ANNUAL PERFORMANCE ANALYSIS 2018-19

CELEBRATING 50 YEARS

HENRICO AREA

MENTAL HEALTH &

DEVELOPMENTAL SERVICES

SERVING THE COUNTIES OF HENRICO, CHARLES CITY & NEW KENT

MANAGEMENT SUMMARY

As we celebrate our 50th anniversary, Henrico Area Mental Health & Developmental Services (HAMHDS) is pleased to present our Fiscal Year 2018-19 Annual Report, which highlights the agency's years of service and exhaustive efforts to provide the innovative programs and initiatives of today. These initiatives have strengthened the quality of care for individuals with mental illness, substance use disorders and developmental disabilities. Thanks to the hard work and dedication of the HAMHDS staff both past and present, the amazing partnerships with many community organizations and the support of our stakeholders, we celebrate and share our accomplishments.

The doors opened for business at the new East Center located at 3908 Nine Mile Road on June 24, 2019. This office replaces a building we had outgrown and offers welcoming, bright, beautiful space that was designed and built with intentionality and care. It affirms the deep commitment that staff and Henrico County officials have to the individuals who enter these doors.

In this report, you will see remarkable stories that show resiliency, recovery, inclusion, wellness, independence and the successful impact of person-centered services. It highlights employment, Office Based Opioid Treatment and Medication Assisted Treatment, Multisystemic Therapy, Case Management, Skill Building and Housing Services.

The 2019-2022 Strategic Plan was completed for the agency. It was developed through a collaborative process of learning and planning based on input from stakeholders, individuals we serve, family members, community partners, CSB Board members and County and HAMHDS employees. Input was captured through a series of meetings, surveys and interviews. We took into account our changing environment and developed initiatives that will position us well for the future. Our initiatives include implementation of STEP-VA, fully maximizing our new electronic health record and developing and implementing a county-wide approach for individuals with substance use disorders.

This year, the agency received three National Association of Counties (NACo) achievement awards for Opiate Jail Diversion, Reducing Re-hospitalization Rates: Same Place Access, and Life Enrichment for those Aging with Developmental Disabilities. Early Intervention was awarded the Collaboration Award by Commonwealth Autism. These awards reflect a sample of the innovative work and commitment to excellence that can be seen throughout the agency.

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

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

VISION & VALUES

We serve people experiencing the effects of or at risk for mental illness, developmental disabilities and substance use disorders and children with developmental delay. Henrico Area Mental Health & Developmental Services (HAMHDS) promotes dignity, recovery and self-sufficiency in the lives of the people we serve.

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 FY19 cross functional workgroups completed their work on the 2016-2019 strategic initiatives.

FY19 Accomplishments Provide Same Day Access (SDA)

Same Day Access to services was implemented on April 20, 2017 at our East and Woodman Road Offices. The program is staffed with 6 full time licensed therapists and 1.5 clinical supervisors. Implementation of Same Day Access took a coordinated effort by administrative/business staff and clinical staff to ensure that individuals seeking services were seen quickly and left their first appointment with a clear idea of clinical recommendations, and clear idea of what services would cost. Same Day Access has also required considerable coordination between the Same Day Access staff and Emergency Services staff to ensure appropriate treatment for individuals presenting for services who are experiencing an immediate psychiatric crisis. Same Day Access staff have successfully used tele-health as a means to manage periods of high demand and linking individuals to crisis clinicians.

During fiscal year 2019, Same Day Access staff conducted over 2,500 assessments, averaging approximately 215 assessments each month. Same Day Access has expanded its role in the agency in order to better meet the needs of individuals court referred for evaluation. Same Day Access staff have also participated in a specialized Same Place Access program. Same Place Access was designed to reduce re-hospitalization rates of individuals involuntarily committed to inpatient treatment. Early results of this program have shown significant progress, and the program was recently recognized by the National Association of Counties.

FY19 Accomplishments Explore Electronic Health Records Systems (EHRS)

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. The implementation process continued through the year with system set up, data migration testing, training, forms development and conducting business process reviews. Because of the Welligent functionality, forms were decreased from about 400 to about 200. 40 business process reviews were identified. The Cerner process was submitted to Welligent and they began to write the Welligent processes; some were reviewed with the programs in June. Super user training was conducted in November. More training, specifically around system configuration and functionality was also conducted.

Goals/Action Plans for upcoming year:

System configuration, data migration iterations and testing will continue to occur July – December. Business Process Reviews (BPRs) will be conducted with program staff July – September. Training materials will be developed from the BPRs. Training will occur the month before go live. WaMS development and testing with the State will happen July – September, with the expectation that this part of the Welligent product will be available in October. A final project plan is expected to be rolled out in October. An official Go Live will be determined at that time. The Patient Portal, Meaningful Use functionality and reporting will be implemented post Go Live. Further training and other functions of the system will be brought on throughout the spring of 2020.

FY19 Accomplishments To assure the provision of high quality services for individuals with Developmental Disabilities

- Continue to look at current statewide processes, barriers, and best practices.
- Continue to advocate recruitment of a Positive Behavior Support facilitator, Mental Health Clinician and DD Case Managers with experience serving the developmental disabilities population to provide needed strategies and supports to help decrease the likelihood of hospitalization and to establish/ maintain stability with in the community.
- Posted information on HAMHDS Intranet website for staff access to learn/understand more about DD Case Management and support services.
- Maintained DD Resources Directory.
- Team members continue to share information regarding dually diagnosed DD/MH to increase awareness and advocacy for needed resources.

2019-2022 Strategic Initiatives

The agency continued to follow their strategic planning road map and developed new strategic initiatives for the next three years.

1) To implement DBHDS state wide initiative STEP Virginia

Overview:

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is implementing a state wide System Transformation Excellence and Performance initiative (STEP-VA) to provide access to Virginians to core behavioral health and substance use services regardless of where you live. Developmental Disability Services will also be impacted based on the implementation of these initiatives. STEP-VA is designed to improve the community behavioral health services to all Virginians by July 2021.

Committee Objectives:

- Participate in State wide assessment of BH Services
- Evaluate the nine steps of STEP Virginia (Same Day Access, Primary care screenings, Outpatient Behavioral Health Services, Behavioral Health Crisis Services, Peer/family support Services, Psychiatric Rehabilitation, Veteran Behavioral Health, Case Management for adults and Children, Care Coordination) and implement those STEPs that align with the agency's vision
- Assess the implications of the combination of the DMAS Redesign, STEP-VA and the results of the State wide assessment on the agency's infrastructure
- Evaluate the need for restructuring to meet the implementation needs of STEP VA
- Educate staff and stakeholders of STEP VA

2) To implement Welligent and fully maximize its capabilities

Overview:

Welligent is new to behavioral health and developmental services in the State of Virginia. Welligent is developing capabilities to meet the full needs of all of our services with the intent of becoming fully electronic. Maximizing it's use to the fullest will increase agency efficiency and effectiveness. Understanding how Welligent works will move the agency to more data driven decision making.

This strategic objective has two phases; Phase one is continuing from the previous strategic initiative to implement Welligent, phase two will be to fully maximize the capabilities of Welligent. The current implementation work group will continue to work on phase one. Once implemented a new workgroup will implement phase two. Phase two work group members will not be identified until phase one is completed.

Committee Objectives:

- Work with Welligent to refine software
- Train Staff
- Implement Welligent

3) Substance Use Disorder Recovery Transformation

Overview:

The County of Henrico is committed to developing a comprehensive multi departmental approach to meeting the needs of Henrico residents who are involved in the legal system and primarily in need of substance use services. The focus is multidimensional to include education, prevention, jail diversion and expansion of services.

Committee Objectives**:**

- Participate on the County of Henrico multi department workgroup (known as the Recovery Roundtable) and Implement recommendations approved by the committee
- Expand prevention services within the community
- Increase substance use disorder services in Henrico, Charles City and New Kent Counties
- Continue to advocate for the services and treatment of all substances
- Increase awareness of all of the substance misuse within our three counties

- Reduce the number of individuals with substance use disorders involved in the legal system

FY19 ACCOMPLISHMENTS/ FY20 GOALS

Administration Accomplishments

- Completed the deployment of over 200 laptops including LSC and Hermitage Enterprises
  - Planned system set up, including program, security and billing & authorization modalities and configured the system
  - Identified and completed appropriate templates for data conversion
  - Map the systems interfaces and extracts
  - Created over 200 Forms
  - Worked with Welligent on developing required State Reporting
- Completed building the East Center
  - Ordered all new furniture for the building
  - Working with County IT to ensure state of the art wiring, Wi-Fi, telecommunications capabilities
  - Opened the new Center on time, June 24, 2019, with a ribbon cutting ceremony on June 27.
- Implemented Medallion 4
  - Worked with the MCOs to establish a smooth credentialing process with each of them.
  - Built and tested billing modalities
  - Ensured that eligibility is verified as clients come in the front door
  - Created forms and system sweeps for Authorizations
- Implemented Medicaid Expansion
  - Worked with the MCOs to establish a smooth credentialing process with each of them.
  - Built and tested billing modalities
  - Ensured that eligibility is verified as clients come in the front door
  - Created forms and system sweeps for Authorizations
  - Senior Controller served on the State Advisory Council and was part of the pilot to report Medicaid Expansion revenue
- Developed MH productivity reports to aid the programs in reaching their State Dashboard goals
- Implemented SPQM
- Added second monitors to improve work efficiency to 125 computers
- Enhanced the iRIS functionality to respond to increased state reporting requirements
- Implemented the Governor's interoperability initiative with emergency rooms via the EDCC Premanage program
- Completed the OBOT administrative parts for implementation (billing, credentialing, etc.)
- Replaced a roof at one home, gutters at 3 homes, improved lighting, indoors and outside of various locations, added outdoor security cameras to Providence Forge and Lakeside Center
- Created auto-sampling to pull records for internal review in the Chart Tracker system
- Developed a new and more meaningful Monthly County Manager Report
- Served with program staff on 3 major RFPs (Transportation, Methadone contract and on-site Pharmacy contract)
- Developed Q/A monitoring in the PIP administrative area to ensure that all State requirements are met timely
- Added a number of Administrative supports for the CST department in response to the DOJ requirements

Administration Goals

- Complete implementation of Welligent and begin operationalizing the system
  - Perform Data Conversion testing iterations before the final conversion

- Complete system configuration
- Complete Business Process Reviews with the programs and write Welligent processes for each
- Create Testing scenarios
- Plan training strategy and write training materials
- Begin reporting from the system
- Test and ensure accurate state reporting from Welligent
- Create Car and Conference Room calendar capability in Welligent
- Complete forms development and learn how to create forms in Welligent
- Develop interoperability with the Daily Planet
- Implement the Patient Portal
- Develop Meaningful Use reporting
- Implement 835 capability for all insurance carriers
- Implement 271 eligibility look up
- Develop SPQM reporting
- Work with the Program staff and Financial Management to ensure they receive accurate and meaningful data from the new system.
- Operationalize all Business Support and Reimbursement processes

- Add Telecommunications to Conference Room C
- Provide a camera recording solution for a specialized Parent/Child Therapy
- Update Internet and Intranet content and operationalize the process to ensure the most current is available
- Renovate the Woodman Staff Lounge, remodel an ADA bathroom in one group home and replace flooring in another
- Power wash and seal driveways at all the group homes
- Continue to work with the State on Medicaid Expansion reporting
- Work with Program Staff on implementing Step VA
  - 2 Administrative staff will serve on the Strategic Initiative committee, one of which will co-chair

Administration Outcomes

MEASURABLE OBJECTIVE Customer Value / Efficiency 98% of all children in PIP will have the intake date added into ITOTS the day of the intake appointment to ensure that the Early Intervention gets added timely.	Year end results:	99.5% Met	Recommendations, actions taken, performance improvements:	Goal met, will continue process as implemented. We had 99.5% of all children entered into ITOTS, we did find that at times children were seen in the home and were not on the clinical schedule that morning, so these were put in after.

Quality Assurance Accomplishments

- Attained Licensure Emergency Regulations training
- Received training to conduct Root Cause Analyses (RCAs) by Fidura & Associates, conducted 135 RCAs
- Attended Regional Human Rights Training at Varina Library, sponsored by Office of Human Rights
- Coordinated training on Advance Directives and identified staff to become certified Advanced Directive Facilitators

- Facilitated agency training on Substitute Decision Maker at two locations presented by Henrico County Attorneys
- Assisted ID Employment Day Services and Residential services in preparing for Home & Community-based Services regulations
- Continued monitoring of our Quality Improvement Plan following DBHDS Consultation of DD services
- Participated in Welligent Implementation Committee
- Evaluated new EHR functionality for tracking disclosures, record reviews, and incident reporting and become superusers of the system
- 173 Serious Incidents reported to DBHDS in CHRIS
- Thirty-five Human Rights investigations completed in a timely manner
- Medical Records responded to 1,325 record requests and 14 subpoenas
- Supported 66 external audits, 283 records being reviewed
- Received three Corrective Action Plans and provided responses timely
- Held CARF meetings with programs to review new manuals and prepare for CARF reaccreditation 2020-2023

Quality Assurance Goals

- Revise iRIS system to reflect changes in reporting requirements, streamline entry and increase reporting capabilities
- Assist with improvement of Statewide Performance Measures
- Prepare for implementation of new EHR
- Prepare for the implementation of scanning functionality, create process and train staff
- Implementation of new Licensure Regulations, participate in Regional pilot with Incident Management Unit and Incident Investigative Unit Let's remove this

Quality Assurance Outcomes

MEASURABLE OBJECTIVE Quality / Efficiency Report incidents within required timeframe, 24 hours	Year end results:	3 late reports/1 CAP issued Not met	Recommendations, actions taken, performance improvements:	Performance Improvements: Continued education provided; Agency leadership team discussed expectations and policy was reviewed.

MEASURABLE OBJECTIVE Quality / Efficiency Complete RCAs within required timeframe, 30 days	Year end results:	135 RCAs/0 late Met	Recommendations, actions taken, performance improvements:	Performance Improvements: Continue weekly monitoring. Conducting QA review of RCAs as needed to ensure 30 day requirement is met.

Community Support Services Accomplishments

- 2 staff and 2 individuals completed Leadership for Empowerment and Abuse Prevention (LEAP) training and are now certified trainers for the Region.

Parent Infant Program

- Increased access to services by adding intake slots and assessment teams to East Center and 2 Service Coordinators to be housed at the East Center.
- Early Intervention professionals implemented the use of an evidence based functional assessment titled: Authentic Assessment.
- Won the Collaboration Award with Commonwealth Autism (CA).

Permanent Supportive Housing

- Served 20 individuals in year two of the program
- Successful first audit with no citations
- Intake/Eligibility/Case Management
- Discharged last Henrico Resident from Central Virginia Training Center
- Scheduled/Completed 158 new intakes and 37 transfers (waiver and waitlist) from CSB's all over the state.
- Housing Choice Voucher Program (HCVP)
- Achieved High Performer Status during this fiscal year SEMAP audit.

Residential Services

- All staff completed updated recertification for Medication Administration (a 32-hour course)
- I/DD Case Management Services
- Two staff were certified as Person Centered Thinking trainers
- Implemented new tracking system for Regional Support Team referrals

Employment and Day Services

- Implemented Extended Employment Services billing for Department of Aging and Rehabilitation Services for those who are entering more community-based employment services
- Received a NACo award as well as a VACo award for Life Enrichment Program for those Aging with Developmental Disabilities
- Started new Group Employment Site for 3 individuals
- Community Integration hours for all attendees at Hermitage and Cypress were increased over 15% from last year.
- Successfully completed Qlarant review for Day Programs with no citations.

Community Support Services Goals

- Achieve CARF Accreditation for CSS Residential and CSS Employment and Day Services, including Older Adult designation
- Implement Welligent across the Division
- Achieve Home and Community Based Services compliance across all settings
- Implement all mandates and initiatives from the Commonwealth to meet Department of Justice mandates

Community Support Services Outcomes

CSS ID CASE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Customer	Year end results:	94% (774 of 823) Met	Recommendations, actions taken, performance	Recommendation – Ongoing face to face contacts to be held and document as required. Action taken – Agency sends an ECM status report weekly to staff for follow up as needed.

Value/Effectiveness Individuals receiving enhanced developmental case management services will receive at least one face-to-face contact every 30 days, DBHDS target set at 90%.			improvements:	

MEASURABLE OBJECTIVE Customer Value/Effectiveness Individuals receiving enhanced developmental case management services who received face-to-face contact every 30 days; they will also receive one of those contacts every other month in their residence. DBHDS target set at 90%.	Year end results:	94% (776 of 823) Met	Recommendations, actions taken, performance improvements:	Recommendation – Ongoing face to face contacts to be held and document as required. Action taken – Agency sends an ECM status report weekly to staff for follow up as needed

MEASURABLE OBJECTIVE Quality/ Efficiency Multi Service Progress Notes will be final approved within 5 days of opening	Year end results:	61% (11,848 of 19,306 notes written) Not Met	Recommendations, actions taken, performance improvements:	Supervisors to continue to work with staff to ensure notes are final approved within five days. Action taken – Supervisors run reports to follow up on staff getting notes approved within five days.

<u>CSS DD CASE MANAGEMENT OUTCOMES</u>

MEASURABLE OBJECTIVE Customer Value/Effectiveness Individuals receiving enhanced developmental case management services will receive at least one face-to-face contact per month. Increase above baseline. Baseline: 70%	Year end results:	75% Met	Recommendations, actions taken, performance improvements:	Overall percentage rate of 75% is based upon available data throughout this report. The 4th QR data had wrong percentage and is not accurate. Action – The weekly report continues to aid in achieving the baseline for this outcome. CMs will continue to follow through with individuals receiving ECM services.

MEASURABLE OBJECTIVE	Year end results:	76% Met	Recommendations, actions taken,	The DD private providers and Internal DD CM continues to struggle with getting progress

Quality/ Efficiency Multi Service Progress Notes will be final approved within 5 days of opening. Increase above baseline. Baseline: 60%			performance improvements:	notes completed. Meeting this outcome with current increased caseload levels has proven to be a challenge. It is anticipated that once a new Waiver DD CM position has been hired/trained and caseload numbers decreased then CM's ability to document and final approve documents quickly will improve. This will continue to be an outcome for next year.

MEASURABLE OBJECTIVE Quality/ Efficiency The Developmental Disability team of Henrico Area will conduct quarterly supervision meetings with the DD Contracted Private Providers for the fiscal year	Year end results:	100% Met	Recommendations, actions taken, performance improvements:	This outcome will continue to provide contracted providers with the support they need to increase success rate while meeting requirements. This outcome was met at 100%. The DD Supervisor continued to meet with the Contracted Providers-Catholic Charities and Waiver LLC. Resources, support and information continues to be provided to Providers.

CSS HERMITAGE AND CYPRESS DAY SERVICES OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of the individuals referred to a Day Service program will be contacted within 20 days to discuss /schedule an assessment or visit	Year end results:	18 of 18 Met	Recommendations, actions taken, performance improvements:	Outcome was met, as each of the 18 referrals were contacted within the 20 day window by either the Employment and Day Services team. This quick contact allows us to work with the individual and family, as there are times when they ask for one service but find that another program or service best meets their needs. We will continue this outcome to ensure quick access to the services.

MEASURABLE OBJECTIVE Customer Value / Effectiveness OES: Complete no less than 130 outings in the community each quarter with individuals who do not receive waiver funding Baseline: 120 per quarter	Year end results:	4 of 4 quarters Met	Recommendations, actions taken, performance improvements:	The goal this year was to ensure that those who were not technically in the community engagement service still had access and exposure to their community per Home and Community Based Services (HCBS) regulations. Our goal was for 130 outings per quarter for those who do not have "waiver" services and we exceeded that each quarter. We will be continuing this goal but increasing our target to 150 activities/outings per quarter, as individuals have continued to request full access to different events and activities within their communities.

MEASURABLE OBJECTIVE Customer Value / Effectiveness	Year end results:	19% over 4 quarters Not met	Recommendations, actions taken, performance	There are a number of reasons why this outcome was not met. We struggled with how many hours to authorize and over the course of the year, improved in projecting

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 Baseline: 23%			improvements:	more realistically. Other factors include individual choice, vehicle availability, staff availability and the weather. For the coming year, we will track this outcome, but will lower our goal due to the many factors that are beyond our control. Our new goal for next year will be 30% of authorized hours.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 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 quarterly	Year end results:	4 out of 4 quarters Met	Recommendations, actions taken, performance improvements:	Staff were creative and innovative in finding activities that were engaging and also assisting in skill development over the course of the year. A different array of activities were developed and implemented primarily from things learned at the various training attended by staff. This outcome was met. Next year we will shift the focus to individual ISP goals to personalize the activities to better serve each individual.

MEASURABLE OBJECTIVE Quality/ Efficiency OES: 95% of the elements reviewed will be met for the data collection section of the quality review for all non-waiver individuals. Baseline - 64%	Year end results:	11 of 15 for 73% Not met	Recommendations, actions taken, performance improvements:	There were only 4 non-waiver charts reviewed in the year due to some changes in the system. We did not meet the goal of 95% but it is difficult to determine if there is a trend with such a small sample. We will continue this outcome next year, combining it with the Community Integration program and ensure training occurs for staff to ensure improvement in documentation. We will look at all data elements for the coming year, not just data.

MEASURABLE OBJECTIVE Quality/ Efficiency 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. Baseline: 94%	Year end results:	69/78 elements for 88% Not met	Recommendations, actions taken, performance improvements:	There was a much smaller sample size this year than last. In general, there has been consistent discussion and training on record keeping. While we did not meet the 95% goal, there did appear to be progress in data from the first review to the last. We will keep a similar goal next year but will look at all elements of the utilization review, not just data.

MEASURABLE OBJECTIVE Quality/ Efficiency Older Adults / Dementia Care: LEP staff will receive training on older adults or dementia care or will offer training to other staff each quarter to enhance their knowledge and skills in these areas.	Year end results:	Each quarter staff were trained, 100% were trained during the reporting period Met	Recommendations, actions taken, performance improvements:	The purpose of this outcome was to ensure staff received training to fully implement the work with individuals with dementia who are in the Life Enrichment Program. Results of the increased knowledge can be seen in the more specific and age-related activities within the program. Training efforts will continue; however, the goal will be adjusted to begin to implement the ideas learned at the training by incorporating the information into outcomes in individual plans.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of the individuals served will respond with a positive response (always or almost always) when asked if they are satisfied with the activities, they have been offered	Year end results:	68 of 73 = 93.1% Met	Recommendations, actions taken, performance improvements:	Over 75% of the individuals served in the programs of Organizational Employment, Community Integration and Older Adults completed surveys and of those, 93.1% expresses satisfaction with what they are offered most or almost all of the time. Individuals confirmed that community and work activities are their favored activities and they also indicated that this is what they want more of. This confirms that the program direction is meeting the needs and desires of the majority of individuals we serve.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of the Stakeholders will respond with a positive response to the question about satisfaction with the programs offered through Employment and Day Services	Year end results:	39 of 41 = 95% Met	Recommendations, actions taken, performance improvements:	We sent out surveys through our Quarterly Connection and through the individuals. Forty-one were returned either in person or by mail. We also had a small group complete at the Parents meeting. 95% expressed satisfaction all or almost all of the time. There were areas for improvement such as improving communication about special events and more work and community activities. We have already taken measures to include more information in the Quarterly Connection newsletter and to send information in between the newsletter when it is time sensitive. Choice of activities is offered regularly and will continued to be offered.

CSS GROUP AND INDIVIDUAL SUPPORTED EMPLOYMENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of the individuals will be contacted by the employment specialist within 10 days of assignment	Year end results:	6/13=46% Not met	Recommendations, actions taken, performance improvements:	There are many factors that affect the ability to connect within 10 days. Many individuals do not understand the referral process and often don't want to meet for a job "right now", so don't respond to messages. We are making every attempt to connect within the ten day time frame. We will be working with Case Managers to help make those connections with families and individuals more efficiently.

from the supervisor				

MEASURABLE OBJECTIVE Customer Value / Effectiveness Implement the customized employment model and successfully serve 5 people by the end of the fiscal year	Year end results:	1 person Not met	Recommendations, actions taken, performance improvements:	Due to many administrative issues with DARS and the Customized Employment system, we were not able to add more people to the process. We are still technically getting this one individual enrolled so we can bill for the services, but we are providing the services. We will be working closely with case managers and DARS to get those who need the service into the service more quickly.

MEASURABLE OBJECTIVE Quality/ Efficiency Serve at least 5 new consumers each quarter in Individual or Group Supported Employment	Year end results:	2 of 4 quarters Met	Recommendations, actions taken, performance improvements:	As we get referrals, we are bringing them into the services. We started one new group site and brought in 8 new individuals during the year. We will ensure case managers know we are able to serve people immediately and will also be looking to expand our services to those under age 24 who are attending the day programs to continue to reach the capacity of our program.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of the individuals served will respond with a positive response (always or almost always) when asked if they are satisfied with the activities, they have been offered	Year end results:	26 of 27 for 96% Met	Recommendations, actions taken, performance improvements:	We had a very good response rate by handing out the surveys at the annual meetings. We will continue to do that this year. Individuals are satisfied with services and there were no suggestions for improvement noted in any of the surveys. We will continue to encourage staff to provide excellent customer service and respond to concerns in a timely manner.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of Stakeholders will respond with a positive response to the question about satisfaction with the Group or Individual Supported Employment Services	Year end results:	38 of 39 = 97% Met	Recommendations, actions taken, performance improvements:	We received a much larger number of surveys than in the past since we give out the surveys to Case Managers and Care Givers at the annual ISP meetings. The responses were overwhelmingly positive. We will be reviewing the email policy with staff, as they can email as long as we use the encrypted system. We will continue to explore better ways of communicating with families. We also recognize that one need is for more group sites and will be exploring how we can develop the best sites for the individuals who need that level of service.

CSS INTAKE OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 90% Individuals referred to the agency for services will be offered a face to face intake meeting within 10 days of the first contact	Year end results:	Total 146 /155 or 94% Met	Recommendations, actions taken, performance improvements:	A total of 155 intakes, transfers and internal screenings were scheduled by intake staff. Overall (94%) the majority of individuals were able to schedule an appointment easily within 10 days of the request. The current number of intake slots per week (6-7) seems to be the right amount to offer appointment choice and flexibility. The 155 scheduled intakes resulted in 146 individuals completing the intake process (including meeting diagnostic criteria) and being opened to case management or waitlist monitoring.

CSS RESIDENTIAL OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Vacancies in the program will be offered and accepted by the end of the following quarter	Year end results:	2/3 vacancies met this measure, 67%	Recommendations, actions taken, performance improvements:	This outcome was met with the original 2 openings. The third opening that occurred this year was offered in Q3 but not accepted within goal timeframe due to the client's mother did not submit required documentation. Residential program will set a standing timeline for notifying SA/CM's about residential openings to 10 calendar days after the opening occurs.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 45% of residents will participate in a volunteer activity each month	Year end results:	Overall—0/12 months not met	Recommendations, actions taken, performance improvements:	Recommendation for next year is to lower the percentage from 45 to 35% each quarter. This outcome will be lower to 35% of residents will participate in a volunteer activity each quarter since the program's residents have been more reluctant to participate in these actives.

MEASURABLE OBJECTIVE Quality/ Efficiency 80% of required employees will complete required training on time or before the due date each month	Year end results:	570/585, 97.4% Met	Recommendations, actions taken, performance improvements:	Staff noted that the classes were full, other staff changed status and as yet has not provided a certificate that has not expiring. The third staff simply forgot after the class she needed was full and did not follow up on future classes.

MEASURABLE OBJECTIVE Consumer Satisfaction 80% of residents will be satisfied or highly satisfied with their services and achieve desired outcomes.	Year end results:	19/19, 100% Met	Recommendations, actions taken, performance improvements:	100% of Henrico ID group home residents reported satisfaction in the services they are currently receiving. This goal will continue for next year, the percentage rate will change to 90%.

MEASURABLE	Year end	17/18, 94% Met	Recommendations,	Overall: With a total of 18 respondents, the 72.23% is made up of 55.56% (10

OBJECTIVE Stakeholder Satisfaction 80% of residents' family/AR/guardians will be satisfied with their services and achieve desired outcomes	results:		actions taken, performance improvements:	respondents) were highly satisfied, 16.67% (3 respondents) were very satisfied and 22.22 % (4 respondents) were satisfied. Only 5.56% (1 respondent) was very dissatisfied This goal will continue next year at the current rate. Specific concerns have been forwarded to the individual homes for ongoing improvement.

PARENT INFANT PROGRAM OUTCOMES

MEASURABLE OBJECTIVE Quality / Access The Parent Infant Program will increase the 0-1 child count	Year end results:	61 Met	Recommendations, actions taken, performance improvements:	The Infant and Toddler Connection of Henrico Area exceeded the state target of 1.26%, the official child count was 61 (1.46%). 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 pediatrician and OBGYN offices to expand the relationship.

MEASURABLE OBJECTIVE Quality/ Efficiency The Infant and Toddler Connection of Henrico Area will conduct 3 individual transition conference meetings in collaboration with Henrico Part B Preschool Special Education Program this fiscal year	Year end results:	Goal was met by 3rd quarter. The collaboration between PIP and Part B services has improved this year.	Recommendations, actions taken, performance improvements:	The transition conferences have grown significantly in number. This outcome will be considered met. The Parent Infant Program has been able to sustain compliance with this indicator for 2 years in row. Going forward, we will focus on quality transition reviews for the up and coming fiscal year.

Clinical and Prevention Accomplishments

Adult Recovery Services Case Management

- Successfully partnered with two Managed Care Organizations (MCOs) with the goal to improve physical health outcomes of consumers served with serious mental illness. Through this partnership, agency case management staff and MCO care coordinators were able improve consumer access and follow through with primary medical care providers. With one MCO, agency staff were able to get 96% of consumers connected and seen by their primary care physicians for annual physicals for ongoing care and preventive medical screenings.
- During the first 3 quarters of FY19, the vast majority of newly opened clients (89%) to the Mental Health Case Management and Assessment program demonstrated a reduction in psychiatric hospitalization rates
- Case Management and Assessment staff provided evidenced based group services to consumers to augment traditional case management services and to further consumers' recovery goals. Groups were provided on Wellness Recovery Action Planning (WRAP) and Dialectical Behavior Therapy (DBT) at different agency locations to meet client needs

Assertive Community Treatment Teams:

- Implemented use of a post hospitalization checklist to ensure appropriate services during transition of care.

- Vocational Specialists on teams participated in Individual Placement and Support (IPS) training.
- Participated with two MCO's in integrated health initiatives.
- InSTRIDE had 11 successful graduates from their program which means these consumers were transitioned back into the community and did not need to apply for SSDI. Often these folks were working and/or pursuing educational goals.

Substance Use Services
- Implemented Office Based Opioid Treatment Program (OBOT) and have served 26 individuals
- Hired a full-time peer for Substance Use Services Team
- Received a NACO Award for our Opiate Jail Diversion Program.

Emergency Services
- Provided a high number of debriefings/on scene support deployments this year. There were about 4-5 individuals from the Public Safety team and Emergency Services team who provided on scene support to every Firehouse, every shift over 4 days after a particularly tragic event. We have provided many more debriefings, support at hospitals, support and debriefings for HAMHDS staff, both individuals and teams, and for Henrico County staff, and for the community. We also deployed 5 individuals to VA Beach following a mass shooting to help support their facilitation of a Family Assistance Center where we contributed many hours of counseling and crisis intervention services to the community as well as law enforcement.
- The Crisis Receiving Center (CRC) expanded service hours to 24 hours. This supports our Law Enforcement partners and allows for consistency in process. We continue to work on trauma informed practices and received a grant from SAMHSA (train the trainer model) to increase trauma awareness in our Public Safety partners.
- The Emergency Services Program has been continuing to complete consistently high numbers of emergency evaluations over the last year while experiencing one to three staffing vacancies over the course of the year. We were able to convert a position into a Clinical Supervisor position to increase availability of supervisors in our 24-hour program. We are beginning to plan our processes for mobile crisis services.

Youth and Family
- Re-negotiated MST contract and maintained over 80% capacity for entire year.
- Initiated two Evidence Based Treatments: Trauma Focused –Cognitive Behavioral Therapy and Parent Child Interaction Therapy (accepted as one of 5 sites in the state for this)
- Served 1050 youth during fiscal year

Same Day Access
- Implemented DLA-20
- Enhanced collaboration with Child Protective Services, Henrico Community Corrections Program (HCCP), and the schools. These enhancements included streamlining referral processes, developing protocols to meet individual agency's needs, and improving efficiency.
- Received NACO Award for Same Place Access a unique strategy for engaging individuals who are hospitalized which has resulted in lowering re-hospitalization rates.

Mental Health Skill Building
- Continued focus on providing services that have proven to be instrumental in increasing clients' independence. This has resulted in 20 successful discharges in the first 3 quarters of the fiscal year.
- Integrated both the In-Shape program and the Daily Planet primary care services with MHSS resulting in further attention in the area of health/wellness of our clients.

Employment Services

- Continue implementation of the IPS model resulting in improved communication with ARS clinical teams, a decrease in time from referral to employment development, and an increase in community employer contacts.
- Employment Services supervisor participated on an IPS panel with the Laurie Mitchell Empowerment and Career Center and is scheduled in 7/19 to participate in the Region IV 2019 Conference, "Stepping Up to Healthy Employment," in Chesterfield County.

Psychosocial Rehabilitation (Lakeside Center)

- Continued focus on recovery resulting in 6 successful graduates from the program.
- Implemented interactive group materials resulting in a significant increase in clients' retention of information learned.
- Transferred a MHSS staff to LSC allowing more 1:1 and small group attention to the clients in building various skills.

Prevention

Opioid Social Marketing Campaign to educate the community about the impact of the opioid crisis, providing information about safe Rx drug disposal/security options, and increasing knowledge of mental health/substance abuse treatment resources:

- Bouncebackhc.com PSA promoting REVIVE trainings and recovery during May (Mental Health Month.)- gross impressions 1,029,600
- Billboards (4 English, 1 Spanish) across 4 Henrico locations and one in New Kent.
- Medi- bags distributed from 7 Kroger Pharmacies with information regarding safe medication disposal/storage messaging – 28,600
- Medication lock boxes distributed to community – 1066
- Rx Drug disposal kits distributed to community – 2,183

Marijuana Social Norm Campaign- youth led

- Youth Leadership group sponsored the *3rd Hip-Hop Poetry Slam* promoting substance use prevention.
- JR Tucker marketing class launched "*The Talk*" PSA and social media campaign promoting parents/adult conversations about substance use prevention.

Connect youth achievements as follows:

- 19 Honor Roll (including 1 Presidential Academic Award and Merit Award)
- 10 Perfect Attendance
- 2 Citizenship Awards
- 2 H.S. graduates (ODU, VSU)
- 1 Youth Leader (Summer Abroad- Italy)

Clinical and Prevention Goals

- Full implementation of Parent Child Interaction Therapy
- Expansion of Office Based Opioid Treatment to Providence Forge
- Implementation of System Transformation Excellence and Performance (STEP-VA) steps
- Enhanced services to individuals with limited English proficiency
- Expanded use of Certified Peer Specialists throughout the Division

Clinical and Prevention Outcomes

ADULT SUBSTANCE ABUSE OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of clients admitted to the	Year end results:	92% Not met	Recommendations, actions taken, performance improvements:	Despite significant staff vacancies during the 3rd quarter, the SUD unit was able to ensure that 92% of all people seeking adult SUD services were scheduled within 14 days of their Same Day Access Appointment. We will continue to ensure compliance with this objective and will

program will be scheduled within 14 calendar days for the next available appointment (group and individual sessions combined) following the same day access appointment Baseline: 96% lowest # days 7, highest # days 10 prior to SDA				work to problem solve future vacancies.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 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)	Year end results:	48% Not met	Recommendations, actions taken, performance improvements:	While we have not yet met the objective of 60%, we have increased our retention rates dramatically from 36% last fiscal year to 48% this fiscal year. We plan to continue to work to increase this 3 month retention rate to 60 % in the coming year by growing our OBOT and increasing outreach efforts.

MEASURABLE OBJECTIVE Quality/ Efficiency Of planned discharges, 70% will demonstrate a reduction in substance use or maintain abstinence during the course of treatment	Year end results:	61% Not met	Recommendations, actions taken, performance improvements:	SUD services is diligently working to improve this outcome through the introduction of MAT offered onsite. Our hope is that this new service will assist with this measure increasing over the next year.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of clients surveyed in February will rate their overall satisfaction with services. (4 or 5 rating)	Year end results:	96.1% Met	Recommendations, actions taken, performance improvements:	Services will continue to be provided as they are now due to Services will continue to be provided as they are now due to the overwhelmingly positive results with the satisfaction survey. However, as always staff will strive to provide the most up to date and innovative, evidenced based treatments possible.

<u>ADULT MENTAL HEALTH OUTCOMES</u>

MEASURABLE OBJECTIVE	Year end results:	98.3% Met	Recommendations, actions taken,	Continue to provide services as delivered as clients are overwhelmingly satisfied with the

Consumer Satisfaction 85% of clients surveyed in February will rate their overall satisfaction with services at a 4 or 5 on the survey			performance improvements:	services provided. The unit will continue to work to provide evidence based and results driven therapies for the benefit of our clients.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Clients will be scheduled for a follow up appointment within 14 calendar days of their same day access appointment Baseline: lowest monthly average was 14 days, highest monthly average was 31 days in FY17 prior to initiation of SDA	Year end results:	94% Met	Recommendations, actions taken, performance improvements:	Despite the increases in requests for services by the end of the fiscal year, we were able to maintain above 90% of clients seen within 14 days of their intake assessment. We will continue to monitor this and will coordinate with the supervisors to problem solve should these numbers fall.

CHARLES CITY/NEW KENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Clients will be scheduled for initial appointment within 14 days of contacting Phone Center Baseline: Lowest monthly average was 5 days and highest monthly average was 12 days in FY18	Year end results:	53% Not met	Recommendations, actions taken, performance improvements:	The no show rate for initial appointments impacts this goal and until SDA can start in PF, it is unlikely will can improve on these results. 53% of clients 29 were seen for an initial intake within 14 days of the call Clients did not receive appts to the program after their initial appt either because they were closed or no appt was ever scheduled or client no showed for appts.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 80% of clients surveyed in quarters two and four will rate their overall satisfaction with the session as satisfied utilizing the SRS. Satisfied is defined as 8 or above.	Year end results:	89% Met	Recommendations, actions taken, performance improvements:	45 surveys completed, 27 score a 10, 10 scored a 9, 4 scored an 8 and 4 scored 7 or less. This was an improvement from last year's 85%.

Baseline Lowest score was a 5 and highest score was a 10				

EMERGENCY SERVICES OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Individuals who are treated in the Region IV Crisis Stabilization Unit or who are LIPOS funded during an inpatient treatment episode and plan to follow up with HAMHDS will be scheduled for an appointment within 7 days of discharge 75% of the time. Outreach efforts will be used 90% of the time for those who do not come to their appointments. Baseline: (FY18) 71% of the persons referred to HAMHDS for a non-emergency discharge appointment were seen within 7 days of discharge.	Year end results:	Overall, we met our objective and 80% of the individuals identified as being referred here, came to appointments. Follow was completed 95% of the time and it appears that those who wanted to receive services were able to access those services within 7 days of discharge. It remains difficult to identify the individuals referred to services, but Same Day Access has made access to appointments very easy.	Recommendations, actions taken, performance improvements:	The start of Same Place Access in addition to Same Day Access has made appointments post discharge even more accessible because several of the individuals represented in these numbers met with an access clinician in the hospital to complete the initial assessment. This outreach before discharge from inpatient treatment is an improvement in our ability to engage clients. Discharge appointments from CSU are easier to identify but we did have several individuals who were homeless or from out of state who went into crisis in our county. Although these individuals did not follow up with HAMHDS services, we were involved in the discharge planning.

MEASURABLE OBJECTIVE Quality/ Efficiency 90% of persons (not currently open to the agency) not hospitalized will be contacted by phone within 7 days of their assessment if follow up is indicated in assessment. If the phone call is not able to be completed, a letter will be sent within 7 days. Excluded are persons who live in a group home or are assessed	Year end results:	Met 100% of prescreening evaluations competed by emergency services clinicians were reviewed by supervisors. 302 were determined to require follow up. 291 of 302 (96%) were contacted by a clinician to check on their welfare and offer support. 90% of those individuals had	Recommendations, actions taken, performance improvements:	Overall, we met our objective this year. Due to staffing shortages and external responses to crises both locally and within the state, our June follow-up fell behind which dropped our percentage overall significantly. Most of the year, the percentages of those for whom outreach was done within 7 days was much higher than the average of 90% for the year. Supervisors will make more efforts to review prescreenings daily, however, the current crises will always remain the priority in the moment.

in jail or detention. Baseline: (FY18) 96% had outreach within 7 days		outreach completed within the 7 day timeframe.		

SAME DAY ACCESS OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 80% of clients referred to services will show for their second appointment	Year end results:	2019 2018 RMP 72.9 72.3 East 64.5 69.7 Wood 90.5 83.3 1 of 3 locations met this measure	Recommendations, actions taken, performance improvements:	Our access numbers have remained steady or improved in two of our locations. At East there was a reduction that was due, in part, to significant shortage in outpatient staff for several months.

MEASURABLE OBJECTIVE Consumer Satisfaction 80% of clients will score a total of 24 or better on the SDA Satisfaction Surveys will show for their second appointment	Year end results:	95% Met	Recommendations, actions taken, performance improvements:	For the year, a total of 151 surveys were obtained. The results showed that we significantly overachieved this year, as 95% of all respondents scored 24 or higher! In fact, fifty percent of all scores for the year were perfect scores of 30. The average total score was 28. The annual results overwhelmingly indicate that the Same Day Access process has been and continues to be a valued service and positive experience for the clients and families served. Although neutral or negative responses to all questions on the survey were minimal, we learned that SDA clinicians should continue to be mindful about discussing the recommended service with the client and how those services could help alleviate their concerns/symptoms.

LAKESIDE CENTER OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Consumers referred to the program will be admitted within an average of 10 days from receipt of the referral	Year end results:	Avg. 9.7 days Not met	Recommendations, actions taken, performance improvements:	We have continued the FY18 10 day target for FY19. For FY19, there were fifty total admissions and the individuals were opened in an average of 9.7 days, meeting our target by .3 day. Had consumers and/or their referral sources accepted earlier opening/orientation appointments available this fiscal year the average drops significantly to 6.4 days, a significant improvement. Recommendation is to continue with our present system which is providing access to our services in a timely manner. These results will be shared in Team Meeting.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Consumers will be administered both pre- and post-surveys to determine a percentage	Year end results:	71% pre survey- 93.5% post survey Met	Recommendations, actions taken, performance improvements:	LSC consumers were administered Pre and Post Surveys to measure the retention of information disseminated in their daily psycho-educational groups. A questionnaire with six questions was administered prior to the start of three classes in both the 2nd and 4th quarters which were conducted over four to six-week periods. At the conclusion of these classes, the questionnaire was re-administered. These

increase of the retention of information disseminated in their daily groups				psycho-educational groups were taught with interactive materials so as to contrast them with last FY18's survey of a psycho- educational groups taught without such interactive materials. Our results were dramatically positive with the vast majority of LSC consumers improving their scores or maintaining already good scores. Going forward, these statistically significant improvements in Pre and Post scores endorse the use of interactive materials with LSC consumers to assist them with both learning and retaining psycho-educational group material. These results will be shared in Team Meeting.

MEASURABLE OBJECTIVE Quality/ Efficiency 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	Year end results:	100% Met	Recommendations, actions taken, performance improvements:	Evidence of Care Coordination with other healthcare providers (i.e. SAI, MHSB, Vocational, ALF/Residential, and Private Providers) has been documented in our consumer's records 100% of the time.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of consumers surveyed will report being "satisfied" with services as evidenced by an average 8-10 rating to all survey questions	Year end results:	100% Met	Recommendations, actions taken, performance improvements:	Our goal for this year was to achieve a 90% score indicating that respondents were satisfied with services by rating each survey question an average of 8 or better. Our overall results surpassed our target of 90%, as we achieved a score of 100% with all six questions securing average scores between 8.7 and 9.0. This year 38 members (54% of census) participated, up from 50% last fiscal year. As with previous surveys, this survey of Lakeside Center members also included the open question, "How could services be improved?" The response rate to this question was significantly improved from FY18 with 18 consumers providing feedback. Interestingly, the three themes from last fiscal year, wanting improved lunches, staff to spend more time on the floor, and improved groups were positively commented on this year. The positive comments regarding PSR Groups may be reflective of the related increased use of interactive training materials this past year. In regard to the request for additional job training, plans are in place to develop consumer tasks for supply/inventory control, building security and the utilization of trained consumers at our impending EHR kiosk. Overall, members continue to be satisfied with Lakeside Center

				services. These results will be shared in Team Meeting and options for improving program services will be considered for implementation on an ongoing basis.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of family/significant other stakeholders will respond with an 8-10 rating to all survey questions	Year end results:	97% Met	Recommendations, actions taken, performance improvements:	Our goal was for 90% of HAMHDS SAI's for Lakeside Center consumers to respond with an 8-10 rating to all Stakeholder Satisfaction survey questions. Results provided a score of 97% on their survey questions thereby surpassing our goal significantly and improving our percentage from FY18 by 8%.

MH CASE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Non crisis clients will be scheduled within 7 days of their Same Day Access Appointment into ongoing case management and assessment services Baseline: New Objective for FY18– average wait time to case management appointment is 7.75 days	Year end results:	5 days (on average) Met	Recommendations, actions taken, performance improvements:	The Case Management and Assessment program and the agency as a whole remain committed to providing timely services to clients seeking treatment. Wait times have decreased significantly this year as compared to last fiscal year (decreasing by almost 3 days) which demonstrates that commitment and represent the efforts of teams and supervisors to minimize wait times as much as possible. This commitment will continue into the next fiscal year with the goal of meeting client's needs in most timely manner possible.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Newly opened clients will demonstrate an 80% reduction in hospitalization rate or will maintain 0 hospitalizations. The baseline (measured from 3 months prior to initiation of service to 3 months after initiation of service) will be compared with their hospitalization rate	Year end results:	89% of clients experienced a reduction in hospitalization rates or remained at 0 hospitalizations. Met	Recommendations, actions taken, performance improvements:	A total of 292 clients were referred to case management services during the reporting period. At nine months post admission to services 98 remained active and 87 experienced a reduction in hospitalizations or remained at zero hospitalizations. In addition to these impressive results, of note is these clients experienced a 65% decrease in the number of hospitalizations as compared to the baseline period – dropping from 72 cumulative hospitalizations to only 25 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 the burden of costly and often quite disruptive hospitalizations. Client retention efforts will continue to be explored in hopes of expanding these encouraging results.

from months 4-9. Baseline (FY17 and FY18): 90% of clients experienced a reduction in hospitalizations or remained at 0 hospitalizations post admission to CM&A.				

MEASURABLE OBJECTIVE Quality/ Efficiency At least 75% of cases will have a minimum of one face to face contact with their case manager every 45 days to maintain engagement in services. Baseline: New objective for FY18 - 77% of clients had a minimum of one face to face contact monthly	Year end results:	80% of clients had a minimum of one face to face contact with their case manager monthly. Met	Recommendations, actions taken, 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 and the level of engagement consumers have with their case management staff. These results continue to meet and exceed the established objective and exceed last years' annual results by three percentage points. This is a likely result of case management staff and supervisors' diligent efforts to outreach and maintain regular face to face contact with their clients on their respective teams. 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.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of client responses will be one of the two highest ratings to questions on the satisfaction survey. Baseline (average of FY17 & FY18): 96% of clients responded with the 2 highest ratings	Year end results:	97% Met	Recommendations, actions taken, performance improvements:	Consumer satisfaction rates remain quite encouraging with 97% of responses being one of the top 2 responses within the 257 surveys returned. Team supervisors have reviewed these results with their staff in individual supervision and shared client feedback to enhance and inform services provided. Team supervisors will discuss various ways to increase the survey return rate in the upcoming year in hopes of getting a broader view of consumers' treatment experience and gain additional feedback on services received.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of HAMHDS prescribers' and ARS Collaborative Services providers' responses will be	Year end results:	98% Met	Recommendations, actions taken, performance improvements:	These stakeholder results continue to demonstrate strong satisfaction and collaborative efforts occurring between case management staff and key agency stakeholders. Teams have found that client services are typically most effective when there is good communication and collaboration among treatment providers which is at the core of effective case management services. These

one of the two highest ratings to questions on satisfaction survey rating case managers and clinicians within CM&A Baseline: 97% of stakeholders responded with the 2 highest ratings				overall satisfaction rates of 98% are up slightly from last year and remain a strong indicator of the efforts staff are making to collaborate across and amongst service providers which undoubtedly aids agency clients in receiving well-coordinated care and in turn positive clinical outcomes.

IN-STRIDE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of clients referred for InSTRIDE will be scheduled, on average, for an assessment within 7 days of notification of the referral. Baseline: 6 days based on FY18.	Year end results:	19/24, 79% Met For FY19, InSTRIDE received 30 referrals with 24 meeting criteria and being opened to InSTRIDE. Of the 24 individuals who were opened, 19 were opened within seven days.	Recommendations, actions taken, performance improvements:	These results were not as strong as FY 18 where 22 referrals were opened with 20 of those within 7 days. This outcome should continue to be tracked since results did not exceed the previous year. For FY20, strategies should be developed so that initial appointments are not scheduled more than 7 days out. Plan is for InSTRIDE supervisor to notice if an initial appointment has been scheduled more than 7 days out, and then to contact referral and offer a sooner appointment time.

MEASURABLE OBJECTIVE Customer Value / Effectiveness There will be a decrease in the number of voluntary and involuntary hospitalizations from InSTRIDE recipients as compared to the previous year. (Per consumer report) Baseline: 21 total hospitalizations: 9 voluntary, 12 involuntary in FY18.	Year end results:	For FY19, InSTRIDE consumers experienced a total of 5 voluntary hospitalizations, and 16 involuntary. Total of all hospitalizations was the same as baseline, no decrease. Not met	Recommendations, actions taken, performance improvements:	For FY18, InSTRIDE consumers had experienced 21 hospitalizations, 9 of which were voluntary, and 12 of which were involuntary. As a result, InSTRIDE clients experienced four more involuntary admissions for FY19. Annual results were greatly skewed due to one outlier. One particular consumer had seven involuntary admissions and two voluntary admissions, despite assertive outreach, and looking at other options such as partial hospitalization. Of special note is the fact that this client has stayed out of the hospital since April which involved psychiatric home visits and psychiatrist administering injections in the home.

MEASURABLE OBJECTIVE Quality/ Efficiency Clients will participate at least quarterly in activities within their	Year end results:	86% Met For FY19, a total of 65 different consumers were served over the course of the year. Of these 65 consumers, 9 never	Recommendations, actions taken, performance improvements:	For FY19, 86% of consumers served engaged in at least one community activity which is a significant increase over FY18 which was 80%. Some possible explanations for such a significant improvement include: enhanced vocational supports through adopting IPS model and offering individual social outings before encouraging consumers to participate

community such as vocational, educational, or recreational. Baseline: 80% engagement based on FY18.		participated in a community activity.		in group social outings. InSTRIDE should continue to focus on helping consumers access community resources and integrate into the community at large. This goal will continue to be monitored with the goal to exceed this year's results.

MEASURABLE OBJECTIVE Consumer Satisfaction Consumer's will complete a service satisfaction survey to rate the services being provided to them at a "2" or lower. Baseline: 59% based on FY18.	Year end results:	85% Met	Recommendations, actions taken, performance improvements:	The FY19 result of 85% greatly exceeded FY18 result which was just 59%. Possible explanations for this improvement were cited previously regarding enhanced vocational supports through adoption of IPS model and delivering group services in a different way (i.e. smaller groups and grouping individuals with similar issues).

MEASURABLE OBJECTIVE Stakeholder Satisfaction Stakeholder surveys to be administered to family members of clients. Target to achieve an overall average a 4 or higher Baseline: To be established 5 point Likert scale: 1= Strongly Disagree 2= Disagree 3= Somewhat Agree 4= Agree 5= Strongly Agree	Year end results:	Average score 4.93 Met	Recommendations, actions taken, performance improvements:	For FY19, fifteen surveys were returned by family members. Baseline data has not been established because this survey has never been administered before. For the entire year, the responses were very positive with families overwhelmingly indicating they would recommend HAMHDS to others based on their experiences, which was nearly a perfect score (4.93). Comments that were provided were all positive. Clearly, family members feel that their loved ones are benefitting from the services InSTRIDE provides with the lowest average score being 4.00 regarding whether consumers were perceived by family members as engaging in more community activities. These positive results should be shared with the InSTRIDE team.

<u>MH PACT OUTCOMES</u>

MEASURABLE OBJECTIVE Quality / Access There will be an increase over baseline in access to health care services experienced by persons receiving PACT/ICT services. Such individuals will	Year end results:	85%, not met For FY19, a total of 18 consumers have not yet received any routine medical care out of a total of 136 consumers served which means that 118 consumers did receive some type of routine medical care in the past year. These 118	Recommendations, actions taken, 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. For FY19, 85% of PACT/ICT consumers received routine medical care which is a 6% drop. For FY20, this goal should continue to be tracked, due to goal not being achieved this year. The 18 consumers, who did not receive routine medical care in FY19, will be targeted, encouraged, and assisted with accessing

see a health care provider such as primary care providers, specialists, dentists, optometrists, etc., but not including ED treatment, at least once a year Baseline: FY2018 – 91% of PACT/ICT clients accessed medical care		consumers were accompanied to a total of 675 non-psychiatric medical appointments.		routine medical care. These results will be shared with both teams.

MEASURABLE OBJECTIVE Customer Value / Effectiveness There will be a decrease in the number of involuntary bed days and an increase in the number of voluntary/CSU bed days Baseline: FY2018 – 1535 involuntary bed days, and 149 voluntary bed days	Year end results:	Met -For FY19, the ICT and PACT teams had fewer involuntary bed days than last year (1311 days versus 1535 days). In addition, the PACT/ICT teams had more voluntary bed days than in FY18 (296 versus 148 days). As a result, both parts of this goal were achieved which were to have an increase in voluntary bed days, and to have decrease in involuntary bed days.	Recommendations, actions taken, performance improvements:	This goal was achieved due to a sustained effort of keeping consumer choice in the forefront when possible, and with vigilantly looking for less restrictive options like CSU, mobile crisis, use of natural supports, and increase in community-based services. In addition, the ICT and PACT teams instituted a "Hospital Discharge Checklist," in an effort to reduce rapid re-hospitalizations which had been deemed an issue. For FY20, this goal will remain in an attempt to further reduce involuntary bed days, and to further increase voluntary bed days. Furthermore, the "Hospital Discharge Checklist," which was implemented mid-fiscal year, should continue to be utilized by both teams.

MEASURABLE OBJECTIVE Quality/ Efficiency There Program orientation packets, Initial Assessments, and Initial Individual Service Plans will be completed within 30 days on all new referrals to PACT and ICT services Baseline: FY2018 - 89% of PACT/ICT referrals met their target	Year end results:	East PACT had 79% compliance with completing opening documents within the 30 day window, while the West ICT Team had 78%. The average of both teams was then 78% Not met	Recommendations, actions taken, performance improvements:	This goal of exceeding last year's results was not achieved. Last year, both teams had 89% of referrals opened within 30 days. In interpreting the results, the second quarter, by far, had the most negative effect on these results which as explained previously was due to changes in leadership for both teams. In looking at the fiscal year minus this one quarter, both teams had 94% compliance which exceeded last year's results. Since these measurements greatly improved in the second half of this fiscal year, no further action needs to be taken. Both ICT and PACT supervisors will continue to monitor opening paperwork deadlines and revisit the process if needed.

MEASURABLE OBJECTIVE Consumer Satisfaction	Year end results:	East PACT administered 19 surveys: 12/18 excellent re:	Recommendations, actions taken, performance improvements:	For both teams combined, 50 surveys were administered over the course of FY19. For FY19, 79% of responses were in the excellent range. In terms of the consumers'

Consumers will rate their satisfaction with PACT and ICT services a "7" or higher on the PACT/ICT Consumer Satisfaction Survey Progress: Amount of progress consumer feels they have made. Respect: Amount of respect consumer feels they have received from staff. Empowerment: Extent Staff have encouraged and empowered consumers to be more independent. Baseline: FY 2018 - 95% of responses		progress; 15/19 excellent re: respect; 16/19 excellent re: empowerment. West ICT administered 31 surveys: 21/31 excellent re: progress; 29/31 excellent re: respect; 25/31 excellent re: empowerment. The highest percentage of combined team responses was in the area of consumers' perception of respect given by staff, 82% of responses were in the excellent range. All other survey areas fell lower. Established a new baseline.		perception of progress, 67% of responses were in the excellent range. With regards to consumers' perception of respect given by staff, 82% of responses were in the excellent range, while in terms of consumers feeling empowered by staff, 70% of responses were in the excellent range. Since this was a brand-new survey, comparing results to FY18 would not be meaningful; however, a baseline has now been established. The goal for next year will be to exceed this year's results. Results will again be shared with both teams, and supervisors will take measures to ensure that we continue to maintain a recovery-oriented culture.

MEASURABLE OBJECTIVE Stakeholder Satisfaction Clients' families/ identified primary support system will complete a service satisfaction survey to rate the on a scale 1-5 services being provided to their family members. Target is a rating of 4 or higher indicating satisfaction per question BASELINE: FY 2018 - 61% of responses Questions: #1: Consumer more effectively deals with his/her problems. #2: Consumer can more effectively communicate his/her needs and wants. #3 Consumer is participating more in	Year end results:	PACT/ICT had 10 stakeholders, mostly family members, complete the survey this quarter. The percentage rating their satisfaction as 4 or higher, per question, was as follows #1: 90% #2: 90% #3: 80% #4: 100% #5: 100% Each exceeded baseline, Met	Recommendations, actions taken, performance improvements:	The East PACT and West ICT Teams had similar results. No patterns emerged that were worth interpreting. Family comments were more revealing: "Team shows compassion and caring; I would not be able to care for my daughter without the help of the PACT team; mental health employees are very kind and understanding; <client name> would not be alive if it wasn't for y'all." These results and comments were shared with both teams.

community activities. #4: Consumer is better educated about his/her illness. #5: I would recommend this agency to another family member of friend.				

MH RESIDENTIAL OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Vacancies in the program will be offered and accepted within 45 days from the date a resident vacates the home to the move-in date of a new resident	Year end results:	74 days Not met	Recommendations, actions taken, performance improvements:	During this reporting period we had one vacancy at Walton Farms. While we did not meet the objective of filling the vacancy within 45 days, it was not due to the program's lack of readiness. Shortly after the vacancy occurred information was sent to ARS case managers informing them of the vacancy. The referral period was opened for two weeks, however, due to a lack of response the referral period was extended. After the extension three clients showed interest, two declined and the third initially hesitated and later accepted. The issue for those interviewed was knowing that they were unable to stay home Monday thru Friday from 9:30-4:30 pm when staff is not present as this is a supervised home. The person who accepted has adjusted very well.

MEASURABLE OBJECTIVE Customer Value / Effectiveness The residents' health and wellness will improve as evidenced by 100% of residents achieving weight loss through the reporting period	Year end results:	75% Not met	Recommendations, actions taken, performance improvements:	During this reporting period we had 3/4 residents lose weight. The weight lost ranged from 1-6 lbs. This objective was challenging to due to outside influences. The residents attend various day programs where they have access to a variety of food. Another challenge to their weight loss is the impact that their psychotropic medication has on their weight, often causing a weight gain. The staff at Walton Farms continues to encourage, educate, and provide healthy food choices for snacks and meals. While challenging the program is committed to working with residents on their health and well-being and will continue this objective for the next reporting period.

MEASURABLE OBJECTIVE Quality/ Efficiency Residential staff will demonstrate improvement in their organization skills as evidenced by planning one community outing a	Year end results:	100% Met	Recommendations, actions taken, performance improvements:	Throughout the reporting period residential staff met this objective 100% of the time. Staff consistently demonstrated efficiency with their time resulting in opportunities for the residents to be involved in various community activities. Throughout this period residents participated in a variety of community activities to include: Cultural festivals/celebrations, museums, bowling, movies, shopping, dining out, library, and many others. While it will be expected for staff to continue to remain efficient with their

week to increase opportunities for residents to integrate into their community				time resulting in opportunities for residents to be a part of their community, this objective will not continue for the next reporting period.

MEASURABLE OBJECTIVE Consumer Satisfaction Three out of the four residents will respond with an 8-10 rating to focus group survey questions	Year end results:	100% Met	Recommendations, actions taken, performance improvements:	Walton Farms conducted a focus group during the first and third quarter. The questions were the same. We are pleased that our score increased from 60% (first quarter) to 100% (third quarter) satisfaction regarding services received at Walton Farms. While there was a change in composition of the home from the first to third quarter there were three consistent residents that resided at WF for the entire evaluation period. We are also pleased that the new resident scored an 8-10 satisfaction rating in all areas.

MEASURABLE OBJECTIVE Stakeholder Satisfaction The residents' Case Manager will respond with an 8-10 rating on all survey questions	Year end results:	100% Met	Recommendations, actions taken, performance improvements:	Walton Farms staff works closely with the primary case managers of those residents we serve. We are pleased to report a high level of satisfaction on surveys collected. Surveys went out to three case managers and despite reminders received 2/3 surveys. The two surveys received scored a 100% satisfaction on all five questions, which included measuring communication between staff, responsiveness of residential staff, residents' improvement with services, overall satisfaction with services received, and if they would refer other clients to the program.

MH SKILL BUILDING OUTCOMES

MEASURABLE OBJECTIVE Quality / Access MHSS will open 80% of referrals within 7 days of referral from case manager	Year end results:	30% Not met	Recommendations, actions taken, performance improvements:	For FY19 there were a total of 26 consumers opened to MHSS. The longest wait time was 29 days and the shortest was 1 day. Some extenuating circumstances which contributed to the longer wait times included client hospitalizations or medical appointments and the need to schedule an interpreter. A decision was made during the third quarter to no longer require the Case Manager to be present for the assessment. This appeared to reduce wait times during the fourth quarter. Supervisor recommends continuing this practice in FY20 as a result.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 50% of all consumers discharged from MHSS will be considered "successful."	Year end results:	73% Met	Recommendations, actions taken, performance improvements:	MHSS met this objective each quarter of FY19. We will be continuing to measure discharges in FY20. The new outcome states 75% of all discharges from MHSS will be considered successful and planned. Documentation in the third quarter, if clinically indicated, will evidence discussion of readiness for discharge.

"Successful discharge" is defined as a consumer achieving their ISP goal(s), and did not require transfer to another provider				

MEASURABLE OBJECTIVE Quality/ Efficiency MHSS staff will document monthly collateral contacts 90% of the time	Year end results:	This objective was not met in any quarter of FY19	Recommendations, actions taken, performance improvements:	There was improvement during the third quarter after Supervisor gave direction to staff on developing a system to track collateral contacts. Supervisor also recommended to staff not to wait until the very end of the month to complete collaterals. This objective is being discontinued for FY20. Since each client has only one EHR that spans across all agency programs, the standard for collateral contacts is already met. Supervisor will direct staff to document any significant communication that takes place between MHSS and Case Management or other agency service provider in a Collateral contact note. Otherwise, collateral information can be found in the client's universal EHR.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of consumers will respond positively to each survey question as evidenced by a score of 8 or higher for every question	Year end results:	75% Not met	Recommendations, actions taken, performance improvements:	We will continue this Objective into FY20. MHSS Supervisor will, however, develop a strategy to gain additional information regarding client's perception of respect and encouragement / empowerment. Supervisor provided supervision to one staff who had a lower score on respect and encouragement / empowerment. Supervisor provided feedback on how staff might approach client differently and/or less directly due to the client's extreme paranoia and delusional thoughts. Consumers reported that the most progress made was in the areas of completing ADL's and improving both their mental and physical health. Consumers reported that they'd like to build more Skill in the areas of shopping, budgeting, and developing positive social Skill.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 80% of ARS case manager responses will be in the excellent range (8-10)	Year end results:	Questions: 1. 100% 4.88% 2. 100% 5.81% 3. 100% Total 94% Met	Recommendations, actions taken, performance improvements:	We are pleased that we met our objective of 80% of responses will be in the excellent range with a total of 94% of responses scoring in this range. The two questions with lower scores rated collaborative efforts between MHSS staff and the case manager and the level of improvement since the consumer began services. The comments related to the lower rating noted that the consumer receiving MHSS only just began so it made it difficult to measure. Although lower scores were received regarding collaborative efforts between MHSS and Case Management, there were still several positive comments about collaboration on the majority of surveys

				returned. Case Managers stated that collaboration was done via e mail and face to face contacts.

MH VOCATIONAL OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Person referred will be contacted within seven days of referral	Year end results:	27 of 34 73% Not met	Recommendations, actions taken, performance improvements:	Vocational staff has discussed the importance of clients being made aware of referrals made and for them & to answer calls and check for messages from vocational staff. Vocational staff contacts case managers regarding problems reaching referrals earlier in attempts to stay within goal timeframe.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Staff will assist program participants with obtaining twenty-three additional jobs during the evaluation period	Year end results:	15 Not met	Recommendations, actions taken, performance improvements:	Vocational services assisted with clients obtaining fifteen new jobs for the year. This number is short of the goal of twenty-four. Staff has been encouraged to increase job development interventions and decrease initial start-up time with services.

MEASURABLE OBJECTIVE Quality/ Efficiency Each full time job coach will develop twenty-four new employer contacts monthly	Year end results:	6.6 new monthly contacts for the year average Not met 7.6 new monthly contacts for the year average Not met	Recommendations, actions taken, performance improvements:	Staff continues to make progress with updating existing contacts, especially over the last two quarters. The number of new monthly contacts has remained below the goal for both job coaches for the year (6.6% and 7.6%). The subject has been discussed at length and staff is encouraged to increase the numbers through carving out a larger portion of their schedules to make improvements.

MEASURABLE OBJECTIVE Quality/ Efficiency Full time job coaches will average at least fifty-five direct service hours monthly	Year end results:	46 direct service hours monthly average for the year Not met	Recommendations, actions taken, performance improvements:	The 46 direct service hours falls somewhat short of the goal of 55. Several months like Dec 2018 (29), June 2019 (38) and Jan 2019 (39) were the lowest months. Winter weather and staff vacations attribute to pulling the overall average down. Staff will continue to outreach clients and better schedule job development.

MEASURABLE OBJECTIVE Quality/ Efficiency Job coach will facilitate applicant to employer contact within fifteen days from first meeting, 85% of the time.	Year end results:	18 of 28 64% Not met	Recommendations, actions taken, performance improvements:	The team did not reach this objective for the year. However, are learning the value of meeting with clients as soon as possible and assisting with scheduling multiple employers. This increases the likelihood of employment and exposes the clients to various types of jobs and employers.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of all responding consumers will score a rating of at least '8" to the survey questions regarding satisfaction. The questions will developed from feedback during focus group discussion in the 1st quarter	Year end results:	20 of 24 83% Not Met	Recommendations, actions taken, performance improvements:	The consumer satisfaction was measured in two different formats this year. The 1st quarter was by a focus group (92%) and the 4th quarter by individual written surveys. The "revamped "survey utilized in the 4th quarter provided information that will be valuable in improving the program and meeting consumer needs around employment. Staff will make efforts to increase consumer satisfaction and bolster IPS concepts with treatment team and rapid job search.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of responding employers will score a rating of at least "8" to the question regarding satisfaction. The questions will be developed from feedback during employer focus group held in 1st quarter.	Year end results:	21 of 26 81% Not met	Recommendations, actions taken, performance improvements:	The year-end results are a combination of telephone interviews (1st quarter) & surveys (4th quarter). The surveys tended to produce more detailed data and staff will work harder to increase the number of responding employers.

PREVENTION OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Consumers will be approved for admission into the CONNECT program within 5 business days of request for services	Year end results:	37 Met	Recommendations, actions taken, performance improvements:	Prevention met this objective with 37 youth approved for admission within 5 days of request. Program Coordinators registered youth on-site in the community, and placed youth on a waiting list when program capacity was reached. Parents of youth placed on the waiting list were notified when a spot became available.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 90% of CONNECT 1st – 3rd grade participants shall be	Year end results:	63% Not met	Recommendations, actions taken, performance improvements:	The Connect program did not meet this objective for FY 19. However, five youth made notable progress moving onto grade level. The majority of participants maintained reading on grade level throughout the school year. A significant cohort of participants did not progress to grade level from the first report card despite multiple reading

reading on or above grade level. Baseline- Taken from first 9th weeks report card				initiatives. Several factors may have impacted these program outcomes, including staff turnover, vacancies, transitions, and acute environmental stressors in the community. Interns from area colleges/universities, supervised by Connect Coordinators, helped mitigate some of the impact of staff shortages. Programming to bolster academic outcomes were expanded, including weekly library trips, library cards, and book donations. Programs were visited regularly by volunteers from the Love of Learning Read Aloud Program, a mobile resource van, and youth received incentives for reading.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Students will show a decrease in favorable attitudes towards Alcohol, Tobacco and other Drugs (ATOD) as demonstrated by the evaluation outcomes of evidence-based curriculums implemented in the community	Year end results:	Al's Pals = 24 participants completed, 0% favorable attitudes Life skills Training = 28 participants completed, 9% favorable attitudes Met	Recommendations, actions taken, performance improvements:	Early elementary youth respond well to the Al's Pals substance use prevention curriculum. However, by 3rd grade youth begin to show more uncertainty re: the risks of substance use. Current environmental messages often obscure the prevention messages of LST therefore producing more mixed results regarding attitudes toward substances at an early age. Staffing has also had an impact on outcomes as new staff come on board and require training in the program. We continue to focus on the importance of program implementation fidelity to improve outcomes.

MEASURABLE OBJECTIVE Quality/ Efficiency Prevention Services shall implement environmental approaches, in collaboration with community partners, to address substance use prevention and mental wellness as measured by the delivery of a minimum of 2 community-level activities; e.g., community forum, social norms campaign, media campaigns and merchant education activities	Year end results:	Prevention used a variety of methods to educate the community about the Opioid crisis, provide information and tangible resources to reduce substance misuse across the life span. Met	Recommendations, actions taken, performance improvements:	Prevention exceeded this objective, working with numerous community partners, including police, schools, senior programs, the Heroin Task Force and others. Environmental approaches will continue in an effort to reach broad segments of the population with Prevention information to promote wellness. Prevention may also develop additional Prevention campaigns for culturally and linguistically diverse communities, where feasible.

MEASURABLE OBJECTIVE Consumer Satisfaction 85% of CONNECT participants (3rd grade and above) shall give a response of 1 (i.e., agree) on the consumer satisfaction survey	Year end results:	87% Met	Recommendations, actions taken, performance improvements:	Prevention exceeded this objective with the vast majority of afterschool-program participants reporting benefits from attending the program. Most notable, participants expressed that they can talk to staff about concerns, enjoy the fieldtrips, can receive meals and snacks, and are taught healthy habits. For older youth leadership and job training skills/employment are perceived as most valuable.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 95% of CONNECT key stakeholders shall give a response of 1 (i.e., agree) on the satisfaction survey	Year end results:	96.5% Met	Recommendations, actions taken, performance improvements:	Overall, Prevention exceeded this objective. Parents having had more direct contact with the program expressed more benefits from the program than other stakeholders. Consensus among parents and other stakeholders is that the program provides a safe space for youth to improve academic and social skills, expand exposure to experiences beyond their community, and families can receive much needed support as well. Greater resources are needed to provide suggested improvements.

YOUTH & FAMILY OUTCOMES

MEASURABLE OBJECTIVE Quality / Access Youth &Family Services Outpatient clinicians will schedule their clients within 10 days of their Initial session 90% of the time	Year end results:	Youth and family services met this goal during Q2, Q3 and Q4	Recommendations, actions taken, performance improvements:	The first quarter of the year, we were learning and adjustment curve. Since that time, this goal has been met and exceeded the expectation of 90%.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Newly opened case management clients will receive a minimum of 3 hours of case management services within the first 60 days of service to be considered engaged	Year end results:	38% Not met	Recommendations, actions taken, performance improvements:	Many of the clients serviced by the Youth and Family team receive both case management and outpatient therapy services. This measure does not account for the time clients spend in outpatient therapy. In those instances, the clients most likely receive the amount of case management required by DMAS which does not specify a time but rather number of contacts. The recommendation would be to only look at clients in case management only or consider all of the service time provided by the HMH Youth and Family team.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Reoffending rates	Year end results:	6.25% Not met	Recommendations, actions taken, performance improvements:	The Multi-Systemic Therapy (MST) program is an evidence-based, home-based therapy proven to be effective with youth who display high risk behaviors and/or are involved with the court system. This model looks at several outcomes as

will remain at or below 10% for MST clients during the course of treatment				a means for tracking success in the program. One of the ultimate outcomes of the MST program model is success in keeping the youth from reoffending. This goal reflects influence of collaboration between and among stakeholders. To show overall improvements across areas of life functioning as a result of participation in services the HAMHDS MST program tracked the percent of youth who reoffended during the course of treatment. The quality improvement outcome was to look at the percentage of youth who avoided reoffending and keep the overall percentage below 10% of all youth. The reoffending rate for MST cases during fiscal year 2019 was 6.25%. This is a decrease from last year (15%) and below our target mark of 10%. Potential factors for the improvement in the placement rate include coordination and shared goal of limiting placement of youth if avoidable among stakeholders, consistency among team with increased experience with identifying alternatives to placement, and successful advocacy for families with the court system during his past year. Looking forward to FY20, focus will be on efforts to maintain regular communication between MST and court services staff and continued efforts to identify alternative to placement of youth served.

DBHDS PERFORMANCE MEASURES

The DBHDS dashboard targets for 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. The measures were under revision this year, settling on 9 measures. FY19 ended as the following: completion of adult (94%) & child (100%) suicide risk assessments, receiving an annual physical exam (22%), calculating BMI (88%), tracking of Individuals Outside the BMI Normal Range (82%), following-up of BMI plans (72%), and the initiation (74%)/engagement (50%)/retention (24%) of individuals in SUD services.

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

Completeness reports of: employment discussions, employment outcomes, employment status, discussion of last physical/date, discussion of last dental exam/date, substance use primary drug type

Consistency reports of: DD Waiver individuals as compared to those in WaMS, PACT individuals without a recorded service, DD Waiver individuals without a recorded service, Medication Assisted Treatment individuals without a recorded service

Accuracy reports of: SMI/SED/SED at Risk Individuals age outside correct range, individuals with no substance use primary drug type but secondary or tertiary type present, and pregnant substance use women without a recorded service

The DBHDS Dashboard and Data Quality Reports 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.

New this year, Service Process Quality Management (SPQM) was initiated. SPQM is an analytical tool offered by MTM Services in partnership with the National Council for Behavioral Health. DBHDS has contracted to use MTM's SPQM to aggregate VA CSB's data to strategize for the future, demonstrate outcomes, quantify quality and service improvements, and measure cost-efficiency gains. CSB's hope to utilize SPQM to prepare for the dynamic new value-based healthcare marketplace while achieving better health outcomes for persons receiving their services. The data from fiscal year 2018-19 was provided to MTM and analysis will begin in late September 2019.

SATISFACTION

SAMHSA's Performance Accountability and Reporting System (SPARS) Perception of Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) perception of care surveys are an important method for involving clients in improving the quality and effectiveness of services. The Perception of Care Survey System (POC) is intended to support service providers in implementing effective client surveys as part of our Quality Improvement program.

- There were 207 total responses from 131 different consumers.
- The POC is only administered at reassessment and clinical discharge, and an interview with the consumer has to be conducted.
- The last column looks at number of respondents who answered "agree" or "strongly agree"; the combined total was between 161 (77.78%) and 199 (96.14%) indicating favorable experience with the clinic.

	strongly agree		agree		undecided		disagree		strongly disagree		refused		missing data		not applicable		People who answered "agree" or "strongly agree"		
Staff here believe that I can grow, change and recover.	49	23.67%	139	67.15%	8	3.86%	4	1.93%	2	0.97%	4	1.93%	1	0.48%	0	0.00%	188	90.82%	
I felt free to complain.	28	13.53%	142	68.60%	14	6.76%	17	8.21%	3	1.45%	3	1.45%	0	0.00%	0	0.00%	170	82.13%	
I was given information about my rights.	30	14.49%	163	78.74%	7	3.38%	5	2.42%	0	0.00%	2	0.97%	0	0.00%	0	0.00%	193	93.24%	
Staff encouraged me to take responsibility for how I live my life.	29	14.01%	155	74.88%	12	5.80%	8	3.86%	1	0.48%	2	0.97%	0	0.00%	0	0.00%	184	88.89%	
Staff told me what side effects to watch out for.	25	12.08%	160	77.29%	6	2.90%	13	6.28%	1	0.48%	1	0.48%	0	0.00%	1	0.48%	185	89.37%	
Staff respected my wishes about who is and who is not to be given information about my treatment.	30	14.49%	164	79.23%	5	2.42%	5	2.42%	0	0.00%	1	0.48%	0	0.00%	2	0.97%	194	93.72%	
Staff were sensitive to my cultural background (race. religion. language. etc.).	31	14.98%	161	77.78%	8	3.86%	4	1.93%	1	0.48%	2	0.97%	0	0.00%	0	0.00%	192	92.75%	
Staff helped me obtain the information I needed so that I could take charge of managing my illness.	34	16.43%	165	79.71%	3	1.45%	0	0.00%	1	0.48%	3	1.45%	0	0.00%	1	0.48%	199	96.14%	highest
I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	17	8.21%	144	69.57%	20	9.66%	18	8.70%	1	0.48%	1	0.48%	0	0.00%	6	2.90%	161	77.78%	lowest
I felt comfortable asking questions about my treatment and medication.	36	17.39%	163	78.74%	4	1.93%	2	0.97%	0	0.00%	1	0.48%	0	0.00%	1	0.48%	199	96.14%	highest
I, not staff, decided my treatment goals.	23	11.11%	154	74.40%	14	6.76%	13	6.28%	0	0.00%	3	1.45%	0	0.00%	0	0.00%	177	85.51%	
I like the services I received here.	45	21.74%	154	74.40%	1	0.48%	2	0.97%	1	0.48%	4	1.93%	0	0.00%	0	0.00%	199	96.14%	highest
If I had other choices, I would still get services from this agency.	35	16.91%	161	77.78%	4	1.93%	3	1.45%	1	0.48%	3	1.45%	0	0.00%	0	0.00%	196	94.69%	
I would recommend this agency to a friend or family member.	37	17.87%	159	76.81%	4	1.93%	3	1.45%	0	0.00%	4	1.93%	0	0.00%	0	0.00%	196	94.69%	
Average		15.49%		75.36%		3.80%		3.35%		0.41%		1.17%		0.03%		0.38%			

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. Individuals are asked if the service received helped with goals with work, school, housing, increasing knowledge, improving daily life or engaging in community activities. Each survey includes a satisfaction question. In order to complete a timely annual report, the reporting period covers the period of April 1, 2018 through March 31, 2019.

During this fiscal year, eleven separate services were tracked. Inclusion of ID Residential services in the post discharge survey was planned, however the only discharges from the service were deaths; deaths are excluded from the discharge survey. A total of 483 surveys were mailed and 50 were returned. The response rate for programs ranged from 0% to 67% with an average response rate for all of the CARF services of 10%, up from the response rate of 4% for FY18. Individual comments are forwarded to the respective program. 83% of the returned surveys noted satisfaction ratings of either very satisfied or satisfied.

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

FY2019 ANNUAL POST DISCHARGE REPORT

HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Discharges by Program (Apr 2018 - Mar 2019)														
CM&A	MH Case Management	23	36	29	27	27	14	31	24	18	39	19	25	**312**
PACT	Assertive Community Treatment	6	4	0	3	3	1	4	8	3	6	6	3	**47**
MH Day Support	MH Community Integration	3	2	2	4	4	4	5	3	3	4	8	4	**46**
MH Residential	MH Community Housing	0	0	3	0	0	1	1	0	0	0	0	0	**5**
MH Vocational	MH Community Employment	0	4	0	0	0	4	0	3	0	2	1	2	**16**
MH Supported Svcs	MH Supported Living	1	5	4	3	3	3	0	5	1	4	2	4	**35**
ID Residential	ID Residential	0	0	0	0	0	0	0	0	0	0	0	0	
LEP	ID Community Integration	0	0	0	1	1	0	0	1	0	0	1	0	**4**
ID Supp Employ	ID Community Employment	0	1	0	0	0	3	0	2	0	3	0	0	**9**
Sheltered Employ	ID Organizational Employment	2	0	0	0	0	0	0	1	0	3	0	0	**6**
ID Group Supp Empl	ID Community Employment	0	0	1	0	0	0	0	2	0	0	0	0	**3**
Total		35	52	39	38	38	30	41	49	25	61	37	38	**483**

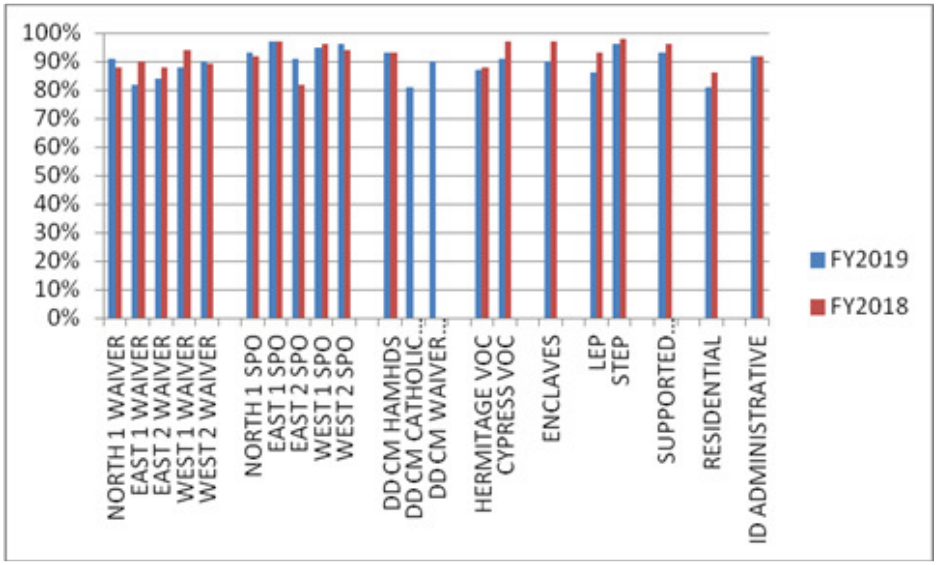
HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Response Rate%
Survey Response Rates (Apr 2018 - Mar 2019)															
CM&A	MH Case Management	0	9	0	2	1	3	2	1	2	4	0	2	**26**	8.3%
PACT	Assertive Community Treatment	0	3	0	1	1	0	1	1	0	0	1	0	**8**	17.0%
MH Day Support	MH Community Integration	0	1	0	0	0	0	1	0	0	0	0	0	**2**	4.3%
MH Residential	MH Community Housing	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0.0%
MH Vocational	MH Community Employment	0	1	0	0	0	1	0	0	0	0	0	0	**2**	12.5%
MH Supported Svcs	MH Supported Living	0	2	1	0	1	0	0	1	0	0	0	1	**6**	17.1%
ID Residential	ID Residential	0	0	0	0	0	0	0	0	0	0	0	0		
LEP	ID Community Integration	0	0	0	1	0	0	0	0	0	0	0	0	**1**	25.0%
ID Supp Employ	ID Community Employment	0	1	0	0	0	0	0	0	0	1	0	0	**2**	22.2%
Sheltered Employ	ID Organizational Employment	0	0	0	0	0	0	0	0	0	1	0	0	**1**	16.7%
ID Group Supp Empl	ID Community Employment	0	1	0	0	0	0	0	1	0	0	0	0	**2**	66.7%
Total		0	18	1	4	3	4	4	4	2	6	1	3	**50**	**10%**
Response Rate		0%	35%	3%	11%	8%	13%	10%	8%	8%	10%	3%	8%	10%	

INTERNAL AGENCY RECORD REVIEWS

Approximately 535 quality record reviews and 165 Administrative Reviews were completed in FY 2019. The number of quality record reviews completed was fewer this year due to time needed for implementing a new electronic health record.

CSS RECORD REVIEW RESULTS SUMMARY

Reviewed Waiver (20%-30%) cases and Non-Waiver cases (10%-20%).100% of Residential charts reviewed.
14 programs met the target of 90% or greater compliance with standards reviewed (North 1 Waiver & SPO, West 2 Waiver & SPO, East 1, East 2 & West 1 SPO, DD CM HAMHDS & Waiver Services, Cypress, Enclaves. STEP, Supported Employment, Administration).
7 programs were below the 90% target (East 1, East 2 & West 1 Waiver, DD CM Catholic Charities, Hermitage Vocational, LEP and Residential).



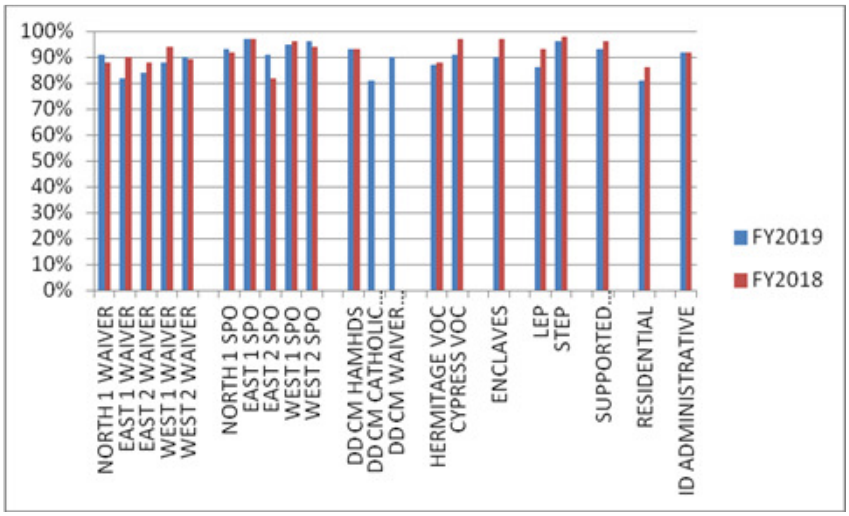
FY 2019 CSS RECORD REVIEW RESULTS SUMMARY
Year Total Results
Target for All Programs is 90%

	FY2019	FY2018	Comments
NORTH 1 WAIVER	91%	88%	
EAST 1 WAIVER	82%	90%	↓ 8 percentage points from FY18
EAST 2 WAIVER	84%	88%	
WEST 1 WAIVER	88%	94%	↓ 6 percentage points from FY18
WEST 2 WAIVER	90%	89%	
NORTH 1 SPO	93%	92%	
EAST 1 SPO	97%	97%	
EAST 2 SPO	91%	82%	↑ 9 percentage points from FY18
WEST 1 SPO	95%	96%	
WEST 2 SPO	96%	94%	
DD CM HAMHDS	93%	93%	
DD CM CATHOLIC CHARITIES	81%		
DD CM WAIVER SERVICES	90%		
HERMITAGE VOC	87%	88%	
CYPRESS VOC	91%	97%	
ENCLAVES	90%	97%	
LEP	86%	93%	↓ 6 percentage points from FY18
STEP	96%	98%	
SUPPORTED EMPLOYMENT	93%	96%	
RESIDENTIAL	81%	86%	↓ 5 percentage points from FY18
ID ADMINISTRATIVE	92%	92%	

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

MH/SA RECORD REVIEW RESULTS SUMMARY

Reviewed Medicaid (7%) and Non-Medicaid (3%) cases. 100% of Residential charts reviewed.
14 programs met the target of 90% or greater compliance with standards reviewed (ESP, Same Day Access, Youth & Family, MH/SA Outpatient, Lakeside Center, PACT West, Skills-Building and Residential).
6 programs were below the target (CM&A-East, West 1 & West 2, PACT East, Physician, Administration).



FY 2019 MH/SA RECORD REVIEW RESULTS SUMMARY
Year Total Results
Percentage represents compliance with standards reviewed
Target for All Programs is 90%

	FY2019	FY2018	Comments
ESP/PRESCREENING	95%	95%	
SAME DAY ACCESS EAST	97%	96%	
SAME DAY ACCESS WEST	97%	96%	
YOUTH & FAMILY	93%	93%	
MHOP EAST/WEST	95%	96%	
MHOP/SA/YOUTH PF	91%	91%	
SA EAST	92%	93%	
SA RMP	95%	94%	
LAKESIDE CENTER	98%	99%	
LAKESIDE CTR VOC	90%	92%	
PACT EAST	80%	88%	↓ 8 percentage points from FY18
PACT WEST	93%	90%	
CM&A EAST	84%	89%	↓ 5 percentage points from FY18
CM&A WEST 1	84%	82%	
CM&A WEST 2	87%	92%	↓ 5 percentage points from FY18
CM&A PF	na	91%	
MH SKILLS-BUILDING WEST	93%	94%	
MH SKILLS-BUILDING EAST/PF	93%	96%	
MH RESIDENTIAL	97%	94%	
PHYSICIAN	85%	85%	
MH ADMINISTRATIVE	88%	92%	

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

FY20 Objectives for the Coming Year

- Continue improvements of the Utilization Review process
- Continue to train Medical Records OAIV to pull record review samples
- Identify and report trends to AMT and program managers
- Evaluate audit functionality in Welligent

EXTERNAL AGENCY REVIEWS

	FY19	FY18	FY17
Total number of Reviews:	66	82	44
Admin:	1	1	1
C&P:	21	33	14
CSS:	37	37	26
Across All Divisions:	7	11	3
# of Desk Reviews	59	74	39
# of Onsite Reviews	7	8	5
# of C&P/CSS from Licensure review	N/A	28	N/A
# of C&P client records reviewed	72	61	33
# of CSS client records reviewed	211	381	76
Total number of records reviewed	283	470	109

Trends/Outcomes

Reviews were sent by secure email exchange, Virtru

100% of reviews were completed within the specified timeframes

Requests decreased by 20%

External Reviewers

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(Ionhealthcare), Anthem Healthkeepers (Inovalon, Datafield, CIOX), Anthem (Cotiviti), Myers and Stauffer for DMAS, Office of Human Rights, Cigna(CIOX), CMS (Center for Medicare and Medicaid), Qlarant(formerly known as Delmarva), Virginia Supportive Housing, Virginia Premier, Board of Pharmacy, disability Law Center, United Healthcare, Aetna (Arrohealth, Cotiviti), Partnership for People with Disabilities

Types of Reviews

Meaningful Use, Mortality Reviews, SIS (Supports Intensity Scale), HEDIS, Risk adjustment; Dx coding, Claims coding/submissions, Wellness Exams, Clinical Risk adjustment, Well visits, Quality of Care Review, NCI(national core indicators), Quality Improvement Initiatives, SEMAP/HQS Inspections, Shelter Plus Review, Review of services, monitoring visit of PSH((Permanent Supportive Housing), Block Grants, Functional Assessment and COS Monitoring, Developmental Disability waiver services, Waiver look behind, Pharmacy Inspection, Measuring improper payments (PERM), follow up on CHRIS reports, Crisis service review through REACH, progress notes from Independent Homes, Verification request

Goals

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

RISK MANAGEMENT COMMITTEE SUMMARY

The Risk Management Committee (RMC) is a cross-functional agency workgroup that meets on a quarterly basis to monitor the risk and accessibility needs of the agency. Yearly a risk management and accessibility plan is developed along with improvement plans documenting areas the agency is working on to continue to mitigate our risks. In September 2018, the Office of Licensure added regulatory requirements for providers to annually access their risks including a review of serious injuries very similarly to accreditation standards and are represented in our risk management planning.

Committee highlights: RMC reviews the critical incident data produced by the Incident Review Committee. FY19 data continues to trend an increase in the number of falls, particularly in services that have individuals with increased medical needs. The committee sponsored for the second year training on why falls happen and how to prevent them and facilitated a falls discussion with CSS extended management team in May. In FY20, the committee will use National Falls Prevention month in September to increase awareness on how to prevent falls. During the year, committee members researched materials to share for this awareness campaign.

An individual receiving services from Hermitage Enterprises is an active member of the committee and regularly provides input. During the flu season she reported a number of her peers had the flu, which was also representative of staff that was also sick with the flu. The committee recommended distribution of flu prevention information, which resulted in posted flyers developed by an agency nurse and information distributed regarding the importance of flu shots and other prevention methods. Every three years RMC completes an accessibility review of each site; this review began in FY19, any areas of improvement will be added to the FY20 Risk management plan. Other areas of the committee work included; review and input into agency Risk Management policy, review of revised licensure regulations, strategic planning input, received updates on facility projects, recommended carbon monoxide detectors which were added in appropriate locations, assessment of our wheelchairs, CARF preparation. Additional information is documented in the FY19 risk management improvement plan and the FY19 accessibility plan of correction.

In May, Virginians were impacted by a mass shooting which occurred at a municipal building in Virginia Beach. HAMHDS Emergency Services staff assisted our Virginia Beach public service counterparts and was part of their front line grief counseling. In response to this event, Henrico County, led by the division of Police, began to assess each County facilities for safety through the workplace violence self-assessment tool and developed a four hour workplace emergency preparedness training, which included active shooting training for all Henrico County employees. The training was developed and presented at multiple times and various locations by Police, Office of Emergency Management and HAMHDS. Recommendations from the site assessments will be implemented by the agency and become part of FY20 Agency Risk Management planning. Also in FY20, the agency will identify a safety liaison to work with the County of Henrico's Emergency Management and Workplace Safety (EMWS) team on best practices throughout the county for safe work environments and preparedness drills.

CRITICAL INCIDENTS AND COMPLAINTS

The Incident Review Committee met quarterly to review each incident submitted in the agency's incident reporting information system (iRIS) located on the agency's intranet. The committee's review includes a review of the incident, discussions of cause, actions for improvement if indicated, prevention strategies and other needed strategies. The review of individual incidents is documented in iRIS under committee notes. Staff report incidents in iRIS and reportable incidents are submitted to DBHDS through their electronic reporting system, CHRIS within 24

hours of agency notification. Effective September 2019 root cause analysis of required incidents was completed within 30 days and documented in iRIS.

Incident Type	FY18	FY19	Q1	Q2	Q3	Q4
Assault by client	5	1	0	0	1	0
Behavioral incident	11	22	7	4	8	3
Biohazard incident/bomb threats	1	3	1	2	0	0
Communicable Disease	0	0	0	0	0	0
County vehicle*	4	16	5	3	3	5
Death-accidental	6	4	0	1	2	1
Death-likely homicide	1	0	0	0	0	0
Death-likely suicide	3	0	0	0	0	0
Death-natural causes	30	36	7	9	13	7
Fall- with injury requiring med. Attn	29	26	7	6	5	8
Fall- without injury	44	76	19	17	21	19
Fire	0	0	0	0	0	0
Illness (e.g. seizure, diabetic reaction)	27	61	13	16	17	15
Licit/Illicit drugs or weapons	0	0	0	0	0	0
Med incident- req. med. Attn	0	1	1	0	0	0
Med incident- NO adverse reaction	23	41	6	10	16	9
Other	20	67	7	7	23	30
Property damage	6	3	2	1	0	0
Property loss/theft	9	8	2	3	2	1
Self-injurious behavior	9	7	3	1	2	1
Serious injury	2	3	0	2	0	1
Sexual incident	1	3	0	1	2	0
Suicide attempt	37	44	9	12	11	12
Threats/violence	0	3	1	1	0	1
Violent crime by client	0	0	0	0	0	0
Totals	**268**	**425**	**90**	**96**	**126**	**113**
Restraints	**1**	**2**	**0**	**2**	**0**	**0**
0	0	0	0	0	0	0

Trends and Observations

- No specific trends were noted that required significant or organizational-wide interventions.
- Looking back at data over the last three fiscal years there has been a significant increase in incidents in 2019. There were regulation changes that required reporting of additional categories that occurred in this fiscal year which impacted these numbers.
- 135 Root Cause Analysis (RCAs) were completed within the 30 day requirement.
- The "Other" category has increased primarily due to these changes in state reporting requirements which includes unplanned psychiatric hospitalizations.
- The increase in Deaths may be impacted by people living longer with DD and dying from natural causes while on the BH side, it may be from unhealthy lifestyles.
- Suicide deaths has decreased while attempts have increased. This lower death rate by suicide may be the result of more attention to prevention.
- Falls have drastically increased they are individually evaluated through the root cause analysis and have offered prevention of falls training to staff.

- Medication errors have increased, possibly a result of staff shortages but will also evaluate to ensure ongoing training is being kept current. Will begin looking at type of med errors to see if there are further opportunities for intervention.
- There was a large jump in illness. This is a large category with lots of different areas covered. Will monitor each quarter for specific trends.

FY20 Goals

- Develop a workgroup to reevaluate how incident reports are categorized to mirror the new regulation changes and to assist with the reporting process. Update iRIS to include these changes.
- Meet the needs of the new DBHDS Office of Licensure incident management unit (IMU)
- The agency continues to provide education and competency- based training to support staff.

HUMAN RIGHTS INCIDENTS

There was a 21% increase in the number of human rights reported for FY19 (70 to 88). Of the 88 reported 35 were determined formal complaints and reported to the State DBHDS, representing a 23% increase in the number of formal complaints from FY18. Of the 35 formal complaints (6) were founded and (29) were unfounded. The reporting trends of complaints continue to be the same as in previous years with the majority of complaints reported in the area of privacy and peer-to-peer (P2P). There was a significant increase, 45% (10 to 18) in P2P reports. This number is duplicative as 2-3 individuals had more than one P2P in the year. The number of reportable formal privacy report has slightly reduced from last year (from 7 to 5) with the number of breaks in agency policy remains fairly comparative to last FY (30+) and within baseline for the number of individuals the agency serves per year, over 9,500.

Staff training continues in the areas of confidentiality and other human rights at orientation and annually thereafter in efforts to improve performance. Trends are shared with staff during new staff orientation, providing information regarding types of privacy breeches and other complaints that have occurred and how they can be avoided. An example includes a list of similar names of staff within the agency and in other government departments was provided in efforts to reduce privacy breaks in policy. Focused training with units also occurred upon request within the year.

Type	FY18	FY19	Q1	Q2	Q3	Q4
iRIS Human Rights (HR) reports	70	88	20	13	28	27
Formal HR reported in CHRIS/OCR	27 9 OCR	35 5 OCR	6 1 OCR	6 2 OCR	10 0 OCR	13 2 OCR
Founded in CHRIS	9	6	2	1	1	2
Unfounded in CHRIS	18	29	4	5	9	11
Late HR reports in CHRIS > 24 hrs	3	0	0	0	0	0
HR appeal to ED	1	2	0	0	1	1
HR appeal to County Manager	0	0	0	0	0	0
HR appeal OHR	1	0	0	0	0	0
HR appeal to LHRC / SHRC	0	0	0	0	0	0

Restraints	1	2	0	2	0	0
HR reported to MCO	0	0	0	0	0	0

There continues to be an increase in monitoring and oversight of providers. This year the disABILITY Law Center (dLCVA) was provided access to the DBHDS CHRIS reports. During the third quarter, the agency received a request of our human rights investigation report from the dLCVA regarding a CHRIS report that was both a serious injury and human rights report. A comprehensive report was provided with complementary feedback regarding the agency's investigative process and program charting documentation.

CSS Day and Residential programs developed a workgroup to implement new human rights requirements under the Home and Community Based Waiver Services (HCBS). Agency policies and procedures were updated to include additional HCBS rights. Forms, posters and brochures were developed to educate individuals on the new human rights. Leases were developed and signed by individuals in residential services. HCBS training occurred with staff and individuals receiving services, the training was posted to the agency intranet and added as an annual training for these programs. Documentation of compliance and implementation of new regulations were uploaded as required into the DMAS RedCap system.

Early Intervention mediation process for human rights complaints was added to the agency human rights policies and procedures.

The Office of Human Rights now offers quarterly training on reporting in the state system CHRIS. QA staff attend quarterly training to keep abreast of new state reporting requirements. In FY20 the state reporting system CHRIS will undergo changes to reflect new serious injury reporting and human rights reporting. Individuals at Hermitage Enterprises received Leadership for Empowerment and Abuse Prevention (LEAP) training. This training covers appropriate interaction, knowing your rights, identifying inappropriate behaviors, and what to do if inappropriate treatment occurs.

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 36 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 80 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; Trauma & Resilience Basics, Working with the Blind and Visually Impaired, Health Equity in Mental Health, Hearing Voices Network, Providing Trauma-informed and Inclusive Care to LGBTQ+ Populations within Mental Health Settings, Using

Mandalas to promote healing in self and with others., My Side of the Story featuring HAMHDS HR staff, Vicarious Trauma, HCBS Rights & Incident Reporting, Documentation - Support Instructions and Notes, Why Falls Happen and How to Prevent them, Working with Hispanic/Latinx clients and Families, Rational Emotive Behavior Therapy, Vicarious Trauma, Medication Assistant Treatment, Promoting Staff Safety, Introduction to Behavioral Health Homes, Home & Community Based Services, Fata Morgana, Acceptance & Commitment Therapy Matrix, Child DLA-20, Mental Health First Aid, Understanding Play and Play Therapy, My Side of the Story-Jail Diversion, Adult DLA-20, EMDR Resourcing, Trauma informed approach to working with immigrant and refugee populations: part one, Trauma informed approach to working with immigrant and refugee populations: part two, Advance Directives, Afraid Of The Dark - Nat King Cole Documentary, Strategies in providing telehealth therapy, Tracing Your Roots - Session 1, Tracing Your Roots - Session 2, MST Fit Circle, Utilizing the media to promote DD Awareness, FATA MORGANA, Termination with clients- Strategies to say goodbye, PTSD, Cultural Competency - Aging & the Arts, Money Management when living paycheck to paycheck, CAN, Using Mindfulness Strategies with Clients, Ethics Training

Accomplishments

- New Red Cross purchases included; 260 Red Cross Key Chains, 100 Prestan Face shield/lung bags, 200 First Aid/CPR training kits, Protective gloves
- Recertified 5 TO trainers
- Certified 4 new Red Cross trainers
- Created a Competency based POV test for CARF
- Created a new power point for POV

Goals

- Certify 2 new TO trainers
- Recertify 3 TO Trainers
- Update POV of violence training
- Explore options for grading the competency based trainings

INFORMATION TECHNOLOGY

The Information Technology Plan is reviewed yearly to assess the progress of projects and update their timelines as needed. Accomplishments and initiatives of the past year are updated accordingly. For FY19 the team was a part of the agency wide initiative implementing a new electronic health record system.

Accomplishments

- Began Implementation of the Welligent electronic health system
    - Completed the deployment of over 200 laptops including LSC and Hermitage Enterprises
    - Planned system set up, including program, security and billing & authorization modalities and configured the system
    - Identified and completed appropriate templates for data conversion
    - Map the systems interfaces and extracts
    - Created over 200 Forms
    - Worked with Welligent on developing required State Reporting

- Worked with County IT to ensure state of the art wiring wifi, telecommunications capabilities were properly installed at the newly built East Center
- Built and tested billing modalities for Medallion 4 and Medicaid Expansion
- Developed MH productivity reports to aid the programs in reaching their State Dashboard goals
- Implemented SPQM
- Added second monitors to improve work efficiency to 125 computers
- Enhanced the iRIS functionality to respond to increased state reporting requirements
- Implemented the Governor's interoperability initiative with emergency rooms via the EDCC Premanage program
- Completed the OBOT administrative parts for implementation (billing, credentialing, etc.)
- Created auto-sampling to pull records for internal review in the Chart Tracker system
- Developed a new and more meaningful Monthly County Manager Report
- Added a number of Administrative supports for the CST department in response to the DOJ requirements

Goals

- Complete implementation of Welligent and begin operationalizing the system
  - Perform Data Conversion testing interactions before the final conversion
  - Complete system configuration
  - Complete Business Process Reviews with the programs and write Welligent processes for each
  - Create Testing scenarios
  - Plan training strategy and write training materials
  - Begin reporting from the system
  - Test and ensure accurate state reporting from Welligent
  - Create Car and Conference Room calendar capability in Welligent
  - Complete forms development and learn how to create forms in Welligent
  - Develop interoperability with the Daily Planet
  - Implement the Patient Portal
  - Develop Meaningful Use reporting
  - Implement 835 capability for all insurance carriers
  - Implement 271 eligibility look up
  - Develop SPQM reporting
  - Work with the Program staff and Financial Management to ensure they receive accurate and meaningful data from the new system.
  - Operationalize all Business Support and Reimbursement processes
- Add Telecommunications to Conference Room C
- Provide a camera recording solution for a specialized Parent/Child Therapy
- Update Internet and Intranet content and operationalize the process to ensure the most current is available

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; Working with the Blind and Visually Impaired, Fata Morgana, a documentary on refugees from Libya, Afraid of the Dark, a documentary of Nat King Cole, and Mental Health Issues in Older Latinos in US.

The committee also planned an agency event to bring all staff together; this year's gathering was a cook-out celebrating Team Spirit.

The agency continued to utilize Cyracom as a network of language interpreters. Cyracom is a full-service language provider that focuses on healthcare. Cyracom provides interpretation services available via phone with consumers. According to Cyracom the top ten languages requested were Swahili, Spanish, Dari, Arabic, Vietnamese, Burmese, Farsi, Nepali, Bengali, and Karen. These Cyracom percentages reflect Cyracom usage and not necessarily reflective of number of individuals. In addition, interpreters used by the agency were posted on the agency's intranet page with contact information and rates.

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 celebrated 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	Spanish
3.	Other	Other / Asian	Korean
4.	Arabic	Arabic	Vietnamese
5.	Non-Verbal***		Arabic
6.	Vietnamese		Tagalog
7.	Farsi/Persian	Chinese	Afro-Asiatic

DEMOGRAPHICS

Total Consumers Served by Program Area

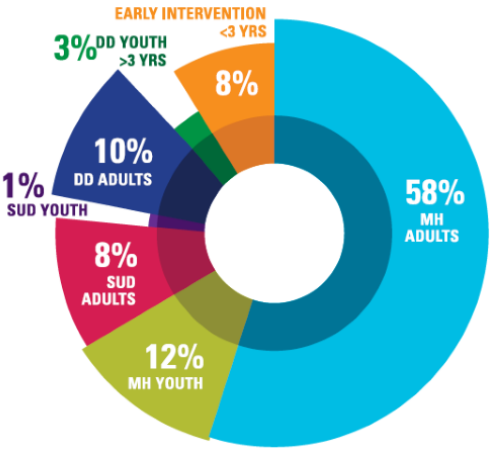
9,783 individuals were served in FY19.

For adults: 58% received Mental Health Services, 10% Developmental Disability Services and 8% Substance Use Disorders Services.

For youth: 12% received Mental Health Services, 3% Developmental Disability Services, 1% Substance Use Disorders Services and 8% Early Intervention < 3-year olds.

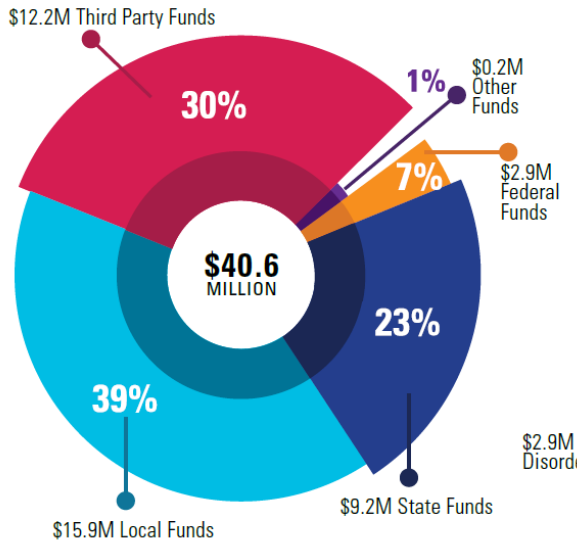
Consumers Served by Gender: Fifty-seven (58) percent of individuals served in were male, and 42% served were female.

Distribution by Race and Ethnicity: 46% served identified themselves as White/Caucasian, 42% Black/African American, 12% Alaskan Native, American Indian, Asian, Pacific Islander, Multi-Racial.

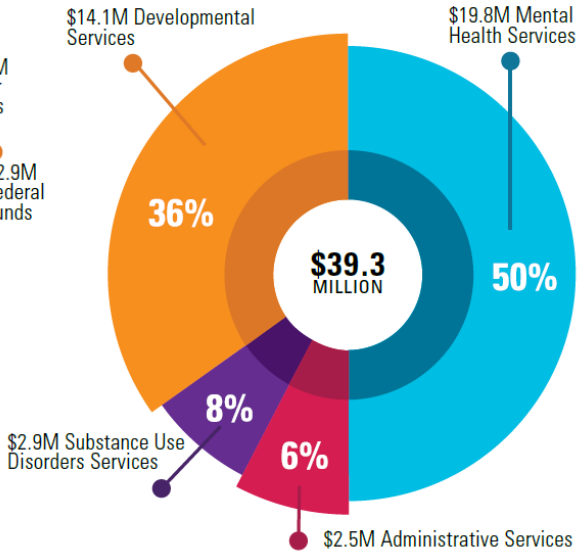


BUDGET

REVENUE



EXPENSES



FY19 Revenue	
State Funds	$9,256,060
Federal Funds	$2,961,603
Local Funds	$15,981,097
Fee Revenues	$12,281,211
Other Funds	$203,868
Total	$40,683,839

FY19 Expenses	
Mental Health Services	$19,682,219
Substance Abuse Services	$2,946,530
Developmental Services	$14,182,267
Administrative Services	$2,551,875
Total	$39,362,891