HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

Serving the counties of Henrico, Charles City & New Kent

ANNUAL PREFORMANCE ANALYSIS 2017-18

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TOTAL CONSUMERS SERVED BY PROGRAM AREA 42

DISTRIBUTION BY RACE AND ETHNICITY: 46% SERVED IDENTIFIED THEMSELVES AS WHITE/CAUCASIAN, 43% BLACK/AFRICAN AMERICAN, 11% ALASKAN NATIVE, AMERICAN INDIAN, ASIAN, PACIFIC ISLANDER, MULTI-RACIAL. 42

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MANAGEMENT SUMMARY

Henrico Area Mental Health & Developmental Services (HAMHDS) is pleased to present our Fiscal Year 2018 Annual Report highlighting many of our major initiatives that strengthen the quality of care for individuals with mental health, substance use disorders and developmental disabilities. Thanks to the hard work and dedication of the HAMHDS staff, the amazing partnerships with many community organizations and the support of our stakeholders, we celebrate and share our accomplishments.

We are pleased to highlight remarkable stories that show resiliency, recovery, inclusion, wellness, and the successful impact of person-centered services. Same Day Access was fully implemented, allowing individuals seeking services to come in for an assessment with a licensed clinician when they are ready. We have enhanced our services for individuals with substance use disorders through an opioid jail diversion program and received grant funding for Medication Assisted Treatment. Housing options were increased through a permanent supportive housing initiative. We have strengthened our efforts with prevention services and continue to prioritize our commitment that all individuals have access to primary health care.

This agency received National Association of Counties (NACo) achievement awards for the Crisis Intervention Team Refresher Training, the Behavioral Activation Group, the Early Intervention Autism Clinic and the Bounce Back From Addiction website. Along with our partners in Chesterfield, Hanover and Richmond, we received a Virginia Association of Counties (VACo) achievement award for the Revive RVA Regional Solutions to the Opioid Crisis Summit.

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 assistance allow critical community services to be in place that strengthen the lives of the individuals we serve and their families.

Jessica Young Brown, PhD	Laura S. Totty
Board Chair	Executive Director

VISION & VALUES

OUR VISION

We envision an inclusive, healthy, safe community where individuals lead full and productive lives.

OUR VALUES

Excellence, Dignity, Partnership

OUR LEADERSHIP PHILOSOPHY

Leadership is the responsibility of everyone at Henrico Area Mental Health & Developmental Services. If we are to be successful, we must lead with integrity, good stewardship, openness, creativity and full participation

STRATEGIC GOALS AND STRATEGIC PLANNING

Strategic Initiatives

During FY18 cross functional workgroups completed their work on the below strategic initiatives.

FY18 Accomplishments Provide Same Day Access (SDA)

Our Same Day Access Program was fully implemented on April 20, 2017. The original goal of this program was to facilitate easy, convenient access to services for individuals in Henrico, Charles City and New Kent counties. The results of the first full year of operation are indicative of success towards meeting this goal:

- 2,522 evaluations were completed
- A 31% increase in the number of individuals served in Mental Health Adult Outpatient Services compared with previous year

Results of satisfaction surveys also demonstrate client's high level of appreciation for the Same Day Access Program. One hundred percent (100%) of the 106 individuals surveyed indicated satisfaction with the service with 46% providing the highest possible rating for their experience.

Last year we set a goal to develop and implement protocols to support individuals who are seen in Same Day Access who are at high risk for hospitalization or harm to self or others and continuing to refine the process for assessing risk of suicide through assessment and screening tools. Over the course of the last year we have developed protocols to identify and serve individuals who are identified at high risk of hospitalization at the time of their Same Day Access assessment. These steps include coordination with Emergency Services Program, a structured process to identify individuals who are at elevated risk for suicide, structured protocols for outreaching and engaging individuals at risk for suicide and procedures to link individuals to services more quickly. We also set a goal last year to develop strategies for efficiently staffing Same Day Access team to accommodate a great deal of variability in demand for services. We have taken steps to enhance the efficiency of staffing Same Day Access. These steps have included assigning additional assessment and outreach tasks to the Same Day Access team that can be conducted

during times of lower demand. Specific tasks include outreach to individuals recently discharged from psychiatric hospitals who have not presented for treatment, outreach to individuals determined to be at high need, completion of Governor's Access Plan (GAP) Assessments, and completion of some court ordered mental health evaluations.

During its first full year of operation, the Same Day Access program has built a strong foundation and has demonstrated the ability to provide quality assessments to a wide range of individuals seeking services. Goals for the next year include:

- Developing protocols to provide individuals at a high level of need rapid access to psychiatric services.
- Participation in a pilot project with a local hospital to enhance access to community based mental health services.
- Establishing procedures for providing more convenient access to services for individuals living in Charles City and New Kent counties.

FY18 Accomplishments Explore Electronic Health Records Systems (EHRS)

In the fall of 2017 a new Request for Proposal was released and the EHRS Implementation Team evaluated the responses. In early November, 2 vendors were invited to demonstrate their system over 2 days. Welligent was selected and the contract was signed in mid-March 2018. The Implementation Team met with Welligent in late March to begin the Gap/Fit analysis. On April 20, 2018, the Agency and Welligent determined that there was a good fit and the implementation phase began. The Team began to meet with Welligent every Wednesday to learn the system.

FY18 Accomplishments To assure the provision of high quality services for individuals with Developmental Disabilities

The DD Strategic Committee was established to find the best practices and high-quality services for individuals with developmental disabilities. The DD committee consists of 11 members from a variety of support services in the agency. The DD committee met each month to review plans of action and progress toward the agency outcome. The DD committee strived to enhance training and education, to improve internal and external services availability, and provide community resources for staff, individuals, and families dealing with DD.

Accomplishments

- Ongoing – Agency developed and will continue to develop relationships with community partners.
- February 2017 - DD Committee invited a guest speaker (Carolyn Turner) from DARS agency to discuss DD supports and case management services with DD committee members for insight.
- March 2017 – DD Committee invited a guest speaker from Compass Counseling Services of Virginia (Hannah Robicheau) to discuss with DD committee on insight of the company and Autism and other diagnosis supports.
- April 2017 – DD Committee conducted an initial survey in April 2017 on what staff wanted to learn on DD supports. The survey replies suggested more resources to be available for staff and families, and more education/training on DD.
- April 2017 – DD committee set-up 2 scheduled brown bag trainings called "Autism 101" presented by Mary-Beth Baker in the month of April 2017. These trainings were provided at the Woodman Road main office and at the East Center location.
- June 2017 – DD Committee hosted a brown bag to share a parent's experience and journey in raising a DD individual. The brown bag was called "A Life Like Yours – A Family's Journey".

- July 2017 – DD committee set-up 1 scheduled brown bag trainings called "Autism 101" presented by Mary-Beth Baker in the month of July 2017. This training was provided at the Woodman Road main office location.
- August 2017 - DD committee along with DD unit wrote up DD article that was placed into the Quality Matters newsletter for staff access to DD information.
- October 2017 - DD Committee hosted a community event called "Community Partners for Developmental Disabilities. Over 25 vendors attended the community event which was held at the Eastern Henrico Recreation Center for any individual and/or families and staff to get information on DD resources.
- January 2018 - DD committee developed and reviewed the set-up of the "DD Resource guide" with a variety of options to offer staff, individuals, and families looking for support with DD needs.
- February 2018 - The Resource Guide was loaded onto the P-Drive and will have ongoing updates on the P-Drive for access to staff
- March 2018 – DD Committee followed up with a second survey that was posted on HAMHDS Intranet to focus on internal and external barriers to access supports and services in the agency and what they desire to learn from future brown bags and trainings. The results were 65 agency staff participated in this survey. The survey results indicated staff feedback around more training/education for dually diagnosed DD individuals and for easily accessible DD information for agency staff use to provide families a quicker response with DD support services.
- March 2018 – DD Committee hosted training with DARS rep (Carolyn Turner) and with the Brain Injury Association rep (Jason Young) on TBI at the Woodman Rd. location.
- March 2018 – DD Committee member and CSS management provided a brown bag to promote DD Awareness month. These brown bags were held at Woodman Road and East Center locations
- April 2018 - HAMHDS and the DD Committee participated in a DBHDS training with a guest speaker (Dr. Fletcher) at the Henrico Theater on dually diagnosed DD individuals.
- April 2018 - DD Committee hosted a REACH Training for staff to learn about REACH support services.
- June 2018 - DD Committee also hosted two-day training with REACH in June 2018 for families to learn more about REACH support services at the Woodman Road location.

Recommendations

- The agency continues to look at current processes, barriers, and best practices to provide and/or offer services for the DD population and families.
- Supervisors encourage staff to utilize the Autism webinars located at "Autismspeaks.com" for self-education about Autism.
- Supervisors encourage staff to utilize the many online websites related to DD services – for example "AutismVA.org".
- HAMHDS hire a fulltime Positive Behavior Support Facilitator to provide strategies from an interdisciplinary perspective that increase a person's competence in community based and inclusive settings.
- Frequently post information on the HAMHDS Intranet website for staff access and to learn more about DD support services.
- To offer agency-wide trainings on dually diagnosed (DD/MH) individuals.

FY18 Accomplishments CCC Plus (+) Workgroup

In December of 2016 a cross functional workgroup formed to prepare the agency for the implementation of CCC+ scheduled to roll out for eligible individuals in the Central Virginia region in September 2017 and January 2018. The Virginia Association of Community Services Boards (VACSB) provided a suggested implementation plan with recommended tasks that was used as a foundation for the workgroup. The group served as a central hub and shared information, updates, staff experiences, discussed challenges, problem solved and developed implementation strategies for various aspects of the agency's processes affected by the transition to CCC+. The workgroup met approximately monthly and shared information and updates via email from December 2016 – June 2018 to implement and oversee the transition plan. A new cross functional workgroup was configured in July 2018 to implement Medallion 4's roll out effective September 2018.

Accomplishments:

- Reviewed and signed contracts with six MCO's
- Provided training and education materials to all staff
- Provided updates in Agency All Staff meetings and in individual team meetings
- Shared information with individuals receiving services regarding what to expect with the CCC+ implementation
- Posted CCC+ information on the agency Intranet with links to the CCC+ website
- Staff attended town hall meetings, participated in webinars, provider calls, member calls and DBHDS/MCO trainings
- Provided training and regular updates to the HAMHDS Community Services Board
- Henrico Area Community Services Board sponsored a CCC+ informational webinar, facilitated by the VACSB lead for CCC+ , for all families and staff hosted at Woodman, East Center and Lakeside Center
- Provided requested data to VACSB regarding elements of the implementation plan
- Completed and attested training for required staff
- Implemented new critical incident reporting process for MCO's established by the Standardization Committee
- Modified billing, authorization processes, forms in Cerner to meet new requirements
- Credentialed required staff
- Invited the six MCO's care coordinators for a meet and greet with agency staff. Five meetings occurred in person and one occurred via webinar.
- Member of and participated in the VACSB Steering committee

FY18 ACCOMPLISHMENTS/ FY19 GOALS

Administration Accomplishments

- Planned and prepared for the EHR implementation
  - Continued to clean up the Cerner system for data migration
  - Began learning the Welligent system to become expert in its functions
  - Mapped VIDES and the WaMS ISP for an FY19 early go live implementation in September 2018.
  - Began the deployment of 200 laptops

- Implemented CCC Plus
  - Worked with the MCOs to establish a smooth credentialing process with each of them.
  - Built and tested billing modalities
  - Created new ways to ensure that eligibility is verified as clients come in the front door
  - Created forms and system sweeps for Authorizations
  - Enhanced iRIS to include CCC Plus information
- Worked with the County and Architects to plan the new East Center facility.
- Operationalized Same Day Access, including developing reporting to track customer service and referral measures
- Developed a new County Manager's Monthly Report
- Developed ID productivity reports to aid the program in reaching their State Dashboard goals
- Expanded the use of Telehealth by adding 2 more meeting spaces at the East and Woodman.
- Implemented the use of Jabber as an enhancement to the use of Telehealth
- Renovated kitchens at two homes
- Added a handicap door at Hermitage to improve accessibility.
- Updated agency job descriptions
- Worked with the County to be one of the first Agencies to implement P cards (county credit cards) which included writing procedures and training staff.
- Implemented the human resources, facilities and financial reporting aspects of the Permanent Housing Support Initiative
- Implemented the Business and administrative support to implement the Opiate Jail Diversion program
- Began the implementation of the OBOT program with credentialing and setting up the billing system.
- Established processes to ensure OIG and SAMS is verified monthly
- Streamlined and added reporting to ensure all administrative and billing aspects of PIP program are in place for timely service and maximized and efficient billing.
- Implemented the County's on-line Defensive Driving to ensure all staff received their electronic notice for re-certification.
- Established process for reimbursing staff for licenses

Administration Goals

- Completion of the new East Center is aimed for June 2019
- Implement new EHR for Agency, expand paperless medical record, explore new EHR capabilities to automate processes, purchase additional hardware
- Extraction of the person centered plan into WaMS
- Prepare for DLA20 and the additional extraction of data for SPQM

Administration Outcomes

Efficiency Objective: There is to be no greater than 4% of clients waiting longer than 15 minutes to meet with a screener.	Results: our overall goal of seeing 96% of clients was met at 110/2708 however for the last quarter we were at 93% due to having more clients coming in during lunch hours.
Recommendations/Action taken: to have staggering lunch times with more staff being able to do screenings.	Performance Improvements:

Efficiency Objective: All ID Private Provider logs will be keyed by the keying deadline each month.	Results: 100%
Recommendations/Action taken: Monthly maintained 100% of the ID Private Provider logs received in FY18 were keyed by the deadline each month.	Performance Improvements:

Quality Assurance Accomplishments

- Additional support (1FTE) added to QA in December 2017
- QA staff trained in Human Rights Investigation Training
- QA began review and follow-up of Suspension Reports in January 2018
- Office of Human Rights retrospective reviews occurred, and internal process established for human rights action plan follow-up
- Internal QA reviews of Agency group homes
- Triennial Licensure Review – Applied for Agency license and facilitated unannounced review
- Began documentation workgroups
- CARF meetings to review new manuals
- Assisted agency in providing comments to draft Office of Licensure regulations and draft CMHRS and Psychiatric Manuals
- Began assisting ID/DD with Case Management Reporting and automated by IT
- Updated processes for changes in Region IV from the Office of Human Rights
- Participated in Welligent Selection Committee
- Lead for Agency CCC+ Workgroup; assisting agency transfer to CCC+ to include coordinating meet and greet for six MCO's
- Twenty-Seven Human Rights investigations completed in a timely manner
- Medical Records responded to 1,225 record requests and 24 subpoenas
- Assisted Community Services Board host a CCC+ meeting for individuals receiving services, family members and staff
- Completed with CSS, QIP for DD services following DBHDS Consultation
- Assisted agency with same day access process

- Instituted 42CFR updates
- Facilitated agency training on Substitute Decision Maker at two locations presented by Henrico County Attorneys

Quality Assurance Goals

- Prepare for CARF reaccreditation
- Attain Licensure Emergency Regulations training
- Evaluate new EHR functionality for tracking disclosures, record reviews, and incident reporting and become superusers of the system
- Coordinate training on Advance Directives and identify staff to become certified Advanced Directive Facilitators

Quality Assurance Outcomes

Efficiency Objective: Report incidents within required timeframes	Results: 97%
Recommendations/Action taken: Agency leadership team discuss expectations and policy was updated.	Performance Improvements: Combined Human rights (27) and serious incident (119) CHRIS reports totaled 146, of which all but 5 were reported within the required 24 hours of notification.

Community Support Services Accomplishments

Parent Infant Program

- The Parent Infant Program was granted a 2018 NACo Achievement Award for the Early Intervention Autism Clinic. The program was also chosen to receive the honor of Best in Category.
- Partnered with MCV/VCU Hospital Pediatric Residency Program and provided training in Part C Early Intervention Services to the Residents.
- Program System Manager was featured on Henrico Public Access channel to discuss the Part C Early Intervention Service System.

Intake/ Eligibility and Case Management

- The final individual from Henrico Area residing in a state training center that is scheduled to be closed was successfully transitioned into the community.
- In October 2017, intake staff worked with other Henrico County Departments to triage an abuse/neglect situation and have since provided on-going case management to two sisters as they received DD Medicaid Waiver services and moved into community/homes and day programs.

Housing

- Currently the administrative agent for 257 individuals receiving VHDA Housing Choice Vouchers.

Permanent Supportive Housing

- In July 2017, Henrico was awarded grant funding from the Department of Behavioral Health and Developmental Services to develop a Permanent Supportive Housing Program (PSH). The target population for this program are individuals with serious mental illness who are also chronically homeless. The grant funds allowed us to hire a

full-time case manager, peer specialist and provide housing supports for up to 30 individuals. We began accepting applications in December and to date the program placed 14 individuals in rental properties around the Henrico area. The program has provided many for the following supports: assistance with startup funds; application fees; furniture; credit clean-up; advocacy; budgeting; cleaning; coordination with other services; subsidized rent payments.

ID/DD Case Management

- Implemented a new tracking process for Enhanced Case Management requirements resulting in meeting targets for Department of Behavioral Health and Developmental Services dashboard.
- Identified all individuals under Commonwealth Coordinated Care Plus Managed Care Organizations and provided staff training to enhance smooth transition for individuals.
- Provided regional training opportunities to Region 4 Developmental Disability Case Management Private Providers.
- Continue to contract with two Developmental Disability Case Management Private Providers.
- Two staff received training to be statewide Person-Centered Thinking trainers.
- Completed Virginia Association of Community Services Boards and Department of Behavioral Health and Developmental Services Case Management self-assessment surveys.

Employment and Day Services

- Held Employer and partner banquet honoring 13 employers and 7 business partners for volunteer opportunities for the individuals we serve in CSS and Collaborative Services.
- Developed three new group/mobile crew sites for employment which includes Henrico's employee fitness center.
- Expanded the role of the consumer in program activities such as having consumer led classes on nutrition and human rights, increased participation in Agency committees and in participation with the LEAP project through the Virginia Board for People with Disabilities.
- Hours of community activities ranged from 1632 to 1930 hours each quarter with over 3540 outings throughout the year. This represents a significant commitment to providing valued opportunities in the community for individuals in our Day Services programs at hermitage and Cypress Enterprises.

Residential Services

- Provided memory care services to residents who are presenting symptoms of aging and dementia as they age in place.
- Residents participated in ongoing volunteer activities with Wreaths Across America, Ronald McDonald's House, Richmond City Parks and Recreation and Henrico County Parks and Recreation Program.
- Residential Services successfully completed a Department of Medical Assistance Services audit with no citations.
- Completed HCBS self-assessment.
- Two staff completed No Wrong Door Person Center Counseling certification through the Partnership for People with Disabilities at VCU.

Community Support Services Goals

- Implement Home and Community-Based Waiver Services, update policies to be in compliance with regulations
- Maintain performance reported on DBHDS Dashboard
- Prepare group homes for CARF accreditation

Community Support Services Outcomes

CSS ID CASE MANAGEMENT OUTCOMES

Access Objective: Individuals receiving enhanced developmental case management services will receive at least one face to face contact every 30 days.	Results: 83%
Recommendations/Action taken: The development and running of running weekly reports and individual follow up effected the change needed to meet the outcome as was done in the last quarter. Focusing on the population of DD Waiver recipients meeting the criteria for ECM and prioritizing those visits through close management led to the ability to meet the outcome.	Performance Improvements: The reports continue to be run and follow up continues to be a priority with the focus on meeting the requirements for individuals falling under ECM criteria who receive DD Waiver funding. This will continue to be an outcome for next year.

Effectiveness Objective: Of the individuals receiving enhanced developmental case management services who received monthly face to face contact; they will also receive one of those contacts every other month in the place of residence.	Results: 78%
Recommendations/Action taken: Changes made to coding of visits for in home and the development and running of running weekly reports and individual follow up effected the change needed to meet the outcome as was done in the last quarter. Focusing on the population of DD Waiver recipients meeting the criteria for ECM and prioritizing those visits through close management led to the ability to meet the outcome.	Performance Improvements: The reports continue to be run and follow up continues to be a priority with the focus on meeting the requirements for individuals falling under ECM criteria who receive DD Waiver funding. It is expected that the numbers will continue to improve as the focus on ECM and ECM in the place of residence is maintained. This will continue to be an outcome for next year.

Efficiency Objective: Multi service progress notes will be final approved within 5 days of opening.	Results: 59%
Recommendations/Action taken: The operation of the Case Management unit at 75% staffing combined with the continuing vacancies and need to train new staff has made meeting this outcome challenging. Recruitment and training of new staff continues to be a priority for supervisors.	Performance Improvements: Training focus is on documentation in progress notes. It is anticipated that once all positions are filled with a trained staff complement the caseload numbers per Case Manager will come down and the ability to document and final approve documents quickly will improve. This will continue to be an outcome for next year.

CSS DD CASE MANAGEMENT OUTCOMES

Access Objective: Individuals receiving enhanced developmental case management services will receive at least one face to face contact every 30 days.	Results: 82%
Recommendations/Action taken: The DD unit met this outcome each quarter however 70%, was a starting point to eventually meet the requirement and exceed expectation. Significant increase in percentage/completion of this outcome was noted due to implementation of running weekly reports and Case Managers/Supervisors oversight of those reports.	Performance Improvements: Continued use of weekly reports and focus on meeting Enhanced Case Management requirements (being seen every 30 days) will remain a priority. This will continue to be an outcome for next year, but percentage will increase to 80%.

Efficiency Objective: Multi service progress notes will be final approved within 5 days of opening.	Results: 55%
Recommendations/Action taken: The Developmental Disability team and contracted provider continue to be a fairly new and implemented outcomes beginning July 2017. Therefore, it is imperative that training and encouragement of time management continue with staff, so this outcome can be met.	Performance Improvements: As the Developmental Disability team along with contracted providers becomes more accustomed to having Agency outcomes, it is believed that this outcome will be met. This will continue to be an outcome for next year.

Effectiveness Objective: The Developmental Disability team of Henrico Area Mental Health will conduct quarterly supervision meetings with the DD Contracted Private Providers for the fiscal year.	Results: 100%
Recommendations/Action taken: Per new mandates for the CSB the DD Supervisor has to maintain quarterly supervision with the contracted private providers. This was accomplished this year and remains an important factor in oversight, training and supervision of contracted private providers.	Performance Improvements: This outcome was met by 100% each quarter. It is imperative that this outcome is met to maintain regulatory compliance so therefore this outcome will continue for the next fiscal year.

CSS HERMITAGE AND CYPRESS DAY SERVICES OUTCOMES

Access Objective: 100% of the individuals referred to a Day Service program will be contacted within 20 days to discuss/schedule an assessment or visit.	Results: 81%
Recommendations/Action taken: All referrals were contacted within one month, with the primary reason for not meeting the twenty days as difficulty in reaching the families. Our process for referral includes the opportunity for a tour which often occurs within days of the case manager informing us of someone's interest.	Performance Improvements: What we have found is that those who complete a tour often are not in a rush to get the assessment completed, so therefore do not always return calls immediately. We will continue to monitor this and attempt to reach referrals within 20 days of letting us know they want an assessment.

Effectiveness Objective: For OES: Increase the number of community activity hours by 30% from the first quarter to the fourth quarter (for those without waiver).	Results: 30%
Recommendations/Action taken: This is our first attempt at tracking our community hours. We used our CBR payroll system to track the hours, number of people and the number of outings. While our goal was high, we realized early in the year, that we had reached our maximum as to community outings with the staff to client ratio and hours in a day.	Performance Improvements: Throughout the year we encouraged more outings as well as the quality of the outings. While we did not reach our 30% increase, we did increase the number of individuals in the community, and the hours in the community. We will continue to track our progress for community activities, with our goal next year to complete at least 130 outings per quarter across all programs.

Effectiveness Objective: For COI: Will increase the number of community activity hours to no less than 50% of the authorized hours for the Community Engagement/Coaching services by the end of the year.	Results: 21.2%
Recommendations/Action taken: Several things occurred during this year. The number of hours we authorized decreased as we learned more and asked for more realistic hours in our authorization requests. We emphasized getting everyone out, whether billable or not. While this ensured more consistency, it did hurt our billable hours, since we have a finite number of staff to provide support on these outings.	Performance Improvements: We will be looking at the staffing patterns in the next few months and will be planning how many activities we can offer, while still maintaining ratios both in the community and in the center-based programs. Our goal for next year will be the same – 50% of authorized hours. We will do so more realistically through improved service authorization and more emphasis on getting people out as often as their plans call for.

Effectiveness Objective: Older Adults/Dementia Care: Two new activities will be developed and introduced (either community or center based) to the older adults in the LEP area each quarter.	Results: 100%
Recommendations/Action taken: Staff tried new activities and used their training to encourage new ideas with consumers in the program	Performance Improvements: As we are new in providing services to those with Alzheimer's/dementia, it was important to explore activities which would enhance a person's memory and help them retain cognitive functioning. We incorporated at least two new ideas each quarter, including a variety of memory stimulation such as watching and discussing old TV shows and movies; art activities that required cognitive functions, gardening for muscle memory and using music as a means of stimulating memories. This goal was met and will be continued next year.

Efficiency Objective: OES: 95% of the elements reviewed will be met for the data collection section of the quality review for all non-waiver individuals.	Results: 64%
Recommendations/Action taken: While this is a small sampling, there were concerns noted in each program and within almost all of the charts. This is clearly an area that we will need to address. Data should be collected regularly on each individual. Therefore, we will be instituting some additional discussion in each staff	Performance Improvements: Update the process for completing documentation on non-waiver individuals, including a review process to catch areas of concern more quickly. We will also be implementing a new EHR this year which should assist in a more effective way of documenting progress on outcomes. We will continue

meeting to review protocols and effective documentation. Time is a factor, so we will review processes and make changes to ensure data is collected.	this outcome next year to ensure compliance with regulatory bodies and meet audit requirements

Efficiency Objective: COI: 95% of the elements reviewed will be met for the data collection section of the quality review for all individuals enrolled in waiver services.	Results: 94.3%
Recommendations/Action taken: Being under 1% of meeting our target is essentially meeting the target. The results of the reviews were consistent across programs and across the year. Continued emphasis on waiver documentation has seen an improvement in our documentation during this year.	Performance Improvements: Continue to work with staff and ensure documentation is completed and accurate. Implement a new EHR system including documentation to improve record keeping for individuals with waiver plans. We will continue this outcome next year to ensure compliance with regulatory bodies and meet audit requirements.

Efficiency Objective: Older Adults/Dementia Care: LEP staff will receive training on older adults or dementia care each quarter to enhance their knowledge and skills in these areas.	Results: 75%, 3 out of 4 quarters
Recommendations/Action taken: Training occurred in all but the first quarter, when we were trying to schedule the training from the Alzheimer's Association. A variety of training occurred in the last three quarters of the year, with staff receiving 12 hours of training from the Alzheimer's Association and training through the Area Planning and Service Committee and a Fall risk training.	Performance Improvements: Staff feel more qualified and knowledgeable about the individuals we serve who are aging and have symptoms of Alzheimer's and dementia. We have instituted changes in the program content to assist with memory, recognition and maintaining physical and mental acuity.

Consumer Satisfaction Objective: 90% of the individuals will respond with a positive response (always or almost always) when asked if they are satisfied with the work and/or activities they have been offered.	Results: 92.7%
Recommendations/Action taken: We tried a new way of getting responses and this seemed effective as we had a response rate of over 90% in every program site. Results showed that individuals liked to be busy with either work or a meaningful activity. This will need to be a concentration for the center-based programs. And most individuals (72%) felt they were going out in the community as much or more than they wanted to go out. Clearly finding the right mix of activities in and out of the center continues to be the wish of the vast majority of consumers.	Performance Improvements: With a satisfaction rate of 92.7%, we are doing many good things. However, the feedback is also clear. Have meaningful activities including work in the center and have opportunity for being out in the community are both very important to the vast majority of the individuals attending both Hermitage and Cypress Enterprises. We will be evaluating staffing patterns and resources to ensure we can continue to do both well.

Stakeholder Satisfaction Objective: 90% of the Caregivers/Family members will respond with a positive response to the question about satisfaction with the programs offered through Employment and Day Services	Results: 100%
Recommendations/Action taken: All programs were represented in the very small sample. It is difficult to get respondents to the surveys, even though we attempted a different way this year. We will explore a different	Performance Improvements: Families and Caregivers expressed complete satisfaction with services. With a very small sample size, it is difficult to extrapolate much in terms of changes we need to make. We will continue

method this next year.	to hold meetings and open opportunities for feedback to hear any concerns from the caregiver community.

CSS GROUP AND INDIVIDUAL SUPPORTED EMPLOYMENT OUTCOMES

Access Objective: 100% of individuals will be contacted by the employment specialist within 10 days of assignment from the supervisor.	Results: 80%
Recommendations/Action taken: Due to staff shortages, we did not receive many referrals this year, particularly in the first part of the year. For the last part of the year, the DARS categories were closed, meaning we did not receive any referrals from our primary referral source.	Performance Improvements: We generally meet the requirements for the 10-day contact. Situations occur at times where families are not available or unable to connect after attempts at contact. We will continue to monitor this and strive to meet the 10-day protocol.

Effectiveness Objective: Find jobs of choice for 90% of the targeted demographic (young adults ages 18 to 25) within 6 months of first appointment.	Results: NA
Recommendations/Action taken: When the outcomes were developed it was anticipated that we would receive referrals for those aged 18 to 25 due to the requirement for DARS to provide supports to these individuals. However, DARS made the decision to provide supports in house rather than vend them out. In addition, categories were closed from November 2017 thru the end of the fiscal year. No new referrals were received from DARS	Performance Improvements: While this population remains one that will require services, we will switch our emphasis to all referrals we receive and work to ensure that we utilize the newly acquired skills around customized employment during the next year.

Efficiency Objective: Hold at least one outreach event for the target demographic (young adults ages 18 to 25) in coordination with schools and /or DARS to educate about competitive integrated employment and market our provider services.	Results: 100%
Recommendations/Action taken: When the outcomes were developed it was anticipated that we would receive referrals for those aged 18 to 25 due to the requirement for DARS to provide supports to these individuals. However, DARS made the decision to provide supports in house rather than vend them out. This limited access to events targeting this population group.	Performance Improvements: We attend the Henrico County schools Transition Fair. During the year we connected with Charles City Schools, but no events were held. We will continue to monitor the schools and activities from both DARS and the Schools. We will focus our efficiency outcome on all new referrals, not just this target population.

Consumer Satisfaction Objective: 90% of the individuals served will respond with a positive response (always or almost always) when asked if they are satisfied with the activities they have been offered.	Results: 96%
Recommendations/Action taken: We tried a new way of distributing surveys hoping this would provide a higher ratio of response. Surveys were distributed at annual meetings with an option to return then or via mail. We received only 24% back, with 22% of ISE and 33% of GSE.	Performance Improvements: Of the 25 surveys received all but one rated satisfaction as most or all of the time. The one survey only rated satisfied as some of the time, stating they wanted more pay. We will continue to work with employers and discuss periodic salary reviews for Group SE and will encourage SE consumers to self-advocate for job benefits/pay increases.

Stakeholder Satisfaction Objective: 90% of the Caregivers/Family members will respond with a positive response to the question about satisfaction with the Group or Individual Supported Employment Services.	Results: 94%
Recommendations/Action taken: Caregivers/Family members who attended the annual meeting were given a satisfaction survey and asked to either return at the end of the meeting in a sealed envelope or to mail it back to Hermitage Enterprises. We only received 16 total surveys back. The sample size was too small to divide into Group or Individual SE for any significance. We will survey again this year including Case Managers and Caregivers at the annual meeting and ask them to complete it before leaving.	Performance Improvements: 94% of the surveys returned had either Agree or Strongly Agree when asked about satisfaction. The one survey did not have anything marked to this question. We will continue to ask and monitor discussions with families and make improvements as we can.

CSS INTAKE OUTCOMES

Access Objective: 100% Individuals referred to the agency for services will have a face to face intake meeting within 10 days of the first contact.	Results: 66%
Recommendations/Action taken: There was a significant trend this year of individuals calling for an ID/DD screening and choosing dates outside of the 10-day goal. In most of those situations there were open intakes slots, sometimes even the next day but the individual or caregiver chose another time slot. We realized into the year, the difficultly in measuring time to first contact because we were not collecting the best dates.	Performance Improvements: For the next fiscal year, a new entry has been added to the Central Access form allowing staff to document the date of the call, the first offered appointment and the appointment scheduled. This will allow for more accurate data and a better way to measure if we are getting individuals in timely.

CSS RESIDENTIAL OUTCOMES

Effectiveness Objective: 90% residents will participate in at least 2 community inclusion activities of choice per month.	Results: 77%
Recommendations/Action taken: Investigate if the new EHR for HAMHDS can assist in tracking and scheduling community integrations for residential clients.	Performance Improvements: The overall results were 77% of residents participated in 2 community inclusions activities during FY18. This is an ongoing outcome and it will continue as written for FY19. Group Home Supervisors will need to improve in their outcome reporting and activity planning with the residents

Effectiveness Objective: 60% of the residents will connect/join a volunteer organization of their choice during the 1st quarter of this outcome year	Results: None of the residents are participating in any organized volunteer
Recommendations/Action taken: N/A	Performance Improvements: NA

Effectiveness Objective: 30% of residents will participate in a volunteer activity the 2nd, 3rd and 4th quarter	Results: 37%
Recommendations/Action taken: Increase the percentage to 40%.	Performance Improvements: More residents participated as the year went on, but there are a few residents who have health issues that prohibit their participation and one guardian that refuses their son to participate.

PARENT INFANT PROGRAM OUTCOMES

Access Objective: The Infant and Toddler Connection of Henrico will meet or exceed the December 1 child count of 61 determined by the Part C office.	Results: 62
Recommendations/Action taken: The infant program attributes this accomplishment to the ongoing collaborations with NICU and community partners. In the up and coming year, we will specifically target the Henrico Doctor's NICU to expand the relationship. Additionally, we plan to implement standard processes for all NICU referrals to the system.	Performance Improvements: The Infant and Toddler Connection of Henrico Area exceeded its child count. 62 infants between 0-1 were in the system on December 1st.

Effectiveness Objective: The Infant and Toddler Connection of Henrico Area will conduct 3 transition conference meetings in collaboration with Henrico Part B Preschool Special Education Program this fiscal year.	Results: 3 transition conferences
Recommendations/Action taken: Goal was met by 3rd quarter. The collaboration between PIP and Part B services has improved this year. These conferences have allowed parents the opportunity to meet with Part B to ask questions regarding their child's transition.	Performance Improvements: PIP will provide 3 transition conferences a quarter as well as collaborate with the schools to schedule individual conferences as requested by the family.

Clinical and Prevention Accomplishments

- First full year of Same Day Access with over 2500 assessments completed.
- Experienced a 16% increase in the number of Uniform Pre-Admission Screening Assessments completed. This represents a total of 1,882 assessments completed this year for an average of 157 Pre-Admission Screening Assessments per month.
- Implemented Opiate Jail Diversion Program serving individuals who are incarcerated and have a diagnosed Opiate Use Disorder. This program builds on the Mental Health Jail Diversion model, and quickly links individuals with Medication Assisted Treatment and community based substance use disorders.
- Increased number of screenings for Governor's Access Plan (GAP) by 12%. A total of 413 screenings were completed.
- Trained 327 individuals in Mental Health First Aid. This is an 86% increase over the number of individuals trained last year.
- Received NACO Achievement Awards for Behavioral Activation Group and for Crisis Intervention Team (CIT) Refresher program.
- Increased number of youth receiving case management services by 33%. A total of 461 youth received case management services this year compared with 346 last year.

Clinical and Prevention Goals

- Medicaid Expansion
- Implement the DLA20 as of January 2019
- Integrated Health Care

- New EHR
- STEP-VA
- New East Center
- Psychiatric Bed Crisis
- DOJ Settlement
- DBHDS Dashboard

Clinical and Prevention Outcomes

ADULT SUBSTANCE ABUSE OUTCOMES

Access Objective: Clients will be scheduled for a follow up appointment within 14 days of their same day access appointment.	Results: 96%
Recommendations/Action taken: Results shared with staff and stakeholders.	Performance Improvements: 96% of all clients seen at Same Day Access had their second appointment within the 14-day goal. No specific performance improvements made as a result of this objective.

Consumer Satisfaction Objective: 80% of clients surveyed in February will rate their overall satisfaction with services at a 4 or 5 on the survey.	Results: 97.4%
Recommendations/Action taken: Results shared with staff and stakeholders.	Performance Improvements: 143 people responded to the program satisfaction survey. No specific performance improvements made.

Consumer Satisfaction Objective: 60% of clients opened to this service will be retained in services for a minimum of 3 months. (Demonstrating a service provided each of those 3 months).	Results: 38%
Recommendations/Action taken: We have implemented contingency management interventions with our enhanced outpatient program. Additionally, we are increasing our access to MAT to clients which it is hoped will increase retention rates.	Performance Improvements: Initiate office based opiate treatment (OBOT) for clients. This medication assisted treatment will likely increase the rate of retention among clients.

Consumer Satisfaction Objective: Of planned discharges, 70% will demonstrate a reduction in substance use. (Planned discharges are defined as those where the client is involved in the development of the discharge plan).	Results: 64%
Recommendations/Action taken: Program management will begin to look at trends to determine if there are differences in outcome by staff, length of stay, and drug of choice in order to improve services so as to increase this percentage.	Performance Improvements: The program is working to ensure that the drug tables are updated at discharge in order to capture the most up to date use information. Additionally, the program is reviewing evidenced based curriculum on an ongoing basis to ensure that the most effective treatments are being utilized.

ADULT MENTAL HEALTH OUTCOMES

Access Objective: Clients will be scheduled for a follow up appointment within 14 days of their same day access appointment.	Results: Quarter 1 = 90% Quarter 2 – 93% Quarter 3 – 94% Quarter 4 – 78%
Recommendations/Action taken: Continue to monitor days to second appointment.	Performance Improvements: Work to fill the vacant position.

Consumer Satisfaction Objective: 80% of clients surveyed in February will rate their overall satisfaction with services at a 4 or 5 on the survey.	Results: 98.8%
Recommendations/Action taken: Continue to provide services as currently doing so as clients are highly satisfied with services.	Performance Improvements: None at this time.

CHARLES CITY/NEW KENT OUTCOMES

Access Objective: Clients will be scheduled for initial appointment within 14 days of contacting Phone Center.	Results: 37%
Recommendations/Action taken: PF is moving in the direction of SDA	Performance Improvements: 37% of clients were seen within 14 days based on data from 3 quarters.

Effectiveness Objective: Although this objective was met this year, the overall percentage was down from last year's 90.5%. No client scored below a 5 on any survey.	Results: 85%
Recommendations/Action taken: May use a number system on the survey next year as some clients had difficulty understanding the directions.	Performance Improvements: None

EMERGENCY SERVICES OUTCOMES

Access Objective: Persons not open to the agency hospitalized through the civil involuntary admissions will attend a non-emergency discharge appointment within 7 days of their discharge 75% of the time	Results: 71%
Recommendations/Action taken: We will continue to engage in outreach efforts and discharge coordination with hospitals so that when a client is referred to HAMHDS, we can engage those clients in services. We are beginning a pilot program with a local hospital to identify those individuals who are not engaged in behavioral health services, provide a peer specialist consultation while the individual is being treated on an inpatient unit, and if the individual chooses, provide the completion of the Access there in the hospital or provide some resources for community providers if the individual chooses to seek services other than with HAMHDS.	Performance Improvements: During first three quarters we remained above 70% for a show rate, but during the 4th quarter, we had an increase in no shows for appointments and Same Day Access Services. It is unclear why this spike in no shows for services occurred. Continue outreach efforts and continue to improve collaboration with private hospitals to assist with discharge referrals.

Efficiency Objective: 90% of persons (not currently open to the agency) not hospitalized will be contacted by phone within 7 business days of their assessment if follow up is indicated in assessment. If the phone call is	Results: 96% of those individuals assessed via prescreening but not hospitalized were followed up with after being evaluated. 92% of outreach attempts over the year were within the 7-business day timeframe.

not completed a letter will be sent within 7 days. Excluded are persons who live in a group home or are assessed in jail or detention.	
Recommendations/Action taken: Continue to follow up with clients as this is a continuation of service. Results shared with staff and stakeholders.	Performance Improvements: Continue to provide outreach efforts quickly again now that staffing vacancies have been filled.

Effectiveness Objective: Individuals (Henrico, NK, CC residents) admitted to Central State Hospital under a TDO will be transferred to a local hospital within 5 business days after admission 70% of the time.	Results: 59% of the individuals sent to CSH were transferred to a local hospital. During the last quarter, CSH took over this role so therefore, the CSB was no longer responsible for this task.
Recommendations/Action taken: Continue to collaborate with CSH to assist in discharge, step-downs, and other community services even though the role of locating a local facility has been shifted to CSH.	Performance Improvements: None at this time.

ACCESS OUTCOMES

Access Objective: 80% of clients referred to services will show for their second appointment	Results: 74%
Recommendations/Action taken: The first quarter resulted in the highest average (77%) and the fourth quarter was the lowest (70%). Despite not having achieved the desired results, it should be noted that each office surpassed baseline percentages in the second and third quarters: The Woodman office exceeded theirs by 12% and 3%; Richmond Medical Park exceeded theirs by 11% and 19%; and the East Center exceeded theirs by 2% and 6%. Most notably, the Woodman office achieved a 100% show rate in the second quarter!	Performance Improvements: In general, clients received appointments within 10-14 days. However, our results for the year fell a bit short of the desired outcome, as the overall division average was 74%.

Access Objective: 80% of clients will score a total of 20 or better on the SDA Satisfaction Survey	Results: 100%
Recommendations/Action taken: Individuals and families served through Same Day Access were asked to complete a six-question satisfaction survey. Each question of the survey was assigned a value of 1-5 (strongly disagree to strongly agree) and the respondents were asked to rate the statements based on their Same Day Access experience.	Performance Improvements: We aspired to achieve a minimum of 80% of respondents having scored a 20 or higher. In other words, we sought respondents to generally be "undecided" or "agree" with each statement. 100% of respondents (N= 106) scored a 20 or better. Nearly half, 46% (N=49) of respondents actually provided a perfect score of 30! Only 16 surveys (15%) contained a total score below 25. These results suggest that not only were individuals and families generally satisfied, but almost half were more than satisfied.

LAKESIDE CENTER OUTCOMES

Access Objective: 100% of consumers referred to the program will be admitted within an average of 10 days from receipt of the referral.	Results: 0%
Recommendations/Action taken: For FY18 there was a total of 44 admissions to the program. Excluding Central State Hospital referrals as defined above, there	Performance Improvements: The varied factors contributing to admission delays are detailed in the Quarterly narratives above. Additionally, another factor

were a total of 40 admissions (an increase of 19 from FY17) which averaged eleven days from referral to admission therefore missing the defined objective above by one day. Had consumers and/or their referral sources accepted earlier opening/orientation appointments availed to them, the average drops to nine days which would have more than met our target. During the 4th Quarter of FY17, a Clinician position was added to the program for the first time and among the job description responsibilities for this position is to conduct all orientations/openings to the Lakeside Center Psychosocial Program. This has already proven to increase the timeliness and efficiency of admissions.	delaying orientations/openings post-referral is the lack of transportation available to consumer's referred to Lakeside Center, so they can attend the Orientation appointment. Though our current processes, including the hiring of a Clinician a year ago, has resulted in more timely access to services, referral sources should continue to be encouraged to have consumers tour Lakeside Center and complete a trial visit to determine interest prior to referral. A significant number of referrals who have not completed tours and/or trial visits are, in turn, closed due to lack of interest. This delays the opening of consumers who are motivated to attend Lakeside Center. In this regard, our LSC Program Description has been revised to recommend both tours and trial visits for prospective members.

Effectiveness Objective: Consumers will be administered both pre- and post-surveys to determine the retention of information disseminated in their daily groups as evidenced by a 50% improvement in post-survey scores.	Results: 41%
Recommendations/Action taken: For FY '18 pre and post surveys were administered to a total of 25 Lakeside Center consumers in the 3rd Quarter and 4th Quarters measuring the learning and retention of information in LSC psychosocial groups.	Performance Improvements: Following the 31% achieved in the 3rd Quarter, interactive teaching materials were utilized in the 4th Quarter psychosocial group resulting in a significant improvement to 50%. Recommendations are to continue/expand upon the use of interactive teaching materials and to revise future surveys to address the flaw identified in the 4th Quarter.

Efficiency Objective: Evidence of Care Coordination with other healthcare providers (i.e. SAI, MHSB, Vocational, ALF/Residential, and Private Providers) will be documented in the record 100% of the time over the past year.	Results: 100%
Recommendations/Action taken: For FY18, following the outcome measure revision to include Care Coordination with the SAI and other healthcare providers we were able to meet the desired outcome of 100% of the time.	Performance Improvements: Continue to stress to staff the requirement of documentation related to collateral contacts identified on the individual ISP.

Consumer Satisfaction Objective: 90% of consumers surveyed will report being "satisfied" with services as evidenced by an 8-10 rating to all survey questions.	Results: 90%
Recommendations/Action taken: In the 3rd Quarter of FY 18, a total of 40 Lakeside Center members were administered a program satisfaction survey. The combined survey score was 90%, thereby achieving our stated goal. It appears that this survey continues to be a viable measure of our consumer's satisfaction with this program and I would therefore recommend that we continue it on an annual basis.	Performance Improvements: Themes to address: Healthier lunches and increased staff time on the floor with our consumers. Suggestions are discussed in Team Meetings. Feedback included a desire for improved groups. Another 3rd Quarter Outcome pre and post survey of our member's retention of information disseminated in groups may support this request. Lakeside Center has purchased and implemented extensive interactive teaching materials which include cd's, worksheets, workbooks, etc. The early feedback from members regarding the use of these interactive materials in psychosocial groups has been very positive.

Stakeholder Satisfaction Objective: 90% of family/significant other stakeholders will respond with an 8-10 rating to all survey questions.	Results: 89%
Recommendations/Action taken: In FY 18, a total of 22 stakeholders (HAMHDS SAI's for Lakeside Center consumers) surveys were conducted. The combined survey score was 89.09%, thereby missing our stated goal, 90%, by less than 1%.	Performance Improvements: As the two questions, detailed in the 1st Quarter narrative above have, as in previous years, resulted in qualified answers, it is recommended that they be reworded for future surveys to more accurately measure stakeholder satisfaction.

MH CASE MANAGEMENT OUTCOMES

Access Objective: Non-crisis clients will be seen for ongoing case management services within 7 days of their same day access initial assessment.	Results: average 7.75 days
Recommendations/Action taken: Staff vacancies on all three case management teams have been a significant factor for the majority of the reporting period creating longer than desired wait times. Supervisors have been diligent in on-boarding new staff and creating new client appointment times for their new staff once oriented to the agency to minimize client wait times for services. Business staff have also instituted a tracking system to capture first offered appointment to more fully capture actual wait times to second appointment versus merely the scheduled appointment times.	Performance Improvement: Wait times to second appointment will continue to be tracked in FY19, along with first offered appointments. Staff and supervisors will continue to strive to minimize wait times whenever possible to ensure that client's needs are met in the timeliest manner possible.

Effectiveness Objective: Newly opened clients will demonstrate an 80% reduction in hospitalization rates or remain at 0 hospitalizations. The baseline (measured from 3 months pretreatment initiation to 3 months after treatment) as compared to hospitalization rates in months 4-9.	Results: 90%
Recommendations/Action taken: These results remain quite positive and have remained consistent over the past couple of years demonstrating the effectiveness of case management services and the impact that these services can make in a client's life. Being that one of the main goals of case management services is to assist clients with obtaining all the needed services and supports to live successfully in the community and to avoid the costly and often disruptive nature of inpatient hospitalization, these results seem to signal loudly that these goals are being met with a high level of effectiveness.	Performance Improvements: A total of 285 clients were opened to case management services during the reporting period. At nine months post admission to services 124 remained active and 112 experienced a reduction in hospitalizations or remained at zero hospitalizations. In addition to these impressive results, of note is that clients that remained in case management services for at least 9 months experienced a 67% decrease in the number of hospitalizations as compared to the baseline period – dropping from 130 cumulative hospitalizations to only 43 in months 4-9 of services. These results speak loudly to the importance of clients remaining in case management services to increase their community tenure and decrease hospitalization rates. Client retention efforts will continue to be explored in hopes of expanding these encouraging results.

Efficiency Objective: At least 75% of clients will have a minimum of one face to face contact with their case	Results: 77%

manager monthly to maintain engagement in services.	
Recommendations/Action taken: Client engagement efforts and efficiency strategies have been discussed in staff supervision and team meetings to increase and maintain compliance rates and maximize client outcomes.	Performance Improvements: These results are overall quite positive and speak both to the diligent efforts case managers have made to maintain regular face to face contact with their clients despite a myriad intervening variable and the level of engagement consumers have with their case management staff. Client engagement efforts will remain a focus in the upcoming year coupled with a focus on any technological efficiencies that become available through our newly selected EHR vendor to aid staff in tracking face to face contacts in a more efficient manner.

Consumer Satisfaction Objective: 90% of client responses will be one of the two highest ratings to questions on the satisfaction survey.	Results: 95%
Recommendations/Action taken: The overall client satisfaction results were shared with all CM&A case management staff. Specific team and individual staff feedback was shared with team supervisors whom in turn shared with individual staff in clinical supervision. In addition to inquiring about client satisfaction with case management services, consumers were also asked about their interest in a variety of psychoeducational group topics - This feedback will be used in planning for upcoming agency group offerings to best meet needs and interests.	Performance Improvements: It remains encouraging that client satisfaction rates remain exceedingly positive. Teams have been challenged with increased staff turnover this past year, but despite this, satisfaction with case management services remains strong. The return rate of surveys dipped a bit from last year from 46% to 38% this year. Staff vacancies were undoubtedly a factor here in having fewer available staff collecting client's feedback. Teams have found that a client's experience in agency services remains central to a client's engagement and often to yielding positive clinical outcomes – Staff will continue to strive to meet or exceed these results in upcoming surveys and increasing survey return rates.

Stakeholder Satisfaction Objective: 90% of HAMHDS prescribers' and ARS Collaborative Services providers' responses will be one of the two highest ratings to questions on satisfaction survey rating CMs and clinicians within CM&A	Results: 96%
Recommendations/Action taken: Overall results were shared with all Case Management and Assessment staff and individual and team results were shared with team supervisors to share with individual team members during clinical supervision meetings. There was some really good feedback provided that highlighted some very positive collaboration between providers. This partnership and collaboration with stakeholders will remain at the forefront of services provided in the upcoming year.	Performance Improvements: At total of 91 surveys were collected from agency prescribers, mental health skills building, psychosocial, and residential staff which is a 36% increase in surveys received as compared to last year's results. Collaboration with stakeholders remains a key and core component of effective case management services and will remain at the forefront of services provided. Teams will utilize feedback provided to enhance and inform service delivery to maximize client outcomes.

<u>IN-STRIDE MANAGEMENT OUTCOMES</u>

Access Objective: Consumers referred for InSTRIDE will be contacted, on average, for an assessment within 7 days of notification of the referral.	Results: 6 days
Recommendations/Action taken: There were 32 referrals this past fiscal year. Of these 32 referrals, 22 met criteria and were opened into the program. Of the 22	Performance Improvements: InSTRIDE's ability to meet this standard is due to the continued flexibility and willingness of the clinical supervisor and clinician to meet

individuals who were opened, 20 were opened within seven days. The individuals were seen and assessed within an average of 6 days.	with referrals wherever they are at the time which clearly enhances access to the program.

Effectiveness Objective: There will be a decrease in the number of hospitalizations from InSTRIDE recipients as compared to the previous year. (per consumer report)	Results: FY18 21 hospitalizations compared to FY17 22 hospitalizations.
Recommendations/Action taken: Since FY17 had significant gains (14 FY16, 22 FY17), and since these gains were maintained for FY18, InSTRIDE should strive to see if further gains could be achieved for FY19. InSTRIDE should continue to explore using less restrictive options such as Mobile Crisis Team and the Crisis Stabilization Unit as a means to reduce the use of inpatient hospitalizations.	Performance Improvements: For FY18, InSTRIDE consumers experienced 21 hospitalizations, nine of which were voluntary, and twelve of which were involuntary. FY18 results are consistent with FY17 results in which InSTRIDE consumers also experienced 21 hospitalizations, ten of which were voluntary, and eleven of which were involuntary.

Effectiveness Objective: 100% of consumers will participate at least quarterly in activities within their community such as vocational, educational, or recreational.	Results: 80%
Recommendations/Action taken: During the next fiscal year, InSTRIDE will examine and attempt to develop additional opportunities to assist consumers with community engagement, so that more than 80% of consumers served will have engaged in some type of vocational, educational, and/or recreational activity.	Performance Improvements: 80% of consumers have participated in an activity in the community to include vocational, educational, or recreational which is an increase from FY17 which was 77% of consumers served.

Efficiency Objective: Program orientation packets, initial assessment, and initial individual service plans will be completed within 30 days on 100% of new referrals to InSTRIDE services.	Results: 100%
Recommendations/Action taken: InSTRIDE will continue to monitor this objective and maintain this high standard.	Performance Improvements: This objective was again met with 100% compliance as it was last fiscal year. Both the clinical supervisor and the clinician have continued to ensure paperwork is completed by the set deadlines.

Consumer Satisfaction Objective: Consumer's will complete a service satisfaction survey to rate the services being provided to them at a "2" or lower.	Results: 59% for FY18 as compared to 74% for FY17	
Recommendations/Action taken: As with the two previous years, the highest rated score continues to be question number one, which continues to demonstrate staff dedication, and hard work regarding providing the best possible services. With regards to the rest of the questions, performance improvements were not noted with the lowest scores being questions number 5, 9 and 13.	Performance Improvements: For the year, a total of 23 surveys were completed.	
	FY18: 23 Surveys #1: 89% #2: 77% #3: 77% #4: 59% #5: 39% #6: 63% #7: 55% #8: 61% #9: 45% #10: 64%	FY17: 28 Surveys #1: 89% #2: 82% #3: 82% #4: 75% #5: 79% #6: 86% #7: 79% #8: 64% #9: 62% #10: 68%

	#11: 48% #12: 49% #13: 45% #14: 50% #15: 57% Total: 59%	#11: 64% #12: 75% #13: 71% #14: 75% #15: 57% Total: 74%

Stakeholder Satisfaction Objective: The InSTRIDE Physician will complete a Practitioner Outcome Survey to rate the symptom management of the clients participating in services, with a target goal of a "2" or lower	Results: 2.94 for FY18 compared to 2.68 for FY17.
Recommendations/Action taken: Results may have been skewed due to different prescribers filling out these forms from year to year. Inter-rater reliability may have been an issue. For next fiscal year, the LMHP clinician on the team will start filling out these surveys for the purpose of consistency.	Performance Improvements: Sixteen surveys were administered. The average score was 2.94 which surpassed last year's results of 2.68. FY18: 16 Surveys FY17: 23 Surveys #1: 2.87 #1: 2.86 #2: 3.43 #2: 2.82 #3: 4.06 #3: 3.52 #4: 3.56 #4:3.34 #5: 3.25 #5: 3.13 #6: 2.43 #6: 1.52 #7: 3.12 #7: 2.69 #8: 3.25 #8: 3.00 #9: 3.43 #9:2.95 #10: 1.93 #10:2.21 #11: 1.06 #11:1.39

MH PACT OUTCOMES

Access Objective: There will be an increase in access to health care services experienced by persons receiving PACT/ICT services. Such individuals will see a health care provider, to include primary care providers, specialists, dentists, optometrists, etc., but not including emergency room treatment, at least once per year.	Results: 91% FY18, 66% FY17
Recommendations/Action taken: PACT/ICT teams will continue to provide support as needed regarding helping consumers maintain routine medical care and will continue to collaborate and refer consumers to the Daily Planet who do not already have primary care.	Performance Improvements: For FY17, only 66% of PACT/ICT consumers had received some degree of routine medical care other than psychiatric care. For FY18, 91% of PACT/ICT consumers received routine medical care. This drastic increase can be attributed to (1) having on-site primary care provided by the Daily Planet, and (2) staff who accompanied consumers to over 500 non-psychiatric, medical appointments in FY18.

Effectiveness Objective: There will be more voluntary hospitalization bed days versus involuntary hospitalization bed days utilized by PACT and ICT service recipients.	Results: Goal was not achieved as involuntary bed days greatly exceeded voluntary bed days.
Recommendations/Action taken: Since PACT/ICT teams are tasked with serving some consumers who may believe they do not have a mental health diagnosis, or who believe they do not need to take psychotropic	Performance Improvements: PACT/ICT consumers experienced a total of 1535 involuntary bed days versus 149 voluntary bed days for the year. Despite teams trying to be more recovery oriented and wanting to

medications, these same individuals are more than likely going to experience involuntary admissions as opposed to voluntary admissions. As a result, this goal is being re-worded. The new goal is to decrease the number of involuntary bed days and increase the number of voluntary bed days.	empower consumers to be able to decide when he or she needs/wants to be hospitalized, consumers were often either unwilling to go voluntarily, or they lacked the capacity to make this decision.

Efficiency Objective: Program orientation packets, PACT/ICT assessments, and initial individual service plans will be completed within 30 days on 100% of new referrals to PACT or ICT services.	Results: 89%
Recommendations/Action taken: PACT/ICT supervisors should continue to monitor to ensure all opening paperwork is completed within 30 days. New benchmark should be set to exceed 90% compliance.	Performance Improvements: Both teams had 89% compliance with completing opening documents within the 30-day window which is a huge improvement over last year's result (56%). Both ICT and PACT supervisors will continue to monitor opening paperwork deadlines and revisit the process if needed. This outcome is an important marker for our efficiency and serves the consumer by engaging them in services and identifying treatment needs quickly.

Consumer Satisfaction Objective: Consumers will rate their satisfaction with PACT and ICT services a "4" or higher on the PACT/ICT Consumer Satisfaction Survey.	Results: 95%
Recommendations/Action taken: Sample size was on the small side with only 15 surveys being returned. Efforts need to be taken to have a larger sample size.	Performance Improvements: FY18 result exceeded FY17 result which was 81%.

Stakeholder Satisfaction Objective: 90% of consumer's families/identified primary support system will rate their satisfaction with PACT and ICT services at a "4" or higher on the PACT/ICT Family Satisfaction Survey.	Results: 91%
Recommendations/Action taken: Based on these results, no actions need to be taken, and no recommendations.	Performance Improvements: FY18 result exceeded FY17 result which was 61%.

MH RESIDENTIAL OUTCOMES

Access Objective: Vacancies in the program will be offered and accepted within 45 days from the date a resident vacates the home to the move-in date of a new resident	Results: 65 days
Recommendations/Action taken: While we did not meet our access objective, no action is needed as the circumstances around the person coming to the home were out of the control of staff (person was an inpatient at Central State Hospital). Had external factors not play a role in the person's admission she would have been admitted to the program within 30 days of the vacancy, well within our time frame of 45 days.	Performance Improvements: NA

Effectiveness Objective: The residents' health and wellness will improve as evidenced by their weight loss	Results: 50%

through the reporting period.	
Recommendations/Action taken: During the full reporting period we were successful with 50% of the residents losing weight. Both residential staff and residents work together to plan, purchase, and prepare healthy meals. In addition, those who are able are encouraged to perform low level of exercise, such as walking, all in an effort to improve their overall health. The actions taken during this year will continue as will this objective. While improvements have been made in the home, all the residents attend various day programs where they have access to other food. It is suspected that this is having a negative impact on the residents' weight loss.	Performance Improvements: In addition to residential staff encouraging residents to maintain a healthy diet while in the home, residents will also be educated on healthy choices they can make when at their day program.

Efficiency Objective: There will be improved coordination of the residents' health care needs as evidenced by residential staff communicating weekly updates to the Group Home Supervisor.	Results: 100%, 52/52 weeks
Recommendations/Action taken: Throughout the year we have been successful with residential staff providing weekly updates regarding the residents' health issues to the group home supervisor. These weekly updates have not only proven to be helpful with staff communicating with the group home supervisor, but also has shown to improve care coordination between the group home supervisor and designated case manager for each resident. While the expectation related to ongoing communication will continue it will not continue as an outcome for the next reporting period.	Performance Improvements: NA, no improvements indicated as we were successful in meeting this objective 100% of the time. This objective will not be an outcome measured for the next reporting period.

Consumer Satisfaction Objective: Four out of five residents will respond with an 8-10 rating to focus group survey questions.	Results: 100%
Recommendations/Action taken: A focus group followed by a survey was held at the end of the third month of the first quarter. The questions measured their rate of comfort at Walton Farms, satisfaction with community outings, relationship with fellow housemates, sharing of household chores, and the help they receive from residential staff in achieving their goals. All residents scored the highest rating of a ten on all five questions. Due to scoring 100% on all survey questions, a second survey was not conducted. However, house meetings continued to provide the residents with an ongoing opportunity to express any issues/concerns.	Performance Improvements: NA, none needed at this time. A focused group followed by a survey will continue during the next reporting period.

Stakeholder Satisfaction Objective: The residents' Case Manager will respond with an 8-10 rating on all survey questions.	Results: 100%
Recommendations/Action taken: A satisfaction survey was given to the three primary case managers of those that reside at Walton Farms. The questions measured	Performance Improvements: NA none needed at this time. Case managers will continue to receive a satisfaction survey during the next reporting period.

residential staffs' communication, responsiveness, care, and overall satisfaction with the services their client receives in residential services. The fifth question asked if they would recommend our program to others. All three case managers' responses were within an 8-10 rating with the majority of the ratings being at a 9 or 10. In addition they all stated they would refer other clients to residential services.	

MH SKILLS BUILDING OUTCOMES

Access Objective: MHSS will open 80% of referrals within 7 days of referral from the case manager	Results: 50%
Recommendations/Action taken: For FY18 there were a total of 14 consumers opened to MHSS. Wait times varied with the shortest wait time of 4 days occurring in the first quarter and the longest wait time of 16 days occurring in the second quarter. The objective of 7 days was met in the first and third quarter. The objective of 7 days was missed by one day during the fourth quarter. As a result, the objective was met twice during the year. Extenuating circumstances such as the hospitalization of a client between the time of referral and admission, questions regarding the appropriateness of a referral and issues pertaining to communication between case manager, supervisor, and identified clinician played a role in the objective not being met at a rate of 100%.	Performance Improvements: Case managers were reminded of requirement to refer clients to MHSS upon acceptance at a support home.

Effectiveness Objective: 25% of all consumers discharged from MHSS will be considered "successful."	Results: 47%
Recommendations/Action taken: 17 clients were discharged from MHSS during FY18. 8 of these 17 discharges were considered successful given the definition of success in this objective. Discharges deemed unsuccessful were the result of clients moving out of the catchment area, non-compliance, lack of engagement, and premature termination of services.	Performance Improvements: The target rate for successful discharges will be increased from 25% to 50% for FY19 as the objective of 25% was met consistently throughout the year.

Effectiveness Objective: 50% of all consumers who have weight loss as a goal, will have lost some weight	Results: 42%
Recommendations/Action taken: Medication continues to play a role in clients' weights remaining the same or increasing. Difficulty with motivation, inability to independently prepare meals due to living in an ALF or with family members who discourage cooking, and limited incomes are also barriers to meeting this objective.	Performance Improvements: Overall, a total of 28 pounds were lost (between three clients) and 39 pounds were gained (between four clients). One client's final weight is not available but between the first and third quarters, he gained 12 pounds. Considering this, the grand total of weight gained over the course of the year was 51 pounds (between five clients). If this client is removed from the final outcome, 42% lost weight and the outcome was not met. Supervisor will explore adding a health and nutrition group designed for MHSS clients and will promote referrals to the InShape Program as well.

Efficiency Objective: MHSS staff will document monthly collateral contacts 90% of the time.	Results: 81%
Recommendations/Action taken: This objective was met once during FY18 in the third quarter and only one percentage point away from being met in the first quarter. Significant improvement occurred between the second and third quarter once staff was counseled regarding how to implement a system for tracking collateral contacts. The reduction from 91% in the third quarter to 81% in the fourth quarter is attributed to a sudden downsizing of staff due to reassignment of duties and illness as well as time needed to reassign cases.	Performance Improvements: Supervisor will regularly discuss each staff's rate of documenting collateral contacts once a month during a supervisory session.

Consumer Satisfaction Objective: 90% of consumers will respond positively to each survey question as evidenced by a score of 8 or higher for every question.	Results: 79%
Recommendations/Action taken: There was very little difference between this year and last year's Consumer Satisfaction Survey and no action was taken as a result.	Performance Improvements: We will continue this Objective into FY19.

Stakeholder Satisfaction Objective: 80% of ARS case manager responses will be in the excellent range (8-10).	Results: 85%
Recommendations/Action taken: Supervisor is making recommendations regarding Question 2: "Staff responds in a timely manner to requests for information" and Question 5: "The improvements consumers have made since beginning MHSS is" on the Stakeholder Survey. Communication between MHSS staff and collateral contacts needs improvement (Question 2). More information is needed in order to determine what improvements can be made to Question 5.	Performance Improvements: Two follow-up questions will be added to Question 5 in order to elicit from stakeholders' specific examples of progress. Room for comments will also be added under Question 2 and Question 5.

MH VOCATIONAL OUTCOMES

Access Objective: Each full-time job coach will develop twenty-four new employer contacts monthly.	Results: average 15 contacts
Recommendations/Action taken: Although we did not reach this object for FY18, we will continue IPS concept of developing new employer contacts, at the same rate of twenty-four per month for each full-time job coach. The 1st quarter only includes September 2018 (actual start time of new process). During the first two quarters, staff had more time to work on marketing and meeting new employers. After that, there was an increase in referrals and opening of new clients. This seems to have decreased time for marketing.	Performance improvements: Staff has been encouraged to dedicate allotted time in their schedules for marketing and program development. This seems to be the key as all are busy with other aspects of the job & new employer contact has been somewhat of causality. Also, the development of the new electronic form (on the P-Drive) is expected to make recording less of a problem. In addition, vocational staff will have a resource of employers/contacts to view potential employment resources.

Effectiveness Objective: Average of 50 direct service hours by f/t job coaches	Results: 50 direct service hours
Recommendations/Action taken: The program will continue to measure staff direct service hours. This objective gives credibility to the	Performance Improvements: This objective was achieved for the year. Staff was able to survive a dismal 3rd quarter (37%) by way of the tremendous effort in the 4th

amount of time staff spends with this particular task. They will increase to 55 direct service hours per month for staff. This subject has been discussed with staff during supervision. Also, the team is recording other duties performed on their individual service logs.	quarter (65%) to meet this goal. This objective has served as a means of measuring staff interactions and time spent with meaningful employment activities as well as promoting the inclusiveness on IPS principals of rapid job search.

Efficiency Objective: Increase the number of participants that received employment services by eighteen.	Results: 20 participants
Recommendations/Action taken: The efficiency objective will change for upcoming year. However, we plan to continue to expand program numbers and review progress through generated reports	Performance Improvements: This objective was reached due to the 4th quarter increase. Vocational staff will continue to attend case management meetings in effort to increase individuals served and to answer questions, especially by newer staff.

Consumer Satisfaction Objective: 90% of all responding consumers will score a rating of at least "8" to the survey question regarding satisfaction.	Results: 96%
Recommendations/Action taken: It is recommended that we continue to measure consumer satisfaction. Therefore, we will encourage new and more participants to give feedback on what has/has not worked.	Performance Improvements: This method of consumer satisfaction has been very informative in the past. However, it has been traditionally been completed by the same individuals with limited insight to program improvements. We are changing the format of survey to that of focus group and will utilize the 1st quarter meeting to engage participants in discussions around pertinent issues with regard to employment.

Stakeholder Satisfaction Objective: 90% of responding employers will score a rating of at least "8" to the question regarding satisfaction.	Results: 93%
Recommendations/Action taken: The program will continue to measure stakeholder satisfaction. We feel this is a valuable to program development and enhancement.	Performance improvements: We have decided to change the method of obtaining stakeholder satisfaction to that of a focus group. The events will be held during the 1st & 3rd quarters. Staff will meet with and become better acquainted with employers. Hopefully, this will assist with any issues of possible miscommunication and create additional employment opportunities.

<u>PREVENTION OUTCOMES</u>

Access Objective: 100% of consumers will be approved for admission into the CONNECT program within 5 business days of request for services.	Results: 100%
Recommendations/Action taken: Staff will move youth from waiting list at Connect sites as space becomes available due to non-attendance or participants moving out of the community.	Performance Improvements: Staff maintained and managed a waiting list when programs reached capacity.

Effectiveness Objective: 95% of CONNECT of 1st – 3rd grade participants shall be reading on or above grade level.	Results: 62%

Recommendations/Action taken: Evaluate impact of lowering the age for program participants and increase academic resources for the program (i.e., tutors/mentors, additional staff training in academic support, increase parent support for academics, community partnerships)	Performance Improvements: Additional staff, training and community resources needed to bolster academic programming.

Efficiency Objective: Students will show a decrease in favorable attitudes towards Alcohol, Tobacco and other Drugs (ATOD) as demonstrated by the evaluation outcomes of evidence-based curriculums implemented in the community.	Results: 100% of 1-2nd graders, (pre 100% and post 94%) 77% of 3-5th graders (pre 65% and post was 77%).
Recommendations/Action taken: Continue reinforcement of ATOD prevention messages and activities. Prevention staff, in collaboration with HCPS and CVS, developed a supplement to the Life Skills Training curriculum focused on prevention of Rx drug abuse for middle and high school students.	Performance Improvements: 100% of 1-2nd graders reported unfavorable attitudes toward substance use after participating in the Al's Pals curriculum. 77% of 3-5th graders reported unfavorable attitudes toward substance use after participating in the Life Skills training curriculum compared to 65% prior to receiving the curriculum. There was a significant decrease in youth's ambivalence toward substance use after receiving the curriculum.

Efficiency Objective: Prevention Services shall implement environmental approaches, in collaboration with community partners, to address substance use prevention and mental wellness as measured by the delivery of a social norms campaign and/or merchant education activities annually.	Results: Two campaigns occurred during the year.
Recommendations/Action taken: Continue focus on environmental strategies addressing substance use issues in an effort to reach large populations with prevention messages and resources.	Performance Improvements: Staff will work with diverse group of youth and parents across the metro area to develop a social norms campaign to address the risks of marijuana use, and opioid abuse.

Consumer Satisfaction Objective: 85% of CONNECT participants (3rd grade and above) shall give a response of 1 (i.e., agree) on the satisfaction survey.	Results: 91%
Recommendations/Action taken: Coordinator will continue program planning with p/t staff considering input from youth.	Performance Improvements: Integrate youth feedback into program planning as feasible.

Stakeholder Satisfaction Objective: 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree that program is beneficial) on the satisfaction survey	Results: 98% Parents, 90% Community
Recommendations/Action taken: Continue promoting communication between families, schools and communities. Keep all stakeholders informed about Connect program objectives and activities.	Performance Improvements: Increase engagement with parents/families to promote increased involvement in Connect and schools.

<u>YOUTH & FAMILY OUTCOMES</u>

Efficiency Objective: Youth &Family Services Outpatient clinicians will schedule their clients within 14 days of their Initial session 90% of the time.	Results: 92%

Recommendations/Action taken: Assignment issues during the first quarter were corrected. Overall services were scheduled fewer days from intake for Youth and Family services. This is consistent with our earlier outcomes and are related to implementation of Same Day Access for intakes.	Performance Improvements: We averaged meeting the access objective (seeing clients within 14 days of initial session) 92% of the time this fiscal year. During Q4 we met it 98% of the time seeing all 131 clients well within the 14-day period.

Efficiency Objective: Newly opened case management clients will receive a minimum of 3 hours of case management services within the first 60 days of service to be considered engaged.	Results: 52%
Recommendations/Action taken: The agency and the state data are not consistent, and this has been a continuous issue. At this current time the state has not offered how they are gathering their data in a way would facilitate the agency replicating the data. Over this year the number of case management cases opened has increased significantly many of these cases are also receiving outpatient therapy which is not captured in this data.	Performance Improvements: The supervisory team continues to work with staff regarding initial engagement into services. This information will be used to continually look at how we are engaging case management clients in those first months of services.

Consumer Satisfaction Objective: Reoffending rates will remain at or below 10% for MST clients during the course of treatment.	Results: 15%
Recommendations/Action taken: Looking forward to FY19, focus will be on efforts to ensure regular communication between MST and court services staff and continued efforts to identify alternative to placement of youth served. There were also fluctuations in caseload sizes which may impact consistency of service delivery. Efforts to increase and maintain caseloads have demonstrated some success as the relationship with AMIKids grows. Percentage of youth linked with prosocial activities held steady at 67% which remains a focus for the program.	Performance Improvements: It should be noted that CSU is focused on referring only youth with moderate and high-risk levels to MST, which typically means that youth have demonstrated and documented high need. This may place them at higher risk for out of home placement and reoffending before they are referred to MST.

DBHDS PERFORMANCE DASHBOARD

Performance targets are set by the DBHDS and the Secretary for all 40 of the State's Community Service Boards. The data used is submitted monthly by CSBs as outlined in the State's performance contract with CSBs. HAMHDS met 3 of 5 Behavioral Health Quality targets points throughout the year and DD Quality met all 7 targets by the end of FY18. At times measures were difficult to meet due to many reasons, i.e. shorter treatment program durations, movement of the recording of the services into Same Day Access, staff turnover, increased caseloads and increased documentation requirements. The DBHDS Performance Measures have been incorporated as another component of the Agency's Continuous Quality Improvement Plan. If targets are not met, those measures may be adopted and become a program outcome so that trends and development areas be identified and pursued. For the coming year DBHDS announced the collection of new data and measures for FY18.

Post Discharge Survey

Post discharge information is collected for CARF services. The post discharge surveys are mailed approximately 30-60 days after the client is discharge from a CARF service. At least two questions are asked in each survey, including a satisfaction question and a question that refers back to the program goals. Survey questions are reviewed and updated as needed on an annual basis to correspond with the current goals and objectives. In order to complete a timely annual report, the reporting period covers the period of April 1, 2017 through March 31, 2018.

During this fiscal year, ten separate services were tracked. A total of 365 surveys were mailed and 14 were returned. The response rate for programs ranged from 0% to 14% with an average response rate for all of the CARF services of 4%, up from the response rate of 8% for FY17. Individual comments are forwarded to the respective program.

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

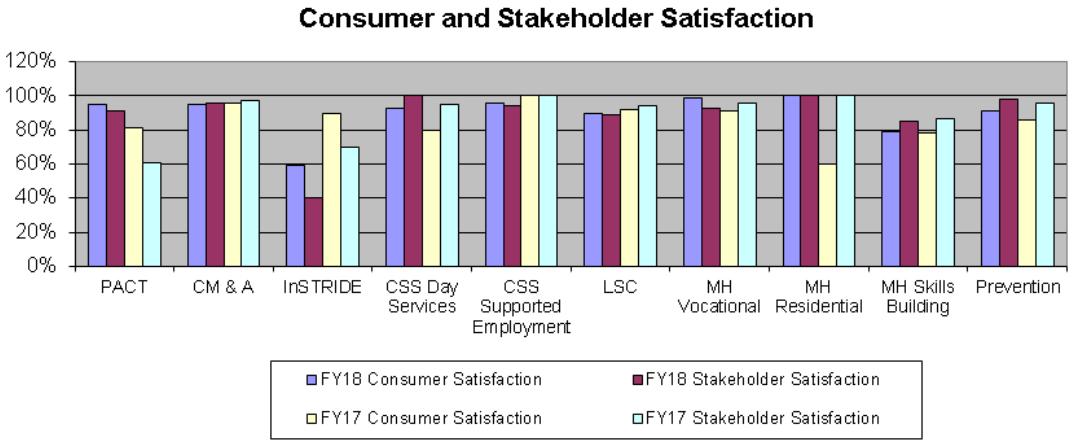
FY2018 ANNUAL POST DISCHARGE REPORT

Unit	SubUnit	HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Discharges by Program (Apr 2017 - Mar 2018)																
1300	HCE1,HCPF,HCW1&2	CM&A	MH Case Management	19	20	18	15	22	14	15	17	32	24	22	35	253
1301	HACF,HACW,HYAR	PACT	Assertive Community Treatment	3	4	3	2	3	1	2	2	0	4	5	7	36
1302	HDLH	MH Day Support	MH Community Integration	2	0	1	4	1	2	3	2	4	4	3	3	29
1303	HRTO	MH Residential	MH Community Housing	0	0	0	0	0	0	0	0	0	0	0	0	0
1304	HSEL	MH Vocational	MH Community Employment	2	1	1	1	0	0	1	1	1	1	1	3	13
1306	HSSW, HSSE, HSSP	MH Supported Svcs	MH Supported Living	2	7	2	1	3	1	0	0	1	0	1	4	22
2001	RDST,RDEP,RDNW	LEP	ID Community Integration	0	0	0	0	0	0	0	0	0	0	0	1	1
2002	RSEU	ID Supp Employ	ID Community Employment	0	0	0	0	1	1	1	0	1	2	1	0	7
2007, 2008	RDSH, RDSC, RDSP, RDHE, RDCY	Sheltered Employ	ID Organizational Employment	0	0	1	1	0	0	0	0	1	1	0	0	4
2008	RSGE, RSGH, RSGW, RDEN	ID Group Supp Empl	ID Community Employment	0	0	0	0	0	0	0	0	0	0	0	0	0
Total				**28**	**32**	**26**	**24**	**30**	**19**	**22**	**22**	**40**	**36**	**33**	**53**	**365**

Unit	SubUnit	HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Response Rate%
Survey Response Rates (Apr 2017 - Mar 2018)																	
1300	HCE1,HCPF,HCW1&2	CM&A	MH Case Management	2	2	2		1			1					8	3%
1301	HACF,HACW,HYAR	PACT	Assertive Community Treatment					2								2	6%
1302	HDLH	MH Day Support	MH Community Integration			1										1	3%
1303	HRTO	MH Residential	MH Community Housing													0	0%
1304	HSEL	MH Vocational	MH Community Employment													0	0%
1306	HSSW, HSSE, HSSP	MH Supported Svcs	MH Supported Living		1	2										3	14%
2001	RDST,RDEP,RDNW	LEP	ID Community Integration													0	0%
2002	RSEU	ID Supp Employ	ID Community Employment													0	0%
2007, 2008	RDSH, RDSC, RDSP, RDHE, RDCY	Sheltered Employ	ID Organizational Employment													0	0%
2008	RSGE, RSGH, RSGW, RDEN	ID Group Supp Empl	ID Community Employment													0	#DIV/0!
Total				**2**	**3**	**5**	**0**	**3**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**14**	**4%**
Response Rate				**7%**	**9%**	**19%**	**0%**	**10%**	**0%**	**0%**	**5%**	**0%**	**0%**	**0%**	**0%**	**4%**	

Agency Satisfaction Survey

HAMHDS directly conducted Consumer and Stakeholder satisfaction surveys in CARF programs. Results below indicate all responders report a satisfaction rate with services between 40% to 100%, with the majority of responses indicating at or above 89%. Seven programs demonstrated an increase in consumer satisfaction ratings, and three programs demonstrated an increase in stakeholder satisfaction.



INTERNAL AGENCY RECORD REVIEWS

CSS RECORD REVIEW RESULTS SUMMARY

FY 2018 CSS RECORD REVIEW RESULTS SUMMARY

Target for All Programs is 90%

	FY2018	FY2017	Comments
NORTH 1 WAIVER	88%	na	↑ 7 percentage points from FY16
EAST 1 WAIVER	90%	na	↑ 4 percentage points from FY16
EAST 2 WAIVER	88%	na	↑ 3 percentage points from FY16
WEST 1 WAIVER	94%	na	maintaining 90+ compliance
WEST 2 WAIVER	89%	na	↓ 2 percentage points from FY16
NORTH 1 SPO	92%	na	↑ 3 percentage points from FY16
EAST 1 SPO	97%	na	↑ 18 percentage points from FY16
EAST 2 SPO	82%	na	↓ 9 percentage points from FY16
WEST 1 SPO	96%	na	maintaining 90+ compliance
WEST 2 SPO	94%	na	↑ 9 percentage points from FY16
DD CM HAMHDS	93%		DD CM started reviews in Oct 17
HERMITAGE VOC	88%	92%	↓ 4 percentage points from FY17
CYPRESS VOC	97%	96%	maintaining 90+ compliance
ENCLAVES	97%	94%	maintaining 90+ compliance
LEP	93%	95%	maintaining 90+ compliance
STEP	98%	95%	maintaining 90+ compliance
SUPPORTED EMPLOYMENT	96%	95%	maintaining 90+ compliance
RESIDENTIAL	86%	83%	↑ 3 percentage points from FY17
ID ADMINISTRATIVE	92%	91%	maintaining 90+ compliance

Represents area in compliance 90% or better

Represents areas where results are below 85%, in BOLD is under 80%

Represents areas that improved by more than 5 percentage points

Represents areas that improved by 1-4 percentage points (not done in 90%+ range)

MH/SA RECORD REVIEW RESULTS SUMMARY

FY 2018 MH/SA RECORD REVIEW RESULTS SUMMARY

Percentage represents compliance with standards reviewed

Target for All Programs is 90%

	FY2018	FY2017	Comments
ESP/PRESCREENING	95%	96%	maintaining 90+ compliance
SAME DAY ACCESS EAST	96%		SDA started reviews in Nov 17
SAME DAY ACCESS WEST	96%		SDA started reviews in Nov 17
YOUTH & FAMILY	93%	90%	maintaining 90+ compliance
MHOP EAST/WEST	96%	96%	maintaining 90+ compliance
MHOP/SA/YOUTH PF	91%	91%	maintaining 90+ compliance
SA EAST	93%	93%	maintaining 90+ compliance
SA RMP	94%	91%	maintaining 90+ compliance
LAKESIDE CENTER	99%	85%	↑ 14 percentage points from FY17
LAKESIDE CTR VOC	92%	92%	maintaining 90+ compliance
PACT EAST	88%	87%	↑ 1 percentage points from FY17
PACT WEST	90%	83%	↑ 7 percentage points from FY17
CM&A EAST	89%	86%	↑ 3 percentage points from FY17
CM&A WEST 1	82%	84%	↓ 2 percentage points from FY17
CM&A WEST 2	92%	87%	↑ 5 percentage points from FY17
CM&A PF	91%	89%	↑ 2 percentage points from FY17
MH SKILLS-BUILDING WEST	94%	95%	maintaining 90+ compliance
MH SKILLS-BUILDING EAST/PF	96%	93%	maintaining 90+ compliance
MH RESIDENTIAL	94%	96%	maintaining 90+ compliance
PHYSICIAN	85%	86%	↓ 1 percentage point from FY17
MH ADMINISTRATIVE	92%	95%	maintaining 90+ compliance

Represents area in compliance 90% or better

Represents areas where results are below 85%, in BOLD is under 80%

Represents areas that improved by more than 5 percentage points

Represents areas that improved by 1-4 percentage points

EXTERNAL AGENCY REVIEWS

	FY18	FY17	FY16
Total number of Reviews:	82	44	75
Admin:	1	1	2
C&P:	33	14	29
CSS:	37	26	33
Across All Divisions:	11	3	11
# of Desk Reviews	74	39	64
# of Onsite Reviews	8	5	11
# of C&P/CSS from Licensure review	28	N/A	
# of C&P client records reviewed	61	33	-
# of CSS client records reviewed	381	76	
Total number of records reviewed	470	109	-

Trends/Outcomes

- Reviews were sent by secure email exchange, Cisco and new this year Virtru
- 100% of reviews were completed within the specified timeframes
- Reviews increased by 50%

External Reviewers

Magellan on behalf of DMAS (Department of Medical Assistance), DBHDS (Virginia Department of Behavioral Health and Developmental Services), HHS (Department of Health and Human Services), DOJ (Department of Justice), VHDA (Virginia Housing Development Authority), National Core Indicators Survey (NCI), Va Premier, Delmarva, Anthem BC/BS (Inovalon), Anthem Health Keepers (Altegra, CIOX), Myers and Stauffer for DMAS, Office of Attorney General, Office of Human Rights, Cigna, County director of Internal Audit, Aetna (Episource), CBBG, CMS (Center for Medicare and Medicaid)

Types of Reviews

Mortality Reviews, SIS (Supports Intensity Scale), HEDIS, Risk adjustment-Dx coding, Medical Records (Colorectal Cancer, Comprehensive Diabetes Care) , Quality of Care Review, Medical Record Review Initiative, Homicide Review, Human Rights Retrospective, ISR-Individual Services Review, Supervisory Review, Quality Improvement Initiatives, QMR-Quality Management Review, Complaint, Coordinated Care Model, Program Integrity- Environmental Modification and Assistive Technology, Medical Fraud Investigation, Self-Assessment, Licensure Review, SEMAP/HQS Inspections, Timely Initiation of Services and Transition

Goals

- Meet all audit deadlines
- Review new methods of tracking audits

RISK MANAGEMENT COMMITTEE SUMMARY

The twelve members Risk Management Committee met on a quarterly basis to monitor the risks and accessibility needs of the organization. The committee is responsible for the development and monitoring of the agency's risk management and accessibility plan. Yearly these plans are summarized and reviewed with the agency leadership group and posted on the public intranet drive for staff access.

Committee highlights: An individual receiving services from Hermitage Enterprises is an active member of the committee and regularly provides input, meet with and reviewed plans with Henrico County Risk Management in November 2017; provided input to the bed bug workgroup, shared facility needs list and project updates , another handicapped accessible door installed at Hermitage, shared updates on the design of the new East Center, upgrades occurred for agency phone from flip phones to smart phones, new EHR purchased, reviewed regulations and external requirements, provided falls training on 5.10.18 entitled why falls happen and how to prevent them, discussed the incident review committee's quarterly reports, agency gathered a workgroup to prepare the agency as services moved from a fee for services delivery model to a managed care model with six managed care organizations in September 2017, and discussed the work of the agency's safety committees. In FY19 the Department of Behavioral Health and Developmental Services as part of their new Office of Licensing regulations will require all licensed providers to complete an annual risk assessment and written plan. Currently the risk management and accessibility plans meet CARF requirements and additional elements will be added for licensure compliance.

CRITICAL INCIDENTS AND COMPLAINTS

Critical incidents were reviewed regularly each quarter. The agency continues to provide education and training to support staff in their duties.

Incident Type *	FY17	FY18
Assault by client	10	5
Behavioral incident	29	11
Biohazard incident/bomb threats	0	1
Communicable Disease	0	0
County vehicle*	8	4
Death-accidental	3	6
Death-likely homicide	0	1
Death-likely suicide	5	3
Death-natural causes	21	30
Fall- with injury requiring med.	12	29
Fall- without injury	40	44
Fire	1	0
Illness (e.g. seizure, diabetic	26	27
Licit/Illicit drugs or weapons	0	0
Med incident- req. med. Attn.	0	0
Med incident- NO adverse reaction	22	23
Other	24	20
Property damage	4	6

Brief Description of "other"	FY18
mental status change	3
missing client	7
client left program	1
First Aid	4
choking	1
missing medication	1
behavior	2
security	1
Total	20

Property loss/theft	4	9
Self-injurious behavior	11	9
Serious injury	1	2
Sexual incident	2	1
Suicide attempt	25	37
Threats/violence	1	0
Violent crime by client	0	0
Totals	249	268
Restraints	1	1

Trends and Observations

- Suicide attempts increased. CSS services added a suicide protocol this year. This will be an area we continue to monitor.
- With an aging population, deaths from natural causes have increased.
- Falls with injury requiring medical attention had a large increase -these were reviewed with no trends noted. Training "Why Falls happen and how to prevent them" was offered to all staff as a result of the consistent data on falls.
- Assaults by clients and behavioral incidents were down by 50%.

Goals

- Meet new Office of Licensing requirement to complete root cause analyses within 30 days.

STAFF TRAINING

Agency employees have the opportunity to obtain training through a number of venues to include the County of Henrico Employee Development and Training, Risk Management, Human Resources Department 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 MyTraining account.

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

Henrico Area Mental Health & Developmental Services has a group of 34 staff trainers that provide training in a variety of areas such as First Aid & CPR, Prevention of Violence (POV), Therapeutic Options, Cultural Competency, Brown Bags, Wellness series; My side of the Story, MH First Aid, EHR and other professional training.

Approximately 93 classroom style training sessions were offered. Staff register for training directly through the use of an internal web-based system known as MyTraining.

Examples of training offered included; Brown Bag - Autism 101, My Side of the Story: Jail Diversion, Balancing Act - The Musical, My Story - Moses Harris from Liberia, Substance Use 101, Growing Up Mennonite, Wolf Creek Cherokee Tribe, Substance Use 101+ Clinical supervision for SUD, DOL Training & 14C Certificate, Documentation Training (Including H Drive & ISPs), My Side of the Story: Same Day Access, Balancing Act - The Musical, The Healing Power of Music , Building your team's morale and spirit, DMAS webinar training for the transition to CCC Plus from CMHRS, Brown Bag - Network of Care The 7 Core Issues of Adoption and how they impact adoptees, adoptive parents and birth parents, Building your Team's Morale and Spirit, Bayard Rustin, Tracing Your Roots , 13th Amendment Documentary- Abolishing Slavery, Black Art Painting, Integrating Behavioral Health for Adolescents with Chronic Illness, Cyracom/Language Access Webinar, Applying for Disability Benefits, Long Term Services and Supports for Persons with Brain Injury, My side of the story; Vocational Services, Developmental Disabilities On TV, The Art of Writing, Refugee Population in Henrico, Overview of REACH Services, Applying for Disability Benefits, PREVENT-A-THON, Working with Hispanic Latinx Clients and Families, Understanding Millennials, Substance Exposed Infants and Their, Mothers: laws, treatment, our process, Why Falls happen and how to prevent them, Mental Health in Henrico Refugee Populations, HPO Series: Emotional Intelligence - A Deeper Look, Cultural Competency - Current Events, Ethics Training: The Intersection of Ethics and Cultural Competence, Navigating Through the Challenges to, Strengthen Emotional Connection, Powers of Attorney, Advanced Directives/Health Care Powers of Attorney, and Guardianships, Ethical Implications in Risk Assessment

Accomplishments

- New Red Cross purchases included; 6 Adult and 15 Child replacement pads, 200 combination training packs, 200 face shields/lung bags, sanitizing wipes
- Downloaded the Red Cross course presentations for staff trainers, gaining easier access to training materials
- Researched all required programs to confirm employee CPR/FA certificates are in their HR record
- Updated Prevention of Violence training
- 2 new Prevention of Violence trainers
- 3 new Therapeutic Options trainers
- Recertified 3 Therapeutic Options trainers

Goals

- Certify 4 new Red Cross trainers
- Create Competency based Prevention of Violence test
- Update the Prevention of Violence PowerPoint
- Recertify 4 Therapeutic Option trainers

INFORMATION TECHNOLOGY

The Information Technology Plan is reviewed periodically to assess the progress of projects and update their timelines as needed. Accomplishments and initiatives of the past year and update accordingly. For FY18 the team was a part of the agency wide initiative selecting a new electronic health record system. During this year the implementation project also kicked off with requirement gathering and customizing the EHR as per the agency need.

Additional accomplishments include:

- Program outcomes reporting for program performance measures
- Expanded Public WIFI
- Install Cisco Jabber: Cisco Jabber allows Same Day Access and Emergency Service the ability to connect workstations to Cisco Endpoints directly without scheduling a Cisco WebEx meeting. The feature allows staff to assess clients quicker.
- IRIS Critical Incident Reporting enhancement and additional sampling routines for chart reviews
- Automated ID dashboard productivity reports
- Implementation of CCC+ and setup in the EHR
- System set up: Cerner (Pay sources/Benefit Plans, Billing and Authorization rules), Insurance Sweep for submission of authorization
- MCO Portals: Set up accounts and identify agency users and purpose of using portals.
- Verification of clients MCO coverage
- Establish Business Process for updating clients accounts and transition continuity of care (Administrative and Clinical)
- Auto Sampling Medical Record Reviews: Added, extended the chart tracker sampling algorithm to support new programs and the particular characteristics relevant to those programs. For example, sampling across clients that are Medicaid and non-Medicaid.
- Medical Provider Communication form: ITS worked on this project with clinical staff to develop form that could be used as a pilot for the youth and family doctor and later to be rolled out as functionality that other prescribers could use.
- SAMHSA Grant, Integrated Health Care: We submitted our second submission for the SAMHSA grant for integrated health care. The IT department assisted in obtaining the necessary information that needed to be provided for reporting in relation to the grant to mathmatica. Worked with both the daily planet staff and staff at Richmond Behavioral Health to get all the information together for submission performing quality performance of data gathered prior to submission due date.
- Opioid Jail Diversion: IT staff participated on project committee to implement the Opiate Jail diversion services. IT staff assisted in writing policy related to this business process, set up service codes and units and sub units to track this service activity and also continues to report to DBHDS weekly the number of clients that are seen at our agency for this service provided through the grant.
- Same Day Access (SDA): IT staff continued last year to work on reporting related to Same Day Access by providing reports and have implemented new forms that are used by business staff to report outcomes related to time of first offered appointment and accepted appointment. IT staff report these outcomes quarterly to program staff and management.

Goals

- Windows 10 Implementation: Install, deploy windows 10 PC and train staffs
- Successfully Implement Welligent EHR system

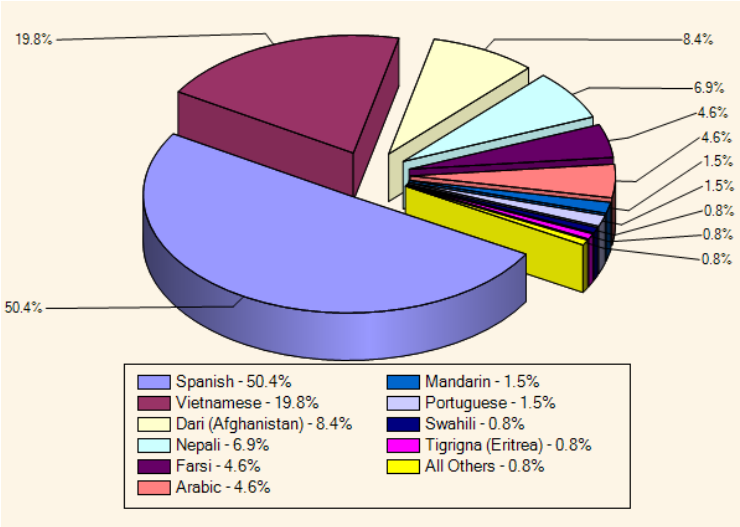
- System Configuration and Setup
- Data Extract, Transform and Load
- Process integration with new EHR
- Implement WaMS/VIDES and CCS3 reporting in Welligent
- Implement specialized program modules (Lakeside Center and ID Day Services)
- OBOT setup and configuration

- Successfully test and promote Cerner to run the CCS3 extract as well as submit the data using the new state software
- Develop new County Manager Report
- IRIS Critical Incident Reporting enhancement and added root cause analysis
- Automate the Dashboard productivity reports for MH/SA
- SPQM implementation/data interface with Welligent
- Successfully bring Cerner to ready only mode at Welligent go live and keep Cerner running for data retrieval purposes.
- Implement Medallion 4
- Review and update intranet and internal apps to reflect new processes due to EHR changes

CULTURAL AWARENESS AND COMPETENCY COMMITTEE SUMMARY

The cultural competency and awareness committee (CACC) meets approximately every six weeks to implement the annual CACC plan. The committee has representation from each division and representatives from the agency's leadership group and management team. The agency requires all staff to gain yearly cultural and/or linguistic training annually. At least monthly opportunities are available to staff to meet this requirement including training for new staff on sensitivity and awareness class and classes on the cultural aspects of our community. Highlights from this year's training includes; growing up Mennonite, presentation by the Wolf Creek Cherokee Tribe of Virginia, suggested book readings for black history month, a workshop on tracing your roots by a local genealogist, Judy Ledbetter, painting classes on afro-art, overview of refugee population in Henrico from a professor at VCU Dr. Hyojin Im, understanding millennial, working with Hispanic LatinX client and families by Dr. Rosa Morales and the intersection of ethics and cultural competency by Dr. Lisa Moon. The committee also planned an agency event to bring all staff together; this year's gathering was a cook-out celebrating employee's fashion, music, dances and other aspects of their favorite decade. Interpreters used by the agency were posted on the agency's intranet page with contact information and rates. Cyracom, the

Percentage of Cyrcam Calls by Language, Top 10 Languages



contract language service, also provided an in-service on working with interpreters. According to Cyracom the top ten languages requested were Spanish, Vietnamese, Dari, Nepali, Farsi, Arabic, Mandarin, Swahili, Portuguese and Brazil-Portuguese. The committee tracks demographic data related to Henrico, Charles City and New Kent counties, persons served and employees that is documented in the CACC report. In FY19 the agency will celebrate its 25th anniversary of cultural awareness. The CACC committee began its work in 1993 and in FY19 will celebrate this accomplishment quarterly across various agency locations.

Language Comparison with County of Henrico and State of Virginia

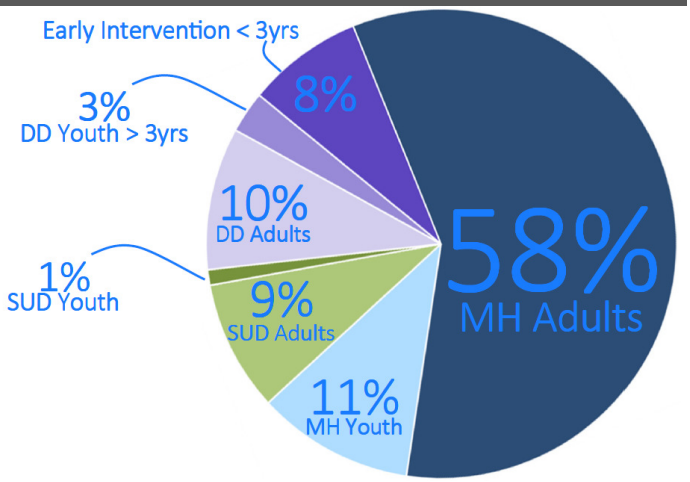
Order/Frequency	Seen within Agency	Within Henrico County*	State of Virginia**
1.	English	English	English
2.	Spanish	Spanish	Korean
3.	Other	Other / Asian	Vietnamese
4.	Arabic	Arabic	Chinese
5.	Chinese	Chinese	Arabic
6.	Farsi	Vietnamese	Tagalog
7.	Vietnamese	Hindi	Farsi/Persian

**Data Source: StatisticalAtlas - https://statisticalatlas.com*

***https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15-non-english-by-state-MM-508_update12-20-16.pd*

DEMOGRAPHICS

Total Consumers Served by Program Area



9,976 individuals were served in FY18.

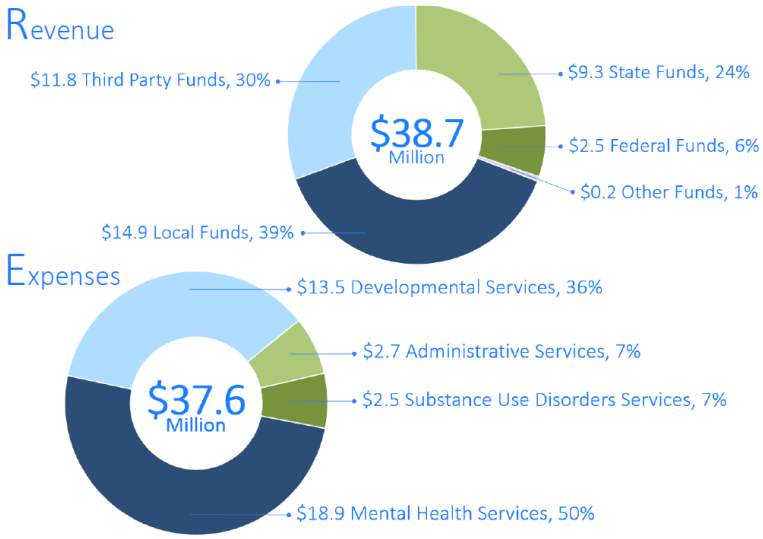
For adults: 58% received Mental Health Services, 10% Developmental Disability Services and 9% Substance Use Disorders Services.

For youth: 11% received Mental Health Services, 3% Developmental Disability Services, 1% Substance Use Disorders Services and 8% Early Intervention < 3-year olds.

Consumers Served by Gender: Fifty-seven (57) percent of individuals served in were male, and 43% served were female.

Distribution by Race and Ethnicity: 46% served identified themselves as White/Caucasian, 43% Black/African American, 11% Alaskan Native, American Indian, Asian, Pacific Islander, Multi-Racial.

BUDGET



FY18 Revenue	
Local Funds	$ 14,917,422
Third Party Fees	$ 11,771,624
State Funds	$ 9,277,083
Federal Funds	$ 2,465,364
Other Funds	$ 223,227
Total	$ 38,654,720

FY18 Expenses	
Mental Health Services	$ 18,949,092
Developmental Services	$ 13,501,935
Administrative Services	$ 2,675,834
Substance Use Disorders Services	$ 2,530,021
Total	$ 37,656,882