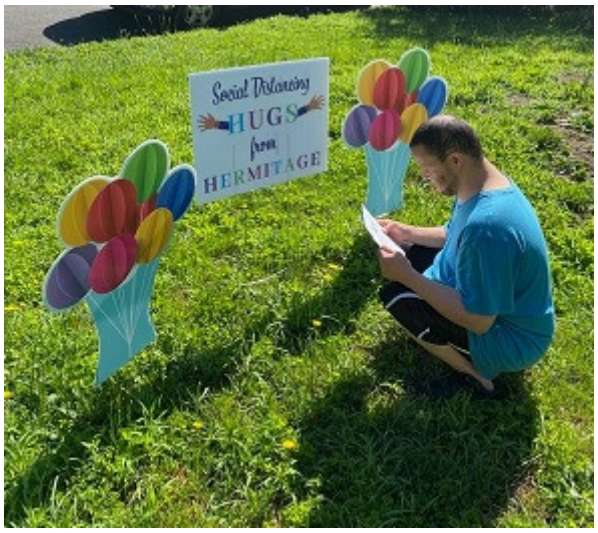
ANNUAL PERFORMANCE ANALYSIS 2020-2021

SERVING THE COUNTIES OF HENRICO, CHARLES CITY & NEW KENT



MANAGEMENT SUMMARY

On behalf of the Community Services Board and staff, we are pleased to present the Henrico Area Mental Health & Developmental Services (HAMHDS) Fiscal Year 2021 Annual Report. This report reflects the services offered to the residents of Henrico, Charles City, and New Kent Counties in supporting individuals who are experiencing behavioral health, substance use or developmental disabilities to live in an inclusive, healthy, safe community where they can lead full and productive lives.

For a second year, the global pandemic continues to impact the way we all live. We have worked diligently to provide the level of services needed while ensuring the safety and well-being of staff, individuals, and communities. The commitment, resiliency, creativity, and compassion of our staff have not wavered as they have risen to meet the challenges to successfully carry out our mission. The impact of our evidence-based services and best practices are reflected in the words of our staff.

"Infant massage proves to be extremely beneficial to babies and caregivers. While infant massage is known for stimulating brain function and development, it also helps to relieve babies' pain from gas/colic and, through touch, smiles and hugs, it promotes and enhances the bond between the baby and caregiver."

Bernita Sykes, Psy. M., Program Coord./ Local System Mgr.

" Peer support is about hope, mutuality, and lived experience. As a peer recovery specialist, we give hope to the clients we serve by letting them know that recovery is possible for "everyone." It has been said that we are all in recovery from life's physical and mental challenges, especially with what has happened in our society's current and past traumas. By serving others and giving back, it has helped me in my own recovery. Sometimes we do not see immediate successes with the people we are serving. Our "aha" moments come with a simple "thank you," a smile, a hint of laughter, and a tear of faith. We try to help others realize that you can see light in the broken bottle as well as in the diamond crystal. Life and recovery are about growth. No one is ever finished. The top of one mountain is the bottom of another. Peer support has given me a great purpose and the great knowing that we are all connected. Once you choose hope anything is possible."

Jim Kochany, Peer Recovery Specialist

"An individual's risk of death is reduced by 50% when they are engaged in long-term medication-assisted treatment for opioid use disorder. Developing our rapid access program and continually working to identify and eliminate barriers to access for anyone seeking this care is critically important. We never know how long an individual who presents for treatment will remain willing to start recovery, and this might be the only chance we have to save their life."

Shannon Garrett, RN, MSN, FNP-C

"Permanent Supported Housing has given some of the most vulnerable population an avenue of hope and a second chance at life to live with dignity in a space of safety they can call their own."

Traci Paskins-Brower, Case Manager

"Being a front-end staff can be a rewarding part of an individual's recovery. It takes courage to walk through the front door or pick up the phone and seek services. A warm greeting or an offer of assistance as the individual navigates services helps to ease their fears and starts their recovery."

Christy Kipps, Business Supervisor

" Having an onsite pharmacy has had numerous benefits for clients and the agency. Pharmacy costs for subsidized medications have been reduced by 85% through effective collaboration with Westwood pharmacy. More total clients have been served through this partnership while decreasing utilization of funds. This partnership also has allowed us to

offer onsite flu vaccines for clients and staff and COVID-19 vaccines for staff. They are helping to streamline patient care by providing prepackaged, daily medications for the ACT Teams and case management clients."

Jennifer Pearce, MSN, RN

"Medical records play an essential role to the agency because our job focuses on providing a high level of customer service to the individuals we support. We obtain, safely maintain, and securely release health information. Medical records bridge the gap between mental illness, developmental disabilities, substance use disorders, and continuity of care because we are the gateway to allow direct access yet secure accessibility to client's health information. This will enable our clients to get linked with the most appropriate resources to benefit from the highest quality of care; therefore, promoting a better quality of life."

Juanita Turner, HIM Management Assistant

All of these successes and accomplishments would not be possible without many strong and supportive partnerships. We are thankful for the ongoing support of the Boards of Supervisors of the counties of Henrico, Charles City, and New Kent who truly understand the need for services. We are extremely grateful to the dedicated and committed members of the Henrico Community Services Board. We are incredibly proud of our competent, dedicated staff who work every day to improve the lives of the individuals and families we serve. We hope this report gives you a glimpse into the vital work of the agency as we focus on hope, dignity, recovery, self-sufficiency, support and service.

Karen W. Grizzard
Board Chairperson

Laura S. Totty, MS
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

2019-2022 Strategic Initiatives

The agency continued to follow the strategic planning road map that was developed last year. At the end of FY20 an addition strategic initiative on Social Justice was added. The strategic initiatives for 2019-2022 are as follows.

1) To implement DBHDS statewide 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.

Objectives:

- Participate in statewide 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 Statewide assessment on the agency's infrastructure
- Evaluate the need for restructuring to meet the implementation needs of STEP VA
- Evaluate the staffing needs both programmatic and administrative
- Educate staff and stakeholders of STEP VA

FY21 Accomplishments - To implement DBHDS statewide initiative STEP Virginia

The COVID pandemic and the Commonwealth's State of Emergency delayed implementation and funding for some STEP-VA initiatives. During this delay, the STEP-VA Strategic Initiative Committee did not regularly meet since there was no work to be done. By the end of the fiscal year, STEP-VA was once again moving forward, and state funds were released to support these initiatives. The Strategic Committee resumed meeting and developed the following plans for three STEPS:

Peer Services:

- Add one full-time Family Support Partner who will be housed in the Youth and Family Services Program.
- Add one full-time Peer Support Services Specialist focused on community integration for individuals currently and formerly served by Adult Recovery and Collaborative Services.

Outpatient Services:

- Add one full-time Substance Use Services Clinician to meet increased demand.
- Add one full-time Clinical Psychologist who will spend half their time providing testing for individuals served throughout the agency and half their time providing therapy within the Youth and Family Services Program. The enhanced therapy services in Youth and Family will allow us to have one full-time staff member whose total time will be committed to Parent Child Interaction Therapy and provision of Child-Adult Relationship Enhancement (CARE) training.
- Add one full-time Medical Records Specialist to assist with increased infrastructure demands related to program expansion.

Service Members, Veterans, and their Families (SMVF):

- Add one full-time Peer Recovery Specialist who will focus on identification, outreach and engagement. This Peer Recovery Specialist will also be responsible for providing training and consultation to agency staff and staff of community partners.
- Enhance availability of Eye Movement Desensitization and Reprocessing (EMDR) services to SMVF with history of trauma through increased training and support of clinical staff.

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 1 is continuing from the previous strategic initiative to implement Welligent, phase 2 will be to fully maximize the capabilities of Welligent. The current implementation work group will continue to work on phase 1. Once implemented a new workgroup will implement phase 2. Phase 2 work group members will not be identified until phase one is completed.

Objectives:

Phase 1

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

Phase 2

- Strengthen EHR capabilities. Intensive staff training on new system
- Strengthen data infrastructure to increase data driven decision making
- Meet Statewide initiatives for data exchange, such as WAMS

FY21 Accomplishments - To implement Welligent and fully maximize its capabilities

- 40 BPRS (Business Process Reviews) were completed
- Over 80 UATs (User Acceptance Testing) sessions were completed
- 75% of tickets were closed
- Data for data migrations was submitted
- 100% of Superuser training was delivered
- 50% of staff training was developed and delivered by IT staff in collaboration with Welligent

In June 2021, the Welligent contract was terminated for convenience.

FY22 Goal – in partnership with County IT, select and implement an EHR by June 30, 2022.

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.

The SUD Strategic Initiative committee was formed in 2019. Current members: Laura Totty, Leslie Stephen, Terese Hunter, Rodney Gore, Robin Edwards, Shareka Eldrige, Allison MacKay, Jocelyn Hamilton, Dr. Coster, Jennifer Pearce. Co-Chairs, Janice Atwell, and Karen Branin

In 2019, HAMHDS identified SUD services as part of its regular strategic initiative selection process. Simultaneously, the County Manager and Board of Supervisors created the "Recovery RoundTable" committee that included agency and community partners to explore effective ways Henrico County could respond to the Opioid Epidemic. The SUD strategic Initiative Committee was identified as the group that would carry out any recommendations received from the Recovery Roundtable. As the Recovery Roundtable participants chose to expand the focus of the group to all substance use disorders. The group was renamed, The Addiction Task Force (ATF).

Over the past year, The SUD Strategic Initiative Committee continued to work on the objectives identified below despite the challenges that the COVID-19 Epidemic presented.

Objectives:

- Implement Addiction Task Force (ATF) recommendations
- Expand SUD Services/Prevention and education efforts within the catchment area to include Henrico County, Charles City and New Kent.
- Advocate for services and treatment for individuals with substance use disorders.
- Reduce the number of individuals with substance use disorders involved in the criminal justice system.

FY21 Accomplishments - Substance Use Disorder Recovery Transformation

- Streamlined referral process to our Office Based Opiate Treatment Program from Same Day Access with the development of Rapid OBOT admissions.
- Completed and submitted the application for SUD Case Management license.
- Developed referral process/job description for Jail Diversion Case Manager
- Hired Jail Diversion Supervisor and Case Manager
- In conjunction with Henrico Community Corrections, developed the Community-based Housing for Individuals in the Recovery Process (CHIRP) program. CHIRP provides financial assistance to individuals with SUD who need recovery homes and meet certain income criteria. Grant funding was obtained from the Department of Behavioral Health & Developmental Services.

- Participated in the ATFs Detox Center work group to identify expansion opportunities on a county wide level.

4) In October 2020, an additional strategic initiative was added, and a committee formed: Committee for the Advancement of Racial and Social Equity.

Overview:

HAMHDS is actively committed to eliminating systemic inequities and developing an environment free of racism. Racism, systemic racism, racial inequities and social injustices exist and negatively effects our work towards actualizing our vision and values. HAMHDS works to ensure an inclusive work environment, for all races, cultures, and identities.

Objectives:

- Discussions with all agency staff
- Gain input, suggestions from staff, persons served and stakeholders
- Research possible training opportunities
- Develop and implement a work plan consider the following;
    - Reporting and Responding to Acts of Racism
    - Policies, Procedures and Data Analysis
    - Hiring, Promotional, Performance and Disciplinary Actions
    - Training, Increase Awareness and Professional Development
    - Caucusing and Safe Spaces

FY21 Accomplishments – To implement diversity, equity and inclusion strategies
CARSE has identified four areas where further assessment is needed and there are opportunities for growth. These areas are Training, Response to Incidents, Hiring/Promotional Practices and Management/Communication. We are actively developing objectives and action plans related to these four areas, which include:

- Increased training sessions offered to staff and leadership
- An all staff survey
- Training internal facilitators to facilitate conversation regarding race and equity
- Conducting an organizational equity assessment
- Installing suggestion boxes to encourage staff feedback on DEI (diversity, equity, inclusion) topics

In addition to working on these objectives, we have offered processing spaces to staff following significant events on the national news. We plan to work with agency leadership to ensure that processing spaces are more regularly offered to staff.

The Department of Behavioral Health and Developmental Services recently awarded HAMHDS a Behavioral Health Equity Grant in the amount of $10,000. The grant proposal's focus is on addressing the needs of the African-American community, particularly the needs and concerns voiced by Black staff members, as well as our client population. The grant will be used to fund many of CARSE's objectives.

FY21 ACCOMPLISHMENTS/ FY22 GOALS

Medical Accomplishments

- Prescribers continued to serve clients in most parts of the agency including Outpatient, Case Management, SUD services including OBOT, Youth and Family services, Developmental Disability, Assertive Community Treatment, Jail Diversion, and Medication Only services and had more encounters and persons served in the height of the pandemic through utilization of a variety of encounter types including in-person face to face services in the office or home visits, when needed for ACT services, and Telehealth.

- HAMHDS psychiatrist utilized his community connections to help facilitate connecting over 900 members to vaccines in the community through a local pharmacy.
- Continued work with the Virginia Mental Health Access Program (VMAP) to expand access to child psychiatry services through education and consultation with pediatricians and family practice providers.
- HAMHDS psychiatrist provided exemplary customer service by at times providing home visits and transportation.
- Provided supervision for students and residents looking for clinical hours to satisfy their program requirements
- Responded in less than 24 hours to administer 110 vaccines in January 2021 to staff and again in February
- Served more clients in FY 21 compared to the previous year
- The relationship and services were expanded through Westwood Pharmacy with the addition of the alternative delivery site at the Woodman office in January. The expanded services include payment acceptance and Westwood staff on site which has improved convenience to clients and staff.
- Increased prescriber time dedicated to Substance Use Disorder Services
- The medication repackaging training was adapted to online availability which decreased face to face time during the pandemic and improved accessibility for staff.
- Medication samples were maintained and available to clients through the pandemic by utilizing other virtual collaboration tools.
- Implemented a new electronic prescribing platform
- The alternative delivery sites (ADS) and HIPPA BAA agreements with local pharmacies have been brought up to date and expanded.
- In light of the ongoing opioid epidemic, the total number of prescriptions for and injections given of Vivitrol have increased.
- With knowledge of decreased availability of standard sharps containers, the medical unit immediately instituted a collection of alternative sharps containers to have them available if the need arose.
- Reduced pharmacy costs for subsidized medications by 85% through effective collaboration with Westwood Pharmacy.
- Further collaboration with Westwood Clinical Pharmacy allowed for more efficient use of opiate jail diversion grant funds for purchase of Vivitrol which ensured adequate supply with less risk of waste.
- All offices including both ACT teams now have updated glucometers and strips available to improve access to testing.
- Our Nurse Manager earned her Master of Science in Nursing (MSN) degree.
- Additional Clinical and Educational Activities included:
    - NIMH Meetings for DSM 6.0 Guidance Workgroup and FEP
    - CIT/FBI/ATF Meetings
    - CIT Collaborations
    - DBHDS Consults
    - County Prosecutor Meetings
    - Court Reports
    - Jail Visits
    - Hospital Visits
    - Hospital Treatment Team Collaborations
    - ED/CRC Consults
    - NAMI Presentations
    - National Educational Webinars

Medical Goals

- Support all agency strategic initiatives.
- Develop and implement a medication treatment management type program focused on whole health.
- Use best practices for providing telehealth services ongoing.
- In line with the agency's strategic initiatives, to fully implement use of our new electronic prescription platform into the new EHR product and/or successfully transition to a combined product.

Administration Accomplishments

- Staff from Business Support, Human Resources, Reimbursement and Financial Management volunteered at the RIR Vaccination events for short term and long-term assignments.
- Successfully applied for COVID Funding and provided required reporting for:
  - DBHDS SAMHSA COVID-19 Emergency Grant to supplement SUD services $158,686
  - CARES Act Provider Relief Round 2 funds to Medicaid providers $208,082
  - Virginia Housing COVID-19 Equipment Funding Round 2 $28,619
  - Virginia Department of Aging & Rehabilitative Services COVID Emergency Support $53,983
  - Virginia DMAS Cares Act funds Residential $48,199
  - Virginia DMAS Cares Act funds Day Services $155,194
- Appropriated the FY21 budget by quarter instead of annually per guidance from Henrico Office of Management and Budget.
- Continued to report COVID time from 214 reports and expenses to county SharePoint site.
- An audit of expenditures by Internal Audit resulted in no recommendations and two observations.
- Participated on a workgroup with DBHDS to develop a Federal Grant Reimbursement process.
- Collaborated across teams in Admin – Financial Management staff began to code EFT (electronic funds transfer) remits that cannot be downloaded into Cerner, tabulate the total per paysource/benefit plan and balance the totals to the EFT to assist the Reimbursement team.
- Financial Management began scanning the daily check log and support to allow processing by Reimbursement staff working remotely.
- Completed the Minimum Wage Private Provider Survey and contributed to the DD Waiver Rebase Survey
- Worked with VA Premier to reprocess and reimburse 2019 and 2020 claims due to system changes and set up to include agency's NPI in box 24J
- EOM closing process completed 8 out of 12 months on and/or less than two business days after the 10th business day
- Business Support transitioned from remote work to in the office by July 1, 2021.
- Successfully managed all facilities needs between telework and in-office work without compromise in proficiency.
- Responded to 794 facility work orders, completed 130 projects
- IT responded to 3105 work orders and replaced 125 desktops with laptops for staff mobility
- 97% completion of Woodman Staff Lounge Uplift (complete except for a few pieces of furniture)
- Worked with Reimbursement and QA on completion/reporting of MCO's required training
- Tested and trained on new Learning Management System
- Worked closely with county HR to fill agency vacancies
- EHR credentialing training
- Continued work with agency CDP program
- Maintained and track staff COVID leave and absences
- Began planning for MH/DS Job Fair
- Tracked staff annual trainings 95% compliance
- Successfully coordinated remote agency orientation
- Ensured new hires received new/required COVID Webnet trainings
- Successfully transferred in person NIMS700 training to online via the FEMA website
- Ensured staff defensive driving refresher/initial training is current
- Performed Cerner promotion to version 2.32 with the testing help of the Promotion Committee within 10 business days and ahead of July 1st deadline.
- Presented three options for e-Prescribe software to Dr. Coster and medical team within two days of notification of need and implemented solution prior to July 1st deadline.
- July 2020 – performed Cerner database and application move to a new SQL server.

- Redesigned Chart Tracker reports. Gave business ability to obtain chart review listings on demand without IT intervention.
- Implemented new SharePoint site to replace outdated Intranet
- Developed materials and delivered Welligent EHR training. Worked closely with clinical staff to convert current work processes to Welligent workflows.
- Performed Welligent EHR testing and collaborated with Clinical Staff, Arlington CSB and the vendor in developing the product.
- Completed equipment replacement of all desktops with laptops for staff mobility. Installed docking stations with additional monitors.
- Implemented new technology for mass deployment of new laptops.
- Updated all staff to new Office 365 version.
- Built a new Windows 10 operating system image for use by the Agency in deployment.
- Replaced printers and enabled faxing on multi-function devices.
- Reconfigured call center for a new hunt group configuration to assist with COVID processes.
- Setup teleconferences for agency-wide meetings.
- Developed new reporting dashboards: Emergency Services, Addiction Task Force, Substance Use, CIT.
- Supported Reimbursement by mentoring and updating billing modalities and service codes and all things Cerner. Answered requests for setup of new billing codes and service codes.
- Created new subunits in Cerner to reflect additional services provided by the agency and maintained Cerner forms.
- Developed new web application for updating staff emergency contact information. Linked the information to active directory for automatic updates.
- Developed application for CIT to enter suicide information from Police, keep track of CIT training for individuals and class information. This application feeds into CIT dashboard.
- Completed Jail, SAMHSA, and other surveys for the agency.
- Moved iRIS application to the new SQL server and implemented a new version.
- Installed CIT cameras at Woodman and East Center.
- Consulted with Clinical staff to ensure that services were reported accurately to CCS during COVID.

Administration Goals

- Partner with IT to select and implement an electronic health record system by June 30, 2022.
- Partner with HR to host the first MH/DS Job Fair in August 2021
- Improve the EOM closing process to ensure a consistent and timely close each month
- Reduce accounts receivables throughout all programs
- Implement 835 electronic process for VA Premier, Aetna Better Health and Optum payment remits
- Reduce A/R balances over 90 thru 120+ days by 5% every quarter. This is also our FY22 outcome.

Administration Outcomes

MEASURABLE OBJECTIVE Staff annual trainings will be 100% complete by agency deadline. Human Resources receive 100% of staff annual trainings; follow-up complete and trainings appropriately recorded within 30 days of agency cut-	Year end results:	95.05% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Training completion and submission continues to be a manual process for the agency. The integration of a new Learning Management System will help to streamline the process. An electronic process for completion, scoring, recording, and reporting trainings will eliminate manual processes and reduce extensive follow-up.

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Quality Assurance Accomplishments

- COVID-19 Operations:
  - Reported in CHRIS confirmed COVID-19 cases.
  - Created weekly report of COVID cases, shared with Leadership Group.
  - COVID-19 operation implications: tracking DBHDS and DMAS flexibilities.
  - Developed agency's Emergency Policies & Procedures, continually updated.
  - Reported COVID Closing/Re-opening service transitions to DBHDS/Office of Licensure.
- Reviews:
  - 62 external audits reviewing 607 records - 181% increase
  - On-going Office of Licensure Mortality Reviews within 10 business days of death discovery
  - On-going Support Coordinator Quality Review (SCQR) a DD Retrospective Desk Reviews
  - On-going SIS Verifications
  - Health Services Advisory Group (HSAG) to do Quality Service Reviews (QSRs) for DBHDS, Round 1 & 2 completed, Round 3 yet to come
  - MH/SA Block Grant Review, Amanda Stehura requested reduced documentation due to COVID-19
  - SAMHSA Review
  - Independent Reviewer DOJ Review
  - Continuation of Challis Smith's DD CM Quality Reports for DOJ SA, Regional Quality Improvement Specialists to do retrospective reviews of the Support Coordinator Quality Reviews and help CSBs implement quality improvement programs
  - UnitedHealthcare (UHC) audits, review of performance improvement plan (PIP)
  - AMIKids annual review
  - Licensure Triennial review
  - DD Crisis Risk Assessment Tool: Quality Review and feedback received; we received a score of 100%
  - Phase 2 of Home and Community-Based Settings HCBS submitted
  - Managed Care Organizations desk audits
  - DD CM Data Metrics Review, Deborah N. Bailey-Raynor Quality Improvement Specialist with the Office of Community Quality Improvement (CQI)
  - The National Core Indicators (NCI) Staff Stability Survey gather data on the workforce of Direct Support Professionals (DSPs) serving adults with intellectual and developmental disabilities age 18 and older.
  - Waiver Waiting List Reviews
  - CMS Certification – PECOS virtual site visit – Magellan Healthcare
  - DBHDS Med Error investigation
  - DMAS Quality Management Review of DD services
- Training:
  - QA and Facilities attended ADA training: Assistant United States Attorney General training on the Americans with Disabilities Act ("ADA") in Human and Social Service Settings.
  - Attended Home and Community-Based Settings HCBS Phase 2 training
  - Quarterly Office Human Rights trainings
  - DBHDS Office of Behavioral Health Equity statewide training on diversity, equity and inclusion series Dr. Joseph Williams
  - New Office of Licensure regulations training, Enhanced RCAs, Thresholds
  - Quality Improvement Risk Management Training
  - Office of Licensure Incident Report Trainings
  - DBHDS DOJ Change Management
  - QSR Dropbox training
  - Provided internal iRIS system and incident report training
  - OHR Human Rights regulations
  - OHR Investigating Abuse and Neglect
  - Social Determinants of Health

    - HCBS settings validations
    - DMAS Training – Coordinating Care for Patients with Substance Use Disorders in Virginia: Privacy Considerations
    - VACSB Workshop: 42 CFR Part II: Confidentiality in SUD Programs-What you don't know can hurt your patients
- Implemented new incident reporting database, unexpectedly when merging the old iRIS database, the database lost data during the time period 10/1/20-12/31/20, QA developed a plan to recover the data from past emails
- New OL Emergency Regulations became effective August 1, 2020, enforced November 1st
- OL established thresholds of repeated individual's incidents (three hospitalizations) or repeated incident types (Falls at a particular group home); Enhanced Began tracking repeated citations/corrective action plans
- RCAs -added to agency policy RCA thresholds determined based on trend history
- New CHRIS Care Concerns / LSA (Licensing Specialist Action) report – new tool for QA to work into QIP, reviewing weekly
- New OL staff: Quality Improvement Specialist hired to review CAPs on quality improvements or risk management regulations; Additional staff hired to investigate DD complaints regarding licensing requirements
- New OL staff: OHR CAP Specialist, Tonya Carr hired to issue citations on behalf of Office of Human Rights
- New licenses, service modifications for ACT teams (small/large teams) and SUD OP submitted 5/15th, effective 7/1
- Provided public comments on draft regulations
- Reviewed and updated policies the yearly changes to the CARF Manual that become effective in July 2021
- Reported Annual Restraint reporting to OHR, completed online
- Provided public comments on Office of Human Rights regulations, draft Medication Errors guidance document
- Completed Agency's Annual Report, Annual Performance Analysis and QA Quality Report
- Reviewed and developed policies & procedures and implemented new regulations
- Welligent preparations to go live 7/1/21
- Formed Scanning Workgroup, preparation for scanning in Welligent
- Created 21st century cures act workgroup
- Conducted internal Quality Look Behind reviews
- Throughout pandemic chart rooms provided timely response for record requests, subpoenas and chart reviews

Quality Assurance Goals

- Assist the agency with implementation of new electronic health record including scanning
- Training and implementation of the proposed new OL regulations, 105, 106, 107, 108
- With assistance of County IT improve iRIS incident reporting system
- Explore use of project management software
- Recruit, hire and train one new full-time OAIV staff to support the East Center Chart Room

Quality Assurance Outcomes

MEASURABLE OBJECTIVE Quality / Efficiency Report incidents within required timeframe, 24-hours	Year end results:	4 late reports/3 CAP issued Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Performance Improvements: A total of 268 reports were made into CHRIS for FY21. Four were late, of which we received three CAPs. Three times the Office of Licensure sited us for reporting Level II or Level III serious incidents beyond the 24-hours reporting period. The incidents occurred in different services, not under the same license. Staff was retrained on regulation 160.D. Continued education provided; Agency leadership team discussed expectations and policy was reviewed.

MEASURABLE OBJECTIVE	Year end results:	100% Met	Recommendations, actions taken,	Performance Improvements: 115 RCAs/0 late Continue weekly monitoring. Conducting QA

Quality / Efficiency Complete RCAs within required timeframe, 30 days		Actions during the year did not produce the desired results	performance improvements:	review of RCAs as needed to ensure 30-day requirement is met.

Community Support Services Accomplishments

Meeting DOJ initiatives:

- Met the Department of Justice Settlement Agreement 86% compliance expectation with reported/extracted data from Developmental Disabilities (DD) Case Management
- Completed all requirements. All programs are maintaining the standards and are waiting on the official site visits.
- Each unit determined best practices for COVID and met these practices throughout the year when under the COVID Emergency Order – details under highlights for each program.
- Individual team discussions were held throughout the division, CSS members have joined the CARSE committee, and continue involvement in the CACC committee, including hosting brown bags.

The CSS Therapeutic Options trainers developed an online training course and ensured that all CSS staff who were scheduled to complete the training in the fiscal year, completed both the online portion and the physical test-out process.

Eight staff completed levels in the County Emerging Leaders Certification Program, with two of those completing Level 3 and one completing Level 4.

Approved for one-time OBRA funding to purchase a Stair-lift, ADA toilets, new Van for Sherbrooke, furniture for aging program at Hermitage and an individual's environmental modification for their home.

CSS Divisional staff supported the Agency as needed throughout the pandemic period. Areas included:
Intake staff: supported other teams during much of this year to include housing program (contact updates); reimbursement (insurance look up); North 2 (conducting annual periodic surveys).
Employment and Day Services staff : 35 of the 40 Employment and Day Services staff were re-deployed to a large variety of work within the Agency, providing assistance and work including filing in chartrooms, grocery shopping for group homes, working with IT on projects, assisting with reimbursement on collecting retainer payments for Group Day and Community Engagement, taking temperatures at the front desk at Richmond Medical Park and working shifts in the group homes, to name a few. These tasks continued even when the program began to re-open.

Parent Infant Program
Parent Infant Program staff person Katy Nowlin was a speaker for the regional Advocacy in Action Fall Meet & Greet. She shared her story about her son who received Early Intervention services and the need for the community and service providers to understand the importance of starting early with intervention services.

Parent Infant Program staff obtained their Infant Massage certifications. Practice hours were completed via telehealth sessions with the families and therapists.

The Parent Infant Program came together through the global pandemic of COVID-19 to ensure that each family had the choice of continuing their services. An immediate transition to Telehealth/Web Ex was put into place when face to face visits were no longer an option. This quick and efficient transition allowed all services including Intakes, Assessments, Reviews, Annuals, ongoing therapy and Transition Planning Conferences to continue without interruption to ensure that our families had access to necessary services.

Results included:
- 346 initial assessments
- 588 intake appointments
- 110 toddlers transitioned to Part B Preschool Special Education services in the three-county area

Permanent Supportive Housing
The program reached capacity when six individuals who were homeless and diagnosed with Serious Mental Illness were accepted into the program and moved into rental units. Two on-going participants moved to more accessible units.

Staff worked diligently to support individuals throughout the year, while adhering to all pandemic protocols to ensure the safety of all.

Intake, Eligibility and Housing
The intake unit logged 383 calls from the dedicated intake phone number. This is an increase in call from last year where 348 calls were logged. This does not include inquiry calls that came to staff direct line.

During the pandemic, staff completed 88 intakes with 84 deemed eligible and sent to the Community Teams. All intakes were completed either through telehealth or direct face to face. This is less than our numbers from last year (125) but demonstrates staff commitment to keeping the program running at a high level despite the restrictions of the pandemic.

Residential Services
Green Run provided ongoing and continual support for an individual who was at risk for nursing home placement, he has adjusted to the group home and will remain in community-based housing.

Gayton staff have supported an individual who is aging and unable to attend her day program, requiring continual personal care and support, to assist her in aging in place.

Two residents from two different homes decided to reside with families during the pandemic. Group Home supervisors kept regular contact, delivered monthly medication, and assisted with telehealth appointments for their medical appointments.

Hosted three COVID-19 vaccine clinics for staff and residents.

Put protocols in place to minimize risk COVID-19 transmission in the group homes

Virtual home visits with residents and their families were supported as one effort to lower risk.

Employment and Day Services
Four staff completed and were certified in the Customized Employment Training offered by the Association of Community Rehabilitation Educators (ACRE).

One staff and five individuals represented Hermitage Enterprises in the Autism Walkers walk-a-thon in April 2021.

90% of those served in Individual Supported Employment and 66% of those served in Group Supported Employment retained their jobs throughout the year

Developed and implemented a You Tube channel for the individuals we serve who were not able to attend due to the COVID-19 pandemic. At the end of June 2021, there were 203 subscribers, and 50,156 views of the over 100 videos.

As of the end of June 2021, 75% of the individuals who were attending Hermitage and Cypress Pre-COVID, were attending the programs. The others are scheduled to attend beginning July 2021.

DD Case Management
Case Management provided 11,041 significant contacts

Active individuals in DD CM for HAMHDS as of now = 1,465 (includes all waiver, non-waiver, and waiver waitlist individuals across all DD CM teams)

Enhanced Case Management (ECM) contacts in the past year (in person and/or telehealth) = @766 ECM contacts per month

Residential contacts in the past year (in person and telehealth) = @816 residential contacts occurring in residential setting every other month

Continued monitoring and all case management activities using a combination of video conferencing, telephonic conferencing and face to face contacts based on the needs and preferences of the individuals served. Met all deadlines for holding annuals, etc. in a person-centered manner as per DMAS guidance.
CST DD Unit set-up two vaccine clinics through VDH at Woodman Road location for DD individuals and caregivers in June 2021

Housing
Currently administer approximately 250 vouchers.

The small team of housing specialists were able to meet all Virginia Housing and HUD requirements that included:

- 221 Virtual Inspections
- 31 Paper processed Inspections.
- 56 In person inspections (this increased dramatically from 16 in the first half of the year, to 40 in the second half)
- 316 Phone Interviews for annuals/recertifications
- Over 1200 letters sent.

Community Support Services Goals

- Implement mandates and initiatives to meet the Department of Justice Settlement Agreement and all other State and Federal mandates.
- Recruit and retain staff for all CSS programs.
- Evaluate and develop an action plan on the loss of Section 14c for future Day Services planning
- In addition to the main CSS Division goals, is the CST DD Unit program goals below:
  - Documentation of CM services in progress notes will be completed in a timely manner.
  - Documentation of Provider Choice offered to individuals with a DD Waiver annually and when changes occur using a new form each time.
  - Documentation of Person-Centered Reviews completed in timely manner.

- To ensure supervisory quality review services to meet Developmental Disability Services mandate.
- Documentation of DD CM enhanced case management services every 30 days will be completed in a timely manner.
- Documentation of DD CM enhanced case management services every other month in residential setting will be completed in a timely manner.

- Employment and Day Services goals:
  - Implement Community Engagement Activities to the same level or higher than pre-pandemic levels.
  - Evaluate, develop and begin planning for transition from working under a 14c certificate.
  - Expand community employment to incorporate customized employment activities.

Community Support Services Outcomes

CSS CASE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Quality/ Efficiency 90% of Multi Service Progress Notes will be final approved within 5 days of opening	Year end results:	ID 71.96% DD 77.80% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This yearly period occurred during COVID-19 emergency pandemic time period. The 90% outcome was not met for the year. The ID results for the year was a total of 71.96% and the DD results for the year was a total of 77.80%. This outcome to be re-evaluated by the CST DD Unit. Supervisors will continue to review monthly reports and follow up with staff to ensure all staff are trained on the final approval process for progress notes.

MEASURABLE OBJECTIVE Customer Value/Effectiveness 90% of DD Waiver charts reviewed will have a VIC completed accurately, thoroughly at the time of the annual and when a change occurs	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This yearly outcome occurred during COVID-19 pandemic time period. This outcome was met for the year. The reviews completed were modified due to COVID-19 (e.g. desk reviews, working from home). This outcome will be evaluated, and supervisors will continue to conduct quality reviews and follow up with staff on training to ensure provider choice forms are completed thoroughly and filed in charts.

MEASURABLE OBJECTIVE Quality/ Efficiency 90% of Person-Centered Reviews will be completed and final approved within 30 days from due date noted by EHR report.	Year end results:	89.10% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Note, this yearly period occurred during COVID-19 pandemic emergency time period. The yearly 90% outcome was not met. The overall yearly total for this outcome was 89.10%. CST DD Unit will continue to evaluate outcome and have supervisors train and run reports to monitor QRs being completed and approved within 30 days of due date.

MEASURABLE	Year end	100%	Recommendations,	This yearly outcome was met. The CST DD Unit

OBJECTIVE Quality/ Efficiency 100% of the quarterly supervision meetings by the Developmental Disability supervisor will be conducted with the DD Contracted Private Providers for the fiscal year.	results:	Met Actions during the year did produce the desired results	actions taken, performance improvements:	will continue to evaluate this outcome regarding supervision visits with contracted private providers to follow the various CSB's expectations and polices/procedures. Note, this yearly outcome occurred during COVID-19 pandemic emergency time period.

MEASURABLE OBJECTIVE Customer Value/Effectiveness 90% of individuals receiving enhanced case management services will receive at least one face to face contact every 30 days	Year end results:	ID 92% Met Actions during the year did produce the desired results DD 88% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This yearly outcome was met. The CST DD Unit will continue to evaluate this outcome regarding supervision visits with contracted private providers to follow the various CSB's expectations and polices/procedures. Note, this yearly outcome occurred during COVID-19 pandemic emergency time period.

MEASURABLE OBJECTIVE Customer Value/Effectiveness 90% of individuals receiving enhanced case management services, who received face to face contact every 30 days, will also receive one of those contacts every other month in their residence.	Year end results:	ID 99% DD 100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This yearly period occurred during COVID-19 pandemic timeframe. This yearly outcome of 90% was met for both ID (99.29%) and DD (100%). The CST DD Unit will continue to evaluate outcome and have supervisors train staff and monitor by running reports and following up on face-to-face contact needs.

<u>CSS HERMITAGE AND CYPRESS DAY SERVICES OUTCOMES</u>

MEASURABLE OBJECTIVE Quality / Access 100% of the individuals referred to a Day Service	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	During the COVID-19 pandemic, Hermitage and Cypress Enterprises were not operating at full capacity. We accepted four emergency referrals in the early part of the fiscal year, and all four were contacted within 20 days of the referral. Once we started opening to more

program will be contacted within 20 days to discuss /schedule an assessment or visit Baseline 2020: 100%				individuals, we did not accept new referrals since we were concentrating on the return of those who had attended pre-COVID shutdown. During this time, we did evaluate our procedures and forms. Adjustments were made to the forms to ensure we were better able to document the date received, the assessment dates and the results of the assessments.

MEASURABLE OBJECTIVE Customer Value / Effectiveness OES: Due to shut down from COVID-19, we will be starting program in a new way in July 2020. Increase the number of hours of service for Group Day activities as demonstrated by increasing the number of individuals served to equal 80% of those served in February 2020. Baseline: 97-7=90 By end of the year – there were 9 who withdrew for various reasons. Total available to return - 81	Year end results:	85% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	In February of 2020, we were close to capacity at 97 individuals served. Over the shutdown from the pandemic, 9 individuals either moved, passed away or decided to attend a different day program. Of the 88 individuals left, 81 would be our goal of 80%. As of June 30, 2021, we were serving 69 individuals for 85%. We were able to serve these individuals by redesigning the space to allow for pods – smaller groups of individuals with designated staff (keeping the numbers around 15 of both staff and individuals) to maintain social distancing and practice good hygiene/cleaning protocols. While this was accomplished due to COVID, both staff and individuals have found this redesign has been beneficial in many ways. We have redesignated the areas and made the pods a more permanent part of our service delivery methods.

MEASURABLE OBJECTIVE Customer Value / Effectiveness COI and older adult: Due to shut down from COVID-19, we will be starting program in a new way in July 2020. Increase Community Engagement activities as demonstrated by increasing the number of hours to 75% of the hours provided the third	Year end results:	0 Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Due to the COVID-19 pandemic, we did not provide any billable community engagement services in the fiscal year. There were many factors, but primarily, we concentrated on helping individuals return to the center-based program. Starting in March of 2021, we slowly introduced some community activities, primarily concentrating on outdoor activities such as walks in the park and some smaller activities such as picking up lunch or snacks at drive thru restaurants. We began connecting with community partners as the restrictions lessoned and had plans to return to some volunteer sites beginning in August 2021. We did not meet this outcome; however, strong planning is underway to reestablish our community presence in the fiscal year 2022.

quarter of FY 2020. Baseline: 344 hours				

MEASURABLE OBJECTIVE Quality / Efficiency OES, COI and Older Adult: Maximize billing for all individuals who attend Hermitage and Cypress and are enrolled in a waiver service by reaching 75% of billing projection by the end of the fiscal year. Projection: $1,001,384 (75% = 751,038 which is $187,759.50 per quarter)	Year end results:	21.4% ($160,653) Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	COVID pandemic had a much more significant impact that we could have imagined last June when the outcomes were developed. Opening did not occur at all until July, and we only served very small numbers of individuals as we implemented safety procedures. With a surge in the late fall, numbers decreased in December and January. By the end of June 2021 we were serving only 86% of our individuals with waiver funding and we were open both decreased days and hours from the previous year. We have learned a lot over the last year about the best way to keep people active and safe and have redesigned the service delivery methods to ensure both of those objectives while still maintaining the heart of the programs.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of all individuals who attend the Hermitage or Cypress programs will express satisfaction for their services in the annual survey with a 4 or 5 on 5 point scale	Year end results:	97% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	For the year, thirty-eight surveys were returned with thirty-seven rating satisfaction as most of almost all of the time, the two highest ratings, for a score of 97%. This exceeded the goal of 90% satisfaction. Twenty-three of the surveys indicated that they had seen and used the YouTube channel videos for the individuals while the program was shutdown. In total there were over 100 videos uploaded to the channel. Throughout the shutdown, staff connected with the individuals and families on a weekly or bi-weekly basis. The responses were representative of individuals receiving both community integration and group day services from both Hermitage and Cypress.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of families or caregivers will respond with a 4 or 5 on a 5 pt scale when asked if satisfied with the services	Year end results:	91% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Ten of the eleven case managers who responded to the survey rated their overall satisfaction as a 4 or 5 on a 5-point scale. Case Managers were representative of individuals who attended for both group day and community integration services. There was a suggestion for more community options, which we hope to increase as we begin being more active in the community as the pandemic eases. Very few community options were offered. Overall, case managers indicated that individuals were safe, and active with skills being built and that these things occurred despite difficult circumstances. We will begin to provide more community integration

				options. We will also continue to ensure health and safety is a priority.

CSS GROUP AND INDIVIDUAL SUPPORTED EMPLOYMENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 90% of the individuals referred to an Employment program will be contacted within 10 days of assignment to an Employment Specialist. Baseline – 2020: 0%	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	COVID reduced the number of individuals looking for work and requesting services. We did meet the objective of contacting within 10 days for the one referral we did receive. We will continue this outcome next year and anticipate more referrals.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Assist 90% of those who lost jobs with finding a new job and will serve three additional people per year in job development/ placement, finding a total of 10 people jobs.	Year end results:	50% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	We anticipated many more individuals to be looking for work than we saw. Of the individuals who lost their jobs due to COVID, we were able to assist 5 individuals with getting new jobs. Several who lost their jobs are not yet comfortable going back to work and we continue to assist them in job development. We will also be working with case managers and DARS to gain new referrals.

MEASURABLE OBJECTIVE Quality/ Efficiency Ensure two contacts per month for 90% of those in LTESS in order to maximize billing.	Year end results:	98.5% average for the year Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Only four individuals did not have two notes per month in the first quarter, and all individuals had two notes the rest of the year, resulting in an average of 98%.. Those four individuals were served by the same staff and performance improvement measures were taken. There were no errors the rest of the year. At the beginning of the fiscal year, we added an additional 20 individuals to LTESS, a long-term funding source through the Department of Aging and Rehabilitation. This created the need for continued vigilance in ensuring the needs of all were met. The staff stepped up to the task, and we met this objective. No further improvements need to be made.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of the individuals served	Year end results:	91% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	We received 11 surveys back from the individuals served and 10 of them expressed high satisfaction. We will continue to solicit more formal feedback. This year, most annuals were virtually, making us rely on mailing the surveys and asking for return mail. Next year, we will again be meeting in person and will be

will respond with a positive response (always or almost always) when asked if they are satisfied with the services they have been offered				able to hand the surveys to the individuals. We will continue to review the survey results and make changes that are suggested by the individuals we serve.

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:	96% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Surveys were sent to Case Managers and DARS counselors for individuals served in the past year. We received 24 responses. All were highly or mostly satisfied, with one neutral response. Comments were positive praising staff for excellent communication and responsiveness to needs. We will continue to monitor satisfaction of stakeholders, choosing to gather input from employers next year.

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:	99% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Overall, this has been a careful but steady year with intakes. With constant changing restrictions due to the pandemic, we transitioned back and forth from virtual to in person intakes, moving more fully to in person in May. We are still working with each individual family to assess risk and scheduling the appointments based on these assessments. Staff have been vigilant and creative in making sure all documents are obtained/signed before the charts move to case management teams. Will continue to monitor this objective going forward but will be adding a satisfaction survey that will go to individuals/families after the intake. This will allow us to gain more insight to the participants experiences and expectations.

CSS RESIDENTIAL OUTCOMES

MEASURABLE OBJECTIVE Quality / Access All vacancies in the program will be offered and accepted within 90 days.	Year end results:	2 vacancy/0 accepted Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Due to ongoing staffing crisis*, the residential program will not be filling any vacancies. This outcome will continue as written for next year. *The State of Virginia, specifically HAMHDS, has had a difficult time recruiting staff for residential positions and Direct Service Professional positions.

MEASURABLE OBJECTIVE Customer Value / Effectiveness	Year end results:	0 of 4 quarters Not met Actions during the year did not	Recommendations, actions taken, performance improvements:	No participation in volunteer activities this quarter. Volunteer sites were closed due to COVID-19 pandemic. The residential team discussed other volunteer

35% of residents will participate in a volunteer activity each quarter		produce the desired results		options (i.e.: Chesterfield Food Bank) that may be more appropriate for our resident to participate in that would limit their contact with the public during the pandemic. There may be one of our residents that is appropriate for the Chesterfield Food Bank, if he is interested in participating in the activity. The Group Home Supervisors that had residents doing Rec./Parks, feel that this type of activity is better since it can be done with limited contact to the public and possible transmission. Since the pandemic appears to be reemerging, this outcome will be discontinuing.

MEASURABLE OBJECTIVE Quality/ Efficiency 95% of employees will be current with all required training each quarter.	Year end results:	94% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This outcome was met the first three quarters of the year at the cited percentage but missed meeting the yearly overall by 1%. The same Issues arose this year surrounding staff failing to register for classes early enough to reserve a seat in a class that only allows 20 people. Relief staff were the primary factor again this year (4 out of the 6 staff) that were out of compliance, who can only register for classes during their shifts. The Program Coordinator held special CPR classes (for Residential and other programs) during the year to help with this issue. This outcome will continue as written for next year.

MEASURABLE OBJECTIVE Consumer Satisfaction 100% of residents will be satisfied with their services and achieve desired outcomes documented in their quarterly reviews	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	100% of Henrico ID group home residents reported satisfaction in the services they are currently receiving. This information was captured and documented during the residents' quarterly reviews. This goal will continue for next year, the percentage rate will change to 100%. The residents stated during their quarterly reviews that they like their staff, their home and some of their housemates.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of residents' family/AR/guardians will be highly satisfied with their services and achieve desired outcomes via an annual survey	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Due to the pandemic, visitations to the homes were suspended until early 2021. The survey was shortened to only address communication and overall appearance of the home since most contact was virtual. We had four responses to this year's stakeholder satisfaction with the residential program. All ratings were either Satisfied or Very Satisfied in all areas sited.

<u>PARENT INFANT PROGRAM OUTCOMES</u>

MEASURABLE OBJECTIVE	Year end results:	94% Not met	Recommendations, actions taken,	The following process was implemented and maintained this quarter to ensure that SCs are aware of their progress towards meeting this

Quality/ Efficiency 95% of all Targeted Case Management (TCM) contacts will be met every month.		Actions during the year did not produce the desired results	performance improvements:	target: •The SCs are forwarded a report documenting the progress of the TCM contacts on the 15th of the month. The SC supervisor follows up with the team regarding any red flags (0 to low contact numbers). •The SCs are forwarded a report documenting the progress of the TCM contacts on the 20th of the month. The SC supervisor follows up with the team regarding any red flags (0 to low contact numbers). •The SCs are forwarded a report documenting the progress of the TCM contacts on the 1st day of the following month regarding the previous month. The SC supervisor follows up with the individual team members regarding any red flags/ missed contacts. SCs are expected to provide details to SC supervisor of any missed contact and future plans for the following month if the same issues resurface. This process has helped to improve our Targeted Case Management contacts. We have noticed that when we are down staff and caseloads are higher, it is difficult for staff to follow up on all of their TCM families. We will continue to check in more frequently while we are down staff to see what assistance staff will need. We will continue this outcome.

Clinical and Prevention Accomplishments

Ensure Division is structured in a manner that supports the priorities of the County and DBHDS, and efficiently meets the needs of our clients

The pandemic created some barriers to implementing structural changes to our programming, but we did utilize the year to develop plans for expansion and re-structuring of some program areas. STEP-VA funds have been allocated for expansion of outpatient services, peer services and our services to Service Members, Veterans, and their Families (SMVF).

For Outpatient Services, we plan to add one Clinical Psychologist to our Youth and Family Team, one clinician to our Substance Use Disorder team, and one Medical Records staff to assist with the infrastructure impact of program expansion. In Peer Services, we will be adding one Family Support Partner to our Youth and Family Team and creating a new Full-time Peer position focusing on community integration for individuals with serious mental illness as they are leaving services. Finally in our services to SMVF, we will add one full-time Peer Specialist who will focus on outreach, engagement and training of staff and community partners. The SMVF Funds will also allow us to expand our training in Eye Movement Desensitization and Reprocessing.

This year we were also able to obtain funds for expansion of our Permanent Supportive Housing (PSH) Program. These funds will allow us to create 15 new PSH slots and will also significantly increase our staffing for this program. We plan on administratively re-structuring this program to link the housing support staff with Adult Recovery Services to have the staff who provide more administrative oversight linked to the agency's housing program.

Enhance substance use services through coordination with Addiction Task Force and community partners

We have remained actively engaged in the work of the Addiction Task Force. We have been able to expand Office Based Opioid Treatment options to include a Rapid Access process for this program. We are offering OBOT at three sites—the East Center, Providence Forge and Richmond Medical Park.

We have also applied for licensure of Substance Use Case Management Services. Licensure of this service would enhance the array of services that we are able to provide and would also create enhanced revenue opportunities.

As part of our efforts to ensure individuals with legal involvement have access to appropriate services, we added a Substance use Disorder Case Manager and Clinician to our diversion efforts as well as a Diversion Supervisor. The addition of these positions had been recommended through the County's Recovery Roundtable.
The SUD Strategic Planning Group has also partnered with the Addiction Task Force around prevention activities. Most recently the group has taken on the responsibility for creating Overdose Protection Kits which will include literature regarding access to services and signs of overdose, along with Narcan and Fentanyl testing strips. The Overdoes Protection Kits will be distributed as part of a pilot program by HAMHDS, the Sheriff's office, District 32, and Community Corrections.

Identify strategies to enhance behavioral health equity and identify measures to monitor progress
During this fiscal year we were able to create a Program Manager level position with responsibility for enhancing behavioral health equity. The Program Manager has joint responsibility for Prevention Services and Behavior Health Equity. Specifically, the Program Manager is responsible for:
Provide agency wide leadership in ensuring equitable access and equitable provision of services regardless of individuals' race, age, gender, socio-economic status, sexual orientation, or disability. Assist in leading agency's efforts to ensure the delivery of culturally sensitive trauma informed person-centered services.

Continue to expand the range of evidence-based programming
The expansion of evidence-based programming has occurred primarily in our Youth and Family Program. We have continued to expand the number of staff providing and families receiving Parent Child Interaction Therapy (PCIT). As an adjunct to this service, we have also had one staff trained in providing the evidence-based Child Adult Relationship Enhancement (CARE) Training. With the expansion of Youth and Family Services mentioned above, we plan on having one full-time staff member devoted to providing PCIT and CARE services.
The planned expansion of Permanent Supportive Housing mentioned above also includes provision of two evidence-based programs—Peer Bridger Services and Critical Time Intervention case management. These two services will be implemented in the upcoming year.

Strengthen coordination with state hospitals to ensure timely discharge of individuals being treated
Efforts to increase coordination with state hospitals during the year have included:

- monthly internal meetings with liaisons, supervisors, and senior management to ensure timely and appropriate discharge planning;
- senior management participation in weekly census management calls;
- periodic state level staffing's with senior leadership from DBHDS and the state hospitals to assist in planning for individuals who have been on the extraordinary barriers list for a significant length of time; and
- resumption of in-person visits to the state hospitals in Spring of 2021.

We have also spent time this year developing plans for further enhancement of our coordination with state hospitals which we hope to implement in the upcoming fiscal year.

Develop sustainability plan for Primary Care Services
The grant that supports on site Primary Care Services will be ending in September 2021. We participate in monthly calls with our Primary Care partner, Daily Planet Health Services to review operational issues as well as sustainability planning.
STEP-VA Strategic Initiative Annual Update
The COVID pandemic and the Commonwealth's State of Emergency delayed implementation and funding for some STEP-VA initiatives. During this delay, the STEP-VA Strategic Initiative Committee did not regularly meet since there was no work to be done. By the end of the fiscal year, STEP-VA was once again moving forward, and state funds were released to support these initiatives. The Strategic Committee resumed meeting and developed the following plans for three STEPS:
Peer Services:

- Add one full-time Family Support Partner who will be housed in the Youth and Family Services Program.

- Add one full-time Peer Support Services Specialist focused on community integration for individuals currently and formerly served by Adult Recovery and Collaborative Services.

Outpatient Services:

- Add one full-time Substance Use Services clinician to meet increased demand.
- Add one full-time Clinical Psychologist who will spend half their time providing testing for individuals served throughout the agency and half their time providing therapy within the Youth and Family Services Program. The enhanced therapy services in Youth and Family will allow us to have one full-time staff member whose total time will be committed to Parent Child Interaction Therapy and provision of Child-Adult Relationship Enhancement (CARE) training.
- Add one full-time Medical Records Specialist to assist with increased infrastructure demands related to program expansion.

Service Members, Veterans, and their Families (SMVF):

- Add one full-time Peer Recovery Specialist who will focus on identification, outreach and engagement. This Peer Recovery Specialist will also be responsible for providing training and consultation to agency staff and staff of community partners.
- Enhance availability of Eye Movement Desensitization and Reprocessing (EMDR) services to SMVF with history of trauma through increased training and support of clinical staff.

Adult Recovery Services Case Management

- Continued successful partnership with two Managed Care Organizations (MCOs) with the goal to improve physical health outcomes of consumers served with serious mental illness. With one MCO, agency staff were able to get 90% of consumers connected and seen by their primary care physicians for annual physicals for ongoing care and preventive medical screenings.
- 93% of individuals with serious mental illness newly opened to case management services demonstrated reduction in their hospitalization rates or remained at zero (0) hospitalizations in fiscal year 2021.
- Case Management and Assessment staff provided education to their clients regarding following CDC guidance related to COVID-19 mitigation strategies, assisted and linked clients with resources for COVID testing and vaccines, while continuing to provide wrap around mental health services to meet their clients individualized needs throughout the COVID-19 pandemic.

ICT/PACT Accomplishments:

- During COVID-19 pandemic, continued to provide direct face-to-face supports-- medication delivery, injections, lab work, linkage to medical appointments, and linkage to other needed resources such as food banks
- Reduced risk of clients acquiring COVID-19 through teaching clients about on-line grocery shopping and distributing food from food banks to clients.
- Continued efforts to transition clients from state hospitals to the community.
- Over the course of the past fiscal year, ICT and PACT have had 9 different clients employed.
- Prepared the ICT and ACT teams for the change to ACT
- 80% of client satisfaction surveys were in the above average range in most areas.

InSTRIDE Accomplishments:

- InSTRIDE served approximately 52 consumers throughout the year.
- Peer Counselor has provided groups for substance use, family support group and a peer workout group.
- Organized volunteer opportunities for four peers.
- Implemented Illness Resiliency Training (IRT) with consumers as well as the "Family Treatment and Resource Manual" which has been utilized for InSTRIDE's family support group.
- InSTRIDE's Supported Employment Services assisted 14 individuals throughout the year to either be connected to employment or educational opportunities. 29 total consumers engaged in either school or work.

Adult Mental Health / Substance Use Services

- NACO award for Virtual REVIVE trainings
- Begin Rapid access for OBOT – significant growth in OBOT participation
- The number of individuals participating in Office Based Opioid Treatment increased by 93% from FY20 (60 individuals) to FY21 (116 individuals)
- Successful implementation of telehealth groups and individual sessions, and pivoting back to in person
- Implementation of hybrid groups (some people in person some online at the same time)
- Submitted application for SUD CM license
- Survive significant turnover

Jail

- Expansion of jail diversion efforts – addition of an SUD Clinician and CM to diversion + Diversion Supervisor
- Growth in number of diversion participants
- Purchase of WebEx screens for jail to increase access of inmates to staff
- Implementation of virtual MH crisis intervention and assessment
- Survive significant staff vacancies

Oversight of CHIRP program

- Update Bouncebackhc site – include some teen information, overhaul of treatment and recovery providers.

Youth and Family

- Brittany Zuniga-Fulton presented to the Board on the positive impact of the Spanish-speaking mini team on engagement with Spanish-speaking population in the county.
- 68% of Youth and Family staff have certification in specialized evidence-based services including Trauma-Focused Cognitive Behavioral Therapy, Parent Child Interaction Therapy and Multisystemic Therapy
- Continue to provide case management to over 200 youth and their families each month.
- Successfully transitioned to providing tele-health and other creative approaches during pandemic.
- Expanded vocational services to youth.
- Laura Bullock became certified in Child-Adult Relationship Enhancement (CARE) training. She has provided two trainings (one via Webex, one in person). Plus, she's provided a lunch and learn to CASA regarding PCIT.
- We continue to provide CAP-SA services and court assessments during the pandemic-shifting to a telehealth model.
- Of the 27 youth who received Multisystemic Therapy (an evidence-based program for court involved youth) only one of those youth reoffended. Additionally, all 27 youth were living at home and attending school or working.
- MST services continued to provide intensive community-based services, finding creative ways to maintain engagement and connecting with families face to face while following CDC guidelines.
- Provided various services including Outpatient counseling, case management, MST, vocational, outreach and assessments to around 1000 different children in our community.
- Continued to build and sustain strong working relationships with other child serving agencies via our Systems of Care model. Utilized SOC team to staff unique cases where options for services could be identified: staffed around 10 thus far.
- Representatives from Y&F joined Prevention and Emergency Services staff on a panel discussion regarding supporting children during traumatic events following tragic killing of a youth in the County.

Lakeside Center (LSC)

In the past year, Lakeside Center successfully adapted to providing psychosocial services throughout the COVID-19 pandemic. This occurred through creative and thoughtful strategies that also maintained the health and safety of our members and staff.

During the Pandemic, LSC has:

- Developed COVID-19 plans and guidelines in order to maintain safety of staff and members, reducing the risk of virus contraction/spread.
- Provided virtual, psychotherapy groups via telephone calls and Webex interventions.

- Provided regular 1:1 telephonic intervention during physical closing of the program.
- Provided Clinician and Case manager to support the CM&A team for several months, managing extensive caseloads and primary case management duties during staff shortage (Natalie & Stephanie).
- Provided staff support to other collaborative services and therapeutic homes for assistance with daily functioning (Steve and Tracey).
- Managed "larger-than-normal caseload ratios" due to some LSC staff being assigned to other HAMHDS programs (Stevie).
- Adopted strategies of cleaning, maintaining hygiene, and other safety precautions related to the pandemic as a regular part of service provision to assist members with maintaining wellness.
- Taken gradual and incremental expansion approach to increasing members' attendance to reflect the state and CDC guidelines of reopening.

Lakeside Center staff have displayed their level of commitment to members through their flexibility, hard work, and willingness to assist outside of their primary program duties.

Vocational Services:

- 97% of individuals with serious mental illness who enrolled in vocational services had an interview within 15 days of enrollment. 50% of these individuals were employed within 15 days of enrollment in vocational services
- Continued to provide services and community supports during the midst of the COVID-19 State of Emergency and shutdowns resulting in securing employment for 35 newly enrolled program participants. This number does not include 4th quarter data.
- Was able to retain and/or obtain seamless employment for all program participants employed pre-pandemic.
- No known or reported COVID cases of program participants engaged in community employment.
- Was able to maintain DARS funding for current and newly opened program participants.
- The ARS Vocational Team was able to sustain employer relationships to businesses that were closed and/or working abbreviated functions during the pandemic that resulted in persons remaining on the employer's schedule.

Walton Farms (WF) Enhanced Support Home:

- Continued providing support and supervision, without interruption, to four residents without the transmission of the virus to residents or staff.
- Successfully vaccinated both residents and staff.
- Worked collaboratively with LSC supervisor to provide additional staff to the residents. Staff provided support by involving them in different activities and linking them to LSC psychosocial groups via Webex.
- WF and LSC staff worked together to successfully prevent psychiatric decompensation of a resident by providing 1:1 support.

Mental Health Skill Building Services (MHSS):

- Clients in all the homes demonstrated a high level of resilience during the pandemic. They coped with living under a state of emergency which resulted in an abrupt change in how they were living their lives. Clients also adapted to receiving services in different ways and continued to do well. Only one client needed psychiatric hospitalization out of 25 clients who live in our homes.
- Clients in the homes followed all COVID protocols and stayed healthy and safe. There were no positive COVID cases in any of the homes.
- Staff observed clients' ability to utilize and develop new coping skills as the challenges of the pandemic continued. For example, one client began to take more walks which improved her overall health. This client later requested discharge from the InShape program because she felt she could reach the remainder of her goals on her own.
- One client in one of our support homes just graduated MHSS after being part of the program since 2011. He is now working, can independently order and pick up his medication, and has learned to successfully budget his money.

- Staff also became very creative when presented with the challenge of providing services in an unconventional manner due to the pandemic. Staff provided some services over the phone, learned to use telehealth technology, and held sessions with clients outdoors. Staff continued to connect clients to necessary community resources such as food pantries. Staff located new resources as they became available and quickly connected clients.
- Staff was instrumental in assisting residents in all our homes with obtaining the COVID-19 vaccination. No one in the homes became infected with the virus.

Prevention Accomplishments

- CONNECT Programming – Converted the face-to-face program onto a virtual platform. All CONNECT and prevention forms were converted electronically. 117 youth registered for virtual program. Prevention continued COVID Wellness campaign providing meals (averaging 150 meals a day), behavioral health wellness information, and COVID information/resources to the Connect communities.
- Richfield CONNECT – received a NACo award in collaboration with The Henrico County Public Library. The CONNECT and Library implemented a journaling and storytelling program.
- Distributed over 1000 disposal kits and over 500 lockboxes and 135 lock pouches to promote safe medication disposal, storage of medications and guns.
- Prevention launched PSAs promoting Revive trainings and Bouncebackhc website for resources to address opioid crisis. PSA airing on Mix 98, Q94, 103.7, 105.7 / 99.3 daily. PSAs (English and Spanish) promoting Revive trainings and Bouncebackhc website for resources to address opioid crisis increase from COVID-19. PSAs aired on 94.1fm, 8.1fm,105.7fm, Henrico Citizen daily podcast, and 1380 AM Radio Poder. · Youth Leadership group launched Vaping prevention interviews done in collaboration with the American Heart Association airing on social media platforms.
- COVID social media campaign initiated on FB and Instagram.
- Despite the challenges created by the pandemic, 123 participated in Mental Health First Aid.
- Prevention launched a TV commercial targeting the misuse of opioids and Over the Counter (OTC) medications. The commercial aired on all major and cable networks.
- Community events include participation in Town Hall meetings, Drug Take Back Day, Revive Trainings, and Mental Health First Aid trainings. Resource material on COVID related issues such as managing stress and wellness were distributed at these events also.
- Prevention partnered with all Kroger grocery stores in Henrico County to provide 24,000 total medi-bags with OTC drug misuse prevention messaging.

Crisis Intervention Team (CIT)

- Composed a weekly wellness newsletter sent out via email
- Developed virtual training for CIT refresher classes and other trauma informed training
- Provided debriefings and presentations to support communities and schools following several tragic events
- Provided consultation and support to First Responders, including the following:
    - Immediate access 24/7 to respond to critical incidents and other challenging situations
    - Support around identified challenges along with COVID19 related issues such as exposure risks and concerns
    - Supported consultation requests from command staff and management teams as the need arose
    - CID and ATIP protocols from EMDR to assist with critical incidents and issues
    - SCP-C (Self Care Procedure for Coronavirus) EMDR offered to first responders via our team or community resources
    - COVID19 resource list for use by them, their partners/spouses and children

Emergency Services

- 1,618 Preadmission screening evaluations were completed in FY20
- 760 Individuals were assessed at our Crisis Receiving Center through May2021
- Participated in developing the plan for implementing both the Youth Mobile Crisis Expansion and the Adult Mobile Crisis Regional Services
- Participated in the launch of the Alternative Transportation program utilizing G4S
- Established procedures for holding civil commitments hearings in the ER and on medical units in response to the Census crisis which has increased the amount of delay in acceptance and admissions, especially to state hospitals
- Continued throughout the Pandemic to respond out in the community with police to aid and engage individuals who needed mental health services
- Supervisory review of 100% of preadmission screening documents
- Expanded role of hospital liaisons to closely track individuals admitted to state hospitals for the first 14 days, and LIPOS funded individuals at private hospitals, and to develop discharge plans for these individuals
- Continued to provide telehealth evaluations and expand our capabilities in response to the COVID-19 State of Emergency
- Maintained crisis line using Jabber technology so that crisis phone line could be answered remotely and will continue to use that technology to expand our ability during overnight hours to have 2 clinicians available to respond to calls instead of just one as in the past
- Continued to revise business processes to respond to COVID-19 State of Emergency and make procedures more efficient and helpful to individuals requiring assistance and will continue some of these digital processes for documentation into the future as they have improved efficiency
- Continued representation on the interdisciplinary STAR (Services To Aid Recovery) team
- Offered an increased number of debriefings to community and agency members experiencing a traumatic event
- Trained an increased number of clinicians, especially in other Agency programs, so that they could be certified as Prescreeners; 80 hours of training per individual
- Continued to engage in outreach phone calls and letters for those clients not hospitalized during an emergency evaluation

Clinical and Prevention Goals

Maintain focus on implementation of Evidence Based Services to include:

- Increase number of staff trained and using EMDR for treatment of trauma
- Implement Peer Bridger services for individuals leaving state hospitals and entering Permanent Supportive Housing
- Train Intensive Case Managers in Critical Time Intervention Case Management
- Fully implement Assertive Community Treatment (ACT) teams and review fidelity to treatment model
- Have one full-time Youth and Family staff with full-time responsibility for PCIT and CARE

Increase outreach and engagement to SMVF individuals. This will include increased number of staff and community partners participating in Military Cultural Competence training.

Provide community integrations services for individuals currently and formerly participating in Adulty Recovery and Collaborative Services.

Enhance jail diversion and forensic discharge planning efforts.

Participate in planning and implementation of Marcus Alert and Mobile Crisis Services.

Develop substance use and suicide prevention campaigns using traditional and social media outlets as well as community-based events.

Clinical and Prevention Outcomes

ADULT SUBSTANCE ABUSE OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of clients admitted to the program will be scheduled within 14 calendar days for the next available appointment (group and individual sessions combined) following the same day access appointment	Year end results:	84% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	COVID19 and staffing shortages impacted our ability to meet the objective as we had hoped. However, by the end of the year, the ability to see clients quickly had greatly increased. We understand the importance of providing services quickly and worked to reduce barriers to obtaining access to MAT particularly, as quickly as possible.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Average length of stay will be 3 months or more for all clients in the program.	Year end results:	54% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	54% of the people that were closed to services had an average length of stay of 3 months or more. OBOT services negatively impacted this number. The team is currently generating a plan to address engagement within the OBOT service with the hope of increasing retention.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Of planned discharges, 70% will demonstrate a reduction in substance use or maintain abstinence during treatment. (Planned discharges are defined as those where the client is involved in the development of the discharge plan)	Year end results:	61% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Unfortunately, this objective was not met. However, the individuals we serve demonstrate improvement or continued abstinence 61 % of the time for those who have participated in their discharge planning. Considering the increased overdoses and increased use during the pandemic, we have moved to see people in person both in individual and group sessions utilizing all the necessary precautions as recommended by the CDC.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of clients surveyed in February will rate their overall satisfaction with services. (4 or 5 rating)	Year end results:	97% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	We are pleased that of those that completed a survey, the overwhelming majority were happy with the services provided to them. Staff are currently investigating alternative ways to receive feedback should a pandemic or a similar situation occur again.

ADULT MENTAL HEALTH OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 87% Clients will be seen at their first appointment after SDA within 14 calendar days.	Year end results:	73% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Staff vacancies and difficulty recruiting qualified candidates have negatively impacted the outcome this past year. The second quarter low of 39% prompted the agency to work to refer out to community providers all of those individuals with insurance. However, by the end of the year, for the last quarter, we were able to meet the objective 94% of the time. The team continues to operate with only 67% of the staff positions filled, but recruitment continues in earnest. For the year we met the measure 73.25% of the time.

MEASURABLE OBJECTIVE Consumer Satisfaction 85% of clients surveyed in February will rate their overall satisfaction with services at a 4 or 5 on the survey	Year end results:	94% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Obtaining survey responses was more difficult this year than in years past due to COVID19 as the majority of services were provided by electronic means. However, those surveys that were completed on site were extremely positive. We plan to investigate alternatives to in person surveys should we ever be in a position again where over ½ of our services are not provided face to face.

CHARLES CITY/NEW KENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of clients will be scheduled for initial appointment within 14 days of contacting Phone Center	Year end results:	93.64 % Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Due to staff schedules, vacation and clients rescheduling, PF met the goal one quarter. In two quarters we were able to meet the goal over 90 % of the time. In the first quarter, clinicians were assisting East and West with overload of clients due to staff shortages that impacted the ability to meet the 14 days. Will continue to strive to meet the 14-day objective.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 100% of clients will not have positive UDS for Opioids.	Year end results:	91.66% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Quarterly group members in the PF OBOT gave numerous urine drug screens. 91.66%l were negative for opioids. This was a new objective for this year and will be continued next year.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 50% of clients will stay engaged in PF OBOT program	Year end results:	63.3% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Progressively each quarter engagement improved. By the 4th quarter 80% of clients in OBOT program stayed engaged in treatment. Some clients could not sustain engagement due to going to jail. This is the first year for this objective. PF OBOT was able to meet this objective in keeping clients engaged in the program 63.3%.

EMERGENCY SERVICES OUTCOMES

MEASURABLE OBJECTIVE Quality / Effectiveness 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.	Year end results:	100%, 35% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Appointments were offered within a 7-day time period consistently but the outreach efforts for those who did not show were well below the desired objective. Significant staffing shortages throughout the year and the effects of COVID-19 pandemic made this objective difficult to reach. Tracking whether a client showed for their appointment in another program proved difficult. Recommendations for the coming year are to assign a particular staff each week to check the spreadsheet and call those who have not come into Same Day Access after hospitalization funded by LIPOS funds or after discharge from CSU. Once the program is fully staffed, the outreach aspect of this objective will be more feasible to meet.

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 in jail or	Year end results:	91% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	100% of preadmission screening forms completed by certified preadmission screeners in Emergency Services were reviewed by clinical supervisors. Due to staffing shortages, reviews of the prescreenings were not always completed in a timely fashion, however, a spreadsheet was created to track these situations even if they were not reviewed within the 7 days. The average percentage for those who received a follow up attempt within 7 days of their evaluation, is 91% which does meet the objective. Overall this year, the objective of follow up attempts occurring within seven days of the assessment was met two of the four quarters. During the two quarters in which the objective was not met, staffing shortages and effects of COVID-19 pandemic influenced the ability of clinicians and supervisors to be able to complete outreach

detention.				within the 7-day time period. Recommendations are to continue utilizing the spreadsheet so that cases that require follow up are identified as soon as possible and the outcome of the outreach method are documented. Additionally, during the next fiscal year, when possible, the certified peer recovery specialist will assist with the follow up activities to help ensure that the follow up occurs quickly. The average of the percentages met throughout all four quarters is 91% which does meet the objective set.

MEASURABLE OBJECTIVE Quality / Effectiveness Peer Specialist will contact 100% of individuals who are experiencing a crisis and are being evaluated for hospitalization, follow up with these individuals, and attempt to engage in services.	Year end results:	18% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Over the year, an average of 18% of the CRC crisis incidents involved the Peer Recovery Specialist having contact with the individual at the CRC. The COVID-19 pandemic affected the number of clients that the Peer Recovery Specialist was able to contact. This year was to establish a baseline for the objective and since the pandemic and technology accessibility challenges negatively affected the ability to connect with clients at the CRC significantly, the objective will be set higher than the baseline. The objective for the next fiscal year will be set for 25% of those served at the CRC to be seen by the Peer Recovery Specialist. Since the CRC operates 24 hours and the Peer Recovery Specialist works Monday through Friday from 8 a.m. - 4:30 p.m., she will not be able to connect with all those served. The Peer Recovery Specialist's schedule will be examined and if feasible, will be flexible to attempt to contact more CRC clients.

MEASURABLE OBJECTIVE Quality / Effectiveness Law enforcement and emergency services clinicians will communicate and identify 100% of individuals who may be better served by receiving mental health treatment instead of or before legal charges are placed to divert individuals from jail when appropriate	Year end results:	8% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This year's objective was to establish a baseline for how many individuals are currently actively being diverted from the criminal justice system through the ECO process and being treated at the CRC. Since an average of about 8% were diverted, the objective for FY22 will be set for 12% so that the goal will be to increase the number of individuals who are appropriately diverted from the criminal justice system. Police officers will be asked to document this information; currently, there is under reporting of this information due to police reporting procedures. CIT leadership is addressing how to improve the accuracy of this data.

and possible.				

SAME DAY ACCESS OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of individuals who answer yes to one of the Crisis Risk Assessment Questions will be offered a referral to REACH.	Year end results:	57% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	For the year, SDA achieved a disappointing overall 57% with completing the Crisis Risk Assessment Tool. When completed, one of the two desired results were achieved: referral made or referral declined. In the first quarter of the year, there was great success with this outcome as 100% of the Tools were completed. By the second quarter, however, results dropped significantly to only 50%. Results improved ever so slightly in the third quarter but then plummeted to 17% in the fourth quarter. It is surmised that the first quarter results what they were because this was a newly implemented mandate that was fresh in clinicians' minds. It is suspected that the COVID-19 State of Emergency played a large role in the success rate dropping overall in the latter three quarters. Results were reviewed with staff on 7/30/21. Clinicians were provided with visual results and a high emphasis was placed on ensuring the completion of the Assessment Tool. Clinicians were reminded of the State mandate.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 100% of individuals completing Same Day Access and being referred to SUD Services will have a completed TB Screening	Year end results:	92% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This outcome measure was not effective for the first quarter of the year and was not tracked in the second quarter. For the year (third & fourth quarters), there were 147 total SUD referrals and 134 TB screenings for an overall 92% rate of referral. It appears that SDA clinicians are generally completing the required form. A gentle reminder to staff about this State mandate may prove to further enhance results. Results were reviewed with clinicians on 7/30/21.

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. 8.4 days Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Despite the low percentages of admissions meeting the 10-day objective, the overall average still remains under 10 days. This average reflects the concentrated efforts of LSC to have quick turnarounds for admissions following the referral process, despite many inevitable delays for which the program has no control. The program has made changes in the middle of the fiscal year to accommodate others' schedules, having orientations scheduled on any day of the week instead of only Mondays and Wednesdays. Also, the program supervisor will be trained and familiar with the admission process in order to manage admissions when the program clinician is out or unavailable. Lastly, the LSC supervisor will aim to continue providing information about the

				referral process to colleagues within the agency in order to prevent delays in admission because of scheduling trials and tours.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 80 percent of Consumers given a pre and post survey will show an improve score demonstrating an increase in knowledge of information shared in psychoeducational groups.	Year end results:	83% pre-survey 66% post survey Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The results from the second quarter are difficult to interpret due to significantly low sample size, though more than 80% of participants did in fact demonstrate an increase in knowledge following the post-tests. The results from the fourth quarter had only a 66% improvement rate. Both quarters appear to be heavily influenced by programmatic changes in relation to COVID-19 STATE OF EMERGENCY. Scheduling conflicts and inconsistencies proved difficult to regularly facilitate the EBP "Illness Management" groups to a consistent group of people. Lakeside Center will plan to implement more EBP, structured groups with pre and post-tests now that functioning is less limited from COVID-19 restrictions and daily census is significantly increased.

MEASURABLE OBJECTIVE Quality/ Efficiency 90% of Charts reviewed will demonstrate discharge planning that is measurable, includes any barriers to discharge.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	All charts reviewed in this fiscal year contained measurable discharge planning and barriers to discharge. However, with varying degrees of specificity with the discharge barriers, there was a marked improvement in Quarter 4. Lakeside Center will continue to emphasize discharge planning, even upon admission, and include the discharge barriers that need to be addressed in order to make progress in the program.

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:	82.75% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Programming was significantly impacted by COVID-19 STATE OF EMERGENCY. Lakeside Center staff plan to regularly ask for group topic suggestions and ask for member feedback. LSC will also facilitate house meetings twice monthly to facilitate discussions between staff and members in attempt to improve program functioning and consumer satisfaction.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of family/significant other stakeholders will respond with an 8-10 rating to all	Year end results:	1. 4/5 or 80% 2. 4/5 or 80% 3. 3/5 or 60% 4. 4/5 or 80% Not met Actions during the year did not produce the	Recommendations, actions taken, performance improvements:	Some ALF dissatisfaction appears to be contributed by a perceived lack of alternative community resources for members post-discharge from Lakeside Center. LSC aims to partner with ALFs, along with members and their support system, to identify alternative resources in the community prior to discharge from the program. Lakeside Center will also prioritize regular communication with ALFs to facilitate

survey questions		desired results		continuity of care and lean and on a collaborative partnership in terms of discharge planning.

MH CASE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access On average non crisis clients will be scheduled within 7 days of their Same Day Access Appointment into ongoing case management and assessment services	Year end results:	4.75 days Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Over the past fiscal year, a total of 336 clients have been referred to Case Management and Assessment Unit of Henrico Mental Health. Wait times for each of these clients were averaged and yielded an average wait time of 4.75 business days from the Same Day Access appointment to the appointment with their assigned case manager, thus meeting and exceeding the benchmark for this objective. Henrico Mental Health and the Case Management and Assessment Unit remain committed to provide timely services to clients seeking agency treatment services and these results support this focus. This past year has proven to be quite difficult due to the COVID-19 pandemic and associated safety and mitigation strategies, but the agency has remained focused on providing quality timely services to those in need, despite these obstacles.

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 from months 4-9.	Year end results:	93% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	A total of 345 clients were referred to case management services during the reporting period. At nine months post admission to services 167 remained active and 156 experienced a reduction in hospitalizations or remained at zero hospitalizations or 93%. In addition to these impressive results, of note is these clients experienced an 85% decrease in the number of hospitalizations as compared to the baseline period – dropping from 94 cumulative hospitalizations to only 14 hospitalizations 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.

MEASURABLE OBJECTIVE Quality/ Efficiency At least 55% of agency case management clients will receive physical annually by a qualified medical provider to identify any health-related issues and develop a plan of care to meet those needs.	Year end results:	54% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This past year has been a challenging one, due to the COVID-19 pandemic and the associated safety and virus mitigation strategies, along with (at some locations) limited community preventative health resources. These factors coupled with understandable client fears surrounding contracting the COVID-19 virus, have been an obstacle in assisting clients in obtaining medical care and their annual physicals. A total of 54% of clients served in the Case Management and Assessment program of Henrico Mental Health received a physical in the past 12 months, thus narrowly missing the target for this objective. Case Managers and team supervisors will continue to be diligent in monitoring and encouraging clients to receive these annual physicals and obtain needed care in the upcoming fiscal year.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of client responses will be one of the two highest ratings to questions on the satisfaction survey	Year end results:	99% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	During the month of June, case managers and agency staff offered and collected client satisfaction surveys to clients that were seen face to face throughout the month. A total of 53 surveys were collected across the four case management teams, with a total of 212 responses given to the four questions asked. Two hundred and nine (209) of those responses were given one of the top two ratings or 98.58% of all the responses given. This meets and exceeds the target for this objective. The number of surveys collected this year did decrease significantly as compared to last year, as a direct result of the COVID-19 pandemic as many services continue to be provided in a virtual or telehealth format, rather than face to face. These results will be shared with team supervisors and staff and client comments and feedback will be incorporated into how services are delivered.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of HAMHDS prescribers' and ARS Collaborative Services providers' responses will be one of the two highest ratings to questions on satisfaction survey rating case managers and clinicians within CM&A	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	A total of 43 surveys were returned from stakeholders from collaborative services (mental health skill building and Lakeside Center psychosocial staff) and agency prescriber staff rating individual case managers across the three case management teams. A total of 169 responses were received from these stakeholders regarding their rating of the case manager's responsiveness, collaborative style, and understanding of and assistance with the client's mental health needs and recovery. All 169 of these responses (or 100%) were given on of the top two ratings thus meeting and exceeding the benchmark for this objective. These results are quite positive and speak clearly to collaborative teamwork occurring on the client's behalf which undoubtably assists the client in achieving well-

				coordinated care, which is a core element to receiving effective case management services.

IN-STRIDE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of clients referred for InSTRIDE will be opened, on average, for an assessment within 7 days of notification of the referral	Year end results:	80% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	100% was not met this year but that was due to staff being out and not being able to complete the intake process within the window. Recommendations are to continue to have set days for intakes and work to meet our goal of opening consumers referred within that seven (7) day period. There was only one instance in the last year when this goal was not met and that was due to staffing. We will be incorporating a new clinician into the team who will also be able to open consumers. Hopefully with this addition we will be in our goal of 100% for the year.

MEASURABLE OBJECTIVE Customer Value / Effectiveness More consumers than not will experience improvement regarding DLA-20 global scores.	Year end results:	40% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The average for the year was around 40% of consumers having an increase in their DLA 20 scores. It is recommended that we continue to try and increase consumer engagement in services and in community activities. The pandemic played a large part in our ability to engage consumers in the community. With restrictions being lifted we hope to increase our consumers community engagement and provide opportunities for outings.

MEASURABLE OBJECTIVE Quality/ Efficiency 70% of clients will participate, at least quarterly, in activities within their community such as vocational, educational, or recreational.	Year end results:	67% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Our year average of consumers participating in one social activity per quarter was 67%. We did not meet our goal of having 70% or more two quarter out of the year. It is recommended to keep this goal. We struggled with being able to safely get consumers to activities in the community due to the Pandemic and restrictions placed on us by the CDC. With those restrictions lifted we hope to engage more consumers in community activities with more regularity. We are only able to transport one consumer at a time in vehicles and transportation is a barrier for our consumers. We hope to be able to have more consumer participation as the limit of consumer in vehicles increases.

MEASURABLE OBJECTIVE Consumer Satisfaction At least 85% of client responses on the client satisfaction survey will be one of	Year end results:	80% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	It is recommended that this goal remain the same. We will again work to increase our engagement in the homes and in the communities with consumers due to the lift on restrictions due to the COVID pandemic. We are increasing our staffing, with a substance abuse clinician which will meet a need that was missing on the team. We are hoping that this will improve our consumer

the top 2 ratings.				satisfaction surveys as a number of consumers on this team have a co-occurring SUD diagnosis.

MEASURABLE OBJECTIVE Stakeholder Satisfaction Stakeholder surveys to be administered to family members of clients. Target is to achieve average of 4 or above 5-point Likert scale: 1= Strongly Disagree 2= Disagree 3= Somewhat Agree 4= Agree 5= Strongly Agree Baseline date: Average 4.24 FY20	Year end results:	Average score above 4 achieved Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Nine surveys were returned by family members. Responses are similar to last year's results with most averages between 4 and 5. Question 3 was median score of 3.6; this is due to COVID-19 and consumers not being able to attend as many community events due to CDC social distancing guidelines. We will maintain this goal and continue to strive for average to above average results as our targets. We will continue to administer these surveys by our team family support specialist in hopes of soliciting an unbiased response.

<u>MH PACT/ICT OUTCOMES</u>

MEASURABLE OBJECTIVE Quality / Access There will be an increase over FY20 89% in access to health care services experienced by persons receiving PACT/ICT services. Such individuals will see a health care provider such as primary care providers, specialists, dentists, optometrists, etc., but not including ED treatment, at least once a year.	Year end results:	69% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	More than half of our consumers were able to see a prescriber for routine medical care this year. Our baseline score for this year is 69%, which is down from last years. We did not increase or maintain our baseline average; that could be explained by COVID and the restrictions for transportation and concern our consumers had for going into a medical providers office during the pandemic. We will continue to measure this goal and hope to see an improvement with the restrictions lifted imposed by the CDC. We will continue to link and assist with appointments to ensure our consumers have access to medical care.

MEASURABLE OBJECTIVE Customer Value / Effectiveness More PACT/ICT consumers than not will show improvement in DLA-20 global scores.	Year end results:	49.2% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	49.2% of consumers showed an improvement in their DLA 20 scores for the year. We are recommending keeping this goal as is. The pandemic and the restrictions imposed by the CDC had a large impact on our consumer overall level of functioning. Day programs and other activities that they were once able to participate in were stalled during the pandemic, as a result it was noted that

				some of the scores showed a decline that was consistent with consumers mood and feelings of isolation. We hope to see an overall improvement now that the CDC has lifted restrictions.

MEASURABLE OBJECTIVE Quality/ Efficiency 100% of 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.	Year end results:	87.5% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	We were not able to meet our goal of 100% of consumers having opening paperwork completed within the first 30 days. This is in part due to staff turnover. We hope to fill vacancies and have the sub specialists available to complete some of their initial paperwork within our 30-day window. We recommend keeping this goal.

MEASURABLE OBJECTIVE Consumer Satisfaction 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 2020 - 68% of responses	Year end results:	78% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	We increased our baseline average this year, with an improvement in consumer satisfaction. We recommend keeping this goal. We had an increase towards the end of the year and believe that this was attributed to being able to do more in the community with consumers due to lifting of the CC restrictions due to the pandemic. We hope to be able to provide more community-based services and to fill vacancies to allow our consumers more time with staff.

MEASURABLE OBJECTIVE Stakeholder Satisfaction Clients' families/ identified primary support system will complete a service satisfaction survey to rate the services being provided to their family	Year end results:	87% of responses were given a rating of '4' or higher Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Results show that 87% of responses were given a rating of '4' or higher. There was a total of nineteen (19) surveys collected between both ICT/PACT teams. Of those nineteen 84% of consumers feel that they can more effectively deal with his/her problems. Of those nineteen 94% can more effectively communicate their needs and wants. 78% of PACT/ICT consumers feels they are participating in more community activities. 89% of PACT/ICT feels they are better educated about their illness, and 94

members. Target is to increase over baseline of 80%.				% would recommend this agency to a family member or friend. It is recommended that we keep this goal. It will allow us to gauge the needs of family and caregivers to ensure that we are meeting the needs of our consumers as well as their support system.

MH SKILL BUILDING OUTCOMES

MEASURABLE OBJECTIVE Quality / Access MHSS will open 80% of referrals within 7 days of referral from the Case Manager	Year end results:	31% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This year, MHSS measured the length of time between referral and admission of new clients into the program. Our objective was to admit clients within 7 calendar days after referral. We struggled with meeting this objective during each quarter of the year. In Q1 and Q3, 43% of clients were opened within 7 days of referral. In Q4, 33% were opened within 7 days. In Q2, no clients were opened within 7 days. Some reasons for why the objective was not achieved include: Supervisor's need to involve the Case Manager in some cases thereby adding another layer to scheduling issues, client hospitalizations, and multiple holidays in Q2 which played a role in delaying the opening of cases. Supervisor does wish to note, however, that in many instances cases were opened a day or a few days after day 7 and there was not a significant wait.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 90% of clients in the sample will demonstrate an increase in their DLA-20 Self-Report Score. Sample will only consist of new admissions to MHSS in the fourth quarter of FY 2020 and the first quarter of FY 2021. The sample will be followed throughout the course of the year.	Year end results:	65% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	MHSS began utilizing the DLA-20 Self-Report tool this year to measure the program's effectiveness. Our objective was to achieve a 90% increase in client scores each quarter. The DLA-20 Self-Report tool measures clients' perception of how they are functioning in the last 30 days in the following areas which are all reflective of the overall goals of the MHSS program: Physical Health and Mental Wellness (management of mental health symptoms, medication compliance, and management of physical health conditions); Nutrition (meal preparation, eating at least two nutritious meals a day, and limiting caffeine and sugar intake); Problem Solving (Solving day to day problems and managing stressful situations) and Relationships (satisfaction with relationships and level of support received in important relationships). The DLA-20 Self Report tool provided concrete data that identified where the program was effective and where more work needed to be done. It also provided data that closely reflected the level of functioning and progress being made by most clients. Q1 of this year was used to establish baseline scores of clients participating in the sample. Going forward, the largest increase in scores occurred in Q2 when 75% of clients surveyed reported

				improvement. In Q3, 50% of clients reported improvement and 70% reported improvement in Q4. Supervisor recommends that MHSS continue to utilize the DLA-20 Self-Report tool next year. The DLA-20 will be the only outcome we will have next year. This is due to the dissolution of the MHSS program with the exception of having one staff who will provide MHSS to clients residing in our support homes.

MEASURABLE OBJECTIVE Quality/ Efficiency 90% of all Prior Authorizations submitted will be accepted	Year end results:	54% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	MHSS' only third-party payer is Medicaid. Medicaid MCO's or Managed Care Organizations require the submission of a Prior Authorization request after a client is assessed by a licensed mental health professional and services are deemed clinically indicated. The Prior Authorization request or PA for short, provides the MCO with a detailed description of why the client needs MHSS and what goals they hope to achieve while in the program. Upon receipt, the MCO determines if the PA will be accepted or if additional information is required. It is also possible that the MCO will grant a partial approval or a denial of services. Our objective was to achieve a 90% acceptance rate on all PAs upon submission. This objective was important because acceptance rates are directly tied to how we provide services and the ability to generate revenue. We have found that it takes staff a considerable amount of time to complete PA requests. Therefore, it made sense to strive toward receiving acceptance upon submission. If we could achieve this goal, staff and supervisor could save time that otherwise would be spent working with the insurance company to approve services. Over the course of the past year, this objective proved difficult to achieve. Supervisor observed an ongoing trend among the MCO's to grant both less time and fewer units of service than they had in the past. Supervisor also participated in numerous peer-to-peer reviews with insurance companies to get these shortened authorizations. While we did not achieve our objective, we came close in Q3 with an 86% acceptance rate. We did not fare as well the rest of the year with acceptance rates of 67% in the first quarter, 23% in the second quarter, and 66% in the third quarter. Supervisor recommends that this outcome be continued next year.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of consumers	Year end results:	86% Not met Actions during the year did not	Recommendations, actions taken, performance improvements:	MHSS did not meet this objective as only 86% of all consumers responded to each survey question with a score of 8 or higher for every question. The question that received the greatest number of responses below a score

will respond positively to each survey question as evidenced by a score of 8 or higher for every question		produce the desired results		of 8 was Question #2 which reads "Over the past year, how much progress do you feel you have made regarding your recovery goals?" Five clients rated themselves in the 5-6 or "Fair" range on this question. Interestingly, staff's assessment of progress in recovery for these same clients is generally much higher the ratings clients gave themselves. Supervisor does with to note that the number of surveys received was low this year (21 surveys) with one staff only returning 3 surveys. Supervisor did not get any surveys for one staff who went out on a leave of absence at the end of the quarter. Supervisor believes that if more surveys were returned, including surveys of the missing staff member that the program would have achieved this objective. Supervisor will again explain the importance of completing and returning surveys in a timely manner during staff meeting on 5/13/21.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 80% of ARS case manager responses will be in the excellent range (8-10)	Year end results:	76% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	MHSS did not achieve this objective in that only 76% of responses in the excellent range. The question that received the lowest rating (28%) was regarding the improvement the consumer has made since beginning MHSS. Explanations as to why stakeholders rated staff lower than an 8 on this question described COVID-19 playing a major role in the client's ability to make progress since the pandemic has prevented MHSS staff from meeting with the client consistently as well as another client becoming less involved in services since the onset of COVID-19, client resistance to change despite staff's best efforts, client's lack of insight into their mental illness which makes MHSS service delivery "impossible/very difficult." Supervisor does wish to note that only 7 surveys were returned this year despite having over 40 clients enrolled in MHSS in the second quarter. Supervisor believes that COVID-19 restrictions have also played a major role in why the rate of survey return is low this year. Stakeholders (Case Managers) were only in the office one day per week in the second quarter thus limiting their general access to MHSS staff in person. Supervisor reached out to the supervisors of all of the case managers to attempt to increase the return rate of the surveys. The majority of the surveys were returned after the first request, but no surveys were returned after the second request was made. Supervisor anticipates return rates of this survey will increase next year when the agency returns to normal operating practices. Question 1: 100% (The services the consumer

				receives are recovery focused) Question 2: 100% (Staff responds in a timely manner to requests for information) Question 3: 71% (Staff contacts you monthly to discuss the consumer) Question 4: 85% (Rate your satisfaction with the collaborative efforts of MHSS in regard to issues concerning shared consumers) Question 5: 28% (The improvement consumer(s) have made since beginning MHSS). Information was shared with staff in team meeting on 2/4/21.

MH VOCATIONAL OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of persons referred will be contacted within seven days of referral	Year end results:	87% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The objective of 100% of persons referred will be contacted within seven days of referral was not met (Q1 86%, Q2 85%, Q3 90%, Q4 88%) but averaged an 87% for the year. This was due to factors outside of ARS Vocational Services control (client hospitalization, client non-working phone, client discharge at referral submittance). To better meet this goal and allow for the above factors this goal will be measured at 90% for the next outcome plan year.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Staff will assist program participants with obtaining 26 additional jobs during the yearly evaluation period	Year end results:	45 Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The objective of assisting program participants in obtaining 26 additional jobs was met. All four quarters show accomplishment during the pandemic with nearly all four quarters resulting in double digit returns for a total of 45 new jobs obtained for the year. Although, this goal was met for the year the focus will continue with obtaining new employment with an increased focus on providing supports to persons in sustaining employment. This goal will be increased to supporting 28 persons during the next plan year.

MEASURABLE OBJECTIVE Quality/ Efficiency Each full-time job coach will develop 24 new employer contacts monthly	Year end results:	221 for the year averaged 9 contacts monthly per job coach Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The objective of each full-time job coach developing twenty-four new employer contacts monthly operated the entire year under COVID guidelines in which the goal was not met yet staff made forward progress each quarter (Q1 new contact average per Job Coach- 4, Q2 new contact average per Job Coach-13, Q3 new contact average per Job Coach-10.5, Q4 new contact average per Job Coach- 12.5) resulting in nearly tripling last year's total of 76 new contacts and ending this current year with 221 new contacts. To continue progression in reaching this outcome the MH Employer Database will be purged for the current year and Job Coaches will submit obtained contacts to the supervisor monthly during supervision to monitor monthly

				progress.

MEASURABLE OBJECTIVE Quality/ Efficiency Full-time job coaches will average at least 55 direct service hours monthly	Year end results:	27 direct service hours monthly average Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	For the entire year ARS Vocational Services has operated under COVID-19 precautions with limited face-to-face contact which has presented as a challenge to achieve this outcome of full-time job coaches averaging at least fifty-five direct service hours monthly. As a means to capture services, all contact type hours (in-person, telephone and virtual) were collected as of quarter two resulting in an increase in contact hours. Q1-14hrs, Q2-22hrs, Q3-36hrs, Q4-36hrs with the entire year averaging 27 contact hours. As of July 1st, agency operations will return to that of pre-COVID in which an increase in direct service hours is expected.

MEASURABLE OBJECTIVE Quality/ Efficiency Job coach will facilitate applicant to employer contact within fifteen days from ISP meeting, 85% of the time	Year end results:	97% average for the year Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This objective of facilitating applicant to employer contact within 15 days of ISP meeting 85% of the time was met each quarter ending with a yearly average of 97%. To continue this progress a continued emphasis on the IPS initiative of a rapid job search will be discussed in Job Club meetings and ARS CM&A staff meetings to better encourage consumers to an informed choice in employment desires and career goals.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of all responders will rate each statement between “8” to “10” in the survey	Year end results:	#1-100% #2-94% #3-97% #4-94%% #5-97% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	All survey measures were met at nearly 100% consumer satisfaction. To promote continued consumer satisfaction, ARS Vocational Services will remain in providing person-centered services with supports that allow all consumers to make an informed choice in their career paths.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of all responders will rate each statement between “8” to “10” in the survey	Year end results:	#1-73% #2-100% #3-100% #4-100% #5-100% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This objective was met at 100% for all questions except question 1 which received a rating of 73%. During this entire plan year limited community contact has been provided due to operating under COVID-19 guidelines. To improve this rating all employers have been given cellphone access to ARS Job Developers and the program supervisor for any employment concerns and to further open the lines of employer-to-program communications.

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:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Prevention met this objective with 138 youth approved for admission within 5 days of request. Program Coordinators registered youth on-site as well as online. No youth needed to be placed on a waiting list this year.

MEASURABLE OBJECTIVE 90% of CONNECT 1st – 3rd grade participants shall be reading on or above grade level.	Year end results:	69% reading on or above grade level. Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Prevention did not meet this program goal due to disruption to school and Connect programming because of the continued COVID pandemic again this school year. However, there was a 7% improvement on reading levels. Youth, as a group, maintained baseline reading levels. Despite the COVID challenge, prevention remains committed to its focus on improving reading skills and overall academic success of participants, Staff have continued to stay connected to community partners who provide enrichment activities and resources that support this objective. Prevention has just started a partnership with HCPS and their SMART Program. This program specifically focuses on improving reading skills in elementary grade levels.

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 = 22 participants completed, 0% favorable attitudes Life skills Training = 26 participants completed, 4% favorable attitudes Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Early elementary school youth involved in Al's Pal's responded well to the SA curriculum. By the 3rd grade youth begin to show more uncertainty around the risk of substance abuse. The new laws surrounding marijuana use along with environmental messages have produced mixed results regarding attitudes towards substances at earlier ages. Staff have begun to incorporate more harm reduction information into the curriculum. It is worth noting that ES Life Skills participants that reported unsure in the pretest decreased by 10% all while delivering services through a virtual format.

MEASURABLE OBJECTIVE Quality/ Efficiency Prevention Services shall implement environmental approaches, in collaboration with community	Year end results:	Campaign reach: Television 7,870,258 Reach Billboards 3,935,129 Reach PSAs 1,480,000 Reach Medi-bags 168,000	Recommendations, actions taken, performance improvements:	Prevention exceeded this goal by completing 16 community level activities despite working with the COVID restrictions.

partners, to address substance use prevention and mental wellness as measured by the delivery of a minimum of 3 community-level activities, e.g., community forum, social norms campaign, or merchant education activities		Medication lockboxes 898 Rx drug disposal kits 1,307 Feeding 150 persons weekly Met Actions during the year did produce the desired results		

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 Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	111 out of 128 CONNECT participants (3rd grade and above) give a response of 1 (i.e., agree) on the consumer satisfaction survey. Despite COVID-19 continuing throughout this entire school year, Connect staff maintained contact with youth/families and continued to provide services. Limited in person programming has been provided for the last two months.

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:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	100% of parents agreed that the program benefits their students. Multiple resources such as food, rent assistance, and COVID vaccinations were made available to program participants. Prevention was able to partner with multiple agencies to provide this assistance

<u>YOUTH & FAMILY OUTCOMES</u>

MEASURABLE OBJECTIVE Quality / Access Youth &Family Services Outpatient clinicians will schedule their clients within 14 days of their Initial session 90% of the time	Year end results:	99% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Overall, this fiscal year, we have met our goal consistently with a slightly longer average during times of staff shortages; but always within the 14-day time period 99% of the time. This goal should remain constant as it is a mandate and even when we have fewer staff to take cases, we are able to meet this.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Youth and family outpatient clinicians	Year end results:	35 TF-CBT clients 23 PCIT clients Met Actions during the year did produce	Recommendations, actions taken, performance improvements:	During this year, COVID-19 presented unique challenges to our unit in the provision of evidenced based practices. Consultants for PCIT and the TF-CBT community rallied to be able to provide guidance in the adherence to the models while using telehealth. During the year

in training and trained for Trauma-Focused CBT and Parent Child Interactive Therapy will provide evidence based services to at least 15 clients		the desired results		services took place both over telehealth and in person when it was safe to do so. During this year, Youth and Family was able to provide TF-CBT to 35 cases. Youth and Family provided PCIT to 23 cases during this year. The unit continues to support the use of evidence-based practice models. In the coming year 4 more clinicians will be trained in TF-CBT. The agency continues to support clinicians being certified.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Reoffending rates will remain at or below 10% for MST clients during the course of treatment	Year end results:	4% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	27 cases closed during this year had an opportunity for a full course of treatment and one of those cases reoffended. Additionally, all 27 youth were living at home and attending school or working. Note that school (and most services) are being offered virtually due to COVID-19 State of Emergency

DBHDS PERFORMANCE MEASURES

The DBHDS dashboard targets are set by the DBHDS and the Secretary for all 40 of the State's Community Service Boards. The data used is submitted monthly by CSBs as outlined in the State's performance contract with CSBs. Quarterly the performance measures are summarized for the HAMHDS CSB Board's review. FY21 ended as the following: completion of adult (100%) & child (100%) suicide risk assessments, receiving an annual physical exam (53.7%), calculating BMI (23%), tracking of Individuals Outside the BMI Normal Range (81.5%), following-up of BMI plans (95.5%), the initiation (50%)/engagement (45.5%)/retention (36.4%) of individuals in SUD services and DD Waiver individuals who meet the criteria for enhanced case management have monthly face-to-face meetings (88%, target 90%), in the residence (87%, target 90%).

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.

SATISFACTION

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, 2020 through March 31, 2021.

During this fiscal year, ten separate services were tracked. A total of 446 surveys were mailed and 39 were returned. The response rate for programs ranged from 0% to 15% with an average response rate for all of the CARF services of 9%, same response rate of 9% for FY20. Individual comments are forwarded to the respective program. 77% of the returned surveys noted satisfaction ratings of either neutral, satisfied or very satisfied.

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

FY2021 ANNUAL POST DISCHARGE REPORT

Unit	SubUnit	HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Discharges by Program (Apr 2020 - Mar 2021)																
1300	HCE1,HCPF,HCW1&2&3	CM&A	MH Case Management	12	15	15	20	22	27	39	21	36	22	27	22	278
1301	HACF,HACW,HYAR	PACT	Assertive Community Treatment	2	2	4	4	0	5	3	3	3	5	0	2	33
1302	HDLH	MH Day Support	MH Community Integration	1	0	4	3	6	2	3	5	5	0	3	5	37
1304	HSEL	MH Vocational	MH Community Employment	2	2	1	2	7	3	1	2	8	2	1	2	33
1306	HSSW, HSSE, HSSP	MH Supported Svcs	MH Supported Living	1	1	2	5	3	4	4	4	3	6	3	2	38
2003	RRGR,RRGY,RRSB,RRTR	ID Residential	ID Residential	0	0	0	0	0	0	0	0	0	0	0	0	0
2001	RDST,RDEP,RDNW	LEP	ID Community Integration	0	1	0	0	0	0	0	0	0	0	0	0	1
2002	RSEU	ID Supp Employ	ID Community Employment	0	0	0	1	0	2	2	0	0	1	0	1	7
2007, 2008	RDSH, RDSC, RDSP, RDHE, RDCY	Sheltered Employ	ID Organizational Employment	0	1	1	3	0	2	1	2	2	0	0	0	12
2008	RSGE, RSGH, RSGW, RDEN	ID Group Supp Empl	ID Community Employment	0	0	0	1	0	2	1	2	0	0	0	1	7
Total				18	22	27	39	38	47	54	39	57	36	34	35	446

Unit	SubUnit	HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Response Rate%
Survey Response Rates (Apr 2020 - Mar 2021)																	
1300	HCE1,HCPF,HCW1&2&3	CM&A	MH Case Management		1	1	2	2	3	5	1	2	2	2	4	25	9%
1301	HACF,HACW,HYAR	PACT	Assertive Community Treatment			1										1	3%
1302	HDLH	MH Day Support	MH Community Integration													0	0%
1303	HRTO	MH Residential	MH Community Housing													0	0%
1304	HSEL	MH Vocational	MH Community Employment					1	1			2	1			5	15%
1306	HSSW, HSSE, HSSP	MH Supported Svcs	MH Supported Living			1	1			1		2				5	13%
2003	RRGR,RRGY,RRSB,RRTR	ID Residential	ID Residential													0	
2001	RDST,RDEP,RDNW	LEP	ID Community Integration													0	0%
2002	RSEU	ID Supp Employ	ID Community Employment							1						1	14%
2007, 2008	RDSH, RDSC, RDSP, RDHE, RDCY	Sheltered Employ	ID Organizational Employment				1									1	8%
2008	RSGE, RSGH, RSGW, RDEN	ID Group Supp Empl	ID Community Employment												1	1	14%
Total				0	1	3	4	3	4	7	1	6	3	2	5	39	9%
Response Rate				0%	5%	11%	10%	8%	9%	13%	3%	11%	8%	6%	14%	9%	

INTERNAL AGENCY RECORD REVIEWS

Approximately 864 quality record reviews and 177 Administrative Reviews were completed in FY2021. The target for all programs is 90% compliance with the standards reviewed.

CSS RECORD REVIEW RESULTS SUMMARY

Targets for all programs is 90%.

- Reviewed 20-30% Waiver cases, 5-30% Non-Waiver cases and 100% of Residential cases
- More than half of the programs met the target goal of 90% (North 1 Waiver, East 1 Waiver, West 1 Waiver, North 1 SPO, DD CM East 1, DD CM East 2, DD CM West 1, DD CM North1, DD CM Catholic Charities, DD CM Waiver Services, Hermitage Voc, Cypress Voc, Enclaves, LEP, STEP and Supported Employment)
- Three programs improved by five or more percentage points from FY20 (North 1 SPO, DD CM Catholic Charities, Hermitage Voc)
- Four programs dropped by five or more percentage points from FY20 (East 1 SPO, East 2 SPO, West 1 SPO, ID Administrative)

	FY2021	FY2020	Comments
NORTH 1 WAIVER	91%	93%	
EAST 1 WAIVER	90%	93%	
EAST 2 WAIVER	87%	88%	
WEST 1 WAIVER	96%	90%	
WEST 2 WAIVER	92%	89%	
NORTH 1 SPO	91%	82%	↑ 9 percentage points from FY20
EAST 1 SPO	80%	94%	↓ 14 percentage points from FY20
EAST 2 SPO	71%	86%	↓ 15 percentage points from FY20
WEST 1 SPO	86%	92%	↓ 6 percentage points from FY20
WEST 2 SPO	na	90%	no charts reviewed
DD CM East 1	91%	97%	
DD CM East 2	94%	97%	
DD CM West 1	90%	97%	
DD CM West 2	89%	97%	
DD CM North 1	94%	97%	
DD CM CATHOLIC CHARITIES	90%	82%	↑ 8 percentage points from FY20
DD CM WAIVER SERVICES	98%	90%	
HERMITAGE VOC	93%	86%	↑ 7 percentage points from FY20
CYPRESS VOC	93%	96%	
ENCLAVES	92%	94%	
LEP	92%	95%	
STEP	96%	97%	
SUPPORTED EMPLOYMENT	98%	99%	
RESIDENTIAL	88%	85%	
ID ADMINISTRATIVE	86%	92%	↓ 6 percentage points from FY20

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

Targets for all programs is 90%.

- Reviewed 5-20% Medicaid cases and 3% Non-Medicaid cases
- More than half of the programs met the target goal of 90% (ESP, Same Day Access East & West, Youth & Family, MH Outpatient East & West, SUD East & West, Lakeside Center, InStride, CM&A West 1, MH Skills-Building West, Prescribers, MH Administrative)
- Four programs improved by five or more percentage points from FY20 (SUD RMP, CM&A PF, Prescriber, MH Administrative)
- Two programs dropped by five or more percentage points from FY20 (CM&A West 2, MH Skills-Building East)

	FY2021	FY2020	Comments
ESP/PRESCREENING	94%	95%	
SAME DAY ACCESS EAST	98%	96%	
SAME DAY ACCESS WEST	99%	97%	
YOUTH & FAMILY	93%	94%	
MHOP EAST/WEST	92%	93%	
MHOP/SA/YOUTH PF	89%	90%	
MHOP CM	74%		
SA EAST	92%	96%	
SA RMP	92%	86%	↑ 6 percentage points from FY20
LAKESIDE CENTER	95%	99%	
LAKESIDE CTR VOC	83%	83%	
PACT EAST	88%	89%	
PACT WEST	87%	86%	
INSTRIDE	92%	89%	
CM&A EAST	84%	87%	
CM&A WEST 1	90%	88%	
CM&A WEST 2	80%	88%	↓ 8 percentage points from FY20
CM&A WEST 3	76%		
CM&A PF	89%	72%	↑17 percentage points from FY20
MH SKILLS-BUILDING WEST	94%	95%	
MH SKILLS-BUILDING EAST/PF	83%	90%	↓ 7 percentage points from FY20
PHYSICIAN	97%	86%	↑ 11 percentage points from FY20
MH ADMINISTRATIVE	93%	88%	↑ 5 percentage points from FY20

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

FY22 Objectives for the Coming Year

- Continue improvements of the Utilization Review process
- Support programs' choice for desk reviews, in person reviews or a combination of the two this year

- Explore how the new electronic health record system can support the internal chart review process
- Partner with IT to update Chart Tracker application
- Identify and report trends to AMT

EXTERNAL AGENCY REVIEWS

	FY21	FY20	FY19
Total number of Reviews:	62	57	66
Admin:	0	0	1
C&P:	15	27	21
CSS:	42	24	37
Across All Divisions:	5	6	7
# of Desk Reviews	62	48	59
# of Onsite Reviews	0	9	7
# of C&P/CSS Licensure/CARF/VHDA	18	51	NA
# of C&P client records reviewed	53	119	72
# of CSS client records reviewed	536	46	211
Total number of records reviewed	607	216	283

- No Onsite visits due to COVID restrictions
- Three "other" requests not sent (nothing sent due to; no charts found, not open during requested time, do not provide what was requested)

Trends/Outcomes

- The number of actual reviews relatively stayed the same with a slight increase from FY20 and the amount of records reviewed increased significantly by 181%.
- There were 11 entities that requested documents or reviews
- Reviews were mailed, faxed, or sent by secure email exchange-Virtru, Move-it, Red Box, ECG Quick connect
- Web mtg, Virtual tour, Zoom, and video conference used to meet requirements/requests in lieu of in person reviews.
- Laptop given for 17 days for reviewer DBHDS to access Cerner from her home.
- 100% of reviews were completed within the specified timeframes
- Record requests increased for CSS due to HSAG (1Q112)/(3Q127) and DMAS Quality Management Review (4Q70)
- Requests decreased for C&P

External Reviewers

DBHDS -Virginia Department of Behavioral Health and Developmental Services: (Licensure, Health Services Advisory Group (HSAG), Office of Community Quality Improvement, Division of Developmental Services, Office of Adult Community Behavioral Health Services, Department of Behavioral Health and Developmental Services, Office of Developmental Services), Cigna(CIOX), Virginia Supportive Housing, National Core Indicators, Amikids, Anthem(Cotiviti/Ciox), Anthem Healthkeepers (Change Healthcare), Highmark(CIOX), Aetna, Magellan Healthcare of Virginia, DMAS

Types of Reviews

Mortality Reviews, SIS (Supports Intensity Scale) Tri-annual Review, Crisis Risk Awareness Tool, SCQR survey(Support Coordinator Quality Reviews), Quality Management Review, PECOS virtual site visit, SAMHSA Block Grant Reviews, Death Investigation/review, Independent Reviewer-behavioral review, Quality Assurance Review (QAR), housing annual review, diagnosis coding, Waiver waitlist review, HEDIS/CMS risk adjustment, Background Information files, annual record review (ARR) for Indicator 01, diagnostic data, Care for older Adults, Med error investigation, Permanent Supportive Housing Assessment

Goals

- Continue to meet all audit requests and deadlines

RISK MANAGEMENT COMMITTEE SUMMARY

The Risk Management Committee (RMC), a cross-functional agency workgroup, met quarterly to monitor the risks and accessibility needs that are addressed in the Agency's FY21 Risk Management and Accessibility Plans. The committee discusses the work of the agency, shares feedback from staff and stakeholders, and provides input into agency processes. The committee met virtually over the year due to the COVID-19 pandemic. Meeting minutes are located on the agency's public drive at P:\HAMHDS\Committees\Risk Management Committee\RMC minutes\Minutes FY21.

The Risk Management plan also references other planning processes of the agency that better position the agency to provide effective services and reduce risks such as the agency's strategic plan, cultural and linguistic plan, technology plan, quality improvement plan and performance measurement plans. The plans are located on the Agency's SharePoint drive and accessible to all staff.

FY21 Agency/County highlights:

- At each agency orientation staff were made aware of the agency's risk management committee, the risk management and accessibility plans and their locations
- The Henrico County Emergency Operations Center (EOC) continued their work under the Office of Emergency Management and Workplace Safety during the COVID-19 pandemic. County Directors met weekly. Daily situational reports were developed and disseminated to County Directors from the EOC during the state of emergency.
- The response to the COVID-19 virus was a major discussion throughout the fiscal year for the agency and the risk management committee. Discussions included staff responses, questions and concerns related to obtaining PPE, cleaning procedures across the programs, anxiety regarding staff and persons served positivity rate, protocols in the group homes and re-opening plans. The committee was another opportunity to share County information on vaccination clinics and information, community resources, supplies, the effectiveness of purchases such as vehicle and table plexiglass, how temperature checks were going, the wearing of face masks and other emergency protocols in place. The agency followed guidance provided by the County of Henrico and any flexibilities in service provision allowed by DMAS and DBHDS. A workgroup was developed to assist with the COVID transition as the agency gradually transitioned services from working from home to the office. Leadership group met frequently throughout the year to ensure everyone was receiving the most up to date guidance and safety instructions.
- COVID kits were made available to persons served. The kits included PPE and information related to COVID and vaccines.

- The county of Henrico in collaboration with regional partners provided large COVID vaccine clinics to the community. Westwood Pharmacy located at the East Center offered vaccines to all MH/DS staff as well.
- Agency in collaboration with stakeholders offered vaccines to all residential homes and the agency offered vaccines to the persons served in various programs.
- The agency hired CREATIVE, to install sound masking system in the East Center. The system is designed to provide soft sound throughout the East Center to mask conversations and increase private conversations in offices. The work was completed on 12/31/20
- Facility maintenance needs identified in the accessibility plan and the facility project list was completed totaling approximately $159,950. This is an increase of $21,698 from the FY20 total of $138,252. Examples of repairs includes deck repairs at Gayton and Sherbrooke replacing boards and
- brackets, evacuation chair for second floor at Woodman, touchless faucets installed at Lakeside Center to increase safety, ring cameras installed at all group homes, exterior light pole at Sherbrook and camera's viewing the gazebo at LSC to increase safety.
- Fall prevention is an ongoing focus to prevent falls at all locations. Weekly information was shared with the agency in September for fall prevention month. A training was held virtually entitled "Falls, and how we prevent them facilitated by Lawrence Rehabilitation, The Gait Center, on September 24, 2020. Yellow ribbons provided by the Center for Healthy Aging in Arlington VA were made available to all staff in support of Falls Prevention Awareness. A large media campaign occurred with Prevention Services regarding suicide prevention that included a commercial in both English and Spanish and other social media releases.
- Guidance was received from CARF that standards were not relaxed during the COVID pandemic. Drills where permissible moved to virtual drills to continue to meet requirements.
- Changes in the new licensure regulations were reviewed and became effective 8.1.20 with enforcement on 11.1.20. Examples of changes included the updating of evacuation plans to include accessible egress routes and locations of flashlights and providing all locations with thermometers to do water temperature checks to be maintained within a range of 100-110°F .
- Additional Risk Management updates can be found in the FY21 Accessibility plan of correction and the FY21 Risk Management Improvement Plan found in the Risk Management folder on the agency's public drive.

Looking ahead to FY22

- HAMHDS will continue to develop and implement approved plans to re-open buildings, have staff return to working in the office and increase face to face services.
- The County Risk Management is requiring exposure control plans for all service locations. The plans will be completed in FY22 and monitored yearly by the Risk Management Committee. Plans will be located on the public drive at P:\HAMHDS\Committees\Risk Management Committee\Exposure Control Plan

A yearly summary of employee work-related injuries and illnesses is posted as required by the U.S. Department of Labor and documented on OSHA'S Form 300A. The following information is for the 2020 calendar year (1/1/2020 – 12/31/2020) tracked by the County of Henrico's Safety Officer.

Summary of Work-Related Injuries and Illnesses 1/1/2020 – 12/31/2020			
Number of Cases			
Total number of Deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
0	1	1	2

Number of Days			
Total number of days away from work		Total number of days of job transfer or restriction	
5		94	
Injury and illness Types			
Injuries	4	Poisonings	0
Skin Disorders	0	Hearing Loss	0
Respiratory Conditions	0	All other illnesses	0

CRITICAL INCIDENTS AND COMPLAINTS

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

Incident Type	FY20	FY21	Q1	Q2	Q3	Q4
Aspiration pneumonia	new	0	0	0	0	0
Assault by client	3	2	1	0	0	1
Biohazard incident/bomb threats	1	0	0	0	0	0
Bowel Obstruction	new	0	0	0	0	0
Choking incidents that require direct physical intervention by another person	new	0	0	0	0	0
Communicable Disease/infection control	25	187	19	72	81	15
Death-accidental	7	3	0	0	1	2
Death-likely homicide	1	0	0	0	0	0
Death-likely suicide	0	2	1	0	0	1
Death-natural causes	33	39	5	8	11	15
Decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer	new	0	0	0	0	0
Emergency Room Visit	new	14	0	0	6	8
Fall- with injury requiring medical attention	11	11	4	4	1	2
Fall- without injury	51	40	6	9	14	11
Illness (e.g., seizure, diabetic reaction)	34	23	8	8	3	4
Individual who is missing	new	1	0	0	1	0
Ingestion of any hazardous material	new	0	0	0	0	0
Licit/Illicit drugs or weapons	0	0	0	0	0	0
Med incident- NO adverse reaction	46	23	6	6	4	7
Med incident- requiring medical attention	0	0	0	0	0	0
Other	116	63	24	23	5	11
Overdose	new	0	0	0	0	0
Serious injury requires med attention	3	1	0	0	0	1
Sexual assault incident	2	0	0	0	0	0
Suicide attempt with hospitalization	new	13	0	0	5	8

Suicide attempt with NO hospitalization	new	13	0	0	5	8
Threats/violence	3	1	0	0	1	0
Unplanned psychiatric (TDO)	new	25	0	0	7	18
Unplanned medical hospital admission	new	5	0	0	2	3
Violent crime by client	0	0	0	0	0	0
Behavioral incident	12	3	1	2	0	0
County vehicle	8	0	0	0	0	0
Fire	0	0	0	0	0	0
Property damage	1	0	0	0	0	0
Property loss/theft	3	0	0	0	0	0
Self-injurious behavior	6	3	1	2	0	0
Suicide attempt	59	20	12	8	0	0
Totals	**425**	**492**	**88**	**142**	**147**	**115**
Restraints	**3**	**0**	**0**	**0**	**0**	**0**

Trends and Observations

- Root Cause Analysis - RCAs were completed within the 30-day requirement.
- 8-1-20 RCA not needed for level 3 reports that did not occur during provision of service or on premises
- Enhanced RCAs/thresholds began 1st Quarter
- Spread sheet updated to reflect the new reporting categories
- Many reports are COVID positive tests
- Supervisors had discussions and retraining as needed for med errors
- Restraint clarification made in regard to Staff and Police
- Weekly COVID reports are being sent to leadership group
- Number of "other's" has decreased since we have added additional categories that more accurately reflect the nature of the incident.
- Falls and illness decrease may be partly attributable to the fact that day programs were closed or partially closed for the first 6 months of the FY
- Clearly the increase in Communicable diseases was due to the COVID pandemic
- Slight increase in natural causes deaths
- First year in many that we have had suicides - may be attributable to pandemic, either directly or indirectly
- Medication errors did decrease in overall numbers

Areas Needing Improvement

- Med errors
- Communicable Diseases (COVID)

Actions to address the improvements needed and actions taken

- Medication refresher training
- Developed and Provided New Medication Administration training course for medical staff
- Provided reporting instructions for accurate COVID reporting
- County of Henrico offered COVID testing for employees
- County of Henrico offered vaccinations for all County citizens and County employees
- County of Henrico created COVID kits and disseminated COVID information and kits to targeted communities
- Posted COVID information on all agency electronic boards
- Temperature and questionnaire checks for all individuals entering County buildings during peak COVID months
- Created a weekly COVID reports of positive COVID cases and related deaths of persons served
- Adjusted service delivery to meet social distancing needs

Actions taken accomplished the Intended results

- Accurate reporting of positive COVID is occurring and appropriate reporting to DBHDS as a result also occurs
- Ongoing medication training occurs. For FY21 there is a reduction in the amount of medication errors, and this will continue to be an area of focus for the agency.

Necessary education and training and prevention of recurrence

- Annual refresher training for all staff who administer medications
- Medication administration training occurred with staff involved in med errors
- County sponsored COVID training
- CDC guidance on COVID provided on electronic boards
- County distributed COVID informational sheets
- COVID information on County Website and County Intranet
- QA staff participated in DBHDS CHRIS training
- Annually all staff participate in competency-based training in the identification and reporting of critical incidents
- Agency maintains a group of American Red Cross, Prevention of Violence and Therapeutic Options trainers to provides first aid/CPR certifications/recertifications, prevention of violence and TO competency-based training.
- All staff completed competency-based health and safety training

Internal and External reporting requirements

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

FY22 Goals

- Continue to monitor med errors more closely
- Continue to implement Henrico County COVID Guidelines

HUMAN RIGHTS INCIDENTS

All allegations of violation of the agency's human rights policy are considered a formal complaint. Overall trends in FY21 include a significant decrease in the overall number of human rights reports received in iRIS and reported to CHRIS compared to the previous year. The areas with the most reports continue to be confidentiality/privacy and services although these numbers are lower than last year. In FY21, there were 60 human rights reports in iRIS which is a 47% decrease from FY20. Of these iRIS reports, 13 were reported to CHRIS and nine resulted in a founded outcome (five confidentiality, two neglect (nonP2P) medication errors). There were five privacy breaches reported to the Office of Civil Rights. Areas needing performance improvement include confidentiality and medication error, as reflected by the four Corrective Action Plans (CAPs) issued by the Office of Licensing on behalf of the Office of Human Rights. Three were for confidentiality and one was for medication error. To address improvements needed in these areas, the following actions were implemented:

Confidentiality/privacy

- Revision to the confidentiality/privacy training to include double checking that PHI is being mailed to the correct recipient
- Retraining of involved staff on confidentiality/privacy

- Sending an email to all staff reviewing agency policies and procedures around emailing
- Retraining by QA staff regarding policies and procedures around emailing

Medication errors

- Written counseling for involved staff
- Creation of a medication administration refresher training by the Nurse Manager which was provided to all agency nurses

Since these actions were implemented, there have not been confidentiality/privacy reports involving email which suggests that actions taken have resulted in some improvement. There have been additional reports of medication error and this is an area that will need continued monitoring and efforts towards improvement.

Type	FY20	FY21	Q1	Q2	Q3	Q4
iRIS Human Rights (HR) reports	114	60 9 founded	14 1 founded	9 0 founded	18 1 founded	19 7 founded
HR reported in CHRIS / OCR	64 8 OCR	13 5 OCR	1 1 OCR	1 0 OCR	3 1 OCR	8 3 OCR
Late HR reports in CHRIS > 24 hrs/ CAP issued	0/0	0/0	0/0	0/0	0/0	0/0
HR appeal to ED	0	0	0	0	0	0
HR appeal to County Manager	0	0	0	0	0	0
HR appeal OHR	0	0	0	0	0	0
HR appeal to LHRC / SHRC	0	0	0	0	0	0
Restraints	3	0	0	0	0	0
HR received from or reported to MCO	1/Anthem	0	0	0	0	0
Code of Ethics	1	0	0	0	0	0

STAFF TRAINING

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

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

Model of Care Training and Provider Overview & Module of Care Training, Cultural Diversity is required by Commonwealth Coordinated Care Project for contract with CMS, DMAS, and MCO (Anthem, Aetna, Optima, UHB, UHC, Molina "Magellan", Va. Premier, and 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 35 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, MH First Aid, EHR and other Professional trainings.

Approximately 46 training sessions were offered. Staff registers for training directly using an internal web-based system known as MyTraining. Examples of training offered are listed below.

Erasing Hate- The Rise in Asian Attacks
JP's Law & how it benefits those with Autism & ID
Two Generations of Activism
An HBU Experience, Black Wall Street
Uncomfortable conversations with a Black Man
Cycle of Prejudice Child-Adult Relationship Enhancement
Bipolar Disorder in the Black Community
Supervision Strategies for Trauma-Focused Cognitive Behavioral Therapy
Disparities in Healthcare and Mental Health Affecting the Black Community
ADHD in African American Children & Youth
Youth Suicide Risk & Prevention
Sexual Harassment Training
Introduction to LGBTIQ+ Populations Mental Health Disparities
Therapeutic Interventions for Hispanic & Latino
A Spotlight on the Work of Howard Cruse
Implication for Latinos with Serious Mental Illness
Afghani Refugees
Medical Racism from 1619 to the Present
Promoting Health Equity Through Community Engagement
Racial Trauma: Recovery Equity - Racial Trauma, Behavioral Health & Healing
Security Awareness

As a result of COVID-19, some classes were presented in a hybrid format. Other classes were presented strictly remotely. Web based learning was used for the classroom component via WebEx for therapeutic Options. Staff were tested on the skills portion with a partner/someone they were comfortable with or had the option of testing with a selected trainer. CPR/First Aid was presented as blended learning. Staff completed the classroom portion online then selected a predetermined date to demonstrate skills with a trainer. These Physical skills were demonstrated on manikins in a large conference room with a trainer. Trainers continued to practice social distancing as prescribed by the CDC.

Accomplishments

- Trainers begin the process of transitioning back to in person trainings
- Trainers were able to add First Aid/CPR classes for agency team/s
- Trainers were able to add additional TO classes to the schedule

Goals

- Update all training power points
- Integrate a new Learning Management System
- Recertify all 8 TO trainers
- Continue to 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 FY21 the team was a part of the agency wide initiative implementing a new electronic health record system.

Accomplishments

- Performed Cerner promotion to version 2.32 with the testing help of the Promotion Committee within 10 business days and ahead of July 1st deadline.
- Presented three options for e-Prescribe software to Dr. Coster and medical team within two days of notification of need and implemented solution prior to July 1st deadline.
- July 2020 – performed Cerner database and application move to a new SQL server.
- Redesigned Chart Tracker reports. Gave business ability to obtain chart review listings on demand without IT intervention.
- Implemented new SharePoint site to replace outdated Intranet. Brought the Agency's intranet in compliance with County IT guidelines. Developed and implemented SharePoint training.
- Developed materials and delivered Welligent EHR training. Worked closely with clinical staff to convert current work processes to Welligent workflows.
- Performed Welligent EHR testing and collaborated with Clinical Staff, Arlington CSB and the vendor in developing the product.
- Completed equipment replacement of all desktops with laptops for staff mobility. Installed docking stations with additional monitors.
- Implemented new technology for mass deployment of new laptops.
- Updated all staff to new Office 365 version.
- Built a new Windows 10 operating system image for use by the Agency in deployment.
- Replaced printers and enabled faxing on multi-function devices.
- Reconfigured call center for a new hunt group configuration to assist with COVID processes.
- Setup teleconferences for agency-wide meetings.
- Developed new reporting dashboards: Emergency Services, Addiction Task Force, Substance Use, CIT.
- Supported reimbursement by mentoring and updating billing modalities and service codes and all things Cerner. Answered requests for setup of new billing codes and service codes.
- Created new subunits in Cerner to reflect additional services provided by the agency and maintained Cerner forms.
- Developed new web application for updating staff emergency contact information. Linked the information to active directory for automatic updates.
- Developed application for CIT to enter suicide information from Police, keep track of CIT training for individuals and class information. This application feeds into CIT dashboard.
- Completed Jail, SAMHSA, and other surveys for the agency.
- Moved iRIS application to the new SQL server and implemented a new version.
- Installed CIT cameras at Woodman and East Center.
- Consulted with Clinical staff to ensure that services were reported accurately to CCS during COVID.

Goals

- Partner with County IT to select and implement an electronic health record by July 1, 2022
- Add telecommunications to Conference Room C
- Implement e-Fax

CULTURAL AWARENESS AND COMPETENCY COMMITTEE SUMMARY

The Cultural Awareness and Competency Committee, CACC, met approximately every 6-8 weeks virtually via WebEx to implement the FY21 CACC plan.

CACC welcomed new members Traci Paskins-Brower and Jenifer Hufner. We also had a few staff leave our committee and we thank Shereka Eldridge, Briel Wade, Jon Furman, and Allen Wentt for their work towards our committee objectives. We are hoping in FY22 to increase our committee membership.

2020 marked a historic moment with nationwide protest of racial inequities and a call social justice reform. Agency Management Team continued their commitment to meet, debrief and discuss current and historic events and how they are impacting our staff, persons served and community. The meetings began in June and the last team meeting was on August 12, 2020. At least two members of agency management team met with agency teams for approximately 52 meetings during from June 29-August 12, 2021. Suggestions were gathered from all teams and the following themes developed; communication, need for safe spaces to share, supervisory training, staff training, justice system, equity, workforce and expand feedback and input, the culture of our agency, and interactions with persons served and the community.

The impact of these critical comments lead to the addition of the agency's fourth strategic initiative; To examine the effects of systemic racism and racial inequities wherever it exists and develop and execute strategies to confront these injustices that will strengthen our workforce and the delivery of culturally sensitive trauma informed person-centered services. This initiative was approved by the Agency's Leadership Group at their August 26, 2020 meeting. A diverse strategic cross-functional workgroup was formed with two Co-chairs and a third co-chair was added in the fourth quarter of FY21. Michael King, (CSS), Brittany Fulton Zuniga, (C&P) and Jacquelyn Smith White (C&P) respectively. The following overview was provided to committee members: HAMHDS is actively committed to eliminating systemic inequities and developing an environment free of racism. Racism, systemic racism, racial inequities and social injustices exist and negatively effects our work towards actualizing our vision and values. HAMHDS works to ensure an inclusive work environment, for all races, cultures, and identities. Their first meeting was on October 20, 2020. The workgroup adopted the name CARSE for their committee, the Committee for the Advancement of Racial and Social Equity. With the support of the Virginia Center for Inclusive Communities (VCIC) and funded by a Behavioral Health Equity Grant with DBHDS three agency trainings occurred on Unconscious Bias, 10/23/20, Cycle of Prejudice, 11/10/20 and Intersectionality on 11/18/2020. The workgroup received training in Using an Equity Lens to help provide a context and framework for their work. The CARSE leads also attended the Virginia Inclusion Summit on November 16, 2020, to strengthen their leadership skills. CARSE continues to meet regularly to implement their recommendations.

All staff are required to attend yearly cultural competency training. This objective can be met by attending internal or community training/conferences. The following internal training opportunities helped staff meet that requirement:

- Islam, One of the Abrahamic Faiths (Webinar) – Dr. Lakhani
- Cultural Aspects of our Community – Michelle Johnson and Serina Gaines
- Two Generations of Activism - Instructor: Ebony Guy, Community Organizer
- JP's Law & how it benefits those with Autism & ID Instructor(s): Pam Mines, Author, Philanthropist
- Erasing Hate - The Rise in Asian American Attacks 5/20/21Helen Rai, MSW Asian American Society of Central Virginia
- Series of DBHDS trainings offered by the Office of Behavioral Health Wellness many lead by Dr. Joseph Williams,

Associate Professor of Education at the University of Virginia (LGBTQ+ Safer Spaces Training, Race, Racism and Implicit Bias in behavioral Healthcare, Addressing Racial Prejudice in Counseling Sessions, Addressing Race-Based Trauma in Therapy, Series of trainings on the black community and mental health, mental health needs of Hispanic/LatinX community in the Commonwealth).

- Black History Month:
- Yearly CACC plans events for Black history month. The following events occurred virtually in 2021:
- Video and discussion with Emmanuel Acho "Uncomfortable Conversations with a Black Man, facilitated by A. Michelle Johnson
- Documentary and Discussion – Black Wall Street, the story of Tulsa Oklahoma facilitated by Annmay Morant
- A HBCU Experience – The history of historical black colleges and universities including a panel discussion of staff who attended HBCUs, and their unique experiences facilitated by Willona Walker
- Weekly Black History Trivia with prizes with Serina Gaines
- About a Book – Staff recommended a book by an African American author. Entries were entered into a drawing for a prize facilitated by Serina Gaines

The agency shared celebrations on our electronic boards to include Juneteenth, Pride Month, Black History, Hispanic Heritage and Minority Mental Health Months. Additionally, in July, as part of one of Minority Mental Health Awareness Activities Prevention Services hosted a virtual dialogue on systemic racism, between teens in the Prevention Services Youth Leadership program and Henrico County Community police.

Yearly, the list of interpreters and translation services are updated and posted to the agency SharePoint drive. The chart lists the name of the organization, cost per hour, minimum hours and certifications an interpreter may require and hold. For FY21 the total spent on interpreters and translation services was $84,303 this amount is down $13,392 from last year's total of $97,695.

Henrico Area Mental Health & Developmental Services, HAMHDS, values a diverse workforce that is representative of the person served. As of 9/1/21 of the approximately 9,015, 46% of consumers served were White/Caucasian and 41% were Black/African American. The remaining 13% were: Alaskan Native, American Indian, Asian/Pacific Islander, and Multi-racial. Of all consumers served 6.04% percent identified themselves as Hispanic.

As of 6/30/21, of the approximately 351 HAMHDS permanent employees 52% self-identify as White/Caucasian, 43% Black/African American, 3% Asian, 2% Other, and 2.5% identified themselves as Latino/Hispanic.

Race & Ethnicity	FY2 Persons Served	FY20 Persons Served	FY19 Persons Served	FY2 HAMHDS Employees	FY20 HAMHDS Employees	FY19 HAMHDS Employees
White/Caucasian	46%	45%	45%	52%	52%	52.86%
Black/African American	41%	42%	43%	43%	44%	41.69%
American Indian, Asian/Pacific Islander, Multi-Racial	13%	13%	10%	5%	3%	2.55%
Persons served who identify themselves as Hispanic	6.04%	5.64%	5%	2.5%	2%	1.53%

DEMOGRAPHICS

Total Consumers Served by Program Area

9,015 individuals were served in FY21.

For adults: 56% received Mental Health Services, 12% Developmental Disability Services and 7% Substance Use Disorders Services.

For youth: 10% received Mental Health Services, 4% Developmental Disability Services and 11% Early Intervention < 3-year olds.

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

Distribution by Race and Ethnicity: 46% served identified themselves as White/Caucasian, 41% Black/African American, 13% Alaskan Native, American Indian, Asian, Pacific Islander, Multi-Racial.

BUDGET

FY21 Revenue	
Local Funds	$16,198,006
Fee Revenues	$12,217,847
State Funds	$9,340,590
Federal Funds	$2,876,015
Other Funds	$27,167
Total	$40,659,625

FY21 Expenses	
Mental Health Services	$19,203,947
Developmental Services	$12,215,025
Administrative Services	$2,729,006
Substance Use Disorder Services	$2,721,287
Total	$36,869,265