVE Stakeholder Satisfaction Stakeholder surveys to be administered to family members of individuals . Target is to achieve average above baseline average 80%	Year end results:	74% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The family satisfaction surveys identified that family members continue to be pleased with services that their family members receive with HAMHDS. The family satisfaction survey demonstrated that family members are pleased with the services that their family receives. The team is engaging and has attempted to have more family involvement, that has not been successful due to low family interest. At this time there is nothing different that we will do. This will remain a goal.

MH ACT OUTCOMES

MEASURABLE OBJECTIVE Access There will be an increase over FY22 68% in access to health care services experienced by persons receiving ACT services. Such individuals will see a health care provider such as primary care providers, specialists, dentists, optometrists, etc., but not including ED treatment, at least once a year.	Year end results:	85% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Our baseline of act individuals accessing medical care last year was 68%, the score for this year was 85%. The west team was fully staffed and was able to transport more consumers to medical appointments this year. While the east was understaffed we understand the importance of continuity of care and made efforts to ensure that individuals were able to get to their medical screenings without issue. We will continue to strive to ensure that everyone gets to medical appointments and we will continue to encourage those who have not gone to allow us to assist with coordinating those appointments.

MEASURABLE OBJECTIVE Effectiveness More ACT consumers	Year end results:	No data Not met	Recommendations, actions taken, performance improvements:	The DLAs are completed twice a year. The team was unable to obtain this data. The agency transitioned to a new electronic health record in July 2022 and reporting

than not will show improvement in DLA-20 global scores, greater than 49.2%.				capabilities and data validation were worked on throughout the year.

MEASURABLE OBJECTIVE Efficiency 100% of program orientation packets, Initial assessments, and Initial individual service plans will be completed within 30 days on all new referrals to ACT services.	Year end results:	91% Not met Actions during the year did produce the desired results most of the time	Recommendations, actions taken, performance improvements:	The team was able to accomplish opening paperwork within the 30 day window for 91% of new consumers. There was one referral that was unable to be completed timely and that was due to refusal from consumer due to symptoms. We will continue to meet with consumers inpatient or in the community and complete opening paperwork within the best of our ability, in the necessary timeframe. This will continue to be a goal.

MEASURABLE OBJECTIVE Consumer Satisfaction Consumers will rate their satisfaction with ACT services a "7" or higher on the ACT Consumer Satisfaction Survey BASELINE: FY21 – 50% of responses, FY22 32%	Year end results:	70% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Our results identified that of the survey participants 70% felt as though services were a seven or higher. That was not across the board, respect and empowerment and progress made were lower. The significant staffing challenges have continued to play a huge role in the lower scores received on the surveys as well as the small sample size. Individuals have been challenged with building a rapport and feeling comfortable with the transition of staff. Our goal will remain the same and we are working on staffing and retention and ensuring that the surveys are distributed in multiple ways so that more individuals have an opportunity to respond.

MEASURABLE OBJECTIVE Stakeholder Satisfaction Individuals ' families/ identified primary support system will complete a service satisfaction survey to rate the services being provided to their family members. Target is to increase over FY22 88%.	Year end results:	75% Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	There was a small number of surveys completed this year for our stakeholder surveys. All results except for one were a four or higher. With Stakeholders feeling like due to the services provided consumers can effectively communicate their needs, effectively deal with their identified problems, are better educated about their illness and would recommend this agency to someone. It appears that stakeholders find that services have been successful in assisting consumers with diagnosis and symptom education and that consumers are better able to express their needs and concerns since in services with the ACT team. The survey needs to be more widely distributed by both teams. We need to try and get feedback from partners and secondary services within the agency as well. This will continue to be a goal.

MH SKILL BUILDING OUTCOMES

MEASURABLE OBJECTIVE Quality / Effectiveness 85% of individuals in the sample will either maintain current level of functioning or demonstrate an increase in their DLA-20 Self-Report Score	Year end results:	77% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The number of individuals served in MHSB remained small throughout the reporting period. Services provided were to those living in our MHSB homes and meeting criteria for services. During this reporting period MHSB served a total of six individuals with one successfully discharged in the second quarter. Each client served received a DLA-20 self-report form to complete at the beginning and again at the end of each quarter. The DLA-20 is a useful tool to measure progress and areas of continued need in five main areas. These areas include physical health and mental wellness, nutrition, problem solving, and relationships with family/significant other. The scores range from 1-5 with 1 being not at all and 5 as always. The low number of individuals impacted our ability to meet our goal of 85% of individuals either showing improved scores or remaining the same. However, while some individuals intermittently showed a decrease in score, the change was not significant. Throughout the reporting period each client received the support they needed to improve in the areas mentioned. However, not all individuals were fully engaged in services, which affected their ability to show consistent improvement. Staff held meetings with those individuals not engaged in services to encourage their participation. Some of these meetings proved to be helpful and the client became more engaged in services. This outcome will not continue in the next reporting period.

MH VOCATIONAL OUTCOMES

MEASURABLE OBJECTIVE Access 90% of persons referred will be contacted within seven days of referral	Year end results:	97% or greater Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This goal was met for the year with each quarter at 90% and above with a year-end average of 97%. As this program operates under the evidenced-based practice model of Individual Placement Supports (IPS), a principle is rapid access to service, this goal will remain as a goal for FY 23 due to it being an IPS access outcome.

MEASURABLE OBJECTIVE Effectiveness 70% of individuals will show an increased knowledge by correctly answering 3 of 5 questions after	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This objective was met at 100% for all questions with the trending incorrect question #2, “I can work full time and receive SSA entitlements”. Although met, this question will further be discussed at the initial vocational meeting and in vocational educational groups.

benefits planning and/or receiving SSA guidelines on earned income from Vocational Supervisor.				

MEASURABLE OBJECTIVE Efficiency Each full-time job coach will develop 24 new employer contacts monthly	Year end results:	31 average contacts monthly Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	381 employer contacts were made. This goal has been ongoing in efforts of improvement and will be discontinued for the upcoming year. Due to this goal being an IPS fidelity outcome it will be continued to be tracked by the program clinical supervisor with each individual Job Coach to present obtained employer contacts in monthly supervision.

MEASURABLE OBJECTIVE Efficiency Full-time job coaches will average at least 55 direct service hours monthly	Year end results:	44 direct service hours monthly average Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This goal was not met this year in which the team ended with an average of 44 direct service hours. Factors such as staff certification trainings and staff on extended leave presented as challenges in obtaining this goal. This goal is expected to increase with all staff completions of certifications and the current increase in staff caseload.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of all responders will rate each statement between “8” to “10” in the survey	Year end results:	90% or better Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	All questions were met this year with 90% or better. Question #2 “I have experienced a treatment team approach with the employment process” was improved ending the year with an average of 93%. To gain consistency in this question’s results the vocational team has increased communication with case managers to include more frequent treatment team meetings.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of all responders will rate each statement between “8” to “10” in the survey	Year end results:	100% #1- 10 of 10-100% #2- 10 of 10-100% #3- 10 of 10-100% #4- 10 of 10-100% #5- 10 of 10-100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This goal was met at 100% for the year. This goal will continue due to the increase of new employment opportunities obtained this year and the frequent change of business managers. This outcome will help ARS Vocational Services gauge the effectiveness and management of employer relationships developed

PREVENTION OUTCOMES

MEASURABLE OBJECTIVE Access Individuals will be approved for admission into the CONNECT program within 5 business days of request for services	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Prevention met this objective with 114 youth approved for admission within 2 days of request. Program Coordinators registered youth on-site. No youth needed to be placed on a waiting list this year.

MEASURABLE OBJECTIVE Effectiveness 80% of CONNECT 1st – 3rd grade participants shall be reading on or above grade level.	Year end results:	77% reading on or above grade level. Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Prevention did not meet this program goal although improvement was made. This is the 2nd full school year post COVID pandemic. Staff have continued to stay connected to community partners who provide enrichment activities and resources that support this objective. Prevention continues to partner with HCPS and their SMART Program as well as the Love of Reading Program to improve reading levels.

MEASURABLE OBJECTIVE 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	Year end results:	Decrease achieved Al's Pals 0% favorable attitudes Life skills Training 6% favorable attitudes Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Post Test of the Al's pal's curriculum with 1st – 2nd graders showed that no youth showed favorable attitudes towards ATODs, down from 6%. Post Test of the ES Life Skills curriculum showed that 6% reported favorable attitudes towards ATOD's, down from 12%. Early elementary school youth involved in Al's Pal's responded well to the SA curriculum. By the 3rd grade youth begin to show more uncertainty around the risk of substance abuse. The new laws surrounding marijuana use along with environmental messages have produced mixed results regarding attitudes towards substances at earlier ages.

MEASURABLE OBJECTIVE Efficiency Prevention Services shall implement environmental approaches, in collaboration with community partners, to address substance use prevention and mental wellness as measured by the delivery of a minimum of 3	Year end results:	27 Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This Outcome was exceeded tremendously. It will be increased for the next fiscal year. 27 Community Level Events were completed

community-level activities, e.g., community forum, social norms campaign, or merchant education activities				

MEASURABLE OBJECTIVE Consumer Satisfaction 85% of CONNECT participants (3rd grade and above) shall give a response of 1 (i.e., agree) on the consumer satisfaction survey	Year end results:	88% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	In the 2nd Quarter, N = 70, 85% of youth responses agreed that the CONNECT Program is beneficial. Data collected in 4th Quarter, N = 70, found 88% of youth responses agreed that the CONNECT Program is beneficial. Prevention exceeded the goal by 3%.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree) on the satisfaction survey	Year end results:	96% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Parents and community stakeholders were surveyed. All 49 parents (100%) agreed that the CONNECT program is beneficial to participants, staff are effective in operating the program and that it is a positive resource for communities and schools. 88% of community stakeholders' responses (N = 27) also agreed. Total of 73/76 agreed.

YOUTH & FAMILY OUTCOMES

MEASURABLE OBJECTIVE Access Youth & Family Services Outpatient clinicians will schedule their individuals within 14 calendar days of their Initial session 90% of the time	Year end results:	57% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	We met our goal 57% of this time this fiscal year. The unprecedented youth health care crisis increased both acuity of cases and volume in our intakes. We had to preserve our workforce and therefore couldn't meet this goal as we would have like.

MEASURABLE OBJECTIVE Effectiveness Youth and family outpatient clinicians in training and trained for Trauma-Focused CBT and Parent Child Interactive Therapy will provide evidence based services to at least 15 individuals	Year end results:	12 cases TF-CBT 14 cases PCIT Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Between Woodman and the East Center, we averaged about 12 TF-CBT and 14 PCIT cases per month. This is very close to our targets of 15 cases served within each EPB. Clinicians continue to progress toward certification in both services, which will ultimately increase capacity. Continued need to manage caseloads has led to increased focus on brief targeted interventions. Also for PCIT staff have shared cases to aid in training which limits capacity during the training process.

MEASURABLE OBJECTIVE Reoffending rates will remain at or below 10% for MST individuals during the course of treatment	Year end results:	20% Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The goal is for 90% of youth to not reoffend. We had 80% of youth not reoffend: 5 out of 25 cases reoffended this year. 25 cases closed during this year had an opportunity for a full course of treatment and 5 of those cases reoffended. Additionally, 18 youth were living at home and 20 were attending school or working

DBHDS PERFORMANCE MEASURES

The DBHDS dashboard targets are set by the DBHDS and the Secretary for all 40 of the State's Community Service Boards. The data used is submitted monthly by CSBs as outlined in the State's performance contract with CSBs. Quarterly the performance measures are summarized for the HAMHDS CSB Board's review. In FY24 new measures for Developmental Delay Case Management and Behavioral Health will be decided upon and posted to the DBHDS Quality & Outcome Dashboard website.

Additional quality measures for completeness, consistency and accuracy were pursued by DBHDS and conveyed in the DBHDS Data Quality Reports. These quality reports assisted CSBs to identify data errors in the electronic health record system. Examples include the following:

Completeness reports of employment discussions, employment outcomes, employment status, discussion of last physical/date, discussion of last dental exam/date

The DBHDS Quality & Outcome Dashboard are incorporated as another component of the Agency's Continuous Quality Improvement Plan. If targets are not met, those measures may be adopted and become a program outcome so that trends and development areas be identified and pursued.

Receiving an annual physical exam

Quarterly HAMHDS' MH CM adults are asked the date of their last complete physical examination so that physical health needs are addressed.

NATIONAL INDICATOR – PREVENTIVE CARE, SCREENING

Physicals	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
HAMHDS	69.9%	68.8%	67.5%	67.0%	64.6%	63.7%	64.2%	62.6%	59.0%	59.2%	58.6%	Not available
Avg of 40 CSBs	54.4%	54.9%	55.0%	54.6%	54.5%	53.7%	54.2%	54.7%	54.8%	54.9%	55.3%	Not available

NATIONAL INDICATOR – SERVICE INITIATION & ENGAGEMENT OF DRUG DEPENDENCE

Initiation/engagement/retention of individuals in SUD services

Individuals, 13 years old or older, that are newly diagnosed with a substance use disorder (SUD) and begin SUD services within 14 days (INITIATION) and who received two or more additional SUD services within 30 days of the first service (ENGAGEMENT) and who received at least two SUD services every 30 days for 90 days following initiation of treatment (RETENTION).

Initiation	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
HAMHDS	57.5%	42.6%	38.3%	40.9%	39.5%	78.3%	81.6%	73.5%	75.8%	75.0%	57.9%	Not available
Avg of 40 CSBs	75.2%	73.7%	73.2%	71.3%	73.8%	73.7%	73.8%	75.7%	74.6%	70.6%	70.1%	Not available

Engagement	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
HAMHDS	57.5 %	42.6%	38.3%	40.9%	39.5%	78.3%	81.6%	73.5%	75.8%	75.0%	57.9%	Not available
Avg of 40 CSBs	75.2 %	73.7%	73.2%	71.3%	73.8%	73.7%	73.8%	75.7%	74.6%	70.6%	70.1%	Not available

Retention	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
HAMHDS	12.5%	5.6%	0.0%	0.0%	11.6%	39.1%	31.6%	29.4%	24.2%	25.0%	15.8%	Not available
Avg of 40 CSBs	30.5%	30.5%	30.4%	30.7%	32.9%	32.5%	32.1%	32.5%	32.0%	29.6%	30.0%	Not available

Enhanced Case Management -

90% of DD Waiver individuals who meet the criteria for enhanced case management (ECM) services, receive at least one face-to-face CM service monthly. Every other month receive at least one face-to-face CM service visit in the individual's residence.

Monthly face-to-face service

Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
New EHR	83.54%	72.27%	68.38%	73.66%	72.95%	65.98%	75.85%	70.46%	68.67%	70.26%	68.00%

In residence face-to-face

Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
New EHR	56.54%	55.04%	55.13%	61.32%	59.43%	58.92%	61.02%	54.85%	51.07%	48.71%	52.44%

Monthly face-to-face or telehealth

Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
New EHR	89.45%	81.93%	80.77%	85.19%	84.43%	84.65%	84.32%	78.90%	78.54%	79.74%	80.44%

SATISFACTION

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. Individuals are asked if the service received helped with goals with work, school, housing, increasing knowledge, improving daily life or engaging in community activities.

Each survey includes a satisfaction question. In order to complete a timely annual report, the reporting period covers the period of April 1, 2022 through March 31, 2023.

During this fiscal year, ten separate services were tracked. A total of 380 surveys were mailed and 15 were returned. The response rate for programs ranged from 0% to 33.3% with an average response rate for all of the CARF services of 4%, down from 8% for FY22. Individual comments are forwarded to the respective program. 75% of the returned surveys noted satisfaction ratings of either satisfied or very satisfied.

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

FY2023 ANNUAL POST DISCHARGE REPORT

HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Discharges by Program (Apr 2022 - Mar 2023)														
MH CM	MH Case Management	20	15	23	39	37	24	35	13	20	33	15	30	**304**
ACT	Assertive Community Treatment	5	1	3	1	1	2	0	0	1	1	2	2	**19**
MH Day Support	MH Community Integration	0	3	3	1	1	3	2	2	3	6	0	0	**24**
MH Vocational	MH Community Employment	1	0	1	1	1	1	0	2	1	1	1	3	**13**
ID Residential	ID Residential	1	0	0	0	0	0	0	0	0	0	0	0	**1**
LEP	ID Community Integration	0	0	0	0	0	0	1	0	0	0	0	0	**1**
ID Supp Employ	ID Community Employment	0	0	0	0	3	0	0	1	0	2	0	0	**6**
Sheltered Employ	ID Organizational Employment	0	1	2	0	1	0	0	4	2	0	1	1	**12**
ID Group Supp Empl	ID Community Employment	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total		**27**	**20**	**32**	**42**	**44**	**30**	**38**	**22**	**27**	**43**	**19**	**36**	**380**

HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Response Rate%
Survey Response Rates (Apr 2022 - Mar 2023)															
MH CM	MH Case Management	1	0	0	3	0	0	5	0	0	2	1	0	**12**	3.9%
ACT	Assertive Community Treatment	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0.0%
MH Day Support	MH Community Integration	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0.0%
MH Vocational	MH Community Employment	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0.0%
ID Residential	ID Residential	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0.0%
LEP	ID Community Integration	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0.0%
ID Supp Employ	ID Community Employment	0	0	0	0	0	0	0	0	0	2	0	0	**2**	33.3%
Sheltered Employ	ID Organizational Employment	0	0	1	0	0	0	0	0	0	0	0	0	**1**	8.3%
ID Group Supp Empl	ID Community Employment	0	0	0	0	0	0	0	0	0	0	0	0	**0**	#DIV/0!
		1	0	1	3	0	0	5	0	0	4	1	0	**15**	**4%**
Response Rate		**4%**	**0%**	**3%**	**7%**	**0%**	**0%**	**13%**	**0%**	**0%**	**9%**	**5%**	**0%**	**4%**	

INTERNAL AGENCY RECORD REVIEWS

Record reviews of open and closed charts were completed by programs quarterly. The percentage of charts pulled for review varied by division and program. The Prescriber program and most MH and SUD programs reviewed 7% of Medicaid charts and 3% of Non-Medicaid charts. The ESP program reviewed 20% of Medicaid charts and 5% of Non-Medicaid charts. DD programs reviewed between 15% to 35% of Waiver charts and between 5% to 30% of Non-Waiver charts. DD Residential program reviewed 100% of their charts. Approximately 475 quality record reviews and 40 administrative reviews were completed in FY2023. This was a reduction in number of reviews completed compared to FY22. The decrease was due to a planned reduction in chart reviews in the first quarter due to implementing a new electronic health record and preparing for the November 2022 CARF Survey. The decrease in completed reviews was also noted throughout the year and is attributed to supervisors having less time to do reviews due to staffing and reviews taking longer to complete with documentation existing in two systems. The target goal for all programs was 90% compliance with the standards reviewed. Summaries of record reviews were provided to AMT quarterly and included trend information for programs with less than 85% compliance. At year end, 11 MH/SUD programs and 11 DD programs attained the 90% compliance goal.

DS RECORD REVIEW RESULTS

	FY2023	FY2022	FY2021	Comments
ID CM NORTH 1 WAIVER	85%	88%	91%	
ID CM EAST 1 WAIVER	77%	85%	90%	↓8
ID CM EAST 2 WAIVER	85%	88%	87%	
ID CM WEST 1 WAIVER	74%	75%	96%	
ID CM WEST 2 WAIVER	91%	75%	92%	↑16
ID CM NORTH 1 SPO	97%	89%	91%	↑8
ID CM EAST 1 SPO	68%	94%	80%	↓26
ID CM EAST 2 SPO	97%	100%	71%	
ID CM WEST 1 SPO	85%	71%	86%	↑14
ID CM WEST 2 SPO	91%	87%	na	
DD CM EAST 1	67%	73%	91%	↓6
DD CM EAST 2	91%	100%	94%	
DD CM WEST 1	83%	no charts reviewed	90%	
DD CM WEST 2	no charts reviewed	no charts reviewed	89%	
DD CM NORTH 1	97%	91%	94%	
DD CM CATHOLIC CHARITIES	86%	95%	90%	↓9
DD CM WAIVER SERVICES	90%	93%	98%	
HERMITAGE VOC	95%	92%	93%	
CYPRESS VOC	99%	100%	93%	
GROUP SUPPORTED EMPLOYMENT	90%	87%	92%	
INDIVIDUAL SUPPORTED EMPLOYMENT	99%	97%	98%	
RESIDENTIAL	80%	84%	88%	
ID ADMINISTRATIVE	80%	87%	86%	↓7

MH/SA RECORD REVIEW RESULTS

	FY2023	FY2022	FY2021	Comments
ESP PRESCREENING	95%	97%	94%	
NON ESP PRESCREENING	97%	91%		*result for prescreenings completed by non-ESP staff; reviewed first month of each quarter
SAME DAY ACCESS EAST	93%	95%	98%	
SAME DAY ACCESS WEST	94%	97%	99%	
YOUTH & FAMILY	94%	94%	93%	
MHOP EAST/WEST	94%	93%	92%	
MHOP/SUD/YOUTH PF	79%	93%	89%	↓14
SUD EAST	90%	90%	92%	
SUD RMP	77%	81%	92%	
LAKESIDE CENTER	94%	95%	95%	
LAKESIDE CTR VOC	92%	91%	83%	
ACT EAST	88%	89%	88%	
ACT WEST	79%	91%	87%	↓12
INSTRIDE	91%	94%	92%	
CM&A EAST	83%	87%	84%	
CM&A WEST 1	77%	82%	90%	
CM&A WEST 2	75%	84%	80%	↓9
CM&A WEST 3	93%	90%	76%	
CM&A PF	80%	98%	89%	↓18
MH SKILLS-BUILDING WEST	84%	95%	94%	↓11
PRESCRIBER	96%	93%	97%	
MH ADMINISTRATIVE	72%	86%	93%	↓14

Objectives for the Coming Year

- Transition chart review process from Chart Tracker to Credible
- Partner with IT to create a new chart review results report
- Continue to refine sampling reports with IT including a new sample report of closed records
- Continue to send quarterly report of record review results to AMT with trend information for programs with lower than 85% compliance with standards reviewed.
- Support programs in developing shorter chart review forms that focus on key documentation requirements for the FY24 review year

EXTERNAL AGENCY REVIEWS

	FY23	FY22	FY22
Total number of Reviews:	**72**	**74**	**62**
Admin:	0	0	0
C&P:	21	25	15
CSS:	43	42	42
Across All Divisions:	8	7	5
# of Desk Reviews	62	68	62
# of Onsite or Virtual Reviews	10	6	0
# of C&P/CSS /Licensure/CARF/VHDA	35	10	18
# of C&P client records reviewed	60	87	53
# of CSS client records reviewed	308	454	536
Total number of records reviewed	403	551	607

Trends/Outcomes

- The number of reviews had a slight decrease from FY22

- Reviews were faxed, or sent by secure email exchange-Virtru, Move-it, Red CAP
- 100% of reviews were completed within the specified timeframes

External Reviewers

DBHDS -Virginia Department of Behavioral Health and Developmental Services: Licensure, Health Services Advisory Group (HSAG), Office of Behavioral Health Wellness, Division of Community Services, Early intervention , Office of Human Rights , Anthem (Cotiviti/Ciox), Aetna (Cotiviti), United Health (CIOX), Partnership for People with Disabilities, AMIKids, Home and Community Based Services (HCBS), NCI- National Core Indicators, CARF- Commission on Accreditation of Rehabilitation Facilities, Virginia Board of Pharmacy

Types of Reviews

Mortality Reviews, Complete and accurate diagnosis coding, Support Coordinator Quality Reviews (SCQRs), Background Information files, Complete diagnostic data, Quality Service Reviews, risk adjustment review, Substance abuse and MH Block Grant Review, Employment and Community Inclusion, , Quality Assurance Review, Targeted Remote ACT Chart Review-full fidelity review, Commission on Accreditation of Rehabilitation Facilities (CARF) survey, Prevention Services, Crisis Risk Assessment Tools (CAT), HCVP audit, SIS- supports intensity scale verification, Licensure Review, DOJ Request, Waitlist review, controlled substance inspection, AIM 30 Review

Goal

- Continue to meet all audit requests and deadlines

RISK MANAGEMENT COMMITTEE SUMMARY

The Risk Management Committee (RMC), a ten-member cross-functional agency workgroup, met quarterly to monitor the risks and accessibility needs that are addressed in the Agency's FY23 Risk Management, Accessibility and Quality Improvement Plans. "Risk management" means an integrated system-wide program to ensure the safety of individuals, employees, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks. These plans help the agency meet the County of Henrico Office of Emergency Management and Workplace Safety, County of Henrico Risk Manager, Department of Behavioral Health and Developmental Services, Office of Licensure, Performance Contract and CARF requirements. The committee discusses the work of the agency, shares feedback from staff and stakeholders, and provides input into agency processes. The work of the Risk Management Committee is available to all staff at P:\HAMHDS\Committees\Risk Management Committee.

The Risk Management and Accessibility plan (areas listed below) also references other planning processes of the agency that better position the agency to provide effective services and reduce risks such as the agency's strategic plan, cultural competency, diversity and inclusion plan, the agency's, technology plan, quality improvement plan and performance measurement plan. All plans are located on the agency's SharePoint and accessible to all staff.

Risk Management Planning	***Accessibility Planning***
• Service Delivery • Workforce Development/Human Resources • Computer Resources • Confidentiality • Financial • Critical Incidents • Human Rights • COVID-19 • Employee and Client Safety • Vehicle Safety	• Architectural • Environmental • Attitudinal • Financial • Employment • Communication • Technology • Transportation • Community Integration • Reasonable Accommodations

• Emergency Disaster Response and Recovery • Health & Safety • Regulatory Compliance • Media Relations and Social Media	

Below are a few FY23 Risk Management Agency/County Highlights:

- Committee members included individuals receiving services from DD Employment and Day Services
- Committee identified a new Co-Chair, Robert Scott, Facilities Manager
- Committee prepared for CARF survey in November 2-4, 2022. Agency received a three-year accreditation outcome.
- Prevention and ID/DD group home received new vehicles in FY23.
- Agency egress plans reviewed and updated to meet licensure requirements and include location of flashlights
- Receives updates regarding the work of facilities and safety committees which includes and not limited to maintaining the physical environment, implementing of FY23 project list, monitoring first aid kits, self-inspections and annual required drills.
- Agency fall and suicide prevention informational campaigns occurred in September 2022.
- Reviewed proposed DBHDS Office of Licensure regulations and the agency submitted public comments.
- Emergency Disaster Response tabletop exercise drill occurred with Leadership Group on October 26, 2022.
- All agency staff completed County of Henrico IT training on security awareness.
- Agency implemented a new learning management system RELIAS in March 2023. Information from the old MyTraining system was uploaded to RELIAS. Agency used a combination of agency and RELIAS training to meet required training. The new system provides a plethora of training topics which are all available to agency staff.
- County of Henrico participated in the National Shake-Out Earthquake drill facilitated by Henrico Emergency Management and Workplace Safety on October 20, 2022.
- Reviewed County vehicle protocols with all staff during a quarterly all staff meeting and a reminder in the agency newsletter. Committee continuing to explore ways to increase staff accountability towards vehicle maintenance.
- Assessed panic buttons throughout the agency and installed two new panic buttons in two psychiatrist's offices.
- Chairlift installation completed at Gayton group home which offers increased safety in the home.
- Increased security at RMP, Hermitage and Cypress by installing cameras.
- Replaced main entrance doors at Lakeside Center.
- Reviewed and received information from the Quality Assurance Unit on serious incidents, which included trends and a quarterly analysis.
- Agency completed record reviews on a quarterly basis.
- Financial reports completed weekly and shared monthly with community services board.
- K9's inspection in all facilities occurred twice this fiscal year.
- Updates to FIDS implemented and as a result can now run reports to monitor drills and semi-annual self-inspections.

Looking ahead to FY24

- Develop FY24 Risk Management Plan, Risk Management Improvement Plan, Accessibility plan, Accessibility Plan of Correction and Quality Improvement Plan
- Emergency Disaster drill with leadership group in September 2023
- Review and update emergency disaster books
- Agency informational campaign for September 2023 National Falls Month and National Suicide Prevention Awareness Month and National Choking Awareness Day in March 2024

CRITICAL INCIDENTS AND COMPLAINTS

The Incident Review Committee met quarterly to review each incident submitted in the agency's incident reporting information system (iRIS) located on the agency's intranet. The committee provides the following each quarter: an analysis of trends, areas needing improvement, potential systemic issues or causes, indicated remediation, actions taken, documentation of steps taken to mitigate the potential for future incidents and if actions taken accomplished the intended results. The review of individual incidents is documented in iRIS under committee notes. Staff report incidents in iRIS and reportable incidents are submitted to DBHDS through their electronic reporting system (CHRIS) within 24 hours of agency notification. A root cause analysis of required incidents was completed within 30 days and documented in iRIS. Reporting to MCO's also occurs for specific incidents.

Incident Type	FY20	FY21	FY22	FY23	Q1	Q2	Q3	Q4
Aspiration pneumonia	new	0	0	0	0	0	0	0
Assault by client	3	2	3	2	0	0	1	1
Biohazard incident/bomb threats	1	0	0	0	0	0	0	0
Bowel Obstruction	new	0	0	0	0	0	0	0
Choking incidents that require direct physical intervention by another person	new	0	1	3	0	1	2	0
Communicable Disease/infection control	25	187	172	23	15	8	0	0
Death-accidental	7	3	10	2	1	1	0	0
Death-likely homicide	1	0	0	0	0	0	0	0
Death-likely suicide	0	2	0	2	0	1	1	0
Death-natural causes	33	39	35	31	8	9	7	10
Decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer	new	0	0	0	0	0	0	0
Emergency Room Visit	new	14	40	47	9	8	10	15
Fall- with injury requiring medical attention	11	11	13	8	0	4	2	2
Fall- without injury	51	40	60	29	6	6	7	10
Illness (e.g. seizure, diabetic reaction)	34	23	11	15	2	1	4	8
Individual who is missing	new	1	6	3	2	0	1	0
Ingestion of any hazardous materia	new	0	0	0	0	0	0	0
Illicit/ illicit drugs or weapons	0	0	1	0	0	0	0	0
Med incident- NO adverse reaction	0	23	18	11	4	2	5	3
Med incident- requiring medical attention	46	0	1	0	0	0	0	0
Other	116	63	25	25	3	5	5	12
Overdose	new	0	4	0	0	0	0	0
Serious injury requires med atten	3	1	1	3	0	3	0	0
Sexual assault incident	2	0	0	0	0	0	0	0
Suicide attempt with hospitalization	new	13	35	33	6	10	10	7
Suicide attempt with NO hospitalization	new	13	18	13	4	1	3	5
Threats/violence	3	1	2	2	0	0	2	0
Unplanned psychiatric (ED)	new	25	49	49	15	14	11	9
Unplanned medical hospital admission	new	5	9	11	5	2	1	3
Violent crime by client	0	0	1	0	0	0	0	0
Behavioral incident	12	3	0	0	0	0	0	0
County vehicle	8	0	0	0	0	0	0	0
Fire	0	0	0	0	0	0	0	0
Property damage	1	0	0	0	0	0	0	0
Property loss/theft	3	0	0	0	0	0	0	0
Self-injurious behavior	6	3	0	0	0	0	0	0
Suicide attempt	59	20	0	0	0	0	0	0
Totals	**425**	**492**	**515**	**313**	**80**	**75**	**72**	**85**
Restraints	**3**	**0**	**2**	**1**	**1**	**0**	**0**	**0**

Trends and Causes

- Reviewed 313 Serious incident reports
- Root Cause Analysis - 125 RCAs were completed within the 30 day requirement.
- Supervisors had discussions and retraining as needed for med errors
- Medication errors continue to decrease, however, we continue to monitor closely
- Falls decreased this year

Areas Needing Improvement

- Medication errors

Actions to address the improvements needed and actions taken

- Medication refresher training
- Provided Medication Administration training course for medical staff
- Monitored location of falls to determine possible environmental factors
- Looking at tablets with air cards so there is direct access to the MAR.

Actions taken accomplished the intended results

- Ongoing medication training continues to occur

Necessary education and training and Prevention of recurrence

- Annual refresher training for all staff who administer medications
- Medication administration re-training occurred with staff involved in med errors
- QA staff participated in DBHDS CHRIS training
- PowerPoints were reviewed and updated when the agency moved to their new learning management system Relias.
- Annually all staff participate in competency-based training in the identification and reporting of critical incidents, which is not recorded in Relias
- Agency maintains a group of American Red Cross , Prevention of Violence and Therapeutic Options trainers to provides first aid/CPR certifications/recertifications, prevention of violence and TO competency-based training.
- All staff complete competency-based health and safety training in Relias
- The DS Division staff within in EDS and Residential take quarterly training on high-risk areas such as choking, seizures, falls and diabetes

Internal and External reporting requirements

- Reportable incidents entered into agency incident reporting information system (iRIS)
- Reportable incidents entered into the Department of Behavioral Health and Developmental Services Office of Licensure Computerized Human Rights Information System (CHRIS)
- Reportable incident submitted to respective managed care organization
- Guardians and Authorized representative are notified of incidents
- Incident reports submitted in iRIS are shared with applicable members of agency management team and other involved agency staff

FY24 Goals

- Re-evaluate the process of reviewing staff who report more than 2 incidents

HUMAN RIGHTS INCIDENTS

All allegations of violation of the agency's human rights policy are considered a formal complaint. Overall trends in FY23 include a decrease in the number of human rights reports received in iRIS and an increase in reports to CHRIS compared to the previous year. The areas with the most reports in iRIS are neglect (includes medication errors and incident of peer-on-peer aggression) and confidentiality/privacy.

In FY23, there were 79 human rights reports in iRIS which is a 5% decrease from FY22 (83). Of these iRIS reports, 38 were reported to the state Department of Behavioral Health & Developmental Services' (DBHDS) Computerized Human Rights Information System (CHRIS) and 13 resulted in a founded outcome:
11 medication errors which DBHDS categorizes as neglect (non-P2P)
1 dignity
1 use of restraint

There were 4 privacy breaches reported to the Office of Civil Rights for FY23.

The number of allegations of abuse, neglect, and exploitation for FY23 (30) reflects a 43% increase from FY22 (21).

Areas needing performance improvement

Areas needing performance improvement include medication error/neglect, dignity, and restraint, as reflected by the 11 Corrective Action Plans (CAPs) issued by the Office of Licensing on behalf of the Office of Human Rights for a total of 11 violations. Nine CAPs were for medication errors, one was for dignity, and one was for the use of restraint.

To address improvements needed in these areas, the following actions were implemented:

Medication errors

- Written or verbal counseling for involved staff
- Retraining of involved staff on medication administration
- Policies and procedures for medication delivery and administration reviewed with the involved team
- Our medication delivery process was reviewed and updated to more clearly identify injections and deliveries involving lock boxes on the daily schedule. A review of the schedule for accuracy during team meetings was implemented.

Dignity

- Retraining of involved staff on human rights
- Root cause analysis following the use of a restraint
- Retraining in Therapeutic Options for involved staff

Results of actions implemented:

Since these actions were implemented, there have not been additional reports involving dignity or restraint which suggests that actions taken have resulted in some improvement. There have been additional reports of medication errors, and this remains an area that will need continued efforts towards improvement.

Type	FY22	FY23	Q1	Q2	Q3	Q4
iRIS Human Rights (HR) reports	83 11 founded	79 13 founded	17 4 founded	14 2 founded	23 4 founded	25 3 founded
HR reported in CHRIS / OCR	30 5 OCR	38 4 OCR	7 1 OCR	6 1 OCR	14 0 OCR	11 2 OCR
Late HR reports in CHRIS > 24 hrs/ CAP issued	4/1	2/0	0/0	0/0	1/0	1/0
HR appeal to ED	3	4	0	0	1	3
HR appeal to County Manager	0	0	0	0	0	0
HR appeal OHR	2	3	0	0	0	3
HR appeal to LHRC / SHRC	0	0	0	0	0	0
Number of Holds	2	2	2	0	0	0
HR received from or reported to MCO	0	0	0	0	0	0
Code of Ethics	1	0	0	0	0	0

STAFF TRAINING

In FY23 the agency implemented a new learning management system Relias. Relias became effective in March 2023. This learning management system allows for custom development and offers a plethora of competency-based training for all staff.

Agency employees can obtain training through a number of venues to include the County of Henrico Employee Development and Training, Risk Management, Human Resources Department, County IT, and internally with Henrico Area Mental Health & Developmental Services.

Training is provided at orientation and annually thereafter through a combination of methods, classroom, online, through their supervisor or team training. Staff are also able to attend external conferences, classes or workshops and add it to their Relias Learning Management transcript.

Model of Care Training and Provider Overview & Module of Care Training, Cultural Diversity is required by Commonwealth Coordinated Care Project for contract with CMS, DMAS, and MCO (Anthem, Aetna, Optima, United Healthcare, Molina "Magellan", and Va. Premier) for MH Programs and Developmental Services Teams. There is Preadmission Screening Certification for Emergency Services and other pre-screeners in the agency.

Henrico Area Mental Health & Developmental Services has a group of 34 staff trainers that provide training in a variety of areas such as First Aid & CPR, Prevention of Violence (POV), Therapeutic Options, Cultural Competency, Diversity, Equity, and Inclusion (DEI), Lunch and Learns, Wellness series, MH First Aid, EHR and other Professional trainings.

Approximately 66 training sessions were offered. Staff are assigned required trainings and are also able to register for elective trainings using several web-based systems to include Relias, Oracle, Webnet, and Litmos. Examples of training offered are listed below.

Child-Adult Relationship Enhancement
Security Awareness
Health Information Management Confidentiality and Privacy
Code of Ethics
Safety Training
Military Culture
Telehealth
Cyber Security
Infection control: Essential Principles
Prevention of Violence
Minimizing Trips, Slips, and Falls
Occupational Therapy for Youth with Mental Needs
Seeking Safety
Mental Health Stigma and The Black Transgender Experience
Walk in My Shoes
Gender Diversity 101
Neuro Diversity and Queerness
Invisible Premier and Panel Discussion
Understanding the ECO/TDO Process since the Covid Pandemic
How to use Narcan

All trainings returned to in person except for CPR/First Aid. This continued as a blended learning training. Staff completed the classroom portion online then selected a predetermined date and time to demonstrate skills with a

trainer. These Physical skills were demonstrated on manikins in a large conference room with a trainer. Trainers continued to practice social distancing as prescribed by the CDC. Some trainings were offered both in person and via WebEx for convenience.

Accomplishments

- Relias, our new Learning Management System, was successfully implemented.
- Two agency staff became certified Relias Administrators
- Trainers were able to add First Aid/CPR classes for agency team(s).
- Trainers were able to add additional TO classes to the schedule.
- Training power points were reviewed, updated, and uploaded into Relias.
- Due to adding Relias, the percentage of staff completion of Annual Trainings on time increased.
- 1 Therapeutic Options trainer was added to the team.
- 1 CPR/First Aid trainer was added to the team.

Goals

- Review and update all training power points in Relias.
- Recruit 1 new Therapeutic Options trainer
- Use Relias to its full potential to assist with training compliance.
- Develop barcode scanning for in-person training events

INFORMATION TECHNOLOGY

The Information Technology Plan is reviewed yearly to assess the progress of projects and update their timelines as needed. Accomplishments and initiatives of the past year are updated accordingly.

Project Management Team 8 (PMT8) is a dedicated IT resource serving Henrico Area Department of Mental Health and Developmental Disabilities Services. In 2022, we implemented the new EHR "Credible" and are continuing to expand the use of the EHR in new areas. PMT8 is also responsible for hardware configuration and distribution, as well as day to day support. Yearly all staff complete IT cybersecurity awareness competency based training in their Litmos learning management system. IT sent a notice to all staff on 1/10/2023 stating training must be completed within 60 days. Additionally, yearly IT completes a disaster recovery test.

General Services Security Division, in partnership with Information Technology and our card access provider, began performing mandated software upgrades to the Card Access Management System for county facilities equipped with card reader-controlled doors. The update began June 28, 2023 and will continue through July 2023.

FY23 accomplishments:

Credible EHR

- eMAR implementation – research, test and implement eMAR with Active Community Support teams to improve medication management
    - Priority: High
    - Target completion: 12/15/22
    - Resources: Business analyst working with ACT supervisors
    - FY23 status: Project paused due to lack of user interest/availability
- Mobile App implementation – research, test and implement Credible Mobile app to improve mobility of the clinical staff
    - Priority: Medum

    - Target completion: 2/28/23
    - Resources: IT Manager, Business Analyst working with ACT supervisors
    - FY23 status: Project is in testing phase with several staff utilizing mobile app with loaner iPads. Will continue for FY24
- Patient Portal – implement Patient Portal in a phased approach, working with clinical staff to develop workflows and forms, and outreaching to persons served to simplify enrollment process
    - Priority: Medum
    - Target completion: 6/30/2023
    - Resources: Business Analyst, Forms developer, Business Manager
    - FY23 status: Project will not be implemented. We are evaluating a new product from Credible called "On-Call"
- Create advanced reports and dashboards in Credible EHR to improve data transparency
    - Priority: High
    - Target completion: 4/1/2023
    - Resources: Systems Developer
    - FY23 status: 9 dashboards with 24 reports have been implemented through YellowFin BI; 12 additional reports have been published on SharePoint. We have implemented Janet data transformation software and have a nightly back up of Credible data. We published 93 Export Tool reports.
- Create Form Groups to streamline intake and other appointments that require multiple forms to be filled out within the same visit
    - Priority: Low
    - Target completion: 12/31/2022
    - Resources: Systems Developer
    - FY23 status: completed
- Work with scanning group to expand usage of direct scanning into individual's chart
    - Priority: Low
    - Target completion: 3/30/2023
    - Resources: System Administrator
    - FY23 status: Completed
- Participate in Credible User group to advocate for EHR changes that would benefit the Agency
    - Priority: Low
    - Target completion: on-going, participation in EHR user group occurred during FY23
    - Resources: EHR Administrator

FY24 additions/goals:

- Credible Plan redesign: customize Credible Plan structure and templates
    - Priority: Medium
    - Target completion: 12/31/2023
    - Resources: Business Analyst working with MHDS Training specialist
- Notification Triggers configuration
    - Priority: Medum
    - Target completion: On going
    - Resources: Business Analyst

Software Initiatives

- County IT will be pushing Windows 10 feature update beginning 5/1/23

    - Target completion: 6/1/23
    - Resources: County IT
    - FY23 status: Completed
- Implement Mission Driven Data Janet product that simplifies access to EHR data and enables advanced reports
    - Priority: High
    - Target completion: 1/31/2023
    - Resources: IT Manager
    - FY23 status: completed
- Implement Relias learning management system to replace current intranet application and enhance reporting
    - Priority: Medium
    - Target completion: 4/30/2023
    - Resources: IT Manager and Systems Administrator working with MHDS implementation team
    - FY23 status: completed
- Implement a new Chart Review system and integrate it with Credible EHR and expand reporting capabilities
    - Priority: Medium
    - Target completion: 6/30/2023
    - Resources: Systems Developer working with QA team
    - FY23 status: implementation completed, FY24 - report development will be completed 11/1/2023.
- Expand the use of eFax to minimize the need for physical fax machines and enable staff to access information from any MHDS location
    - Priority: Low
    - Target completion: on-going
    - Resources: Systems Administrator working with IT Communications team
    - FY23 status: eFax has been implemented in save/receive mode for Emergency Services. All staff have access to Send mode. Completed
- Promote wider use of Teams environment to improve collaboration between MHDS locations
    - Priority: Low
    - Target completion: on-going
    - Resources: IT Manager and Business Analyst
    - FY23: Teams utilization has increased
- Implement secure OneDrive drive document storage sites as well as improve the overall engagement in Office 365 to improve efficiencies in workload across the department
    - Priority: Low
    - Target completion: on-going
    - Resources: IT Manager, Business Analyst and Systems Administrator

FY24 additions/goals:

- Implement a new Incident Reporting system to replace current web application and add reporting capabilities
    - Priority: Medum
    - Target completion: 4/30/2024
    - Resources: Business Analyst and Systems Developer working with QA team
- Expand reporting capabilities for new Chart Review system
    - Priority: Medium
    - Target completion: 11/1/2023

    - Resources: Systems Developer working with QA team
- Implement a new budget application to improve ease of use, reporting and add functionality
    - Priority: Medum
    - Target completion: 6/30/2024
    - Resources: Business Analyst working with Financial Management and IT PMO (Project Management) office
- Expand the use of AdobeSign and Document approval application to simplify the process of requesting changes and tracking approvals
    - Priority: Low
    - Target completion: 12/31/2023
    - Resources: Systems Administrator working with IT Communications team
    - FY23 status: 5 clinical teams have been onboarded; additional onboarding is scheduled.
- Develop reporting/look up solution for legacy EHR to provide better access to archived data.
    - Priority: Medium
    - Target completion: 6/30/2024
    - Resources: Business Analyst working with Enterprise Development team
- Promote wider use of Teams environment to improve collaboration between MHDS locations
    - Priority: Low
    - Target completion: on-going
    - Resources: IT Manager and Business Analyst
    - FY24: Increase Teams utilization
- Implement secure OneDrive drive document storage sites as well as improve the overall engagement in Office 365 to improve efficiencies in workload across the department
    - Priority: Low
    - Target completion: on-going
    - Resources: IT Manager, Business Analyst and Systems Administrator
- CCS Sunset – work with DBHDS on identifying data elements and processes required for transition to new data exchange platform
    - Priority: High
    - Target completion: 6/30/2024
    - Resources: IT Manager and EHR Administrator working with MHDS Admin team
- TRAC-IT EHR implementation – develop EHR upload or billing download for maintaining TRAC-IT information in Credible EHR and in State TRAC-IT portal
    - Priority: High
    - Target Completion: 12/10/2023
    - Resources: IT Manager and Systems Developer working with PIP Program Manager
- SharePoint redesign – update SharePoint pages by removing old links, adding new applications and giving a "facelift" to SharePoint design
    - Priority: Low
    - Target Completion: 6/30/2024
    - Resources: Applications Developer working with MHDS Evaluation & Reporting team

Hardware initiatives

- Conference Room C teleconference equipment update to enable hybrid meeting capabilities
    - Priority: High
    - Target completion: 12/31/2022
    - Resources: Systems Administrator working with Telecommunications team
    - FY23 status: completed; FY24 some screens will be moved and replaced with larger screens

- Refresh computer equipment in all conference rooms and drop-in offices
    - Priority: Medum
    - Target completion: 6/30/2025
    - Resources: Systems Administrator
    - FY23 status: 25 desktops have been replaced; FY24 35 desktops to be replaced
- Annual equipment refresh of laptops and desktops for clinical staff and administration
    - Priority: Medium
    - Target completion: annual
    - Resources: Systems Administrator
    - FY 23 status: 100 laptops have been replaced
- Purchase additional multi-functional printers to support scanning project
    - Priority: Low
    - Target completion: 6/30/2023
    - Resources: Systems Administrator
    - FY 23 status: 50 additional MFPs have been purchased
- Purchase additional signature pads to work with the new EHR
    - Priority: Low
    - Target completion: 6/30/2023
    - Resources: Systems Administrator
    - FY23 status: 50 signature pads have been purchased

FY24 additions/goals:

- Install iDrac on Domain Controllers to allow remote server restart
    - Priority: Medium
    - Target completion: 6/22/23
    - Resources: Systems Administrator
    - FY24 status: completed
- Install iDrac on SQL Server to allow remote server restart
    - Priority: Medium
    - Target completion: 7/31/2023
    - Resources: Systems Administrator
- Equipment Refresh in Prevention Connect Sites
    - Priority: Medium
    - Target completion: 12/31/2023
    - Resources: Systems Administrator
- Air card confirmation of use
    - Priority: Low
    - Target completion: on-going
    - Resources: Systems Administrator

Support initiatives

- Migrate level 1 support to central IT helpdesk
    - Priority: Medium
    - Target completion: 12/1/2022
    - Resources: IT Manager, Systems Administrator working with Operations Team
    - FY23 status: completed
- Migrate server maintenance to enterprise teams
    - Priority: Medium

- Target completion: 1/31/2023 (what is the new target date?)
- Resources: IT Manager working with Operations and Systems Engineering teams
- FY24 status: in progress

- Business Continuity/Disaster Recovery Testing
  - Priority: Medium
  - Completion: 6/23/2023
  - Resources: IT Support
  - FY23: An actual event occurred on 6/23. Hermitage Enterprises network and server went down due to bad weather

CULTURAL AWARENESS AND COMPETENCY COMMITTEE SUMMARY

The Committee for the Advancement of Rights & Equity (CARE) is an extension of the former Cultural Awareness and Competency Committee (CACC) and the Committee for the Advancement of Racial and Social Equity (CARSE) strategic initiative combined.

The main focus for CARE during FY 2022-23 was to build relationships with CARE members and set goals and objectives for the year. CARE also established sub-committees (Education & Community Outreach, Agency Training & Events, Admin & Branding, Translation & Interpretation, and Personal & Onboarding). The larger CARE committee met twice a month during the year while the subcommittees met at least once a month. The meetings continue to be held virtually. Meeting notes are located on the public drive, accessible to all staff at P:\HAMHDS\Committees\CARECommittee

The agency began its work on diversity and cultural awareness in the early 1990's. The first committee, called the Diversity Committee, was formed in 1993 and reorganized in 2002 as the Cultural Awareness and Competency Committee. In fall of 2023, the organization will celebrate 30 years of increasing the competency of the workforce to deliver inclusive, cultural and linguistically competent services. Our journey continues.
The agency continued the expectation that all staff participate in at least one cultural or linguistic training course per year. This requirement can be fulfilled by registering on Relias, attending a training within the agency, a training designed specifically for a unit/program, attending a training developed by the County of Henrico, Virginia State Department of Behavioral Health and Developmental Services (DBHDS) or from any other community partners. The County of Henrico also provided training on their YouTube channel posted by the Department of Human Resources, Organizational Learning and Talent Development.

FY23 Training Opportunities Available to All Staff

- August 26, 2022 – Gender Diversity
- September 20, 2022 – Gender Diversity
- September 8, 2022 – Neuro Diversity & Queerness
- September 17, 2022 – Queer RVA Past & Present (Community Forum & Panel Discussion).
- September 24, 2022 – Pride Fest RVA
- September 13, 2022 – October 18, 2022: Youth Empowerment Series
- October 5, 2022 – Mental Health Stigma and The Black Transgender Experience
- March 27, 2023 – Women in Leadership
- March 27, 2023 – Advancing Health Equity for Community Members Returning from Incarceration
- March 29, 2023 – Workforce Development and Psychological Safety Among BIPOC Women in Leadership
- April 12, 2023 – Maintaining Momentum on Social Justice
- April 26, 2023 - Virginia Tech IDI Training with all supervisor and leaders

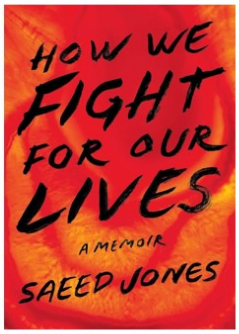
- April 26, 2023 – Creating an Upstanding Culture
- April 27, 2023 – Age and Generations in the workplace
- May 31, 2023 – LGBTQ Video Premier – ~~In~~*Visible* video series (East & West Locations)
- June 12, 2023 – Understanding Trans Identity in the Workplace

The agency celebrated Black History month again this year with a weekly informative series, "Did you Know" featuring African American contributions and achievements. Staff from across the Agency shared recommendations of books and documentaries honoring the African American culture. David Ross, Dalfonzo Williams and Marty Sheppard led the effort by sending out weekly "Did you Know" emails to all Agency staff. Lisa Adams also sent out informational emails throughout the year on special days and events. Some of the topics included were: International Day of the World's Indigenous People, Black Business Month and the Islamic New Year.

2023 Black History Month Flyer & Activities

CARES Committee presents for Black History Month

About A Book



How We Fight for Our Lives: A Memoir by Saeed Jones

Cataloging his life growing up as a gay Black man in the South, this coming-of-age memoir will break your heart wide open. It's a story of one man's journey, but it's also a broader examination of love and power, queerness and identity and what it means to carve out a place in the world.

Schumer, Lizz (2023, Feb 6) 25 Must-Read Books by Black Authors *Good Housekeeping*

If you would like to submit a book for About A Book, please email she04@henrico.us

For the past four years the State Department of Behavioral Health and Developmental Services (DBHDS), offered Behavioral Health Mini-Grants which the agency successfully applied and received. Yeary, the grant period is from June – September of each year with the expectation of a full report of work of the grant in November of each year.

The 2022 BHE grant, the agency received $15,100, with an implementation period of June 2022 – September 2022. This project aimed to increase inclusion of the LGBTQIA+ youth population in the Richmond, Virginia area, as well as to raise awareness about the specific challenges and barriers faced by queer youth and adults. The grant objectives included collaborating with several LGBTQIA+ owned and affirming organizations in the area including local mental health service providers, queer community organizations, and queer-owned businesses to provide training to staff, connect youth and families to inclusive and affirming resources in the area, and to provide safe spaces and opportunities for community-building.

Accomplishments:

- Youth Empowerment Series at Gayton Library
- Panel discussion and Community Resource Fair – Henrico Theater
- Development of database for LGBTQ friendly providers
- Established a book-nook for additional awareness and education for individuals receiving services and staff
- Staff trainings
- Participation in Virginia Pridefest September 2022
- Video produced to raise awareness – ~~*In*~~*Visible* video series

The agency also responded to requests for proposals in February 2020 through DBHDS, utilizing the American Rescue Plan Act (ARPA) Mental Health Block Grant funds to increase knowledge and diversity of the workforce as it related to equity. The agency was awarded $61,973. The implementation of this grant is through September 2025. The focus of the grant is working on staff and supervisory DEI training and community engagement with the Latino, Asian and Afghan (newcomers) communities. One of the accomplishments of the grant this year was the partnership with Virginia Tech, School of Public Administration and Policy to administer the Intercultural Development Inventory, (the IDI) to all supervisory staff across the agency for individual DEI development. The IDI assesses how individuals and groups construe their social interactions with other people. A key area of the IDI impact is helping individuals better assess their capability for recognizing and effectively responding to difference. During the January 2023 Leadership/Supervisory Group meeting the leadership score for the 2022 IDI profile was shared. An IDI profile of key leadership and management teams can reveal what perspectives are used when navigating interpersonal and intrapersonal difference and what specific company policies, training programs and other interventions would help the organization further their equity and include goals. Supervisory/Leadership staff also had the opportunity to meet individually with a trained IDI facilitator for individual growth and development. The agency also partnered with the Virginia Center for Inclusive Communities who provided four DEI training during the fiscal year.

Yearly, the agency works with several community individuals and national organizations that provide interpreter and/or translation services, (about 16). This includes immediate telephonic services from Cyracom International and the United Language group. The list of interpreters and translation services includes the name, cost per hour, minimum hours and any certifications an interpreter may hold. It is updated yearly and posted on the agency SharePoint drive. The agency translates forms and documents in other languages such as Spanish, and Farsi. These forms are posted on our SharePoint drive. The agency has electronic boards in each lobby of our outpatient sites. COVID information is posted on electronic boards in both English and Spanish. Signage is also posted that persons served have a right to an interpreter. Additionally, these sites are equipped with "I Speak" language identification guides to quickly help identify languages spoken to obtain an interpreter. Below trends the amount of funds used within the agency over the last three years. There was a 59.9% increase in use of language services from FY22.

Cyracom Language Services

Language	Calls	Minutes	Percent Calls	Percent Minutes
Spanish	382	9,375	58.1%	61.3%
Dari (Afghanistan)	60	1,192	9.1%	7.8%
Brazilian Portuguese	44	1,187	6.7%	7.8%
Swahili	57	1,182	8.7%	7.7%
Arabic	30	543	4.6%	3.5%
Cambodian	13	404	2.0%	2.6%
Farsi (Persian)	14	374	2.1%	2.4%
Vietnamese	19	231	2.9%	1.5%
Bengali	12	197	1.8%	1.3%
Mandarin	4	125	0.6%	0.8%
Urdu	2	103	0.3%	0.7%
Pashto (Afghanistan)	2	97	0.3%	0.6%
French	3	76	0.5%	0.5%
Cantonese	2	75	0.3%	0.5%
Bosnian	3	70	0.5%	0.5%
Portuguese	4	29	0.6%	0.2%
Haitian Creole	3	14	0.5%	0.1%
Russian	2	12	0.3%	0.1%
Hindi	1	12	0.2%	0.1%
	657	**15,298**		

Fiscal Year	FY23	FY22	FY21	FY20
Yearly amount	$179,819	$112, 475	$84, 303	$97,695

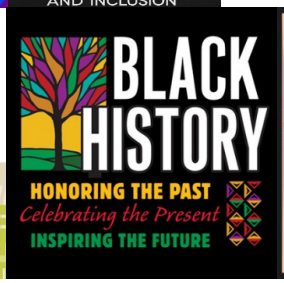
Members of CARE participated in the Agency Orientation of new staff. For FY23 there were 10 agency orientations held over the 12- month period. During agency orientation historical information is shared regarding the agency's journey over the last 30 years towards providing a more inclusive, culturally, and linguistically competent services. Upcoming workshops or training events are also shared. The importance of diversity, inclusion and equity is shared with all new staff as a way of introduction to the culture of our agency.

Yearly, the agency tracks the race and ethnicity of persons served by HAMHDS as well as HAMHDS employees. As of 7/28/2023, of the approximately 379 HAMHDS permanent employees 47% self-identify as White/Caucasian, 46% Black/African American, 4% two or more races including American Indian or Alaskan Native, 2% Asian, 1% not reported and 3% self-identified as Latino/Hispanic. Of the 10,419 individuals receiving services at HAMHDS, 40% self-identify as Black/African American, 39% White/Caucasian, 14% Asian/American Indian/Alaskan Native/Pacific Islander/Multi-racial/ other, 7% did not report and 6.8% Latino/Hispanic.

Three-year Comparison						
Race & Ethnicity	FY23 Persons Served	FY22 Persons Served	FY21 Persons Served	FY23 HAMHDS Employees	FY22 HAMHDS Employees	FY21 HAMHDS Employees
Race						
Black/African American	40%	42%	41%	46%	45.24%	43%
White/Caucasian	39%	43%	46%	47%	48.23%	52%
American Indian, Asian/Pacific Islander, Multi-Racial, Other	14%	15%	13%	6% 2% Asian 4% Other	3.0% 2.18% Other	5%
Unknown/not reported	7%			1%		
Ethnicity						
Persons served and staff who identify themselves as Hispanic	6.80%	6.07%	6.04%	3%	1.9%	2.5%

Agency bulletin and electronic boards

Yearly multicultural calendars are purchased for several bulletin boards across the agency. Monthly celebrations are posted on these boards and the four electronic boards at Woodman, East Center, Richmond Medical Park, and Providence Forge. Community events, such as Juneteenth and Queer RVA Past and Future were advertised on these boards. Below are samples of the flyers posted for various months.



In June the CARE Committee sponsored an agency gathering to encourage networking, supporting agency relationships and a staff appreciation luncheon. A subcommittee gathered to plan the event and sought feedback from the agency staff. The event was held at The Eastern Recreation Center on June 5, 2023, from 11:00am – 2:00pm. Staff had the opportunity to select their choice for a box from Apple Spice, take selfies at the picture booth, play beach themed-games and connect. Based on feedback from staff, this year included plans to deliver food to staff who could not attend. Deliveries were made to Employment and Day Services, DD Residential, CIT and ESP.