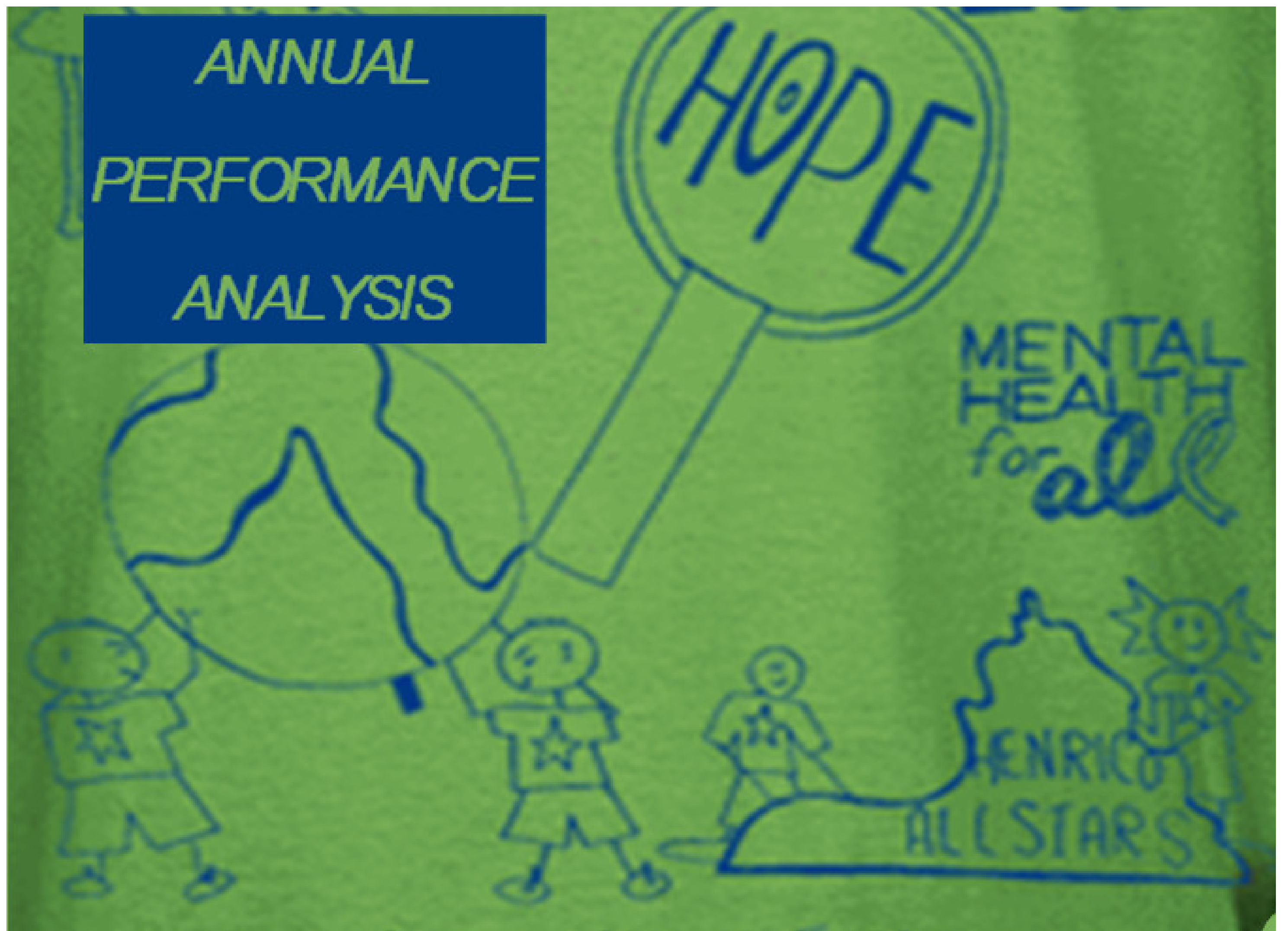
FY2021-22



MANAGEMENT SUMMARY 1

VISION & VALUES 2

STRATEGIC GOALS AND STRATEGIC PLANNING 2

- Wrapping up 2019-2022 Strategic Initiatives 2
- 2022-2025 Strategic Initiatives 4

FY22 ACCOMPLISHMENTS/ FY23 GOALS 6

- Medical Accomplishments 6
- Medical Goals 6
- Administration Accomplishments 6
- Administration Goals 7
- Administration Outcomes 7
- Quality Assurance Outcomes 9
- Developmental Services Accomplishments 10
- Developmental Services Goals 11
- Developmental Services Outcomes 11
- Clinical and Prevention Accomplishments 18
- Clinical and Prevention Goals 24
- Clinical and Prevention Outcomes 24
  - *ADULT MENTAL HEALTH OUTCOMES* 25
  - *CHARLES CITY/NEW KENT OUTCOMES* 25
  - *EMERGENCY SERVICES OUTCOMES* 26
  - *SAME DAY ACCESS OUTCOMES* 28
  - *LAKESIDE CENTER OUTCOMES* 28
  - *MH CASE MANAGEMENT OUTCOMES* 29
  - *IN-STRIDE MANAGEMENT OUTCOMES* 31
  - *MH ACT OUTCOMES* 32
  - *MH SKILL BUILDING OUTCOMES* 34
  - *MH VOCATIONAL OUTCOMES* 34
  - *PREVENTION OUTCOMES* 36
  - *YOUTH & FAMILY OUTCOMES* 37

DBHDS PERFORMANCE MEASURES 38

SATISFACTION 39

- Post Discharge Survey 39

INTERNAL AGENCY RECORD REVIEWS 39

EXTERNAL AGENCY REVIEWS 41

RISK MANAGEMENT COMMITTEE SUMMARY 42

CRITICAL INCIDENTS AND COMPLAINTS 44

HUMAN RIGHTS INCIDENTS 47

STAFF TRAINING 48

INFORMATION TECHNOLOGY 49

CULTURAL AWARENESS AND COMPETENCY COMMITTEE SUMMARY 50

DEMOGRAPHICS 54

BUDGET 54

MANAGEMENT SUMMARY

On Henrico Area Mental Health & Developmental Services (HAMHDS) is pleased to present our Fiscal Year 2022 Annual Report highlighting many of our accomplishments and sharing several remarkable stories of individuals who have experienced resiliency, inclusion, wellness and recovery from mental illness, substance use and developmental disabilities. This is possible through the dedication and commitment to those we serve by our amazing staff. Although there have been incredible challenges this year, staff continually demonstrate their support of our vision and values as they provide the high-quality services necessary to meet the needs of individuals, families and communities we serve.

During an eighteen-month period five colleagues passed away. Each of these individuals had a profound impact on those they worked with. Their legacy of a strong work ethic, immense compassion, willingness to do whatever was needed and unwavering advocacy for all continues to be felt. Their work truly made a difference in the lives of so many people and they are greatly missed. This annual report to dedicated to their memory and in their honor.

This year we expanded services in Youth & Family, Outpatient, Jail Diversion, Emergency Services, Substance Use, Developmental Disabilities Case Management, Housing, Peer Recovery Services, Psychiatry, Prevention and Medical Records. We established several mobile positions to better support our communities and formed a partnership with Henrico County Public Schools to offer on-site services. We accomplished our strategic initiatives of implementing a new electronic health record, integrating the Step-VA behavioral health program, transforming substance use disorder recovery services, and examining the effects of systemic racism and racial inequities. While these efforts will continue, our focus for the coming years will be our workforce, transformation of youth services, crisis services and redesign of day services. Our work with our Henrico partners continues with the Addiction Task Force, reducing youth violence, expanding housing for individuals in vulnerable circumstances and expanding alternatives for individuals in crisis. We received a NACO Achievement Award for our rapid response to the Office Based Opiate Treatment Program. We are committed to providing evidence-based treatment that strengthens the care individuals receive.

HAMHDS is grateful for the valuable ongoing partnerships that allow us to be responsive to the needs of our community and provide a comprehensive range of services. The Board and staff are thankful to the Boards of Supervisors of Henrico, Charles City and New Kent Counties for their ongoing support of our mission and understanding of the need for services. Their commitment and support allow critical community services to be in place that promote recovery, resiliency, wellness, and inclusion for the individuals we serve and their families. Our successes are only possible with the work of our talented and dedicated staff. They work every day to improve the lives of the individuals we serve. We hope this report provides you an overview of the vital work of the agency.

Karen Metz
Board Chairperson

Laura S. Totty, MS
Executive Director

VISION & VALUES

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

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

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

STRATEGIC GOALS AND STRATEGIC PLANNING

Wrapping up 2019-2022 Strategic Initiatives

During FY22 cross functional workgroups completed their work on the 2019-2022 strategic initiatives. The strategic initiatives for 2019-2022 were as follows.

1) To implement DBHDS statewide initiative STEP Virginia

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.

FY22 Accomplishments

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:

- Hired full time Family Support Partner housed in our Youth and Family Services program. Focus has been on outreach and support to the family members of youth that we service as well as participation in community education and outreach events.
- Hired full time Certified Peer Recovery Specialist focused on community integration for individuals with serious and persistent mental illness. Position is housed at Lakeside Center to help facilitate transition from this intensive level of formal behavioral health support to more natural, community-based supports.

Outpatient Services:

- Hired a clinical psychologist who is providing a combination of testing and therapy. Testing services allow us to ensure that individuals are accurately diagnosed and linked to the appropriate level and type of care. We had hoped that the additional therapy time the psychologist could offer would free up time to allow one of our existing therapists to provide PCIT full time. Dues to staffing shortages and significant increased demand for youth services, we have not been able to implement this part of the plan.
- Hired additional Substance Use Disorder Clinician who is housed at the East Center. She has served 86 individuals since starting work in early October.

- Hired a new medical records staff member who is housed at the East Center who co-manages the East Center Chart Room with another staff. She creates charts for new clients, files paper documents, updates and closes assignments in the electronic health record.

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

- Hired a full time Certified Peer Recover Specialist who is housed with our public safety team.
  - Providing training to law enforcement through our CIT Training Program
  - Providing outreach to individuals who are identified as SMVF, with focused outreach on individuals as risk for hospitalization or who are currently hospitalized.
- Enhance Trauma Focused Treatment through the addition of more staff trained in Eye Movement Desensitization and Reprocessing (EMDR)
  - Surveyed potential staff regarding interest in EMDR.
  - Identified Vendor
  - Training planned for Summer 2022

2) In partnership with County IT, select and implement an EHR by June 30, 2022.

Implementation of Credible by July 1, 2022, required an aggressive project timeline. We reach "Go Live" on schedule and successfully transitioned to the new credible electronic health record. A tremendous amount of work went into the implementation of the system and training staff.

3) Substance Use Disorder Recovery Transformation

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.

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.

The SUD Strategic Initiative Committee completed its work early in FY22.
FY22 Accomplishments

- Harm reduction packets given to various localities and distribution of information regarding substance use
- 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 to examine the effects of systemic racism and racial inequities wherever they exist 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. The strategic committee was named CARSE (The Committee for the Advancement of Racial and Social Equity). CARSE completed its work in FY22.

FY22 Accomplishments

- Implementation of the 2021 Behavioral Health Equity Grant with a focus on the African American Community
- Partnered with two community organizations the Virginia Center for Inclusive Committee (VCIC) and Strategic Diversity Initiatives
- Four-part DEI facilitation series occurred training 16 individuals to facilitate race and equity conversations regarding events that occur in our community and nation through safe processing spaces

- Two processing spaces were offered to the agency in November 2021 and December 2021 following two high profile court cases of the Rittenhouse and Arbery verdicts.
- Additional DEI training for staff occurred through (VCIC)
- Staff and community focus groups occurred to gain input on recommendations for DEI work
- Agency equity statement developed and presented to Leadership Group and the County of Henrico
- Created a DEI book nook at the East Center
- Installed DEI equity boxes at all main locations to increase staff input
- Partnered with Strategic Diversity Initiatives and conducted an organizational equity assessment
- Conducted a review of a sample of agency policies and procedures with VCIC using an equity lens.
- The four subcommittees, (response to incidents, training, hiring and promotion and management/communication) developed recommendations based on the input and assessments gathered to continue the agency's DEI work
- Collaborated with the Cultural Awareness and Competency Committee (CACC) to add recommendations from the CARSE committee to their work and supported the restructuring of CACC to develop a committee that joined DEI and cultural and linguistic awareness objectives

2022-2025 Strategic Initiatives

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

1) To improve the recruitment and retention of our workforce

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

- *Support a work life balance*
- *Seek long term retention*
- *Review hiring process, how we hire, how long it takes to complete the process*
- *Examine flexible work hours to include increasing working from home hours where able*
- *Examine with County HR Competitive Compensation*
- *Develop Mentoring opportunities*
- *Create wellness opportunities*
- *Examine the moral of staff*
- *Seek consistency across the agency, break down silos*
- *Research staff incentives*
- *Continue the implementation of career ladders*
- *Succession planning*
- *Examine recruitment strategies*
- *Leadership development/Leadership support*
- *Staff space needs*
- *Evaluate staff feedback for recommendations and track improvements and positive change from Agency and County employee surveys*

2) To Transformation of Youth Services

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

- *Develop strategies to address youth violence in our communities*
- *Examine the impact of COVID on our youth and identify recommendations*
- *Increase the ability of staff to meet the complex needs*
- *Increase support to schools*
- *Seek solutions across MH and DS*
- *Evaluate the need for an agency restructure to best support youth needs*
- *Transition of school age students to workforce*
- *Evaluating the continuum of care for youth services*
- *Infant mental health, at look at trauma of infants, social emotional development and support of families*
- *Early detection of Autism*
- *Building public-private partnerships and building community resources*

3) Crisis Services

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

- *Develop a 23-hour psychiatric care facility*
- *Examine mobile regional crisis response*
- *Crisis model for individuals with developmental disabilities*
- *Emergency respite housing is needed*
- *Examine and prepare for new Office of Licensure regulations*
- *Outcome needed is a larger percentage of people that are prescreened and diverted from hospitalization*
- *Improve collaboration and interactions with regional crisis services*

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

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

- *Redesign Day Services*
- *Increase community engagement*
- *Expand employment opportunities*
- *Work with school age students regarding employment*
- *Assist with DARS grant (if approved)*
- *Meet regulatory expectations, home and community- based services*
- *Educate family members and other stakeholders on the need for transition*

Financial and Workforce Impact

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

FY22 ACCOMPLISHMENTS/ FY23 GOALS

Medical Accomplishments

- Westwood Pharmacy expanded services by adding a Pharmacy Technician at the Woodman location which improves access to medications
- Westwood Pharmacy assisted the West ACT team in organizing complex regimens through bubble packing medications
- The Medical Unit has embraced a Hybrid Telehealth model allowing individuals to choose their preferred appointment type within established criteria to ensure quality care.
- The Medical Unit has continued and increased face to face services in light of the ongoing pandemic with due concern and measures for safety for providers and individuals served. Feedback received implies that services in the community are still largely operating solely via telehealth which may not meet the needs of certain individuals.
- Continued strong collaboration between providers for dually diagnosed individuals.
- Continued mentoring of Nurse Practitioners, Medical Students, and Residents. This year we even had an administrative student hosted who intended to apply for medical school.
- 5 Nurses represented Henrico at the VACPN conference and 2 are now the representative and alternate for Region 4
- Provider aiding in teaching classes to Physician Assistant students.
- Provider participating twice a year in Pathways Free Specialty Clinic in Petersburg VA
- Provider continues to work with VMAP- Virginia Mental Health Access Program in education to improve access to MH care for women and children.
- Provider continues to work with the reach program in integration of Mental Health into primary care
- National Association of Counties achievement award co-recipient for improving rapid access to medication for Opioid Use Disorders.

Medical Goals

- More academic discussion/ case discussion in Medical Unit meetings with a focus on psychopharmacology (topics of interest include current state/impact of marijuana, psychedelics, and other rising issues in Psychiatry).
- Learn to efficiently use the new EHR, including coding visits appropriately, and ultimately increase revenue.
- Increase team awareness about the agency as a whole to improve efficiency in collaboration with other programs and teams.
- Improve networking and collaboration with other CSBs.

Administration Accomplishments

- Partnered with County IT to select and implement an electronic health record system by June 30, 2022.
  - Identified electronic health record systems used by CSBs in Virginia that had contracts with cooperative language
  - Participated in demonstrations of two EHRs
  - Worked with County Purchasing to contract with Credible
  - Participated in the EHR Implementation Committee and the Credible Implementation Committee

- Six Admin staff completed Train the Trainer, partnered with program staff to develop training materials and workflows and assisted with end-user training.
- One Admin staff completed forms training with Credible and created forms prior to Go-Live
- Admin staff worked closely with IT to submit live claims in Credible for services recorded in Cerner for the agencies top ten payers and received payments prior to Go-Live.
- Agency successfully went live on Credible on July 1, 2022.

- Administrative and Financial Services Division reorganized following the IT team move to County IT. Created the Evaluation & Reporting Team that assumed responsibility for EHR training of new staff, creating & updating forms in the EHR, CCS reporting, County Manager reports and support of AMT and programs.
- Throughout the Administrative and Financial Services Division staff at all levels showed incredible flexibility in assisting other teams, assisting programs, and covering job duties from more than one position as we filled positions with internal candidates.
- Business staff began checking Collective Medical each day and informing SAIs of individuals who have been hospitalized.
- Partnered with County HR to host the first MH/DS Job Fair in August 2021. 69 interested candidates attended resulting in 13 staff being hired.
- Participated in Henrico Day at Virginia State University and Henrico County Public Service Career Day.
- Responded to and closed 1,000 Facilities work orders.
- Implemented a temporary 12.5% rate increase to many Medicaid services.
- Partnered with IT staff to provide taxonomy at the provider level for DMAS Medicaid billing.
- Transitioned to the Medicaid Enterprise (MES) system, the new DMAS system for credentialling, checking eligibility and claim status. MH/DS Admin became the MES administrator all Henrico County agencies because MES registers organizations by tax ID instead of NPI.
- Prepared and submitted a Federal Grant application for $ 1,000,000 allocated by Rep. Abigail Spanberger for the Henrico Detox Center.
- Participated on the selection committee for the Architectural and Engineering Services for Henrico Detox Center.
- Track staff annual trainings 98.46% received.
- Evaluation and Reporting Team is updating the agency external internet site.

Administration Goals

- Working with County IT - purchase/install telehealth equipment for Woodman Conf C.
- Purchase/install cubicles in Woodman A building.
- Prepare for successful CARF survey.
- Reduce the percentage of outstanding A/R over 90 days compared to total A/R by 1% each quarter (FY23 Admin outcome)
- Create Outlook mailboxes for invoices and travel paperwork to be submitted to Financial Management.
- Working with County IT, continue implementation of Credible
  - Reports
  - Form name changes and service name changes
  - Mobile App
  - Enhanced Client Engagement for automatic reminder calls and more reminder options (text, email)
  - Patient Portal

Administration Outcomes

MEASURABLE OBJECTIVE Reduce outstanding accounts receivable balances over 90 days old by 5% per	Year end results:	Balances increased Not met Actions during the year did not	Recommendations, actions taken, performance improvements:	The percentage of outstanding accounts receivable balances over 90 days old was reduced during FY22 but the dollar amount of outstanding accounts receivable balances over 90 days old increased significantly during FY22. $ 3,449,951 was over 90 days old. This is 42.8%

quarter.		produce the desired results		of the total A/R of 8,067,036. The baseline at 3/31/2021 was 60.9% of the total A/R of $3,561,622. We have learned that the percentage is a better measure and will continue this measure in FY23 with a target to reduce the total percentage of outstanding receivable balances over 90 days old each quarter. We believe that Credible will provide valuable tools to manage outstanding accounts receivable.

Quality Assurance Accomplishments

- Office of Licensure 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
- Completed 117 RCAs
- Provided public comments on draft regulations
- Reviewed and updated policies the yearly changes to the CARF Manual that become effective in July 2022
- Reported Annual Restraint reporting to OHR, completed online
- Completed Agency's Annual Report, Annual Performance Analysis and QA Quality Report
- Reviewed and developed policies & procedures and implemented new regulations
- Credible preparations to go live 7/1/21
- Conducted internal Quality Look Behind reviews
- Provided timely response for record requests, subpoenas and chart reviews
- COVID-19 Operations:
  - Reported in CHRIS confirmed COVID-19 cases based on reporting requirements
  - Created weekly report of COVID cases, shared with Leadership Group
  - Maintained agency's Emergency Policies & Procedures, through March 2022
- Reviews:
  - 74 external audits reviewing 551 records – 9% decrease
  - On-going Office of Licensure Mortality Reviews completed 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 3 completed, round 4 to occur in FY23
  - Continuation of 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
  - Completed UnitedHealthcare (UHC) audits, review of performance improvement plan (PIP)
  - AMIKids annual review
  - Licensure annual review and conditional licenses reviewed and moved to an annual review
  - DD Crisis Risk Assessment Tool: Quality Review and feedback received
  - Home and Community-Based Settings HCBS review of Day Services
  - Managed Care Organizations desk audits
  - 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
- DMAS Quality Management Review of DD services

- Trainings:
    - 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 training
    - Quarterly Office Human Rights trainings (investigation abuse and neglect, restrictions behavioral treatment plans and restraints, reporting in CHRIS for abuse, neglect, exploitation and human rights complaints)
    - DBHDS, Office of Provider Development, Supported Decision Making Overview Training
    - Legal Guardians, Guardianships and POA's training
    - 42CFR Training
    - County IT SharePoint training
    - County Harassment training
    - DBHDS Compliance with QI, RM and RCA and tips for preparing for 2022 inspections
    - CARF training on new CARF regulations
    - Medicaid Enterprise System (MES) training
    - DBHDS Falls Prevention Training
    - DBHDS OIH and HSN training on Choking and airway obstruction
    - DBHDS CONNECT provider training
    - DBHDS Incident Management training
    - DEI training on implicit bias
    - Quality Improvement Risk Management Training
    - Office of Licensure Incident Report Trainings

Quality Assurance Goals

- Updating reporting of human rights and licensure data based on licensure suggestions
- Assist the agency with implementation of new electronic health record including scanning
- Assist agency with CARF re-accreditation
- Assist agency with Relias LMS implementation
- Request assistance of County IT to improve iRIS incident reporting system
- Report incidents within 24 hours
- Complete 4 Look Behinds every quarter

Quality Assurance Outcomes

MEASURABLE OBJECTIVE Quality / Efficiency Report incidents within required timeframe, 24-hours	Year end results:	5 late reports, one more than last year Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	A total of 225 reports were made into CHRIS for FY22. 5 were late, of which we received 2 CAPs. 2 times the Office of Licensure sited us for reporting Level II or Level III serious incidents beyond the 24 hrs reporting period. The incidents occurred in different services, 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 Quality / Efficiency	Year end results:	100% 117 RCAs/0 late Met	Recommendations, actions taken, performance	Many RCAs were part of QA's Quality Look Behind Reviews this year. The plan is to continue to include RCAs as well as CAPs in the

Complete RCAs within required timeframe, 30 days		Actions during the year produced the desired results	improvements:	Quality Look Behind Reviews. During QA meeting continue weekly monitoring to ensure 30-day requirement is met.

Developmental Services Accomplishments

- Continued efforts to meet the Department of Justice Settlement Agreement.
- Individual team discussions were held throughout the division, DS members have joined the CARSE committee, and continue involvement in the CACC committee, including hosting brown bags.
- 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

- Much of the process for transfers of individuals moving out of the Henrico/NK/CC areas moved from case managers to intake/eligibility Program Coordinator and/or designee.
- March 2022- Completed Scanning preparation project for all 270+ voucher charts within 2.5 weeks timeline set by Virginia Housing
- Engaged in collaboration with Homeward to administer 10 EHV (Emergency Housing Vouchers).
- Added third CM/Housing Specialist to HCVP team

Residential Services

- Protocols practiced to minimize risk COVID-19 transmission in the group homes
- Virtual home visits with residents and their families were supported

Employment and Day Services

- Reinstated community integration activities including volunteering for Meals on Wheels and libraries, attending class at art studio for one individual and an integrated Friendship Café
- Supported staff completed Customized Employment training and one staff achieved their CESP (Certified Employment Specialist Program).
- Partnered with libraries as co-leaders and trainers for hosting the Next Chapter Book Club as two different libraries with plans for expanding to others.

DD Case Management

- 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.
- Person-Centered Reviews outcome data was revised for better accuracy and effectiveness.

Parent Infant Program

- The Parent Infant Program (PIP) moved all therapy and assessment services to telehealth during the height of the COVID pandemic. After positivity numbers decreased in the community, PIP worked hard to move all assessments and therapy sessions back to in-person sessions (except for the few families who desired to continue telehealth sessions).
- Despite the COVID challenges, PIP was able maintain compliance in all of Office of Special Education outcome indicators.

- One of PIP's speech pathologist was a guest lecturer at Virginia Commonwealth University to discuss the speech and language disorders.

Developmental 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 DS programs.
- Evaluate and develop an action plan on the loss of Section 14c for future Day Services planning
- In addition to the main DS Division goals, is the CST DD Unit program goals below:
  - Documentation of DD CM services rendered will be completed in a timely manner.
  - Documentation of Person-Centered Reviews completed in timely manner.
  - Supervision support to ensure quality services to meet Developmental Disability Services mandate.
  - Individuals meeting ECM criteria will be assessed face to face monthly.
  - Individuals meeting ECM criteria will be assessed face to face every other month in residence.
- Employment and Day Services:
  - Transition and streamline processes for intakes and transfers within new Credible system.
  - Assess level of satisfaction with information and guidance offered through the intake process.
  - Develop plans and begin redesign of programs including changes to work options, increased community activities and redesigned group day activities within the building
- Housing:
  - Transition (proposed Fall 2022) to new electronic administration system-Yardi. This also includes training and use of scanned documents within a new Virginia Housing system.
- Residential:
  - Recruit and retain employees for all I/DD residential sites
  - Review referrals for the I/DD residential sites that have vacancies for potential residents that we are able to meet their support needs.
  - Continue to meet HCBS and CARF requirements

Developmental Services Outcomes

DS 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 = 63.04% DD = 71.38% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The yearly outcome was not met. The staff vacancies and high caseload coverage along with internal and external work demands were challenging to get all progress notes approved within the 5 days of rendered services. Until fully staffed, this outcome will be difficult to meet. Supervisors will continue to review reports and provide training and follow up on this outcome measure.

MEASURABLE OBJECTIVE Customer Value /Effectiveness 90% of DD Waiver charts reviewed will have a VIC completed accurately, thoroughly at the	Year end results:	72.13% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	UR desk reviews were conducted due to the COVID-19 pandemic. The yearly 90% outcome was not met. The overall yearly total for this outcome was 72.13%. 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. New reporting methods will be created with the switch to Credible EHR.

time of the annual and when a change occurs				

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:	72% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This yearly outcome was not met. During this 3rd QR reporting period, DBHDS revised data entry for this outcome; prior QR Attachment information was discontinued due to same information is now entered into WaMS; thus, the change in yes and no percentages for the 3rd & 4th QR time periods. The department had multiple staff vacancies and resulted in many staff covering extra cases and attempting to complete quarterly reviews in 30 days, these events were challenging. Staff will continue to try and complete QRs within 30 days and supervisors will continue to train and run reports on QR timeliness.

MEASURABLE 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.	Year end results:	100% Met Actions during the year did 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.

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 85.52% DD 75.7% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This yearly outcome was not met. The ECM face to face visits every 30 days continues to be challenging when the department has multiple vacancies and staff covering extra caseloads. Staff to continue to conduct ECM f/f contacts every 30 days. Supervisors will continue to train staff and monitor reports on ECM f/f contact needs.

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	Year end results:	ID 100% DD 97.2% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	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.

month in their residence.				

DS HERMITAGE AND CYPRESS DAY SERVICES OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% of the individuals referred to a Day Service program will be contacted within 20 days to discuss /schedule an assessment or visit Baseline 2021: 100%	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Over the course of the year, we received 16 referrals for Hermitage or Cypress Enterprises. All those individuals/families/case managers were contacted within 20 days of receiving the referral. With the new pod system, we had to tweak the process for admission. This tweak proved more effective and efficient by the end of the year since individuals were making a much more informed choice of what services and where they would be receiving services. In addition, we received feedback from several stakeholders, including families, that our process was cumbersome and took too long. Due to that feedback, we have made adjustments to our process, eliminating the initial 5-day visit and offering the full 60-day assessment. This will allow individuals to experience all the aspects of the program and allow the program to fully assess the individual. Meetings will be held at 45 days to help make a final decision. So far, this change has been well received. Outcomes for next year will reflect this change.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 80% of all who attend Hermitage and Cypress will participate in at least one community outing each quarter.	Year end results:	Q1 21% Q2 80% Q3 56% Q4 92% 2 of 4 quarters met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Each quarter, individuals who attend Hermitage and Cypress were offered activities in the community. Outings were tracked by staff using daily sheets, capturing how many individuals were on each outing and how many hours were in the community. The number of outings varied greatly each quarter, as did the number of individuals who participated. The high was Q4 with 92% and the low was Q3 with 56%, with an average of 76.5%. There were some issues with data collection in Q1 which were resolved so Q1 data was not reliable and not used in the average. Overall, emphasizing community integration activities is an important part of our services offered at Hermitage and Cypress. We will continue to track the outings offered to all who attend. An additional outcome will track those within the waiver community engagement program.

MEASURABLE OBJECTIVE Customer Value / Efficiency OES and COI: 90% of the elements that track DATA will be met in the utilization reviews completed each	Year end results:	89.7% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	During the year, staff were asked to incorporate multiple points of emphasis in their daily notes. Our goal was 90% and after the final Utilization review, we had reached a rate of 89.7%. The primary point that is consistently missed is the individual's response to the supports staff provided. We provided training and some one-on-one mentoring. The issue persisted throughout the year. In the coming year, as we go into a

quarter.				new electronic health record, we are changing how we put notes into the system, and we are including a series of prompts which we hope will ensure these elements are in all of the notes more consistently.

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:	92.8% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The satisfaction survey was distributed during the individual's annual planning meeting. They were given the option of completing there or mailing in their responses. The return rate was on 30%, across all programs. Those that did respond were satisfied with 93% stating satisfaction most or almost all of the time. Most individuals stated they liked the new pod system and the communication from staff, with a couple noting they missed seeing all of their friends. Efforts have been made to assist cross pod visitation. Next year, we will go back to gathering more consistent information and feedback during the program, asking everyone to complete the questionnaire with a staff who they don't normally work with. This will allow us more feedback from more individuals and in a manner they can respond.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of the customers who we provide work for and 90% of those for whom we volunteer thru Hermitage or Cypress, will express satisfaction by responding with a 4 or 5 on a survey.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	We were able to reach out and receive feedback from 75% of our business customers. They all rated their satisfaction with a 4 or 5 on a 5-point scale. Comments were good with one concern noted. We will be working with our Admin department to ensure timely invoices are sent out. We are unaware of any late invoices, but the County office is the one who mails the invoices, so we will ask that they provide prompt service. We responded throughout the year, to each of our customers' demands/deadlines and requests for ensuring quality. We have maintained our customer base for many years. These positive surveys reinforce that we are providing good customer service to the business stakeholders. As we look at our ability to continuing the work program, we will work to ensure our practices meet our customers' needs and that the transition is smooth.

DS 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	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Over the course of the year, we had 2 referrals. Both individuals were contacted within 10 days. One person decided not to enter the program and we are working with the other person to complete a situational assessment to help DARS, the individual and our program determine skills and interests. This outcome will continue as we want to ensure that everyone is seen as quickly as possible into Supported Employment Services.

Specialist.				

MEASURABLE OBJECTIVE Customer Value / Effectiveness 100% of Individuals in Job Development will be offered at least one of the following: situational assessment, work experience or informational interviewing during their job search.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The goal was to offer every individual in job development the opportunity for more specific techniques that might assist them in finding a better job match. Two of the seven individuals participated in situational assessments. One is still participating in the assessment, so results are not known. The other individual was able to make a better job decision based on his assessment. While these three tools are valuable, it is apparent that not all individuals will benefit from them in the same way. Therefore, they will remain in the Employment Specialists toolbox, but will not be specifically tracked for the outcome measure in the coming year.

MEASURABLE OBJECTIVE Quality/ Effectiveness 2 individuals currently in Group SE will be successfully transferred to an individual SE job within the year.	Year end results:	2 individuals Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Those in Group Supported Employment often have the skills to be successful with an individual placement, which is the goal for employment services. This year, one employer, who employed two individuals, agreed to transition from having a staff member there every day to an employment specialist checking in two times a month. The employer assumed the full responsibility for supporting the individual, something we call "natural supports." This willingness shows the strength of our relationship with the employer and the competence of the two individuals. Their growth in their skills led to this "promotion". We will continue to work with group SE participants to grow and try more independent employment options.

MEASURABLE OBJECTIVE Quality/ Efficiency 100% of the staff in Individual and Group Supported Employment will complete one training related to Supported Employment within the year.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Each of the eleven Supported Employment staff participated in a training designed to enhance their skills in providing quality supported employment. Three participated in the Virginia initiative around customized employment, joining the community of practice quarterly calls and trainings. Other training was offered by Virginia Commonwealth University RRTC in areas such as using technology, serving individuals with mental illness and learning about financial wellbeing for those working and on benefits. This training was successful in assisting the Employment Specialists enhance their skill sets. While training will continue, it will not be a point of emphasis in next year's outcomes.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of the individuals served will respond with a positive response (always or almost always) when asked if they are satisfied with the services which they have received.	Year end results:	93% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	A satisfaction survey was distributed at the time of the annual review meeting. Individuals were given the option of completing it there or mailing it in. We only received 14 surveys back out of a possible 89. 93% of respondents (13) reply with Always or Almost Always. Only one individual responded sometimes. Next year we will be more encouraging of individuals to complete at the meeting with the help of their case manager so that we get a higher response rate.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of the employers involved in Group and Individual Supported Employment will report satisfaction with services by answering Mostly or completely satisfied when asked.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This year, Employers were surveyed to represent the stakeholders. Surveys were mailed and were also hand delivered by Employment Specialists. We received a total of seven surveys. While this response rate is low, it is generally what we would expect from the business community. All have verbally expressed satisfaction so many may have not felt there was not a need to reply in writing. Overall, employers seem to be very satisfied with the work of their employees and the Employment Specialists that work with them. Comments were all complimentary of the individuals working for them and the supports and interactions with the employment specialists. Next year we will survey family and care givers to gauge stakeholder satisfaction.

DS 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:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Intake staff have worked diligently to make sure individuals seeking services or waitlist placement are assessed in a timely manner. This fiscal year the team moved from standard weekly intake slots to scheduling their own intakes based on their availability and individual/family availability. This has allowed for more flexibility in meeting the scheduling needs of the individual. This outcome has consistently met or exceed the standards for the last few years. Our goal is to continue to meet this standard but will no longer use outcome for reporting purposes.

MEASURABLE OBJECTIVE Consumer satisfaction 90% of Individuals/families will report satisfaction with supports received	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Despite the small return of surveys, the intake team was able to meet the objective this year. We will continue this survey into the next fiscal year in order to gain more insight on whether we are providing the resources and support needed for these new families/individuals.

during the intake process. Individuals/families will receive a short survey via mail following the intake. The survey will include feedback on ease of access, resource sharing and staff responsiveness.				

DS RESIDENTIAL OUTCOMES

MEASURABLE OBJECTIVE Quality / Access All vacancies in the program will be offered and accepted within 90 days.	Year end results:	5 vacancy/0 accepted Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The residential program continues to have a significant number of staff vacancies but has filled the two Group Home Supervisors positions, which helps a lot with the onsite management of the programs. Since those positions are filled, the residential attempted to fill the vacancies by informing Case Management's Program Manager that the Residential program is open to tours. Since that time, there have been several tours at three of the group homes. The Residential team will continue to hold tours until the vacancies are filled.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 35% of residents will participate in a volunteer activity each quarter	Year end results:	33% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	During the 2nd/3rd quarter, the Program Coordinator found several volunteer activities that were more outdoor activities to limit COVID exposures. Those and previously participated activities were presented to the residents, more only 5 residents agreed to participate (see 3rd quarter). Staff report that the residents tend to lean towards activities that benefit them personally. This goal will be discontinued and replaced with quarterly community activities for 35% of residents.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Each quarterly the Residential program will host theme events that that the residents choose. This will rotate between the homes.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This is the first year for this goal and did take several of our residents and staff outside of their norm. Once staff realized they could be as creative as they wanted with suggestions to the residents, it seemed to get easier, but many of the residents still struggled with trying new activities. This outcome will continue

MEASURABLE OBJECTIVE Quality/ Efficiency 95% of employees will be current with all required training each quarter.	Year end results:	95% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Due to the manner in which this data can be collected currently within the agency, the data tends to be too fluid to ensure accuracy. In addition, the Human Resource department has added processes in which they monitor when trainings are due. This outcome will be discontinued.

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:	Residential program will continue to work diligently with the residents to meet their TO/FOR outcomes/supports, which is a contributing factor for this outcome. This goal will continue next year with the current satisfaction rating captured in the resident's quarterly reviews.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of residents' family/AR/guardians will be highly satisfied with their services and achieve desired outcomes via an annual survey	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Though there are not adequate responses to the survey at this point, the Residential program will add others as they come in but will strive to provide person-centered quality of care to all residents. We will also be mindful to continue to address concerns mentioned in previous surveys to ensure those concerns do not arise in the future.

PARENT INFANT PROGRAM OUTCOMES

MEASURABLE OBJECTIVE Quality/ Efficiency 95% of all Targeted Case Management (TCM) contacts will be met every month.	Year end results:	79% Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	While this results from this year declined from last year, this outcome continues to assist our team stay mindful of the desired outcome to serve all of our families at the same capacity. This process has helped us to be mindful of our Targeted Case Management contact goals/requirement. We have noticed that when we are down staff and caseloads are higher, it is difficult for staff to follow up on all 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

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**
  - The workgroup looking at expansion of EMDR Services in the agency has conducted a survey of clinical staff to identify individuals who are interested and qualified for EMDR Training. A trainer has been located and we anticipate the actual training to occur during the Summer of 2022.
- **Implement Peer Bridger services for individuals leaving state hospitals and entering Permanent Supportive Housing**
  - We have had significant difficulty finding a qualified candidate to fill this position. A prospective candidate was recently interviewed, and we anticipate an upcoming hire. DBHDS has indicated that they plan to offer Peer Bridger training in Summer or Fall of 2022.
- **Train Intensive Case Managers in Critical Time Intervention Case Management**

- Our 3 intensive Case Managers participated in the Critical Time Intervention training in May of 2022. In addition, their supervisors and two of the Permanent Supportive Housing Case Managers participated in parts of the training.
- **Fully implement Assertive Community Treatment (ACT) teams and review fidelity to treatment model**
  - The transition to ACT was completed. We anticipate a fidelity review by DBHDS in the upcoming year.
- **Have one full-time Youth and Family staff with full-time responsibility for PCIT and CARE**
  - Due to significant staffing challenges and increased demand for youth and family services, we have not been able to fully devote a staff member to PCIT and CARE. Though we have not been able to commit a full FTE to this role, we have completed 5 separate CARE Trainings reaching approximately 100 people. In addition, 61 youth and their families have received PCIT services this year.

Increase outreach and engagement to SMVF individuals. This will include increased number of staff and community partners participating in Military Cultural Competence training.
We hired a full time Peer Recovery Specialist in December 2021 to enhance our engagement efforts with service members, veterans and their family members. The Peer Specialist has been involved in numerous efforts to enhance our services including outreach to local and state hospital patients, working with Same Day Access clinicians to quickly identify SMVF, and partnering with local public and private agencies to develop a resource of supports and services.

Provide community integrations services for individuals currently and formerly participating in Adult Recovery and Collaborative Services.
In November of 2021, we hired a full-time certified Peer Recovery Specialist to serve as the community integration specialist working with adults with serious mental illness. In this role, the Peer Recovery Specialist has developed relationships with local advocacy agencies, stakeholders, and other potential community partners.

Enhance jail diversion and forensic discharge planning efforts.
Enhance jail diversion-
The Jail Diversion team became fully staffed in February of 2022, Subsequently, the Jail Diversion Team met with both Juvenile and Domestic and General District Judges to provide education/awareness of diversion programs with a goal of increasing referrals. As a result, in part to these efforts, Jail Diversion referrals increased by 32% in FY22 compared to FY21 referral totals (50 in '21, 66 in '22). In FY22 the number of clients diverted back into the community increased 114% compared to FY21 (14 in '21, 30 in '22) .

Forensic discharge planning efforts-
As in other program areas, we have struggled with staffing issues in our forensic discharge planning program. One of two CM's have been hired for Forensic Discharge Planning team. Service provision began Jan 2022. Thus far 35 clients have received services via Forensic Discharge Planning. Diversion staff provided Commonwealth Attorney's, Defense Attorney's, Judges education about this new service available to clients with a goal of increasing referrals

Participate in planning and implementation of Marcus Alert and Mobile Crisis Services.
In January 2022, the General Assembly made several changes to the Marcus Alert legislation. One of these changes included clarification that 2020 census data should be used to determine the order in which CSB's begin the implementation of Marcus Alert in their localities. Based on this change, Chesterfield became the next in line for implementation. Though implementation has been delayed, there continues to be coordination among Henrico Police, Henrico Fire and MH/DS to enhance our behavioral response to individuals in crisis.
The Mobile Crisis Services which are being offered regionally have been rolled out slowly over the course of the year. A Call Center has been established and mobile teams have been created. Mobile Crisis Services for adults are currently only available Monday through Friday 10:00 am to 6:00 pm. These limited hours are due to insufficient funding currently allocated for full implementation.
We have successfully work with DBHDS this year to gain funding for year 1 startup costs for a 23-hour center for youth. This will be joint project with St. Joseph's Villa.

Develop substance use and suicide prevention campaigns using traditional and social media outlets as well as community-based events.
We initiated multiple prevention campaigns to address substance use and suicide prevention. These initiatives included:

- Ask The Question (ATQ) Campaign
- Developed a Prevention PSA that aired on television and radio
- Distributed Medi bags in coordination with Kroger Pharmacy to provide information about appropriate disposal of unused medications.
- Provided REVIVE Trainings to CONNECT communities and VUU Social Work Students
- Staffed community events and distributed lock boxes and medication disposal kits.

Same Day Access

- Responded to service demand increase, completed nearly 2,500 assessments
- Continued access to services thru virtual telehealth for hospital discharges and jail diversion individuals

Outpatient Services

- NACO award for Rapid Access for OBOT (24 to 48 hours)
- SUD CM license
- Successful SUD audit
- New full time peer positions
- New mobile clinician position
- Work on overdose response, partnership with fire, SAARA and You Matter

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 100% of consumers connected and seen by their primary care physicians for annual physicals for ongoing care and preventive medical screenings.
- The vast majority of newly opened clients (89%) to the Mental Health Case Management and Assessment program demonstrated a reduction in psychiatric hospitalization rates.
- 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, vaccines and boosters while continuing to provide wrap around mental health services to meet their clients individualized needs throughout the COVID-19 pandemic and beyond.

Peer Services

- Hired full time Family Support Partner housed in our Youth and Family Services program. Focus has been on outreach and support to the family members of youth that we service as well as participation in community education and outreach events.
- Hired full time Certified Peer Recovery Specialist focused on community integration for individuals with serious and persistent mental illness. Position is housed at Lakeside Center to help facilitate transition from this intensive level of formal behavioral health support to more natural, community-based supports

ACT

- Transitioned from ICT/PACT to ACT
- Trained existing and new staff for the changes associated with transition to ACT
- Increased the number of consumers who saw medical providers for preventative care
- Maintained regular consumer care and contact through the pandemic
- Maintained regular consumer care and contact through staff retention loss

- Changed nursing schedule to reflect change consistent with other boards, of 4 days per week and 10 hours per day
- Removed the third shift for staff and made a consistent two shifts across the teams

InSTRIDE

- Served 48 consumers, target is 40
- Worked to increase substance use knowledge amongst staff
- Got funding for a new SUD position to enhance our substance use treatment
- Continue to run a family support group
- Peer specialist has served the highest number of individuals receiving peer support and family support that the program has ever served
- Increased our number of successful completions of the program – 6 successful completions
- Volunteer work program- 8 consumers
- 46% of consumers participated in a structured activity this fiscal year

Adult Mental Health / Substance Use Services

- NACO award for Rapid Access for OBOT (24 to 48 hours)
- SUD CM license
- Successful SUD audit
- New full time peer positions
- New mobile clinician position
- Work on overdose response, partnership with fire, SAARA and You Matter

Jail

- Significant expansion of jail diversion efforts
- Growth in number of diversion participants
- New grant awarded for Forensic Discharge planning
- Responding to significantly more ill inmates in the jail setting
- Restarted RISE programing
- Worked with jail to update policies and procedures as they relate to MH in the jail
- Implemented new law re: release plan for inmates
- Utilization of CHIRP program

Youth and Family

- Respond to an increase in demand for youth mental health services during what the American Academy of Pediatrics has deemed a National State of Emergency in Children's Mental Health
- Continue to expand staff certifications in evidence-based models of intervention including PCIT and TF-CBT. We currently have 4 staff who are certified to provide PCIT and at least 4 staff certified in TF-CBT, with an additional 4 in the certification process. Overall, nearly 75% of Y&F staff have some training in an evidence-based treatment model.
- MST successfully transitioned to becoming a Medicaid funded service. This required going through a licensing process, changing a number of internal processes and coordinating with community partners.
- Laura Bullock continues to offer CARE trainings to community partners, including DSS and CASA, providing education on evidence-based strategies for engaging with children.
- Our new Family Support Partner has supported at least 10 caregivers in developing successful strategies for supporting themselves and their families.
- A new psychologist has joined our team. Dr. Newhard has helped develop a protocol for referrals and has begun to complete psychological assessments for agency clients not just from Y&F but from other programs as well, including ID/DD.

- Our Outreach worker, Julius Kenney, has continued to facilitate the Young Men's Group as well as maintained our partnership with HCPS staff to offer an educational group related to substance use. He has also supported agency efforts to support the County's Teen Violence workgroup.
- Provided support to schools and community in the wake of tragedy following the deaths of multiple students over the past year.
- Our detention staff and court services clinician provide evaluations and treatment recommendations, as well as support for young people in detention.
- In partnership with HCPS, Y&F has been awarded a grant that will fund 2 positions, a clinician and a FSP, that will be housed on the campus of Virginia Randolph to provide direct support the students there.

Lakeside Center (LSC)

- In the past year, the Lakeside Center has been challenged with continued effects from the global COVID-19 pandemic. Program staff have relied on teamwork and perseverance to collectively provide effective service provision while also prioritizing members' health and safety.
- In the last year, Lakeside Center has:
- Remained open for business continuously despite spikes in COVID transmission periodically.
- Maintained safety precautions related to COVID-19 guidelines as part of daily service provision to promote wellness and mitigate risk of virus transmission.
- Increased program attendance gradually to reflect the state and CDC guidelines.
- Obtained a new position: Peer Recovery Specialist focusing on community integration and community inclusion efforts.
- Received 100% satisfaction from the stakeholder surveys sent to administrators of the Assisted Living Facilities (ALF).
- Successfully retained all program staff.
- Assisted with case management duties outside of program due to staff shortages in other areas of Collaborative Services.

Vocational Services

- As of this time supports were given resulting in 33 new jobs for FY 2022
- With supports given of ARS Employment Services no individuals open to the program were terminated from employment during FY 2022
- As of this time 88% or 23 out of 26 individuals opened to ARS Employment Services were linked to an employer contact within 15days of being opened to the program.

Mental Health Skill Building Services (MHSS)

- Successfully restructured program through the appropriate discharge of persons and made referrals of others to alternative internal services and private providers as needed.
- For persons receiving MHSS all retained their placement in agency MH Support Homes. 1 person independently moved.

Prevention

- With Henrico County Public Schools participated in the 'Community Conversation for Peace' discussing youth violence
- Part of task force to address issues of youth violence in Henrico
- Established new relationships with the Henrico Department of Juvenile Justice, YMCA (Thornton Aquatic Center), Lewis Ginter Botanical Gardens, and Henrico Recreation and Parks. These partnerships have provided increase access to community resources and programming for the youth and their families in the CONNECT.

Crisis Intervention Team (CIT)

- Continued to compose and distribute a weekly wellness newsletter sent out via email
- Continued to offer virtual training for CIT refresher classes and other trauma informed training
- Provided in person trainings for CIT Basic, Train the Trainer, police and fire academies, and collaborated with County HR on trainings
- Provided debriefings and presentations to support the community 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
- Began Veteran's Services initiative to increase access to services to SMVF population
- Researched and identified staff to be trained in EMDR so that this evidence-based practice can be utilized as treatment modality for SMVF identified individuals but also for other clients where clinically indicated for trauma, in particular
- Hired a new Veteran's Services Peer Recovery Specialist who in collaboration with supervisor is developing a program to outreach, engage, and refer SMVF identified individuals with appropriate referrals and services within the agency and surrounding community. She has also been working on developing some brown bag presentations for agency staff.

Emergency Services

- Completed 1,393 Preadmission screening evaluations through May 31, 2022
- Assessed 454 Individuals at our Crisis Receiving Center through April 2022
- Collaborated with other CSB's in the region and utilized expanded youth mobile crisis services and the newly launched Adult Mobile Crisis Regional Services to help to reduce hospitalizations and ER utilization
- Participated in the use of Alternative Transportation, which was bought out by Allied Transportation
- Managed and facilitated 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 which has necessitated commitment hearings be held in emergency departments
- Continued throughout the Pandemic to respond out in the community with police to aid and engage individuals who were in need of mental health services; and have increased our community outreach and assessment
- Supervisory review of preadmission screening documents
- Revised the role of hospital liaisons to closely track individuals admitted to state hospitals for the period that individuals are subject to a TDO prior to the commitment hearing, and LIPOS funded individuals at private hospitals, and to develop discharge plans for these individuals as needed. Expanded role to include conducting all recommitment prescreenings for HAMHDS clients and residents.
- Continued to provide telehealth evaluations and expand our capabilities to respond rapidly to the COVID-19 State of Emergency
- Maintained crisis line using Jabber technology so that crisis phone line could be answered remotely and have continued 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 have continued digital processes for documentation into the future as they have improved efficiency
- Continued representation on the interdisciplinary STAR (Services To Aid Recovery) team
- Offered debriefings to community and agency members experiencing traumatic events
- Trained a significant amount 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; these follow-ups call and letters help to engage clients in our services

Clinical and Prevention Goals

Expand community-based services:

- Increase community-based response to traumatic events in communities (Prevention)
- Increase community-based crisis response to youth and individuals with substance use disorder (ESP)
- Increase community-based outreach to individuals with substance use disorders (SUD)
- Increase school-based services to youth and their families (Y&F)
- Continue to build community resources for individuals with SMI (Collaborative Services)

Enhance Crisis Continuum of Services

- Implementation of 23-hour Center for Youth in Collaboration with St. Joseph's Villa
- Increase co-response with police to individuals experiencing behavioral health crises (ESP)
- Enhance coordination with regional crisis programs (Call Center, REACH, CReST) (All programs)

Enhance support to staff

- Implement Career development plans for Clinicians
- Increase training opportunities through regional trainings, use of Relias, and in-house training
- Increase opportunities for interns
- Increase clinical supervision opportunities
    - Ensure that adequate number of individuals are trained/qualified to provide clinical supervision
    - Expand use of clinical supervision for individuals who may not be seeking licensure

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:	94.7% Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The unfortunate aspect of this measure is that vacancies greatly impact this outcome. When we are fully staffed or close to being fully staffed, we can meet the measure, however, when we fall above a 30% vacancy rate, we are unable to fulfil this objective. We have implemented creative ways to try to lessen this impact, including having peer reaching out to new clients and including them in peer groups should they choose to attend.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Average length of stay will be 3 months or more for all clients in the program.	Year end results:	53.5% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Retention is a difficult area to impact. We remained at the same rate of retention this year as last year. Our biggest area of difficulty with retention is in our OBOT services. We will be piloting a contingency management program to attempt to positively impact our retention rates for that service which will then increase our overall rates for SUD retention.

MEASURABLE OBJECTIVE	Year end results:	60% Not met	Recommendations, actions taken,	The team has discussed these outcomes on several occasions. We have hired 2 full time

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)		Actions during the year did not produce the desired results	performance improvements:	peers and hope to utilize their skill set to impact this number positively in the next year. We are starting some new groups that we have not offered in the past such as SMART Recovery and Double Trouble to assist those who have difficulty in the traditional 12 step community. In addition, staff will be trained in acupuncture to assist individuals with reducing cravings and increasing overall sense of wellbeing. We are hopeful that these changes will allow us to impact this number positively.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of clients surveyed in March will rate their overall satisfaction with services. (4 or 5 rating)	Year end results:	98% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Clients are extremely satisfied with the services they receive as indicated by the surveys completed. It is important to note that 89% of clients who answered the surveys also indicated that their substance use had decreased since beginning services.

ADULT MENTAL HEALTH OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 100% Clients will be seen at their first appointment after SDA within 14 calendar days.	Year end results:	61% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	During this past fiscal year, vacancies have plagued this team. Unfortunately, they have plagued other teams in the agency as well that would normally be able to assist with seeing people requesting services. This has significantly impacted our ability to see individuals as quickly as possible. During this last quarter of this fiscal year, we implemented a measure to open those who do not have insurance. Those who have insurance are being referral out to the community. Our hope is that will allow us to be more responsive to those who we open and will be able to begin services more quickly.

MEASURABLE OBJECTIVE Consumer Satisfaction 85% of clients surveyed in March will rate their overall satisfaction with services at a 4 or 5 on the survey	Year end results:	99.3% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Clients who are opened to MH Outpatient are very satisfied with their services. In fact, 94% indicated that their mental health had improved since beginning services with their MH Outpatient clinician.

CHARLES CITY/NEW KENT OUTCOMES

MEASURABLE OBJECTIVE	Year end results:	100% Met	Recommendations, actions taken,	PF was able to meet the 100% objective this year which was up from 93.64% outcome from

Quality / Access 100% Clients will be seen at their first appointment after SDA within 14 calendar days.		Actions during the year did produce the desired results	performance improvements:	last year. This may have been partly due to the decreased number of people coming to PF due to staffing shortages.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 100% of clients will not have positive UDS for Opioids.	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Although we originally started with 3 OBOT group members, but only had one group member at the end of the year due to people dropping out of treatment. This was not due to relapsing on Opioids but not being able to maintain the structure of the program. No one relapsed on Opioids while in treatment in the last year.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 50% of clients will stay engaged in PF OBOT program	Year end results:	50% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	OBOT was stopped in PF in the second quarter and moved to the East Center location. PF OBOT group started with 4 group members, 2 group members dropped out of the program. The remaining 2 group members were in phase 3 of treatment during the second quarter. This measure was discontinued.

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 90% of the time. Outreach efforts will be used 90% of the time for those who do not come to their appointments.	Year end results:	86%, 80% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Overall, the objectives were not met for the year. Processes including a more detailed spreadsheet and a clinician assigned to track these individuals have been developed. Additionally, a checklist is provided for clinicians so that the clinician who is tracking these individuals is notified when someone is admitted to CSU. The no show rate continues to be around 50% and we have established a policy to attempt Same Place Access for anyone that we are able so that a definite discharge appointment date and time is set for individuals upon their discharge. Although we did not follow up on 90% of the individuals who did not follow through with coming in for an intake for services, 80 % is improved from past percentages.

MEASURABLE OBJECTIVE Quality / Effectiveness 90% of persons (not currently open to the agency) not	Year end results:	81% Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Although we did not meet the objective overall, the first and fourth quarters we were at 90% and 99% respectively for outreach attempts within 7 days of evaluation. The tracking system that we put in place after the results in the second and third quarter made a significant and impactful difference. It is important to note

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.				that even though the benchmark of 90% was not obtained for the year-end results, 309 of 312 (99%) individuals requiring follow-up had outreach attempts made even if some were made after the 7-day benchmark. An area for improvement is for clinicians to confirm contact information with the individual whenever possible. The number of those with missing or incorrect information increased during the last quarter. Education and an addition to a reminder task list will be created to improve on this. A factor contributing to this increase, however, is an increased number of individuals without permanent addresses that we are evaluating.

MEASURABLE OBJECTIVE Quality / Efficiency The goal this FY will be to establish a baseline to determine what percentage of evaluations are completed in the community. Once the baseline is established, we will set a goal of increasing the percentage of those evaluations in the community.	Year end results:	29% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Slightly less than a third of those individuals that we had a chance to evaluate in the community were seen in the community. We are striving for a higher number of individuals to be seen in the community. The challenge with this objective has been accurate data. Next fiscal year, we will request a report to gather the location that the evaluation actually occurred. With the advent of more mobile crisis clinicians, we hope to keep increasing the number of assessments and interventions in the community.

MEASURABLE OBJECTIVE Quality / Effectiveness The goal this FY will be to establish a baseline to determine what percentage of evaluations are diverted from hospitalization. Once a baseline is established, we attempt to increase the percentage of hospital diversions.	Year end results:	32% Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	On average, almost a third of individuals evaluated for a TDO were diverted from hospitalization. This is fairly consistent and is a reasonable outcome considering the high number of individual's brought in under ECO. However, we will continue to seek lesser restrictive alternatives to hospitalization.

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:	37% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Overall, SDA averaged about 37% completion of Crisis Risk assessments for individuals diagnosed with ID/DD. When the assessment tool was completed, the desired results were achieved with a referral made or referral declined. The first quarter resulted in 38% completion, second quarter resulted in 25%, third quarter resulted in 36%, and fourth quarter resulted in 47% - which has been the highest in the last fiscal year. The fourth quarter increase may be attributed to Team being reminded at the end of Q3. Yearly results will be reviewed with staff and will be reminded of State requirement reporting.

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:	93% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	In FY22, an average of 93% of TB screenings were completed. In the first quarter, 91% of TB screenings were completed; in the second quarter 96% were completed; in the third quarter 95% were completed, and in the fourth quarter 89% were completed. The decrease in screenings in the last quarter may be attributed to a new hire on the team who has continued to acclimate in her work. Of the screenings completed, it appears that achieved desired results were made of either no referral or a completed referral to the Health Department. Clinicians will be reminded to complete TB screenings as appropriate and reminded of State mandate for completion and referrals to Health Dept as needed.

LAKESIDE CENTER OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 90% of individuals referred to the program will be admitted within 10 days from receipt of the referral	Year end results:	79% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Although the objective was not met, Lakeside Center has made significant changes to its referral process to improve the response time for admission upon the receipt of the referral. When referrals are not quickly resulting in admissions, the reasons appear to be outside of Lakeside Center's control, relating to logistical delays with the referral source. The average response time is 8.2 days despite multiple outliers in the data, one of which resulting in several weeks referral time, indicating the center's effective efforts of access to services generally. LSC plans to develop a different measure to represent Lakeside Center's referral process more accurately. Year end results were discussed in staff meeting on 08/02/2022 and can be found in meeting notes.

MEASURABLE OBJECTIVE Customer Value / Effectiveness 80% of Consumers given a pre and post	Year end results:	57% Not met Actions during the year did not produce the desired	Recommendations, actions taken, performance improvements:	There were mixed results from quarter 2 and quarter 4. Staff experienced significant difficulty with consistent attendance of the Illness Management groups as well as participation with the tests. Inconsistent attendance is impacted by both COVID

survey will show an improve score demonstrating an increase in knowledge of information shared in psychoeducational groups.		results		precautions as well as the nature of the program with members attending on various days of the week. LSC plans to reevaluate measure of customer value/effectiveness for next fiscal year. Year end results were discussed in staff meeting on 08/02/2022 and can be found in meeting notes

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:	Due to intentional changes to clinical documentation and continued training, staff are reminded regularly and have responded well to including measurable discharge planning and barriers to discharge, resulting in 100% compliance in all 20 charts reviewed. Staff continue to benefit from direction with adding more details and revising as needed for the duration of treatment. Year end results were discussed in staff meeting on 08/02/2022 and can be found in meeting notes

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of consumers surveyed will report being "satisfied" with services as evidenced by an average 8-10 rating to all survey questions	Year end results:	Question 1: 8.82 average Question 2: 8.67 average Question 3: 8.39 average Question 4: 8.96 average Met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	All consumers reported being satisfied with services evidenced by an average rating of at least 8 on every question. Though all questions had average scores of members being "satisfied," question 3 was the lowest average. Moving forward, staff plan to incorporate more specific discussions pertaining to treatment goals with members during clinical interventions to address the lower score for this question. Year end results were discussed in staff meeting on 08/02/2022 and can be found in meeting notes

MEASURABLE OBJECTIVE Stakeholder Satisfaction 85% of Assisted Living Facility (ALF) Operators surveyed will respond with an 8-10 rating to all survey questions	Year end results:	100% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	All ALF Operators appeared satisfied with services as evidenced by a score of 10 on all survey questions (100%). LSC plans to provide a satisfaction survey to another stakeholder for the following year. Year end results were discussed in staff meeting on 08/02/2022 and can be found in meeting notes.

MH CASE MANAGEMENT OUTCOMES

MEASURABLE OBJECTIVE Quality / Access On average non crisis clients will be offered an appointment into ongoing case	Year end results:	7 days Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Over the past fiscal year, a total of 310 clients have been referred to the 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 7 business days (6.8 days) from the Same Day Access appointment to the appointment with their assigned case

management and assessment services within 7 business days of their Same Day Access intake assessment.				manager, thus meeting and narrowly 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. Staffing vacancies, at various levels, on all 3 of the main case management teams throughout the fiscal year coupled with ongoing COVID-19 related issues (i.e., staff and client related illness) have continued to be issues affecting this measure, but the agency has remained focused and successful in 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:	87% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	A total of 281 clients were referred to case management services during the reporting period. At nine months post admission to services 114 remained active and 102 experienced a reduction in hospitalizations or remained at zero hospitalizations or 87%. In addition to these impressive results, of note is these clients experienced a 69% decrease in the number of hospitalizations as compared to the baseline period – dropping from 64 cumulative hospitalizations to only 20 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:	55% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	A total of 55% of clients served in the Case Management and Assessment program of Henrico Mental Health received a physical in the past 12 months, thus meeting the target for this objective. This percentage is up slightly compared to last fiscal year, which is encouraging. Case Managers and team supervisors have been diligent in monitoring and encouraging clients to receive these annual physicals and obtain needed care. These results speak to their efficacy in their efforts and the efficacy of case management services in regard to clients receiving needed medical services and ongoing preventative care.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of client	Year end results:	98% Met Actions during the year did produce the	Recommendations, actions taken, performance improvements:	During the month of April, 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 107 surveys were collected across the 3 main

responses will be one of the two highest ratings to questions on the satisfaction survey		desired results		case management teams, with a total of 428 responses given to the 4 questions asked. Four hundred twenty (420) of those responses were given one of the top 2 ratings or 98.13% of all the responses given. This meets and exceeds the target for this objective. The number of surveys collected this year did increase significantly (by more than double) as compared to last year, when more services were provided virtually as a result of the COVID-19 pandemic, but the numbers of surveys collected has still not rebounded to pre-pandemic numbers. These results will be shared with team supervisors and staff along with client comments and feedback will be incorporated into how services are delivered, but overall speak to a high level of satisfaction regarding services received.

MEASURABLE OBJECTIVE Stakeholder Satisfaction 90% of HAMHDS 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:	During the month of June, a total of 29 surveys were collected and returned from agency prescribers and staff from collaborative services rating the services and collaboration that they experienced with case management staff over the past year. All one hundred sixteen (116) of the responses given were one of the top 2 ratings, thus meeting and exceeding the benchmark for this objective. These results along with comments provided were shared with team staff and supervisors and speak to the high level of collaboration that is occurring across teams. Collaboration is fundamental to providing effective case management services and undoubtedly leads to positive client outcomes.

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:	82% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Three quarters of the year we were able to successfully open more than 80% of consumers referred to this program within the seven-day window. We will continue to work to meet expectation in providing alternatives to opening consumers within the seven-day window, i.e., if someone is hospitalized, we will see if they are appropriate to be opened in the hospital. The areas needing improvement were due to staffing to ensure individuals were opened within seven-day period. Although, we have not hired the SUD clinician staffing was not a barrier to opening to consumers. Our objective will remain the same.

MEASURABLE OBJECTIVE Customer Value / Effectiveness	Year end results:	24% Not met Actions during the	Recommendations, actions taken, performance improvements:	The timing of DLA 20s was changed this year and as a result our scores were not collected quarterly. We will review the first and third quarter in the following years and hope to

More consumers than not will experience improvement regarding DLA-20 global scores.		year did produce the desired results		view a change in the level of improvement in scores at that time. The recommendation is to continue to review DLAs and cater services based on their score. There has been a significant increase in the consumers whose ADLs have been impacted due to substance use. We have been recruiting with the goal of bringing those services to consumers.

MEASURABLE OBJECTIVE Quality/ Efficiency 70% of clients will participate, at least quarterly, in activities within their community such as vocational, educational, or recreational to increase community integration and functional improvement.	Year end results:	66% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The team was not able to accomplish their goal of 70% or more client participation at least quarterly in activities within their community. This year was challenging as we were under COVID restrictions for part of the year, so we were not doing our team outings and consumers reported that they were not able to access as many activities in the community due to those restrictions. We will resume our weekend outings and continue to encourage community engagement for consumers. We will continue to look to community resources in the community for our consumers to engage in as well as resources that we can provide our consumers. We will look into doing smaller groups for consumers who are still concerned about COIVD and being in larger numbers/ This will continue to be a goal in the next year.

MEASURABLE OBJECTIVE Consumer Satisfaction At least 85% of client responses on the client satisfaction survey will be one of the top 2 ratings.	Year end results:	69% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	There was only one quarter in which our consumer satisfaction surveys were over 80%. The main area that was scored lower was the community engagement. This area was lower due to several factors including distressing symptoms, lack of motivation and immigration challenges. We hope to maintain what we are doing as well as increasing opportunities for us to support consumers with community engagement.

MEASURABLE OBJECTIVE Stakeholder Satisfaction Stakeholder surveys to be administered to family members of clients. 80% of responses were given a rating of '4' or higher.	Year end results:	80% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The family satisfaction survey demonstrated that family members are pleased with the services that their family receives. We will continue as we have in this area. COVID restrictions played a significant impact on community engagement. The goal will remain, and we hope to improve our scores for the family survey.

MH ACT OUTCOMES

MEASURABLE OBJECTIVE	Year end results:	71% Met	Recommendations, actions taken,	Our baseline of act consumers accessing medical care last year was 68%, the score for

Quality / Access There will be an increase over FY21 69% 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.		Actions during the year did produce the desired results	performance improvements:	this was 71%. We continue to link consumers to appointments and coordinate appointments for consumers as appropriate. We will continue to coordinate and link consumers to appointments as appropriate with the goal of having more consumers see medical providers for routine medical care. This continues to be an area on most consumers treatment plans and will continue to be something that is brought up during quarterlies.

MEASURABLE OBJECTIVE Customer Value / Effectiveness More ACT consumers than not will show improvement in DLA-20 global scores, greater than 50%.	Year end results:	40% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	The DLAs are now completed twice a year. We will measure this goal during the first and third quarters. The score this year measuring first and third quarter was 36%. The goal is to have an improvement in overall scores versus a decline or scores staying the same. The team did not meet the 50% mark this year. The team will view the areas that score lower and work to improve those areas.

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 ACT services.	Year end results:	94% Not met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The team opened all but one consumer in the seven-day window and completed their paperwork within the 30-day window. We will continue to work with our referral sources to have new consumers opened within 7 days of the referral. If a client is in the hospital, we will see if appropriate to accommodate opening them while inpatient. We will continue to maintain this goal.

MEASURABLE OBJECTIVE Consumer Satisfaction Consumers will rate their satisfaction with ACT services a "7" or higher on the ACT Consumer Satisfaction Survey BASELINE: FY 2021 - 50% of responses	Year end results:	32% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	Our average score for satisfaction surveys this year was 32%. This is less than it has been in previous years and we feel this is attributed to staffing vacancies and changing of primary servers more frequently due to those vacancies. Consumers have reported having a hard time feeling connected when staff leave frequently. We are working to hire staff as quickly as possible and trying to keep consumers with case managers as much as possible. We are hoping to have a higher attrition and to improve our consumer satisfaction. This will remain a goal.

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 members. Target is to increase over FY21 87%.	Year end results:	88% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	We exceeded our score from FY21 during this survey. We will continue to provide sound services to our consumers. Results show that 88% of responses were given a rating of '4' or higher. There was a total of 35 surveys collected between both ACT teams. 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 / Effectiveness 90% of clients in the sample will demonstrate an increase in their DLA-20 Self-Report Score	Year end results:	42% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	At the start of this reporting year, MHSB served 15 clients. MHSB significantly changed its scope of services during the second quarter to only providing services to those living in our county support homes. This change drastically reduced the number of clients served. Those not in the homes were either referred to private community providers or successfully discharged. This outcome will continue to the next reporting period, and while numbers will remain relatively small, we do anticipate an increase with new clients moving into the homes. The DLA-20 self-assessment remains a useful tool when collaborating with the client in assessing their strengths, area of need, and developing their person-centered plan.

MH VOCATIONAL OUTCOMES

MEASURABLE OBJECTIVE Quality / Access 90% of persons referred will be contacted within seven days of referral	Year end results:	90% or greater Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	This goal was met for the year with each quarter at 90% and above. As this program operates under the evidenced-based practice model of Individual Placement Supports (IPS) in which a principle is rapid access to service, this goal will remain as a goal for FY23 due to it being an IPS access outcome. (Q1 92%, Q2 90%, Q3 100%, Q4 97%)

MEASURABLE OBJECTIVE Customer Value / Effectiveness Staff will assist program participants with obtaining 28 additional jobs during the yearly evaluation period	Year end results:	35 Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	For the year 35 persons were supported in obtaining new employment. As a result of the consistent meeting of this objective over the past several plan years (FY 21-26 and FY 20-40 supports given to persons obtaining new employment) this goal will be discontinued for FY 23 plan year.

MEASURABLE OBJECTIVE Quality/ Efficiency Each full-time job coach will develop 24 new employer contacts monthly	Year end results:	< 24 contacts monthly per job coach Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	221 employer contacts were made but 24 average contacts monthly weren't maintained. This outcome was not met during this plan year in part due to providing supports to other programs that were short-staffed and operating under Covid precautions. To help improve this outcome vocational staff will transition back to solely providing vocational services which will allow for increased time for employer contact and partnership building. Job Coaches will continue to present employer contacts in supervision and monthly field observation.

MEASURABLE OBJECTIVE Quality/ Efficiency Full-time job coaches will average at least 55 direct service hours monthly	Year end results:	38 direct service hours monthly average Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This outcome was not met during this plan year and was based off of two Job Coaches for three quarters and three Job Coaches in the 4th quarter while operating all quarters under Covid precautions. To help improve this outcome vocational staff will transition back to solely providing vocational services and continue to practice Covid safety precautions during direct service which will allow for an increase in hours of direct service contact.

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:	89% 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 89%. 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. Due to consistent meeting of this objective over the past several plan years (FY 22-89%, F Y21-97%,) this goal will be discontinued for 2022-2023.

MEASURABLE OBJECTIVE Consumer Satisfaction 90% of all responders will rate each statement between "8" to "10" in the survey	Year end results:	#1-88% #2-88% #3-85% #4-88% #5-85% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	This goal was not met in the 1st quarter, in quarter 3 all but question 3 (Benefits planning have been explained to me in a way that I understand) were met above 90%. To improve this outcome the vocational supervisor will continue to give an overview of SSA entitlements and earned income at both intake and first Job Development contact with the Job Coach. To further improve program participants understanding, a knowledge of benefits outcome goal will be in place for FY23.

MEASURABLE OBJECTIVE Stakeholder	Year end results:	#1-90% #2-100% #3-100%	Recommendations, actions taken, performance	This objective was met at 100% for all questions except question 1 which received a rating of 90%. To improve this rating all

Satisfaction 90% of all responders will rate each statement between "8" to "10" in the survey		#4-100% #5-100% Met Actions during the year did not produce the desired results	improvements:	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. This goal was met for the plan year at 90% or above for all quarters and will remain in place for FY 23 as it is a stakeholder satisfaction outcome.

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 115 youth approved for admission within 5 days of request. Program Coordinators registered youth on-site. No youth needed to be placed on a waiting list this year.

MEASURABLE OBJECTIVE 80% of CONNECT 1st – 3rd grade participants shall be reading on or above grade level.	Year end results:	74% 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 of school and Connect programming because of the continued COVID pandemic again this school year. However, there was an 9% 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 partnered with HCPS and their SMART Program as well as the Love of Reading Program to improve reading 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 0% favorable attitudes Life skills Training 3% favorable attitudes Met Actions during the year did 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. Staff delivered the curriculum in an in-person format this year.

MEASURABLE OBJECTIVE Quality/ Efficiency Prevention Services shall implement environmental approaches, in collaboration with community partners, to address substance use prevention and mental wellness as measured by the delivery of a minimum of 3 community-level activities, e.g., community forum, social norms campaign, or merchant education activities	Year end results:	Campaign reach: Television – 7,870,258 Reach PSAs – 1,480,000 Reach Medi-bags - 48,000 Medication lockboxes- 898 Rx drug disposal kits- 856 Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Prevention exceeded this goal by completing 20 community level activities. Medication lockboxes and disposable kits were again difficult to obtain due to the supply chain disruption.

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:	90% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	COVID-19 restrictions were not as prevalent this school year. Connect staff were able to do in-person programming this year. This made it easier to maintain contact with youth, and to provide services. Youth were very excited to know CONNECT would be providing in-person services again. We attribute the increase in satisfaction to that variable.

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:	>95% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	Parents and community stakeholders were excited to know that CONNECT and in-person programming would be held again. CONNECT staff were also able to resume visiting schools and participating in school events.

YOUTH & FAMILY OUTCOMES

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:	85.5% Not met Actions during the year did not produce the desired results	Recommendations, actions taken, performance improvements:	During this fiscal year, youth and family clients were scheduled within 14 days of their initial session on an average of 85.5 % of the time. We fell short of our goal by 4.5% due to unprecedented and extreme volume/high demand during the last month of the fiscal year (June 2022).

MEASURABLE OBJECTIVE Customer Value / Effectiveness Youth and family outpatient clinicians in training and trained for Trauma-Focused CBT and Parent Child Interactive Therapy will provide evidence-based services to at least 15 clients	Year end results:	25 cases TF-CBT 40 cases PCIT Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	The Youth and Family team continues to strive to provide evidenced based practices on a consistent basis. During the 3rd and 4th quarter there was a significant increase in the number of youth coming in for services and the acuity of those youth. The team made some small changes that included having no more than 5 PCIT cases open to any clinician at one time. Cases that have come in requesting PCIT have been assigned a PCIT trained clinician and have been started PCIT when a space was available for weekly session. Clinicians continue to provide TF-CBT, which is forgiving in its model that does not require weekly sessions, although weekly sessions are optimal when processing the Trauma Narrative. The YandF supervisors continue to promote the use of support groups for the use of Evidenced Practice models. The YandF team has begun to work towards a brief model of treatment for youth not enrolled in an EBP to help with capacity and to make room for clients who are in need of weekly sessions for delivery of EBP.

MEASURABLE OBJECTIVE Customer Value / Effectiveness Reoffending rates will remain at or below 10% for MST clients during the course of treatment	Year end results:	9.52% Met Actions during the year did produce the desired results	Recommendations, actions taken, performance improvements:	21 cases closed during this year had an opportunity for a full course of treatment and 3 of those cases reoffended. Additionally, 19 youth were living at home and attending school or working. Note that during the first two quarters of the year that school and some services were 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. FY22 ended with HAMHDS being above the average of the 40 CSB for receiving an annual physical exam (70.5%), the initiation (91.3%)/engagement (65.2%) of individuals in SUD services; however, fell below the average for retention (21.7%) of individuals in SUD services. DD Waiver individuals who meet the criteria for enhanced case management have monthly face-to-face meetings (84%, target 90%), in the residence (86%, 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

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, 2021 through March 31, 2022.

During this fiscal year, ten separate services were tracked. A total of 534 surveys were mailed and 44 were returned. The response rate for programs ranged from 0% to 42.9% with an average response rate for all of the CARF services of 8%, down from 9% for FY21. Individual comments are forwarded to the respective program. 81% of the returned surveys noted satisfaction ratings of either satisfied or very satisfied.

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

FY2022 ANNUAL POST DISCHARGE REPORT

HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Discharges by Program (Apr 2021 - Mar 2022)														
CM&A	MH Case Management	25	27	47	29	21	27	39	41	19	25	24	63	**387**
PACT	Assertive Community Treatment	5	1	4	6	2	4	5	2	4	5	8	4	**50**
MH Day Support	MH Community Integration	0	1	3	2	1	0	3	0	0	1	2	4	**17**
MH Vocational	MH Community Employment	1	0	1	2	0	0	2	0	0	1	1	2	**10**
MH Supported Svcs	MH Supported Living	3	4	2	discontinued									**9**
ID Residential	ID Residential	1	0	0	0	0	0	0	1	0	0	0	0	**2**
LEP	ID Community Integration	0	2	0	0	1	0	6	2	1	0	1	17	**30**
ID Supp Employ	ID Community Employment	0	0	0	3	2	0	1	0	0	0	0	1	**7**
Sheltered Employ	ID Organizational Employment	1	0	1	0	3	0	3	2	2	0	0	0	**12**
ID Group Supp Empl	ID Community Employment	2	3	0	0	0	2	2	1	0	0	0	0	**10**
Total		**38**	**38**	**58**	**42**	**30**	**33**	**61**	**49**	**26**	**32**	**36**	**91**	**534**

HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Response Rate%
Survey Response Rates (Apr 2021 - Mar 2022)															
CM&A	MH Case Management	0	2	6	2	1	2	3	4	2	0	1	2	**25**	6.5%
PACT	Assertive Community Treatment	0	0	1	0	0	0	0	0	1	1	1	0	**4**	8.0%
MH Day Support	MH Community Integration	0	0	1	0	0	0	0	0	0	0	0	0	**1**	5.9%
MH Vocational	MH Community Employment	0	0	0	1	0	0	0	0	0	0	1	0	**2**	20.0%
MH Supported Svcs	MH Supported Living	0	0	0	discontinued									**0**	0.0%
ID Residential	ID Residential	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0.0%
LEP	ID Community Integration	0	0	0	0	0	0	2	0	0	0	0	3	**5**	16.7%
ID Supp Employ	ID Community Employment	0	0	0	1	0	0	1	0	0	0	0	1	**3**	42.9%
Sheltered Employ	ID Organizational Employment	1	0	0	0	0	0	2	0	0	0	0	0	**3**	25.0%
ID Group Supp Empl	ID Community Employment	0	1	0	0	0	0	0	0	0	0	0	0	**1**	10.0%
		1	3	8	4	1	2	8	4	3	1	3	6	**44**	**8%**

INTERNAL AGENCY RECORD REVIEWS

Approximately 600 quality record reviews and 90 Administrative Reviews were completed in FY2022. The target for all programs is 90% compliance with the standards reviewed.

DS RECORD REVIEW RESULTS SUMMARY

Targets for all programs is 90%.

- Reviewed 15-30% Waiver charts, 5-30% non-Waiver charts and 100% of Residential cases
- Ten programs met the target goal of 90% (East 1 SPO, East 2 SPO, DD CM East 2, DD CM North1, DD CM Catholic Charities, DD CM Waiver Services, Hermitage Voc, Cypress Voc, STEP and Supported Employment)
- Two programs improved by five or more percentage points from FY21 (East 1 SPO, East 2 SPO)

Four programs dropped by five or more percentage points from FY21 (West 1 Waiver, West 2 Waiver, West 1 SPO, DD CM East 1)

	FY2022	FY2021	FY2020	Comments
NORTH 1 WAIVER	88%	91%	93%	
EAST 1 WAIVER	85%	90%	93%	
EAST 2 WAIVER	88%	87%	88%	
WEST 1 WAIVER	75%	96%	90%	↓21 percentage points from FY21
WEST 2 WAIVER	75%	92%	89%	↓17 percentage points from FY21
NORTH 1 SPO	89%	91%	82%	
EAST 1 SPO	94%	80%	94%	↑ 14 percentage points from FY21
EAST 2 SPO	100%	71%	86%	↑ 29 percentage points from FY21
WEST 1 SPO	71%	86%	92%	↓15 percentage points from FY21
WEST 2 SPO	87%	na	90%	
DD CM EAST 1	73%	91%	97%	↓18 percentage points from FY21
DD CM EAST 2	100%	94%	97%	
DD CM WEST 1	no charts reviewed	90%	97%	
DD CM WEST 2	no charts reviewed	89%	97%	
DD CM NORTH 1	91%	94%	97%	
DD CM CATHOLIC CHARITIES	95%	90%	82%	
DD CM WAIVER SERVICES	93%	98%	90%	
HERMITAGE VOC	92%	93%	86%	
CYPRESS VOC	100%	93%	96%	
ENCLAVES	87%	92%	94%	
LEP	77%	92%	95%	↓15 percentage points from FY21
STEP	96%	96%	97%	
SUPPORTED EMPLOYMENT	97%	98%	99%	
RESIDENTIAL	84%	88%	85%	
ID ADMINISTRATIVE	87%	86%	92%	

MH/SA RECORD REVIEW RESULTS SUMMARY

Targets for all programs is 90%.

- Reviewed 2.5-20% Medicaid charts and 1.5-5% non-Medicaid charts
- Sixteen programs met the target goal of 90% (ESP, Non-ESP Prescreening, Same Day Access East & West, Youth & Family, MH Outpatient East & West, MH Outpatient & SUD PF, SUD East, Lakeside Center, Lakeside Center Voc, ACT West, InStride, CM&A West 3, CM&A PF, MH Skills-Building West, Prescriber)
- Four programs improved by five or more percentage points from FY21 (Lakeside Center Voc, CM&A West 3, CM&A PF, MH Skills-Building East)

Two programs dropped by five or more percentage points from FY21 (SUD RMP, MH Administrative)

	FY2022	FY2021	FY2020	Comments
ESP PRESCREENING	97%	94%	95%	
NON ESP PRESCREENING	91%			*result for prescreenings completed by non-ESP staff
SAME DAY ACCESS EAST	95%	98%	96%	
SAME DAY ACCESS WEST	97%	99%	97%	
YOUTH & FAMILY	94%	93%	94%	
MHOP EAST/WEST	93%	92%	93%	
MHOP/SUD/YOUTH PF	93%	89%	90%	
SUD EAST	90%	92%	96%	
SUD RMP	81%	92%	86%	↓11 percentage points from FY21
LAKESIDE CENTER	95%	95%	99%	
LAKESIDE CTR VOC	91%	83%	83%	↑8 percentage points from FY21
ACT EAST	89%	88%	89%	
ACT WEST	91%	87%	86%	
INSTRIDE	94%	92%	89%	
CM&A EAST	87%	84%	87%	
CM&A WEST 1	82%	90%	88%	↓8 percentage points from FY21
CM&A WEST 2	84%	80%	88%	
CM&A WEST 3	90%	76%		↑14 percentage points from FY21
CM&A PF	98%	89%	72%	↑9 percentage points from FY21
MH SKILLS-BUILDING WEST	95%	94%	95%	
MH SKILLS-BUILDING EAST/PF	89%	83%	90%	↑6 percentage points from FY21
PRESCRIBER	93%	97%	86%	
MH ADMINISTRATIVE	86%	93%	88%	↓7 percentage points from FY21

FY23 Objectives for the Coming Year

- Continue to support programs preference for desk reviews, in person reviews or a hybrid of the two
- Partner with IT to develop new sampling reports out of the electronic health record and Chart Tracker
- Replace computers in lab with new computers

- Continue to send quarterly report of record review results to AMT with trend information for programs with lower than 85% compliance with standards reviewed

EXTERNAL AGENCY REVIEWS

	FY22	FY21	FY20
Total number of Reviews:	74	62	57
Admin:	0	0	0
C&P:	25	15	27
DS:	42	42	24
Across All Divisions:	7	5	6
# of Desk Reviews	68	62	48
# of Onsite or Virtual Reviews	6	0	9
# of C&P/DS Licensure/CARF/VHDA	10	18	51
# of C&P client records reviewed	87	53	119
# of DS client records reviewed	454	536	46
Total number of records reviewed	551	607	216

6 "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 reviews had a slight increase from FY21
- There were 17 entities that requested documents or reviews
- Reviews were faxed, or sent by secure email exchange-Virtru, Move-it, Red CAP, ECG Quick connect
- Returned to onsite or had virtual reviews
- 100% of reviews were completed within the specified timeframes

External Reviewers

DBHDS -Virginia Department of Behavioral Health and Developmental Services: Licensure, Health Services Advisory Group (HSAG), Case Management Steering Committee (CMSC), Community supportive housing (CSH), Infant & Toddler Connection of Virginia Anthem (Cotiviti/Ciox), Aetna (Cotiviti), United Health Care (Optum/CIOX), Department of Justice (DOJ), CMS (Center for Medicare and Medicaid), Partnership for People with Disabilities, AMIKids, DMAS, Molina Healthcare, Medicaid; Home and Community Based Services (HCBS)

Types of Reviews

Mortality Reviews, Supports Intensity Scale (SIS), Support Coordinator Quality Review (SCQR), Settlement Agreement Individual Service Review, Performance Improvement Plan, Measuring improper payments (PERM), Behavioral programming study review, National Core Indicators (NCI) back ground information, Employment Review, Case Manager notes, Quality Assurance Review (QAR), Quality Service Review, Crisis Risk Assessment Tools (CAT), On-site Visit Tool (OSVT), Service modification/Employee files, Permanent Supportive Housing (PSH) Fidelity Assessment, Review and Action HCBS Desk Audit, Annual inspection, Annual record review (ARR), Unannounced licensure visit, Waiver Waitlist review, Review of conditional licenses, Healthcare Effectiveness Data and Information Set (HEDIS): risk adjustment, Diagnostic data, Transition of care (TRC), Comprehensive diabetes care, Blood Pressure, Complete and accurate diagnosis coding

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 FY22 Risk Management and Accessibility Plans. These plans help the agency meet Office of Licensure and CARF requirements. The committee discusses the work of the agency, shares feedback from staff and stakeholders, and provides input into agency processes. The work of the Risk Management Committee is available to all staff at P:\HAMHDS\Committees\Risk Management Committee.

Risk Management Planning	***Accessibility Planning***
• Service Delivery • Workforce Development/Human Resources • Computer Resources • Confidentiality • Financial • Critical Incidents • Human Rights • COVID-19 • Employee and Client Safety • Vehicle Safety • Emergency Disaster Response and Recovery • Health & Safety • Regulatory Compliance • Media Relations and Social Media	• Architectural • Environmental • Attitudinal • Financial • Employment • Communication • Technology • Transportation • Community Integration • Reasonable Accommodations

The below are a few Agency/County highlights:

- The County of Henrico continued to provide guidance, support to HAMHDS as the agency combated COVID-19. Information was shared with all staff when known positive cases of staff were reported. The email to staff shared symptoms to look for and the number for the County's COVID center for employees. The County of Henrico COVID Center provides assistance to staff for testing and determining when employees can return to work. Home test kits, hand sanitizer, masks were made available upon request. Positive cases of individuals served were reported to DBHDS as required when an individual tested positive or was positive during the provision of services. The agency continued to track positive cases of clients weekly for FY22. This report was shared with leadership group. The agency monitored the federal public health emergency flexibilities with DMAS, specifically as it related to telehealth and verbal consents and adjusted services throughout the year as flexibilities ended for certain services. In March 2022 the County of Henrico began their Doses on Demand Program offering in home vaccinations in Henrico County.

- Policies and procedures were updated throughout the year to reflect new regulatory guidance and agency practices. Emergency policies and procedures that were in effect during the COVID-19 pandemic ended this fiscal year.

- HAMHDS facilities staff provides an update on special projects accomplished throughout the year, specifically those identified in the accessibility plan. As an agency approximately $195,000. is spent each year on special projects such as repairs to the deck at Gayton, replace toilets with ADA high power flush units at Green Run,

Gayton Sherbrooke and Hermitage, chairs with armrests at Hermitage to assist with standing and sitting to prevent falls to name a few.

- The agency launched it CARF Kick-off in September 2021. Meetings and site tours occurred with each team seeking CARF accreditation to review CARF standards. CARF application was submitted towards the end of the fiscal year and survey costs were prepaid from FY22 funds. CARF lead meetings continued at least every two months, reviewing standards, policies and reviewing cross referencing grids in preparations of the survey in the fall of 2022

The risk management committee also reviews the data collected by the incident review committee. Falls with or without injuries and suicide attempts continue represent a fair number of our incident reports. September is Suicide Prevention Awareness Month and Falls Prevention Awareness. September 2021 the risk management committee launched their Falls Prevention Campaign with weekly information, statistics and available resources to be fall free for staff and individuals served. Information from the National Council on Aging, fall prevention workshops from Senior Connections – Capital Area Agency on Aging, and resources from the National Institute on Aging were provided to staff and shared on our electronic boards.

Prevention services shared weekly information regarding suicide prevention during the month of September to include free webinar on World Suicide Prevention Day, 9/10/21, resources from the American Foundation for Suicide Prevention, ministry resources, streaming information such as Traumedy, webinar from GeneSight on "It's time to talk Suicide: Addressing the Stigma around a difficult topic", webinar on suicide prevention during COVID sponsored by NAMI, podcasts, and social media

April Banks, DD Services, is the Co-Chair of the Charles City Chapter of The American Foundation For Suicide Prevention, (AFSP). On October 23, 2021 the chapter hosted their third annual Out of the Darkness Walk, at Harrison Park, in Charles City County. The purpose of the walk is to bring awareness to suicide and promote prevention strategies. AFSP is a voluntary health organization that gives those affected by suicide a nationwide community empowered by research, education and advocacy to take action against this leading cause of death.

FY23 the agency and committee will continue increased awareness in these two areas during the month of September.

Exposure Control Plans were completed for each facility by the Risk Management Committee. The exposure control plan helps the County of Henrico comply with the requirements of Virginia's Occupational Safety & Health (VOSH) bloodborne pathogens standards. The plan is developed to identify situations and job classifications where employees may be exposed to blood or other potentially infectious materials and to protect employees in the form of engineering controls, personal protective equipment, training and risk reduction methods. The County offers health and safety training information through Webnet.

Information from the Office of Licensure and Office of Human Rights are shared and discussed in committee meetings to reduce the reoccurrence of corrective action plans. An example includes water testing to ensure water temperatures are within regulatory guidelines (between 100 and 110 degrees) and as reminders for locations to record water test in FIDS.

Additional planning information for the Risk Management and Accessibility Plan can be found in the FY22 Risk Management Improvement Plan and the Accessibility Plan of Correction.

Looking ahead to FY23

- CARF survey in the fall of FY23
- Develop FY23 Risk Management Plan, Risk Management Improvement Plan, Accessibility plan and Accessibility Plan of Correction
- Provide comments on draft Office of Licensure regulations
- Update Agency Exposure Control Plans (Annual review required)

FY22 Risk Management Committee Members
Thank-you committee members for your commitment to Risk Management.

Name of Committee Member	Title	Division/Program	Location
Ebonee Ausberry	Training Assistant	DS/STEP	Hermitage Enterprises
Joe Armstrong	Clinical Supervisor	C&P/Employment Services/Skill Building	Lakeside Center
Brandy Coullier, Co-Chair	Business Supervisor	Administrative Services	Richmond Medical Park
Serina Gaines	Facilities Coordinator	Administrative Services	Woodman
Steve Hixon	Clinician	C&P/Prevention Services	East Center
Kim Jones	Program Coordinator	DS/Residential Services	Woodman
Christy Kipps	Business Supervisor	Administrative Services	Woodman
Paul	Person Served	DS/Hermitage	Hermitage Enterprises
Yvonne Russell, Chair	QA Manager	AMT/QA	Woodman
Kim Yates	Business Supervisor	Administrative Services	East Center

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	FY21	FY22	Q1	Q2	Q3	Q4
Aspiration pneumonia	0	0	0	0	0	0
Assault by client	2	3	1	1	0	1
Biohazard incident/bomb threats	0	0	0	0	0	0
Bowel Obstruction	0	0	0	0	0	0
Choking incidents that require direct physical intervention by another person	0	1	0	1	0	0
Communicable Disease/infection control	187	172	45	56	62	9
Death-accidental	3	10	1	5	3	1
Death-likely homicide	0	0	0	0	0	0
Death-likely suicide	2	0	0	0	0	0
Death-natural causes	39	35	13	7	9	6
Decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer	0	0	0	0	0	0
Emergency Room Visit	14	40	7	20	4	9
Fall- with injury requiring medical attention	11	13	5	5	1	2
Fall- without injury	40	60	10	26	11	13
Illness (e.g. seizure, diabetic reaction)	23	11	4	3	2	2
Individual who is missing	1	6	2	3	0	1
Ingestion of any hazardous material	0	0	0	0	0	0
Licit/Illicit drugs or weapons	0	1	0	1	0	0
Med incident- NO adverse reaction	23	18	4	5	5	4
Med incident- requiring medical attention	0	1	1	0	0	0
Other	63	25	12	4	6	3
Overdose	0	4	1	2	1	0
Serious injury requires med atten	1	1	1	0	0	0
Sexual assault incident	0	0	0	0	0	0
Suicide attempt with hospitalization	13	35	12	8	11	4
Suicide attempt with NO hospitalization	13	18	3	6	5	4
Threats/violence	1	2	2	0	0	0
Unplanned pshychiatric (TDO)	25	49	8	22	8	11
Unplanned medical hospital admission	5	9	2	2	2	3
Violent crime by client	0	1	0	0	0	1
Behavioral incident	3	0	0	0	0	0
County vehicle	0	0	0	0	0	0
Fire	0	0	0	0	0	0
Property damage	0	0	0	0	0	0
Property loss/theft	0	0	0	0	0	0
Self-injurious behavior	3	0	0	0	0	0
Suicide attempt	20	0	0	0	0	0
Totals	**492**	**515**	**134**	**177**	**130**	**74**
Restraints	**0**	**2**	**1**	**0**	**1**	**0**

Trends and Causes

- Root Cause Analysis - 117 RCAs were completed within the 30 day requirement.
- Supervisors had discussions and retraining as needed for med errors
- Covid reports have decreased due to the change in reporting requirements
- Weekly covid reports are being sent to leadership group
- Medication errors continue to decrease, however, we continue to monitor closely
- Falls increased after re-opening of programs following the pandemic

Areas Needing Improvement

- Med errors
- Communicable Diseases (COVID)
- Falls

Actions to address the improvements needed and actions taken

- Medication refresher training
- Provided 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

- Posted COVID information on all agency electronic boards
- Henrico County offered covid community testing sites
- Covid rapid antigen in-home test kits, masks, and hand sanitizer are available
- Monitor location of falls to determine possible environmental factors
- Henrico County website added educational information on Monkey Pox

Actions taken accomplished the intended results

- Weekly covid reporting to agency leadership
- Accurate reporting of positive COVID
- Ongoing medication training continues to occur
- Collaborated with Employee Health when updating covid reporting guidance

Necessary education and training and Prevention of recurrence

- Annual refresher training for all staff who administer medications
- Medication administration re-training occurred with staff involved in med errors
- CDC guidance on Covid provided on electronic boards
- COVID information on County Intranet and Agency SharePoint
- 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 complete competency-based health and safety training
- Regular covid guidance is shared by Medical Director
- Fall Prevention campaign will occur in September during Fall Prevention awareness month
- Guidance by DBHDS on incident reporting
- Education information is shared by DBHDS office of Integrated Health on Covid
- Choking training
- ADA training
- Med error workgroup
- Residential and Day Services consulted with Va. Dept of Health and followed their guidance for prevention of covid

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

FY23 Goals

- Continue to monitor med errors closely
- Continue to implement Henrico County COVID Guidelines
- Further evaluate falls that occur

HUMAN RIGHTS INCIDENTS

All allegations of violation of the agency's human rights policy are considered a formal complaint. Overall trends in FY22 include an increase in the number of human rights reports received in iRIS and reported to CHRIS compared to the previous year. The areas with the most reports are confidentiality/privacy and neglect (includes peer-to-peer incidents and medication errors).

- In FY22, there were 83 human rights reports in iRIS which is a 38% increase from FY21 (60).
- Of these iRIS reports, 30 were reported to the state Department of Behavioral Health & Developmental Services' (DBHDS) Computerized Human Rights Information System (CHRIS) and 11 resulted in a founded outcome:
  - 6 medication errors which DBHDS categorizes as neglect (non-P2P)
  - 2 dignity
  - 1 neglect (choking incident)
  - 1 confidentiality/privacy
  - 1 use of restraint
- There were 5 privacy breaches reported to the Office of Civil Rights for FY22.
- The number of allegations of abuse, neglect, and exploitation for FY22 (21) reflects a 163% increase from FY21 (8).

Areas needing performance improvement

Areas needing performance improvement include medication error/neglect, dignity, and confidentiality/privacy, as reflected by the 11 Corrective Action Plans (CAPs) issued by the Office of Licensing on behalf of the Office of Human Rights for a total of 13 violations. Five CAPs were for medication errors (one occurred FY21 Q4 and one included two violations), one was for neglect and late reporting, two were for dignity, two were for confidentiality/privacy (one occurred FY21 Q4), and one was for use of restraint.

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

Medication errors

- Written or verbal counseling for involved staff
- Retraining of involved staff on medication administration and/or repackaging
- Policies and procedures for medication delivery and administration reviewed with the involved team
- Our medication delivery process was reviewed and updated to include development of a new medication delivery schedule and review of the schedule for accuracy in daily team meetings.

Dignity and Neglect

- Retraining of involved staff on human rights

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

Confidentiality/privacy

- Retraining of involved staff on confidentiality/privacy
- Retraining by QA staff regarding privacy policies and procedures

Use of Restraint

- Review of our policy on physical holds was provided to involved staff and team
- Added annual requirement for staff in the program to receive Standardized De-escalation and Restraint Training, such as Therapeutic Option

Results of actions implemented:

Since these actions were implemented, there has been a reduction of reports involving dignity, restraint, and confidentiality/privacy which suggests that actions taken have resulted in some improvement. There have been

additional reports of medication errors, and this remains an area that will need continued efforts towards improvement.

Type	FY21	FY22	Q1	Q2	Q3	Q4
iRIS Human Rights (HR) reports	60 9 founded	83 11 founded	23 2 founded	14 1 founded	24 4 founded	22 4 founded
HR reported in CHRIS / OCR	13 5 OCR	30 5 OCR	9 0 OCR	5 1 OCR	11 2 OCR	5 2 OCR
Late HR reports in CHRIS > 24 hrs/ CAP issued	0/0	4/1	2/0	1/0	1/1	0/0
HR appeal to ED	0	3	0	0	3	0
HR appeal to County Manager	0	0	0	0	0	0
HR appeal OHR	0	2	0	0	2	0
HR appeal to LHRC / SHRC	0	0	0	0	0	0
Restraints	0	2	1	0	1	0
HR received from or reported to MCO	0	0	0	0	0	0
Code of Ethics	0	1	0	0	1	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, United Healthcare, Molina "Magellan", and Va. Premier) for MH Programs and Developmental Services Teams. There is Preadmission Screening Certification for Emergency Services and other pre-screeners in the agency.

Henrico Area Mental Health & Developmental Services has a group of 36 staff trainers that provide training in a variety of areas such as First Aid & CPR, Prevention of Violence (POV), Therapeutic Options, Cultural Competency, Diversity, Equity, and Inclusion (DEI), Brown Bags, Wellness series, MH First Aid, EHR and other Professional trainings.

Approximately 57 training sessions were offered. Staff registers for training directly using several web-based system to include MyTraining, Oracle, Webnet, and Litmos. Examples of training offered are listed below.

Current events related to Afghani refugees
Equity Action Continuum
Becoming Anti-Racist
Cultural Aspects of our community
The words of a king-A Reflection of America

Why only one month?
Tribute to Sidney Poitier Podcast and discussion
Understanding & Interrupting Microaggression's
Autism Spectrum Disorder
Facilitating DEI Conversations
International Rescue Committee
Child-Adult Relationship Enhancement
Security Awareness
Information Security Awareness
Health Information Management Confidentiality and Privacy
Code of Ethics
Safety Training
Prevention of Infectious Disease
Military Culture
Telehealth
Pharmacy Services: Fraud, Waste & Abuse
Workplace Harassment
Cyber Security
COVID-19

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 in the beginning of the year 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. The year ended with the Therapeutic Option trainings returning to in person. 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

- Therapeutic Options trainings went back to in person classes as other trainers begin the process of transitioning back to in person as well
- Trainers were able to add First Aid/CPR classes for agency team/s
- Trainers were able to add additional TO classes to the schedule
- Training power points were updated
- 7 Therapeutic Options trainers were recertified
- 9 CPR/First Aid trainers were recertified with new material provided by the Red Cross
- Added Telehealth as a service option for providers

Goals

- Review and update all training power points
- Integrate Relias Learning Management System
- Recruit 1-2 new Therapeutic Options trainers

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 FY22 the team was a part of the agency wide initiative implementing a new electronic health record system.

Accomplishments

Last year's biggest goal for IT was to implement a new EHR. We were running against the deadline of Cerner sunsetting it's support of CCS reporting as of 7/1/22 and were faced with having to make decisions quickly on EHR selection and a very tight implementation schedule. IT have facilitated demonstrations from Cerner Behavior Health and Credible, met with CSBs that were already using Credible and received their feedback and advise. Ultimately, the EHR committee made a decision to move forward with implementing Credible EHR. This was a big task and required hard work from many people who are present here today. We have gathered required data, provided information for system configuration and participated in several weekly meetings with Credible Project group. We have learned that the "usual" Credible project implementation does not include any customizations to forms, but we have persevered in Credible providing us access to Form creation earlier in the project, and with the collaborative efforts from IT and Administration, as well as some extra helping hands from other IT groups and QA, we have created forms and custom libraries for the ISPs. We have sent out billing claims successfully to get us to the finish line. For the first time in Credible implementation history, Stephanie Beach and I have obtained three levels of Certification with Credible in a short period of time, where normally this type of access to the EHR would not have been granted until 45 days past go live. As a result of everyone's efforts, we have successfully implemented Credible by the deadline of 7/1/2022. We have received feedback from Credible that this was the smoothest go live thanks to all the hard work everyone put in getting us to that goal.

In parallel, we continued to advance security of our server infrastructure. We have moved seven physical servers from various MHDS locations to virtual servers securely located in the Western Government Center data center. We have continued with equipment refresh plan and replaced 101 laptops for staff.

Moving forward, we will be continually improving our use of Credible; we will encourage greater engagement of staff with existing tools, such as leveraging Microsoft Teams and Office 365, we will be working with Audio-Visual group on modernizing Conference room C, replace PCs in conference room H and replace another 100 laptops with updated equipment.

Goals

- Work with the new EHR workgroup to advance our use of Credible
- Implement Client Portal
- Implement Mobile app
- Create a full suite of reports

CULTURAL AWARENESS AND COMPETENCY COMMITTEE SUMMARY

The Cultural Awareness and Competency Committee (CACC) meet frequently during the year. The meetings continued to be virtual. During this time CACC also met with the strategic initiative committee for the advancement of racial and social equity, CARSE. The co-chairs of the CACC committee were also members of CARSE. CARSE met on a monthly basis and completed their strategic objectives in June 2022.

A main focus for CACC during the year was evaluating the need to re-structure the committee to include additional equity and inclusion work and recommendations from CARSE. The agency began its work on diversity and cultural awareness in the early 1990's. The first committee was formed in 1993, named, the Diversity Committee and reorganized in 2002 as the Cultural Awareness and Competency Committee and will transform again in 2022 to the Diversity, Equity and Inclusion committee. In 2023, the organization will celebrate 30 years of increasing the competency of the workforce to deliver inclusive, cultural and linguistically competent services. Our journey continues.

The agency continued the expectation that all staff participate in at least one cultural or linguistic training per year. This requirement can be fulfilled by attending a training within the agency, a training designed specifically for a unit/program, attending a training developed by the County of Henrico, Virginia State Department of Behavioral Health and Developmental Services (DBHDS) or from any other community partners. The County of Henrico also provides DEI training on their YouTube channel posted by the Department of Human Resources, Organizational Learning and Talent Development.

FY22 Training Opportunities Available to All Staff

- August 3, 2021 – International Rescue Committee, Michelle Taylor. A discussion on current events related to Afghani refugees
- August 16, 2021 – Equity Action Continuum, Virginia Center for Inclusive Communities. The interactive workshop focused on actions against and in support of inclusion and equity
- September 30, 2021 – Becoming Anti-Racist, Virginia Center for Inclusive Communities
- October 4, 2021 – Facilitating DEI conversations Intro, Virginia Center for Inclusive Communities
- October 11, 2021 – Facilitating DEI conversations II - Virginia Center for Inclusive Communities
- October 18, 2021 – Facilitating DEI conversations III - Virginia Center for Inclusive Communities
- October 25, 2021 – Facilitating DEI conversation IV - Virginia Center for Inclusive Communities
- January 12, 2022 – Cultural aspects of our community, – Michelle Johnson and Serina Gaines, HAMHDS
- January 20, 2022 – The Words of King – A Reflection of American – David Ross, HAMHDS
- February 16, 2022 – Black History Month, The misrepresentation of Black America in American History, – David Ross, HAMHDS
- February 24, 2022 – Tribute to Sidney Poitier Podcast and Discussion, Michelle Johnson, HAMHDS
- February 22, 2022 – How the history of racism has impacted Black Mental Health and Healthcare, Dr. Karen Sherry, Curator of Virginia Museum of History and Culture and co-author of Determined: The 200-year Struggle for Black Equality – sponsored by VA DBHDS
- February 28, 2022 – Healing-Centered Engagement: Storytelling & the power of Cultural reclamation of the Narrative – Chloe's Edwards, sponsored by VA DBHDS
- May 10, 2022 – Understanding and Interrupting Microaggressions, Virginia Center for Inclusive Communities

The agency celebrated Black History month with the theme of "Black Health and Wellness". Staff were invited to attend a discussion on race and health disparities in the African American community through a virtual event by the association for the study of African American Life and History, a Ted Talk on Implicit Bias with Melanie Funchess. Weekly Black History Trivia occurred with prizes facilitated by Serina Gaines. Weekly informative series "Did you Know" featuring African Americans who contributed to American history was facilitated by David Ross and Dal Williams. Staff shared recommendations of books by African American authors and documentaries throughout the month. The CACC committee also reached out to DBHDS, to partner training opportunities which occurred on February 22 and February 28, 2022.

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

For the BHE 2021 grant, the agency received $10.000, with an implementation period of June 2021 – September 2021. The goal was to examine the effects of system racism within our workforce by completing an external organizational equity assessment, comprehensively reviewing our policies and procedure through an equity lens and providing training to staff on addressing effects of systemic racism in the workplace as well as the community at large.

Accomplishments:

- Organizational equity assessment completed by Strategic Initiatives
- Review of policies and procedures through an equity lens from the Virginia Center of Inclusive Communities (VCIC)
- Trained facilitators (17), throughout the agency to lead engaging agency DEI conversations, also provided training to 45 supervisors to increase their facilitation skills and to feel more comfortable with leading DEI conversations within their teams
- Engaged in three agency safe space conversations with trained facilitators on racial events that occurred in the US
- Continued staff training through VCIC. Trainings were offered to staff on action continuum towards equity, becoming anti-racist, and workshop facilitation
- Installed DEI suggestion boxes at all agency locations to promote feedback
- Created a book nook with books on anti-racism to increase awareness
- Community focus groups occurred to gain input on the agency's DEI work

In the BHE 2022 grant, the agency received $15,000, with an implementation period of June 2022 – September 2022. This project aims to increase inclusion of the LGBTQIA+ youth population in the Richmond, Virginia area, as well as raise awareness about the specific challenges and barriers faced by queer youth and adults. The grant objectives include collaborating with several LGBTQIA+ owned and affirming organizations in the area including local mental health service providers, queer community organizations, and queer-owned businesses to provide training to staff, connect youth and families to inclusive and affirming resources in the area, and provide safe spaces and opportunities for community-building.

Planning continues for the following events in 2022:

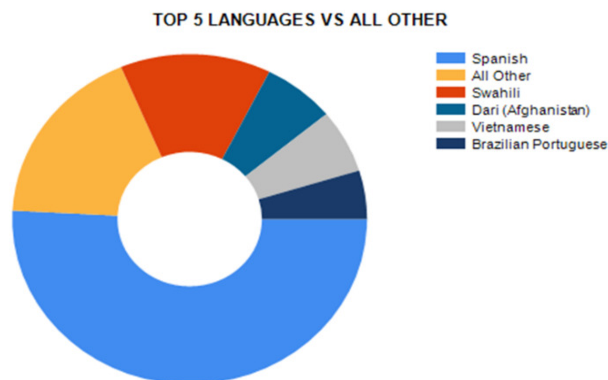
- Youth Empowerment Series – Gayton Library
- Panel discussion and Community Resource Fair – Henrico Theater
- Development of database for LGBTQ friendly providers
- Staff training
- Participation in Virginia Pridefest September 2022
- Video produced to raise awareness

The agency also responded to requests for proposals in February 2002 through DBHDS, utilizing the American Rescue Plan Act (ARPA) Mental Health Block Grant funds to increase knowledge and diversity of the workforce as it related to equity. The agency was awarded, $61,973. The implementation of this grant is through September 2025. The focus of the grant is working on staff and supervisory DEI training, and community engagement with the Latino, Asian and Afghan (newcomers) communities.

Yearly, the agency works with several community individuals and national organizations that provide interpreter and/or translation services, (about 16). This includes immediate telephonic services from Cyracom International and the United Language group. The list of interpreters and translation services includes the name, cost per hour, minimum hours and any certifications an interpreter may hold. It is updated yearly and posted on the agency SharePoint drive. The agency translates forms and documents in other languages such as Spanish, and Farsi. These forms are also posted on our SharePoint drive. The agency has electronic boards in each lobby of our outpatient sites. COVID information is posted on electronic boards in both English and Spanish. Monthly celebration information is also posted on the electronic board. Signage is also posted that persons served have a right to an interpreter. Additionally, these sites are equipped with "I Speak" language identification guides to quickly help identify languages spoken to obtain an interpreter. Below trends the amount of funds used within the agency over the last three years. There was a 33% increase in the use of language services from FY21.

Yearly amount of Interpreter and translations services paid for all HAMHDS services			
Fiscal Year	FY22	FY21	FY20
Yearly amount	$112, 475	$84, 303	$97,695

For example, the below shows the top five language accessed through CyraCom language services:



CyraCom also assisted in interpreting in the following languages, Arabic, Bambara, Bengali, Bosnian, Cambodian, Farsi, Mandarin, Nepali, Pashto (Afghanistan), Portuguese, Romanian, Thai, and Urdu.

Members of CACC participated in the agency orientations of new staff. For FY22 there were 10 agency orientations held over the 12- month period. During agency orientation historical information is shared regarding the agency's journey over the last 29 years towards providing a more inclusive, culturally, and linguistically competent services. Upcoming workshops or training events are also provided. The importance of diversity, inclusion and equity is shared with all new staff as an introduction to the culture of our agency.

Henrico Area Mental Health & Developmental Services, HAMHDS, values a diverse workforce that is representative of the person served.

FY22 Three-year Comparison

Race & Ethnicity	FY22 Persons Served	FY21 Persons Served	FY20 Persons Served	FY22 HAMHDS Employees	FY21 HAMHDS Employees	FY20 HAMHDS Employees
White/Caucasian	43%	46%	45%	48.23%	52%	52%
Black/African American	42%	41%	42%	45.24%	43%	44%
American Indian, Asian/Pacific Islander, Multi-Racial, Other	15%	13%	13%	3.0% 2.18% (other)	5%	3%
Persons served who identify themselves as Hispanic	6.07%	6.04%	5.64%	1.9%	2.5%	2%

As of 9/1/22 of the approximately 9,180 persons served, 43% self-identified as White/Caucasian, 42% Black/African American, 15% Alaskan Native, American Indian, Asian/Pacific Islander, and Multi-racial. Of all consumers served 6.07% self-identified as Latino/Hispanic.

As of 6/30/22, of the approximately 367 HAMHDS permanent employees 48.23% self-identify as White/Caucasian, 45.24% Black/African American, 3% Asian, 2.18% other, and 1.9% self-identified as Latino/Hispanic.
In May the CACC committee sponsored an agency gathering to encourage networking, support agency relationships and a staff appreciation luncheon. Human Resources also used this event to share their appreciation for our agency trainers. A subcommittee gathered (Diane Wells, Winnie Williams, Vicki Ewing, Anna Jones, Lani Hartshorn, Traci Paskins-Brower, Annmay Morant, Allison McKay, Kim James, and Yvonne Russell), to plan the event and sought feedback from the agency staff regarding a theme. The theme selected was "A Celebration of Health & Wellness". The event was held at The Springs Recreation Center, on Tuesday, May 24, 2022, from 11:00am – 2:00pm. Staff had the opportunity to select their choice a box from Apple Spice. Booths included health and wellness resources from the Virginia Cooperative Extension, Power Henrico which includes Employee Relations, Employee Health, Fitness and Wellness, and Recreation and Parks. Tables were decorated with live plants which were given away, games and other tension releasing activities. Grand prizes were available to all staff, as attendance was not required to win.

The agency would like to thank all previous members of CACC for their contributions towards strengthening our agency culture and service provision.

DEMOGRAPHICS

Total Consumers Served by Program Area

9,175 individuals were served in FY22.

For adults: 54% received Mental Health Services, 12% Developmental Disability Services and 6% Substance Use Disorders Services.

For youth: 13% received Mental Health Services, 4% Developmental Disability Services and 11% Early Intervention < 3-year olds.

Consumers Served by Gender: 57% of individuals served in were male, and 43% served were female.

Distribution by Race and Ethnicity: 44% served identified themselves as White/Caucasian, 42% Black/African American, 14% Alaskan Native, American Indian, Asian, Pacific Islander, Multi-Racial.

BUDGET

FY22 Revenues			FY22 Expenses		
State Funds	$ 10,355,258	24%	Mental Health Services	$ 19,992,705	51%
Federal Funds	$ 3,623,722	8%	Substance Use Disorder Services	$ 3,107,195	8%
Local Funds	$ 18,387,549	42%	Developmental Services	$ 13,859,217	35%
Fee Revenues	$ 11,204,727	26%	Administrative Services	$ 2,299,452	6%
Other Funds	$ 46,715	0%			
Total Revenues	$ 43,617,971		Total Expenses	$ 39,258,569	