



**HENRICO AREA
MENTAL HEALTH &
DEVELOPMENTAL SERVICES**

*SERVING THE COUNTIES
OF HENRICO, CHARLES CITY AND NEW KENT*

Annual Performance Analysis

FY11

JULY 1, 2010 - JUNE 30, 2011

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1. MANAGEMENT SUMMARY

We are pleased to present our FY2010-11 Annual Report. The Henrico Area Community Services Board and the staff of Henrico Area Mental Health & Developmental Services have worked hard to maintain a high level of service despite an economy which continues to limit resources in the face of increased demand.

For the fourth consecutive time since 2001, the Commission on Accreditation of Rehabilitation Facilities [CARF] has awarded all programs surveyed a full three year accreditation, its highest survey ranking. The CARF surveyors praised the “commitment of staff to improving the quality of life of the persons served,” and reported that the survey results clearly indicated “a pattern of practice excellence.”

We continue to focus on promoting resilience and recovery in all our programs and held two celebratory events for our consumers featuring keynote speaker Dr. Robert Gardella of the University of Virginia Health System. Both events, attended by Henrico County Manager Virgil Hazelett, were a powerful reminder that living a full life is possible despite the challenges of mental illness.

We are steadfast in our commitment to improve the outcome when people with mental disabilities interact with the criminal justice system. We have enhanced an already strong partnership with the divisions of Police and Fire, the Sheriff and the Courts. Retired Chief of Police Henry W. Stanley has been an important partner in this effort. Upon his retirement, the Board formally honored Chief Stanley for his commitment to citizens with mental disabilities and presented him with a framed resolution of commendation at its March meeting.

Obtaining quality healthcare remains a significant challenge for many of our consumers, who have limited access to primary care, poor health outcomes and shortened life expectancy. We will continue to create partnerships to improve access to basic healthcare and better outcomes for the people we serve. For the second year, the agency has been awarded a “New Lease on Life” grant to locate mental health services in two local “free clinics” serving medically indigent citizens. We look forward to the opportunity to improve our consumers’ health and well-being through Virginia’s healthcare reform efforts.

Finally, we express our appreciation to the Henrico County Board of Supervisors and the Boards of Supervisors of Charles City and New Kent counties. Because of their commitment and the work of a diverse and dedicated staff, the citizens of Henrico, Charles City and New Kent counties receive critical services that promote recovery, independence and self-sufficiency.

Karen W. Grizzard
Board Chairperson

Michael D. O’Connor, L.C.S.W.
Executive Director

2. STRATEGIC GOALS AND STRATEGIC PLANNING

Summary of Agency Strategic Initiatives

In FY11, the workgroups gathered to understand the charge to their group, identify the scope of their task, form processes that would help increase their understanding of what was needed, gathered input from staff and stakeholders, researched best processes in the field, began pilots in some cases and towards the end of the fiscal year formulated recommendations and in some cases began implementation plans for the strategic

initiatives. Regular updates were provided to Leadership Group, the HAMHDS Community Services Board, County of Henrico management and all staff through their supervisors and representatives on the workgroups. The following provides a brief summary of their work.

FY11 Strategic Initiatives

1. DEVELOP A FULLY COMPLIANT ELECTRONIC HEALTH RECORD BY 2013

HAMHDS has utilized Anasazi software as the agency's electronic health record (EHR) since 1999. Promoting the development of Anasazi functionality as the agency's electronic health record ensures secure and protected health information, improves the quality of services and reduces administrative costs. The cross functional committee identified seven areas of focus in order to meet the goal of having a fully electronic health record by 2013.

The areas identified include: mobile devices;, electronic signature pads; further development of assessment tools in Anasazi; document scanning; electronic pharmacy e-prescribing and medication administration; incremental data collection and unified treatment plans. The committee developed subcommittees to do the majority of their intensive research and work. The committee presented recommendations to Leadership Group and in some instances began implementing their recommendations in FY11. Upon approval of their proposal, the committee will prepare and implement a two-year plan to have 100% electronic health records by 2013. This strategic initiative will continue in FY12.

2. ASSURE READINESS IN ALL AREAS FOR THE IMPACT OF HEALTHCARE REFORM

The scope of the committee is to closely track the implementation of healthcare reform in Virginia. The committee's work included two emphases: work external to the agency such as working on the state level to help shape and influence health care reform in Virginia, and work internal to the agency to best prepare the organization for health care reform.

Externally, the agency played an instrumental role in working with the Virginia Association of Community Service Boards in creating the design of a member-owned managed care company. With the use of a consultant, a model similar to the Kansas model was designed and an executive summary was presented to the Department of Medical Assistance Services (DMAS).. The agency, along with three other Community Service Boards, continues to work with the State regarding healthcare reform and behavioral health, Medicaid managed care, and behavioral health and physical health integration.

Internally, the committee members continue to learn more about the possible impact of the Affordable Care Act (ACA), through a Johns Hopkins School of Public Health course on the impact of the Affordable Care Act, on County behavioral health systems, including monthly conference calls regarding ACA implementation with the main instructor and participants of Johns Hopkins course; attending a two-day seminar on integration of behavioral health and physical healthcare; and distributing and reading articles amongst committee members. The committee developed the following themes for agency planning and further research: integration with physical healthcare; specialty BH setting as a health home; accountable care organizations; alternate modes of reimbursement; relationship of prevention to health outcomes; exploration of funding for prevention; quality indicators; relationship with Federally Qualified Healthcare Centers (FQHC's) and free clinics;, Medicaid expansion;, and the impact of substance abuse equity and Medicaid expansion.

The committee provided the following recommendations: evaluate and adopt specific approaches to impact health outcomes and better link, coordinate or integrate medical care; resume face-to-face meeting of workgroup possibly adding members for this specific topic; develop methodology to estimate workload impact on administrative staff of Medicaid expansion and substance abuse equity; continue to track federal

rulemaking and Virginia's approaches to coordinated care. The committee also supports the strategic initiative to fully implement an electronic health record as important planning steps to ready the agency for healthcare reform.

This strategic initiative will continue in FY12.

3. ASSURE CONTINUED PROVISION OF HIGH QUALITY OUTCOME ORIENTED SERVICE.

The initiative identified programs where there is defined evidence-based or promising practices to ensure services are up-to-date, services are more closely linking outcomes to program decisions, supervisory development, assuring competitiveness, and evaluating any lines of business that should be discontinued. Three workgroups were initiated under this initiative: Employment Services, Time Limited Clinical Services and Long Term Clinical Services. All of the services were reviewed and assessed for any areas for potential improvement, linking of outcomes to program decisions, and making any applicable recommendations.

EMPLOYMENT SERVICES

The workgroup's goal was to reflect best practices in the field of employment. Evidenced-based practices were researched and benchmarking occurred with other agencies. The outcome of the research determined the SAMHSA tool with some modification could be used to evaluate the employment services offered within the agency and determine helpful opportunities for improvement. Cross-divisional teams administered the SAMHSA evidence-based best practice tool to evaluate individual supported employment services provided by both Adult Recovery Services and Community Support services.

The SAMHSA tool identified a few areas for improvement but services overall scored high. The group recommended targeting areas identified as needing improvement in the SAMHSA evaluation in the development of program outcomes for FY12. Additionally, a recommendation was made to initiate the planning of a bakery at Lakeside Center employing both ARS and CSS consumers. This would increase the use of existing facility resources and provide training to consumers that would translate into marketable skills. The workgroup has completed their tasks with any recommendations to be followed up as program initiatives.

TIME LIMITED SERVICES

This committee was charged with the task of reviewing all of the treatment options offered in the time - limited services programs of HAMHDS to assure for continued provision of high quality outcome-oriented services. These programs included all of Adult Outpatient Services (Brief Outpatient, Substance Abuse, and Dialectical Behavior Therapy), Emergency Services, Youth & Family Services, Jail Services, and Prevention Services. Within each program, the group examined the variety of Evidenced-Based Practices (EBP's) and promising practices that were being used. The group was able to highlight strengths and weaknesses within the clinical services offered by the agency. Initially the group discussed the options for "system change or improvement" as opposed to changes within individual programs. This highlighted the benefits of the agency moving towards a system that embraces a Trauma Informed System of Care (TISC). Given the scope of this group and that a TISC would be an agency-wide change, the decision was made to narrow the focus to the existing programs in the agency.

The group spent the remaining time analyzing the EBPs used and those that were tied to program outcomes. The group spent some time discussing how to help other programs tie their EBP to program outcomes to make them more meaningful. The group would like to see the agency as whole move more to a TISC model while acknowledging that is a very large endeavor. On a smaller scale, the group recommended that programs continue to work towards being able to link EBPs to outcomes wherever possible. Some programs

will need extra resources in order to make this happen. The workgroup has completed their tasks with any recommendations to be followed up as program initiatives.

LONG TERM CLINICAL SERVICES TO PERSONS WITH SERIOUS MENTAL ILLNESS (SMI)

The work of the committee was to engage in an extensive search of the current evidenced-based practices and best practices utilized with the SMI population and determine the appropriateness and feasibility of implementing any of these practices in our agency.

The research re-affirmed the PACT model as evidenced-based practice and the Recovery philosophy the agency has embraced. It was found that the outcomes used did not fully reflect the recovery philosophy and adopting an evidence-based practice provides tools to clearly measure effectiveness and client recovery. The team additionally noted a need to increase family involvement.

The work group recommended that all clinicians providing therapy in Case management and Assessment utilize Scott Miller's outcome rating scale (ORS) and session rating scale (SRC). It is also recommended that CM&A clinicians develop a family psycho-educational group based on the SAMHSA evidence-based practice. Additional training is required. The workgroup has completed their tasks with any recommendations to be followed up as program initiatives.

4. MEET FACILITY RELATED NEEDS OF THE AGENCY FOR THE NEXT 10 YEARS.

The workgroup focused on a number of facility challenges; this included replacing the rental space at the East Center with a county owned space and more efficiently addressing the inadequate space at Hermitage, Woodman, Providence Forge and Radford. This initiative was divided into two goals as stated and summarized below.

Goal # 1: Replace existing rental facility [East Center] and meet program and growth needs over the next 10 years.

The agency began the County of Henrico's process to obtain approval and funding for construction of an East facility with the use of Community Investment Program (CIP) funds. A feasibility and program study request was submitted to General Services in September 2009 following a CIP request for construction in September 2010. Pending approval of CIP funds, a study and general feasibility of interim rental space was submitted to meet the growing needs of the agency over the next five years. In the interim, the agency negotiated an additional 1800 square feet adjacent to the current East Center space picking up an additional eight offices.

Goal #2: More efficiently meet program needs and address inadequate space [Woodman, Radford, Providence Forge, Hermitage] and accommodate growth over the next 10 years.

The workgroup determined that capital funds are currently very limited and will be for some time and to accommodate for future growth, consolidating into larger operations creates various efficiencies through economies of scale. In September 2010 the agency submitted a CIP request to obtain a feasibility/program study to expand the Woodman road Center to accommodate case management offices at Hermitage, the office space at Radford and the future needs at Woodman. Realizing the CIP requests would be limited, a study cost and general feasibility of interim rental space to meet needs for 5 years of Hermitage Case Management, Radford SA and staff from Woodman was submitted in November 2010. As of June 2011 that agency is seeking rental space of a least 9,000 square feet to accommodate Radford, case management services at Hermitage, and some Woodman staff. Additionally the agency is negotiating space at the Providence Forge center with the owner to reconfigure office space with available rental space downstairs and relinquishing current upstairs rental space. This strategic initiative will continue in FY12.

New Strategic Initiatives for FY 12

In summary the following strategic initiatives will continue in FY12:

1. Develop a fully compliant electronic health record by 2013
2. Assure readiness in all areas for the impact of healthcare reform
3. Meet facility-related needs of the agency for the next 10 years

3. FY 11 PROGRAM INITIATIVES

MANAGEMENT

Outcomes System

- ❖ Coordinated and improved presentation of performance data to key decision makers
 - The agency Dashboard has continued to be manually produced while IS works on automating measures.

ADMINISTRATION

Financial Management

- ❖ Implemented “Going Green” or ordering “green” supplies for our facilities and group homes instead of those with chemicals
 - The use of green products has been written into the scope of work for our janitorial bids and fax quotes. Successful bidders are required to provide a green products list including brand name, purpose, and equipment and how they are to be used under the contract.

Reimbursement

- ❖ Implemented the 835 electronic format for Explanation of Benefits received from insurance companies. The billing system would automatically upload collections
 - Implemented the billing system to automatically post revenue received from Medicaid using the 835 electronic format of the Medicaid Remittance Advice.
 - Implemented SA, and Adult and Y&F Outpatient billing Medicaid Psychiatric Services, tracking/reporting revenue.

Information Services

- ❖ Migrate to Version 3 of the Assessment and Treatment Plan modules in Anasazi.
 - Migration to occur in October 2011. The upgrade includes an enhanced Clinician’s Homepage, electronic signatures and document scanning. These features move us closer to fully implementing electronic health records.
 - A committee comprised of administrative and clinical staff reviewed client electronic signature functionality and scanning capabilities. The committee ran a successful pilot for signature pads and made recommendations for purchase. The committee also evaluated several scanning possibilities and decided to incorporate FileNet, the County’s Enterprise system, as our supplemental medical record. The Information Services team is currently working with the County Information Technology Department on this project.
- ❖ Implemented the Client Notification module in Anasazi

- Client Notifications were implemented for primary programs in October of 2010, which will provide prompts on each Clinician's Homepage to complete consumer-related documentation in a timely manner.
- ❖ Developed a database to automate calculating key performance measures (such as days to first appointment) which will then upload to the Intranet in a user friendly Dashboard. Using the same technology, automate the Manager's Monthly Service report to be available on the intranet as well.
 - The automated Manager's Monthly Service report was put into production in January of 2011 and is available on the intranet..
 - A user friendly Dashboard is available on the intranet and currently contains the following reports: 60 Day No Contact; No face to face contact in 90, 100 or 180 days as appropriate for the program; Non Final Approved Assessments, Notes and Logs; MH/SA Record Review; and CSS Record Review. Additional measures are currently under development.

Facilities

- ❖ Developed a new work order process to reduce the time it takes to resolve a work order and improve status communication between the customer and Facilities
 - Developed a base line of 5 days turnaround for work orders. Areas of improvement within the facilities department were identified to include updating the work order system with accurate and detailed notes, acknowledging work orders in a timely manner within a hour of submission, and educating staff of the two-way communication tool in the work order system. Challenges were also identified that include reduced manpower in general services, scheduling challenges with 3rd party contractors, and approximately a 3 day lag time in the time work orders are being closed at One Stop and the time One Stop notifies the facilities department of the completion.

Human Resources

- ❖ Reviewed and revised all 343 job descriptions, working with the Agency's Oracle Workgroup
 - Agency's Oracle workgroup developed job entries for annual training, computer competency, customer service, leadership, and observance of work schedule.
 - Worked with agency supervisors to revise all the position classifications.
 - Worked with County Human Resources to reset all the passwords in JOSH so employees could access their job descriptions.
 - Provided training to agency supervisors

Business Support

- ❖ Formalized key quality assurance processes to ensure smooth and efficient front desk and front end activities (including Chart Tracker accuracy)
 - Processes were improved and the information in Chart Tracker has been significantly improved.
- ❖ Began to report key front desk volume statistics, show rates and reschedule rates to the Program Divisions, to maximize clinician productivity

Health Information Management

- ❖ Expanded electronic chart reviews in the Chart Tracker System to include remaining programs

CLINICAL AND PREVENTION SERVICES

Access

- ❖ Completed pilot for Access Services 20 hours/week at East Center.

Adult Substance Abuse/ Adult Mental Health Services

- ❖ Implemented reimbursement through third -party payers.

Adult Recovery Services

- ❖ Increased use of Peer Counselors; increased direct service contact, provision of WRAP groups, implementation of phone surveys to engage consumers, and implementation of Recovery Celebration.

Emergency Services

- ❖ Implemented outreach effort including joint CIT trained police officers and ESP staff to follow up with high risk individuals, providing education and consultation to nursing homes in area, and the family recourse group to aid families dealing with persons with mental illness.

Youth & Family

- ❖ Increased use of evidence-based practices; initiated MyOutcomes to track engagement and treatment outcomes, and contracted with a Motivational Interviewing consultant for advanced MI training and support of existing MI supervision group.
- ❖ Contracted with DMAS to provide assessments for State Plan Option Services (VICAP).

COMMUNITY SUPPORT SERVICES

Residential Services

- ❖ Completed change from live-in to 24 hour model on December 1, 2010
 - Gentlemen from the former Walton Farms Family Care home moved into Green Run (1 individual) and Sherbrooke (2 individuals).

Parent Infant Program

- ❖ Implemented System Transformation
 - The Medicaid transformation was successful. PIP continues to work on improving the current system around new processes that were developed due to the System Transformation, timeliness of services, accuracy of documentation, and increasing the child count.

Case Management Services

- ❖ Completed implementation of SIS and PCP
 - All individuals receiving ID or DS Waiver have Person Centered Plans.
 - Individuals not receiving Waiver funding but receiving Active Case Management have Personal Profiles as required.

- All individuals receiving ID or DS Waiver have had SIS evaluations or are scheduled for evaluations this year which completes the first 3 years.
- SIS interviewers have either done or have scheduled SIS evaluations for all children receiving ID or DS Waiver funding.

4. AGENCY OUTCOMES AND PERFORMANCE IMPROVEMENT MEASURES

ADMINISTRATION

Outcomes

Efficiency Objective: 93% of SA walk-in clients will receive a financial on the day they walk-in

Results: 99%

Analysis/ Action Taken: Financial staff consistently provided a financial to all clients that were opened to the agency during SA Walk-in. The Objective was 93% and financial staff achieved 99%.

Performance Improvement: In reviewing financials for SA Walk-in for the year, it was determined that while financials are being performed, complete information is on occasion not available from the client (i.e., insurance info, proof of income, etc). Reimbursement will be addressing how to best identify and capture this information in a timely manner in the coming year.

Efficiency Objective: 95% of openings, closings and transfers will be accurate in Chart Tracker

Results: 84%

Analysis/ Action Taken: It was recognized that there were problems with the accuracy of data within Chart Tracker. For that reason a goal was set to achieve an accuracy rate of 95% for all Chart Tracker changes. To identify errors, supervisors ran monthly reports from Anasazi for openings, closings, server updates, and transfers-in. Supervisors then checked Chart Tracker to see if the information in chart tracker reflected the changes made in Anasazi assignments over the past month. A June 2010 report/CT comparison was used as a baseline. For June 2010 there was an accuracy rate of 84%. The goal was to improve accuracy by 11% (to a 95% accuracy rate), but this was unfortunately not met. While there were improvements at times during the year, overall by the end of the 4th quarter the accuracy rate remained the same as our baseline, 84%.

Performance Improvement: This outcome will continue for FY12.

Objectives for the Coming Year

Effectiveness Objective: 88% of the time Financials are entered in Anasazi within 0-1 days of the due date; 7% of the time Financials are entered in Anasazi within 2-10 days of the due date; 5% of the time Financials are entered in Anasazi within 11-30 days of the due date; 0% of the times Financials are entered in Anasazi within 30 days or more of the due date.

Efficiency Objective: 95% of openings, closing, transfers will be accurate in Chart Tracker.

CLINICAL AND PREVENTION SERVICES

Youth and Family

Outcomes

Effectiveness Objective: With use of My Outcomes (SRS/ORS/CORS), staff participating in pilot will address their client's needs appropriately as evidenced by a 10% decrease in no-show/cancellation rates.

Results: 28.13%

Analysis/ Action Taken: During 2010-2011, Youth and Family Services implemented the use of Client Directed Outcome Informed (CDOI) treatment through the use of MyOutcomes. MyOutcomes is a web-based software system that allows clients to self administer the Outcome Rating Scale (ORS/CORS) and the Session Rating Scale (SRS). These two measures provide feedback to the clinician regarding the client's self report of problems and perceptions of the therapeutic relationship. With use of My Outcomes (SRS/ORS/CORS), staff participating in pilot addressed their client's needs appropriately as evidenced by a 2.5% decrease in no-show/cancellation rates. The goal was to decrease no show/cancellation rates by 10%. Although the goal was not met, clinician staff became more aware of factors that indirectly impact the therapeutic relationship. Clinicians in the pilot attempted to address ORS/SRS in each session, but shared that many times the clients would not provide feedback that was consistent with the results. For example, clinicians reported the client would state, "I liked the session, I don't think you can change anything" when the SRS score was below the clinical cutoff. Clinicians also shared that many clients reviewed their problems not as severe as parents or referral sources. Parental support and engagement in treatment seemed to be a large indicator for Youth and Family Services as to whether the child/adolescent would consistently attend services. When ORS/SRS scores were collected, a decrease in no show/cancellation rates was more evident. This is noticed specifically between third and fourth quarter results.

Performance Improvement: The ORS/SRS and MyOutcomes will remain an outcome measure for the upcoming year. No show/cancellation rates will not be measured, instead pre-treatment scores will be compared to post treatment scores.

Efficiency Objective: There will be a 10% increase in percentage of clients reaching services targets (ORS) following the implementation of My Outcomes.

Results: 73.3%

Analysis/ Action Taken: Following staff training in November 2010, MyOutcomes was implemented throughout Y & F with pilot clinicians on December 1, 2010. Results of this year are based on 13 staff entering data into MyOutcomes. These clinicians had a total of 232 active cases and 88 inactive cases (inactive=no longer participating in services). The overall percentage of cases reaching service targets on ORS (score above 24) was 73.3%. The baseline results indicated that 66.7% of clients met service limits during the first quarter. Youth and

Family Services set a goal to demonstrate a 10% increase in percentage of clients reaching services targets (ORS) following the implementation of MyOutcomes. Although a 10% increase was not obtained, 6.6% increase was noted. Implementation of MyOutcomes is an elaborate process. Due to this impacting the delivery of clinical services, buy-in from staff is critical. This process also must be addressed on a routine basis in order to help staff work through areas of concern and question. Staff continued through the pilot to express shortcomings of the use of these measures with children and adolescents based on lack of feedback. Children and adolescents present in treatment very similar to court-ordered cases, in which they are often made to attend sessions by parents or other concerned adults. Toward the end of the year, clinicians were able to use the MyOutcomes to validate some of their treatment recommendations, this was particularly the case in adolescent services.

Performance Improvement: Progress on the Child & Family Services team was slowed by the extended vacancy in the Clinical Supervisor position, and this will be a focus of clinical supervision and team meetings on the Child & Family Team under the leadership of the new Clinical Supervisor, who comes with experience in using MyOutcomes to guide clinical practice.

Effectiveness Objective: Child and Family Team In-Home Clinicians will address their clients' needs appropriately and more effectively as evidenced by 10% increase in overall scores on Case Discharge/Outcomes Form completed on each family at discharge. Correlation between successful outcomes on Case Discharge/Outcomes Form and CORS scores will also be examined during this year in order to establish baseline for successful graduation.

Results: 83.33%

Analysis/ Action Taken: This year 21 Case Discharge/Outcome Forms were collected with an average score of 83.33%. This is a significant improvement from FY2010's baseline of 67.1%. Of the 21 cases, 3 cases were discharged early into residential facilities and were not able to be maintained in the home (86%). 66.7% reported an increase in parenting skills, 73.3% improved family relations, 80% school attendance, 83.3% behavioral referrals at school, 80% success at school, 70% increased network of support and 66.7% increase in prosocial activities. The low reported increase in parenting skills will prompt the program to look at strengthening the family therapy and parenting education. With lower numbers in network of support and increase in prosocial activities, it will be important for the program to look at assisting clients and families in identifying resources and activities to increase their overall success.

Performance Improvement: This program will also be looking at the ORS data more closely in looking at outcomes of treatment services.

Access Objective: Adolescent non crisis consumers will be seen within 10 business days of initial attempt to access services.

Results: 9.61 days average

Analysis/ Action Taken: FY 11 proved that Adolescent Services was capable of meeting the demand that non-crisis consumers will be seen within 10 business days of initial attempt to

access services. Adolescent Services was able to meet this demand in 9.61 days. The East Center was limited to one clinical staff and one supervisor meeting the demand for 11 out of the 12 months for this fiscal year. East Center's vacancy greatly impacted the wait time for clients in the third quarter. This is often a high demand time for Adolescent Services. Woodman Road clinicians were able to meet the demand for service within 8.28 days and East Center clinician was able to meet the demand in 10.93 days. Clinical staff were also available to take cases when urgent care was needed.

Performance Improvement: In the upcoming fiscal year, the East Center will have two full-time clinicians to address the demand for services.

Access Objective: MST therapists will see the client and family no later than 5 days after the first appointment.

Results: 1.13 days

Analysis/ Action Taken: The MST program has been able to meet its Access goal that the MST therapists will see the client and family no later than 5 days after the first appointment. The baseline rate was recorded as 1.5 days to second appointment. Each quarter, the MST program was able to meet the 5 days to second appointment. Contributors to the continued meeting of this goal include that most families are court-ordered to treatment, the service is home-based, high therapist adherence to the evidence-based model and continued high engagement with the client and family. The MST therapists have remained well above the target adherence rate (61%) and have averaged individual adherence to the evidence-based model at 83% for this quarter.

Performance Improvement: Continue to monitor.

Access Objective: Child and Family non crisis consumers will be seen within 10 business days of initial attempt to access services.

Results: 9.89 average days

Analysis/ Action Taken: The Child and Family Team met the goal of seeing non-crisis consumers within 10 business days of the initial attempt to access services. The average number of days for clients to be seen by the Child and Family Services team for FY2011 is 9.89 days which is an increase from 2010's 8.3 business days. The Child and Family Team is committed to continuing to keep the number of days to access services low for non-crisis consumers. One factor in the increase in number of days from last fiscal year is an absence of a supervisor causing a decrease in the number of intake slots for the 2nd, 3rd and 4th quarter. Staff leave time has also impacted the number of days before the initial contact.

Performance Improvement: The team will continue to strive to meet the goal for FY2012.

Objectives for the Coming Year

Effectiveness Objective: Youth & Family Services Outpatient and In-home Clinicians will address their clients' needs appropriately and more effectively as evidenced by a minimum of a .03 positive effect size on cases discharged from services.

Access Objective: Child and Family non-crisis consumers will be seen within 10 business days of initial attempt to access services.

Access Objective: Adolescent non-crisis consumers will be seen within 10 business days of initial attempt to access services.

Adult Substance Abuse

Outcomes

Effectiveness Objective: 10% of clients will show change on at least one NOMS data element during each treatment episode from July 1, 2010 to June 30, 2011

Results: 17% of sample showed change for the year

Analysis/ Action Taken: A baseline has been established for the year of 17% rate of change for NOMS data elements. This means that 83% of the data did not change or was not updated. Some in-depth analysis was done on quarters 2-4 to see whether the change that was reported was positive or negative. A brief summary of the data is of the four elements looked at shows: Residence: positive change; Employment: slightly positive change; Arrests: neutral; Use of primary drug: slightly positive.

Performance Improvement: This data will be shared with staff to get feedback regarding how the process of collecting and updating this data at admission and discharge may be improved to get the most accurate data possible. It will also be discussed in terms of the importance of demonstrating the impact of our services on clients on these nationally recognized data elements which will be important as we move further into a managed care environment.

Access Objective: 85% of clients admitted to the program will be seen within 5 days for the next available appointment following the initial walk-in intake

Results: 7.43 days average

Recommendations/ Action Taken: The average days until next appointment following walk in was 7.43 for the year. We were clearly impacted by being down one staff for part of this year. In addition, there were higher than average numbers of clients that presented for walk-in during the end of the first quarter and beginning of the second quarter which impacted the number of appointments available for follow up contacts.

Performance Improvement: We will be looking at adjusting our access goal for next year based on these results as well as a survey of industry standards for follow up appointments. We will likely adjust this to 10 days in which case we will exceed our goal if wait times remain the same as this year.

Objectives for the Coming Year

Effectiveness Objective: The successful completion rate of women completing adult substance abuse program will increase by 10% over baseline.

Effectiveness Objective: Clients admitted to RAP groups will report a 10% increase in skills and knowledge related to recovery of substance disorders.

Effectiveness Objective: 10% of clients will show change on at least one NOMS data element during each treatment episode from July 1, 2010 to June 30, 2011.

Access Objective: 85% of clients admitted to the program will be seen within 10 days for the next available appointment following the walk in intake.

Adult Mental Health

Outcomes

Effectiveness Objective: Staff will engage clients and address their needs appropriately as evidenced by an increase in planned discharges.

Results: 33%

Recommendations/ Action Taken: At the start of FY 2011, the adult outpatient mental health team lost more than one FTE due to a restructure of the Clinical and Prevention unit. In addition, a vacant MH OP clinician position in the East was converted to a position dedicated to completing court evaluations. While the demand for MH OP Adult services remains high, the resources at this agency shrunk more than 50% at the start of this year. As a result, case loads of the current clinicians have skyrocketed. It seems likely that the changes in the team providing these services have impacted the ability of clinicians to plan consistently and effectively for discharge with clients whom they have served over this last year.

Performance Improvement: The front door to MH OP services as well as the population to be served is being evaluated. The program managers for Emergency Services, Access, and MH OP will work together to propose a plan that will address both clinical effectiveness and efficiency. Once the plan is approved, changes will be implemented by the end of FY2012.

Effectiveness Objective: Clients will benefit from brief therapy as evidenced by increased GAF scores at the time of discharge.

Results: 63%

Recommendations/ Action Taken: Based on a comparison of GAF scores from the last fiscal year (63% yearly average) and this fiscal year (63% yearly average), there has been no change in the number of clients who, according to GAF score increases at discharge, appear to benefit from outpatient services. Given the many changes that occurred in the Adult MH OP program at the beginning of FY2011, it is remarkable that 63% of clients continued to show improvement from treatment received. While these results show the majority of clients are improving, the GAF score is a very subjective measure.

Performance Improvement: The MH OP clinicians will be trained in and begin using the ORS/SRS during the first half of FY 2012 in order to gain a more meaningful understanding of how services offered are benefitting clients served.

Access Objective: A client will have an initial appointment within five days of requesting services.

Results: 13.79 days average

Recommendations/ Action Taken: A years worth of data has established the current wait time for outpatient services to be almost 14 business days or three weeks before first appointment is offered. This length of time is thought to contribute to the high no show rate at first appointment and negatively impacts client services and clinician efficiency.

Performance Improvement: As stated above, the front door to MH OP services will be evaluated and recommendations for changes made geared towards getting clients into services more quickly and better managing clinician caseloads to improve effectiveness such as coordinating planned discharges.

Objectives for the Coming Year

Effectiveness Objective: 75% of consumers will show an improvement on at least one of the four domains on the ORS by the close of treatment.

Effectiveness Objective: Clients will be scheduled for an initial intake appointment within ten business days of the first request for services

Charles City/ New Kent

Outcomes

Access Objective: All clients will be seen for Initial assessment within 5 Business days.

Results: 8.44 average days

Recommendations/ Action Taken: The high number of client referrals and the limited number of staff in the office have made it difficult to meet the goal of seeing clients within 5 days of contacting the agency. This difficulty has persisted in spite of considerable effort by the clinical staff and the supervisor to see clients quickly.

Performance Improvement: In light of these difficulties, it has been determined that a more realistic goal will be to see clients within 10 days of their contact with the agency. This will be set as a program outcome for the upcoming fiscal year.

Objectives for the Coming Year

Access Objective: Clients will be seen for initial appointment within 10 days of contacting Access

Effectiveness Objective: Staff will engage clients and address their needs appropriately as evidenced by an increase in planned discharges.

Dialectical Behavior Therapy (DBT)

Outcomes

Effectiveness Objective: Clients will show a reduction in the use of inpatient hospitalizations by the end of their treatment year

Results: Total of 3 hospital admissions for a total of 9 hospital days

Recommendations/ Action Taken: Overall we are pleased with this outcome. The original group of clients that were tracked for the year showed an overall decrease in the use of

hospitalizations. In the entire year there were only 3 admissions for these clients. We have achieved our desired objective for this outcome.

Performance Improvement: Our goal is to demonstrate similar results next year by showing a decrease in hospitalizations.

Effectiveness Objective: Clients will report a reduction in the number of times they engage in SH behaviors by the end of their treatment year.

Results: 29 reported acts of SH for the entire year.

Recommendations/ Action Taken: There were 10 reported acts of SH in the first quarter and 4 in the fourth. All clients who reported engaging in SH showed a decrease and/or elimination of SH by the end of the year. We are very pleased with this result and have achieved our desired objective.

Performance Improvement: Our goal is to demonstrate similar results next year by showing a decrease in the reported acts of self-harm behaviors.

Effectiveness Objective: Clients will show a reduction in the reported number of suicide attempts by the end of their treatment year.

Results: 1 reported suicide attempt during the year.

Recommendations/ Action Taken: For the entire year there was only one reported suicide attempt among the clients tracked for outcomes. We are very pleased with this result given the high risk of suicide among the population receiving this form of treatment. We achieved our objective for this outcome.

Performance Improvement: Our goal is to demonstrate similar results next year by showing a decrease in number of reported suicide attempts.

Effectiveness Objective: The intensity of symptoms identified on the Borderline Symptom List 23 (BSL-23) will show a reduction each quarter.

Results: Overall reduction in BSL scores over the year.

Recommendations/ Action Taken: Our objective was to show a reduction in BSL scores each quarter. Second quarter showed a peak, but third and fourth quarters were a decrease from the first quarter. Overall we are pleased with this result and the decrease in reported symptoms experienced by clients in the program. We have achieved our objective for this outcome.

Performance Improvement: Our goal is to demonstrate similar results next year by showing a decrease in reduction in the intensity of symptoms reported on the BSL-23.

Access Objective: : DBT staff will contact clients within 5 business days of assigning the referral in DBT Team Consultation meeting to schedule the first commitment session.

Results: Average .91 days

Recommendations/ Action Taken: The objective for this outcome was to contact clients within 5 business days of assigning the referral. We exceeded our expectations with this objective and continue to demonstrate timely response and prompt start of services.

Performance Improvement: Our Access objective for next year will be changing slightly in an attempt to provide a more meaningful and useful outcome.

Objectives for the Coming Year

Effectiveness Objective: Clients will show a reduction in the use of inpatient hospitalizations by the end of their treatment year.

Effectiveness Objective: Clients will report a reduction in the number of times they engage in SH behaviors by the end of their treatment year.

Effectiveness Objective: Clients will show a reduction in the reported number of suicide attempts by the end of their treatment year.

Effectiveness Objective: The intensity of symptoms identified on the Borderline Symptom List 23 (BSL-23) will show a reduction each quarter.

Access Objective: DBT staff will contact clients within 5 business days of assigning the referral in DBT Team Consultation meeting to schedule the first commitment session.

Emergency Services

Outcomes

Efficiency Objective: ESP will respond to request for face-to-face assessment within one hour 100% of the time.

Results: 97%

Recommendations/ Action Taken: This outcome is a requirement from the State Department and is defined in the performance contract with the CSB. It will be a required outcome for next year. The information continues to prove useful to demonstrate to police and other agencies that the ESP response time is approximately 30 minutes for emergency field evaluations. It also indicates that our consumers are receiving prompt attention. Police and Hospitals are often frustrated by the length of time it takes to obtain a TDO. This data clarifies that this time is a result of negotiating for a hospital bed.

Performance Improvement: Continue to track and report as required.

Efficiency Objective: Persons not open the agency hospitalized through the civil involuntary admissions will attend a non emergency discharge appointment within 7 days of their discharge 75% of the time

Results: 69%

Recommendations/ Action Taken: There has been a slight increase in the percentage of persons attending within 7 days from the previous year (2010-66% 2011-69%) During the fiscal year 2012 ESP has a peer counselor who is working with ESP staff. The plan is use this

position to do increased engagement with persons leaving the hospital and those who are in community in need of services.

Performance Improvement: This is a required outcome for the state performance contract and will be continued next year.

Objectives for the Coming Year

Effectiveness Objective: ESP will respond to request for face to face assessment within one hour 100% of the time

Effectiveness Objective: ESP clinicians will document consideration of preference/choice on prescreenings resulting in hospitalization 80% of the time

Access Objective: Persons not open the agency hospitalized through the civil involuntary admissions will attend a non emergency discharge appointment within 7 days of their discharge 75% of the time

Lakeside Center

Outcomes

Effectiveness Objective: Ten consumers will participate in a WRAP group and complete their own Wellness Recovery Action Plan.

Results: 9

Recommendations/ Action Taken: A WRAP group of ten consumers began in the first quarter and continued into the second quarter. A total of nine consumers were successful in completing their WRAP plan. Although we were one short of the targeted goal, it was the largest number of consumers that were successful in participating in the twelve week group. An anticipated second WRAP group did not occur this year due to the hiring of a new clinical supervisor and loss of a case manager in the latter two quarters.

Performance Improvement: This outcome measure will be discontinued for FY12

Effectiveness Objective: Over the course of the year, there will be a decrease in the percentage rate of those who drop-out of the program (consumers closed to the program due to lack of attendance for 2 months or longer despite outreach efforts).

Results: 25%

Recommendations/ Action Taken: For FY11, thirty-six members were discharged from the program. Nine of the thirty-six discharges (25%) were drop outs from the program despite outreach efforts. During the first quarter, a survey was developed to explore reasons why the individual stopped attending the program, in order to initiate improvements that would decrease the drop out rate. Of the nine drop outs this year, we were successful with obtaining the feedback from only three of them. Due to the lack of specifics provided, the information received did not prove to be of value.

Performance Improvement: An emphasis will be placed on future efforts to obtain responses and obtain useful feedback in an ongoing effort to decrease the drop-out rate.

Efficiency Objective: There will be improved coordination of care with other providers as evidenced by a score of 95% on the record review.

Results: 54%

Recommendations/ Action Taken: For FY11, the average score on the LSC record review was 54%. Although we did not meet our goal, consistent improvements in this area were noted over the course of the year. In the prior year, we were not consistently coordinating care which had a negative impact on our current reviews. With this being a current and ongoing priority, our fourth quarter coordination rate of 75% should prove to be more representative of future consumer records under a two year review and it is anticipated that the coordination rate will continue to increase.

Performance Improvement: Continue to monitor

Access Objective: Clients will be offered orientation to LSC within 15 days from receipt of the referral.

Results: Average 14.38 days

Recommendations/ Action Taken: For FY11, the goal of offering LSC orientation within 15 days was met, with the average wait time being 14.38 days. High daily attendance in the first quarter resulted in a wait time of over twice of our average for the year. In order to meet the demand, admissions needed to be staggered.

Performance Improvement: In FY12, due to some reporting changes, this objective will be modified. Additional staff will be allocated to the process to better enhance access to services.

Objectives for the Coming Year

Effectiveness Objective: There will be a 25% decrease in the drop-out rate (consumers closed to the program due to lack of attendance for 2 months or longer despite outreach efforts).

Efficiency Objective: There will be improved coordination of care with other providers as evidenced by a score of 95% on the record review.

Access Objective: Clients will be admitted to LSC within 30 days from receipt of the referral

MH Case Management

Outcomes

Effectiveness Objective: 90% of clients will rate their initial engagement with the case manager/clinician favorably.

Results: 94%

Recommendations/ Action Taken: Overall clients rated their intake experience with the case manager extremely high. Clients felt heard, respected and expressed that they had adequate time to share what they hoped to during their initial appointment. This result speaks volumes about staff's ability to build rapport and make their clients feel welcomed.

Performance Improvement: Since this measurement demonstrated a positive outcome, the unit will not continue to measure this. However, peer counselors will continue to contact clients after their intake to talk further about services.

Efficiency Objective: **Compliance with completing paperwork with newly opened clients will improve by 15%.**

Results: 6% improvement

Recommendations/ Action Taken: Staff demonstrated a 6% improvement in completing paperwork with newly opened clients. While this result doesn't meet the objective, it does show that staff are paying more attention and efforts at improving compliance are proving worthwhile.

Performance Improvement: Compliance with completing paperwork continues to be important and will continue to be emphasized. Due to the upward trend for paperwork completion, documentation will be measured and reported via the agency chart review process and not reported out as an outcome measure in the upcoming year.

Access Objective: 30% of clients missing their intake appointment will be successfully outreached and result in intake

Results: 8%

Recommendations/ Action Taken: Unfortunately, multiple outreach attempts to potential clients missing their intake appointments have not proven to be statistically significant. Only 8% of those outreached resulted in the client completing an intake appointment.

Performance Improvement: Based on results from the last two years, the CM&A unit is changing the procedure for outreaching clients and focusing more attention on working jointly with ESP to outreach potential clients identified through our emergency services program.

Objectives for the Coming Year

Effectiveness Objective: 15% of all client discharges will demonstrate graduation from case management services

Efficiency Objective: 10% of CM&A clients will participate in a recovery orientated group (DBT skills, WRAP, family psycho educational, DD etc)

Access Objective: At least 4.4% of CM&A clients will receive therapy from CM&A staff. This doubles the number of clients receiving this service currently.

Access Objective: Non-crisis consumers will be seen within 5 business days of initial attempt to access services

MH Vocational Services

Outcomes

Effectiveness Objective: Twenty-four (24) additional assigned program participants will become employed during the evaluation period

Results: 28

Recommendations/ Action Taken: The goal of 24 new jobs was achieved for the year. This was a result of client job readiness. The current intake process meets with interested persons in a timely manner and serves as a “gauge” to assess current status.

Performance Improvement: We will continue to search for jobs in the community and to encourage clients to be active participants in the job search process.

Efficiency Objective: LTMV Vocational Program staff will meet 40% productivity.

Results: 41%

Recommendations/ Action Taken: Throughout the majority of the year the vocational staff met its productivity objective of 40%, with the exception of the fourth quarter when staff fell slightly below its target at 36%. Staff vacation and client cancellations played a part in this result. The third quarter result did not impact the annual result, which slightly exceeded the objective at 41%.

Performance Improvement: The productivity goal is increased for the upcoming year. Staff is encouraged to turn in weekly logs & look at ways of spending more time in the community job developing with clients.

Efficiency Objective: Increase the number of participants that have received employment services by 30.

Results: 25

Recommendations/ Action Taken: The goal of adding 30 new participants was not reached for the year. The 3rd quarter yielded very small numbers. This was due to cold weather and transportation issues.

Performance Improvement: The team will work more closely with referred clients and case managers to improve program inclusiveness for the upcoming year.

Access Objective: 95% of persons referred will be contacted within five business days of receiving referral.

Results: 2.74 average days

Recommendations/ Action Taken: This objective was met for the year. The 1st quarter was relatively high, as several of the referrals were difficult to contact. But the remaining quarters seemed to be more indicative of the time of contact.

Performance Improvement: The vocational team will continue to contact individuals as soon as possible regarding information & intake process.

Objectives for the Coming Year

Effectiveness Objective: Twenty-four (24) additional assigned program participants will become employed during the evaluation period.

Efficiency Objective: LTMI Vocational Program staff will meet 45% productivity.

Access Objective: Increase the number of participants that have received employment services by 30.

Access Objective: 95% of persons referred will be contacted within five business days of receiving referral.

MH PACT

Outcomes

Effectiveness Objective: New referrals to PACT services will experience a decrease in the number of hospitalizations during their first year of PACT services as compared to the year immediately prior to their receiving PACT services.

Results: East PACT – 11 new admissions in the past year. 3 of those have had no admissions since coming to PACT. 5 have had one admission. 1 person has had 2 admissions, one has had 4 admissions, and one has had 6 admissions since coming to PACT. West PACT –5 new admissions in the past year. All of these clients have had hospital admissions since being admitted to PACT services. One client had 3 admissions and all of the other clients have had one admission each.

Recommendations/ Action Taken: East PACT – 11 new admissions in the past year. 3 of those have had no admissions since coming to PACT. 5 have had one admission. 1 person has had 2 admissions, one has had 4 admissions, and one has had 6 admissions since coming to PACT. Woodman PACT— 5 new admissions in the past year. One of those had 3 admissions since coming to PACT. Four clients had one admission each.

Performance Improvement: Complete information on this objective will not be available until one full year following the date of admission of the last PACT client of the fiscal year.

Efficiency Objective: The seven-part PACT Assessments will be completed within 6 months on all new referrals accepted into PACT services.

Results: 7% completed all seven parts

Recommendations/ Action Taken: Due in large part to the difficulty in completing the seven-part PACT assessments, the assessments themselves have been redesigned to be less redundant, less offensive to newly referred clients, and more efficiently completed by PACT staff.

Performance Improvement: Redesign assessment

Access Objective: Consumers referred for PACT services through the LTMI Supervisors' Group will be seen, on average, within 7 days of acceptance into PACT services.

Results: 6 days

Recommendations/ Action Taken: On average, new referrals to the PACT teams are seen approximately 6 days from the date their referrals are received by the PACT team staff. This short turnaround is very necessary in order to quickly get appropriate, intensive services delivered quickly to persons in need of them.

Performance Improvement: Continue to monitor

Objectives for the Coming Year

Effectiveness Objective: New referrals to PACT services will experience a decrease in the number of hospitalizations during their first year of PACT services as compared to the year immediately prior to their receiving PACT services.

Efficiency Objective: The seven-part PACT Assessments will be completed within 6 months on all new referrals accepted into PACT services.

Access Objective: Consumers referred for PACT services through the LTMI Supervisors' Group will be seen, on average, within 7 days of acceptance into PACT services.

MH Residential

Outcomes

Effectiveness Objective: 70% of consumers will maintain or experience an increase in four areas of independent living

Results: 58.92%

Recommendations/ Action Taken: The results of this objective have varied greatly throughout the year from under 30% to 100% with an annual result of just under 60%. There were several factors that impacted the program not meeting this objective. Several residents had various psychiatric symptoms that had a negative impact on their ability to perform tasks of independent living without further assistance from staff. One resident had significant psychiatric/behavioral issues that created conflict within the home and resulted in his discharge from the program. Despite these issues, staff worked diligently with the residents to assist them in becoming more independent. The population served in this program requires intensive services and their psychiatric illness fluctuates.

Performance Improvement: While this objective will be discontinued, staff will continue to work with them to improve skills of daily living.

Efficiency Objective: 85% of Consumers will independently complete weekly pillbox with 75% accuracy within 3-months of admission to program and 90% accuracy thereafter.

Results: 61.9%

Recommendations/ Action Taken: While the objective of having 85% of consumers independently complete their pill box with 90% accuracy was not met, improvement was shown and/or maintained throughout the year. The goal of 90% may have been idealistic in view of the population served in the MH Residential Services. The consumers/residents served in this program require 24 hour supervision.

Performance Improvement: While this objective will not be continued, ongoing efforts will be made to improve the residents' skill/knowledge of medication taken and accurately fill their pill boxes.

Access Objective: Vacancies in the program will be offered and accepted within 30 days of receipt of referral.

Results: 36 days

Recommendations/ Action Taken: The program had one vacancy for the year and while successful in filling the vacancy, we did not meet the objective of having it filled within 30 days. This vacancy was filled within 36 days. There were several interested applicants. Each applicant was seen and assessed for the program, contributing to the time it took to fill the vacancy. Future efforts will be made to shorten the time between vacancies.

Performance Improvement: This objective is being modified for the upcoming year.

Objectives for the Coming Year

Effectiveness Objective: 80% of residents will report an increase in 3/5 survey areas which measures the quality of relationships among the residents in the home

Efficiency Objective: There will be improved active client involvement in developing and reviewing treatment goals and objectives as evidenced by a score of 80% on the record review

Access Objective: Vacancies in the program will be offered and accepted within 45 days from the date a resident vacates the home to the move-in date of a new resident

MH Support Services

Outcomes

Effectiveness Objective: The residents of the support homes will attend the recovery classes at least 85% of the time.

Results: 90.7%

Recommendations/ Action Taken: Attendance rates ranged from 85% to 100%. This objective was achieved for three of four quarters since no groups were offered in the fourth quarter. The average attendance rate for the year was 90.7% which was a significant improvement from the previous year's result which was 85.25%.

Performance Improvement: Based on this goal having been achieved two years in a row, this goal is being discontinued.

Efficiency Objective: MHSS staff will collaborate and then document monthly notes regarding coordinating care with case managers 75% of the time.

Results: 55.5%

Recommendations/ Action Taken: Although gains were made every quarter, the goal of achieving 75% compliance with monthly collateral contacts was not achieved, and thus was not achieved for the year.

Performance Improvement: This outcome will again be measured in an effort to enhance compliance. MHSS supervisor will continue to send out monthly reminders to MHSS staff to complete monthly collateral contacts, and MHSS supervisor will address in supervision with staff who routinely are not completing their monthly contacts.

Access Objective: MHSS will open 8 consumers each quarter.

Results: 5.75

Recommendations/ Action Taken: MHSS opened 23 consumers over the course of this fiscal year which did not achieve our target of 32 consumers, and which is 7 less consumers that MHSS opened in the previous fiscal year which was 30. One possible explanation is the fact that only two consumers were opened in the months of March, April, & May which was in a large part due to a staff person being out on FMLA for 13 weeks. MHSS was unable to open consumers since the rest of the team had to take on additional consumers due to a staff member's extended absence.

Performance Improvement: This access objective is being discontinued in favor of collecting more meaningful data.

Objectives for the Coming Year

Effectiveness Objective: 10% of consumers currently enrolled in MHSS will be discharged successfully in the next year

Efficiency Objective: MHSS staff will document monthly collateral contacts with case managers 90% of time

Access Objective: MHSS will open 90% of consumers within 30 days of case manager being notified of opening

Prevention

Outcomes

Effectiveness Objective: 95% of CONNECT participants shall be on reading level or above by 3rd grade.

Results: 95.5 %

Recommendations/ Action Taken: The annual outcome goal for 3rd graders was met. Reading skills remain a priority within the Connect Program. Building good reading skills is an essential component of the Connect program since research shows that reading skills are a predictor of later success in school and life. All of the 5 Connect programs participate in the Henrico Bookmobile Reading Program and give attention to reading in daily programming. This year, all of the 3rd graders who remained in the Connect program throughout the school year are reading on or above grade level. Over the past few years there has been a significant increase in early elementary youth enrollment (K-2), thus affording the Connect program the opportunity to have an even greater impact on these youths academic preparedness.

Performance Improvement: The program objective for school year 2011-12 is to focus resources on supporting the development of early reading skills in the 1-3 grade population. We will be working with our community partners (i.e., teachers, AmeriCorps and other university resources, Henrico Bookmobile) to address this objective.

Effectiveness Objective: Students will show a decrease in favorable attitudes towards Alcohol, Tobacco and other Drugs (ATOD) as demonstrated by the evaluation outcomes of evidence-based curriculums implemented in the community.

Results: Pre = 64; Post = 51

Recommendations/ Action Taken: Prevention has the capability to track individual and site outcomes longitudinally, allowing for monitoring of trends in the data and adjustments in programming. A comparable number of Connect youth participated in the evidence-based curriculums during FY10 and FY11. However, this year's outcomes were more consistently positive across all 3 evidence-based curriculums. These outcomes ((90% unfavorable responses to alcohol, tobacco and other drug use) are encouraging for this group of youth who often experience many risk factors and fewer protective factors in their immediate environments. Those youth showing higher risk factors by their responses and/or behavior can be identified early and given additional supportive resources.

Performance Improvement: Each program has resources (i.e. interns, teacher or other community volunteers) who will be working closely with Connect participants showing higher risk factors as evidenced by academic performance, behavior or social factors. Prevention staff are engaging area sororities and fraternities in dialogue regarding mentorship of Connect youth. Identification and referral for additional MH services is conducted by Prevention staff where appropriate.

Efficiency Objective: The Henrico Too Smart to Start Community Coalition shall implement community-level prevention strategies as measured by the delivery of 4 events annually.

Results: 8 events

Recommendations/ Action Taken: Prevention Services and the Henrico Too Smart 2 Start Coalition implemented 8 community-level events, surpassing its outcome objective for FY11. New working relationships were developed with the Metro- Richmond Chamber of Commerce, Fortis College, Glen Allen Cultural Arts Center, Richmond Raceway and the Richmond Flying Squirrels. These new partnerships expand opportunities for youth and families participating in Prevention services and strengthen the communities network of protective factors that promote the health and wellness of Henrico County citizens.

Performance Improvement: In FY12, Henrico TS2S Youth Ambassador Leadership group will play a central role in developing and implementing Teen Forums and other environmental strategies to address underage drinking and other at-risk behaviors. The Henrico TS2S Coalition (www.toosmart2start.com) will continue the application process for non-profit, 501(c)3 status.

Efficiency Objective: The Charles City Community Coalition shall implement community- level prevention strategies as measured by the delivery of 2 events annually.

Results: 5 events

Recommendations/ Action Taken: The Charles City Prevention Coalition surpassed its outcome objective for FY11 by implementing 5 activities/events. The Families and Schools Together (FAST) program had more fathers participating during the last cycle than in the past and several graduating families helped to revive the parent support group, FASTWORKS. Project Sticker Shock was expanded to include additional merchants as well. The coalition also successfully implemented new programs supported through funding from the Dept of Alcohol and Beverage Control. A new 4- session, evidence-based parenting group was implemented in the community.

Performance Improvement: The Dept of Alcohol and Beverage Control funding also afforded the coalition the opportunity to purchase the nationally acclaimed evidence-based curriculum, Life Skills Training (LST), to be implemented in grades 3-12 in FY12. Henrico Prevention Services will provide LST training and on-going consultation to the Charles City Schools Physical Education Dept.

Access Objective: Consumers will be enrolled in the CONNECT program within 5 business days of request for services.

Results: .05 days

Recommendations/ Action Taken: Registration for the Connect program continues to be offered at each program site. The majority of admissions occur at the beginning and end of the school year. Access to the program is determined based on capacity. In most instances, youth can begin participation in the program immediately following registration based on parental preference.

Performance Improvement: Continue to monitor

Objectives for the Coming Year

Effectiveness Objective: 95% of CONNECT participants shall be on reading level or above by 3rd grade

Effectiveness Objective: Students will show a decrease in favorable attitudes towards Alcohol, Tobacco and other Drugs (ATOD) as demonstrated by the evaluation outcomes of evidence-based curriculums implemented in the community

Efficiency Objective: The Henrico Too Smart to Start Community Coalition shall implement community-level prevention strategies as measured by the delivery of 4 events annually

The Charles City Community Coalition shall implement community- level prevention strategies as measured by the delivery of 2 events annually

Access Objective: Consumers will be approved for admission into the CONNECT program within 5 business days of request for services.

COMMUNITY SUPPORT SERVICES

CSS Intake

Outcomes

Access Objective: 90% of individuals referred to the agency for services will have a face to face intake meeting within 10 business days of the first contact.

Results: 90%

Recommendations/ Action Taken: The CSS intake unit was able to meet their objective of meeting with new intakes within 10 days of the initial call with 90% accuracy. In most cases families were very excited to be able to get an appointment within the week of their call. Upon review of the intakes and the available slots, the 10 intakes that fell outside of the 10 day window were the result of the family members or individual requesting dates in the future due to work schedules, school holidays, vacations, etc.

Performance Improvement: The intake unit will continue for the next year to make sure those requesting services are seen in the most timely manner that meets their schedule needs.

Access Objective: 90% of individuals receiving intake for MR Services will have eligibility resolved within 60 days from initial face-to-face visit.

Results: 96%

Recommendations/ Action Taken: For FY11, intake staff have continued to make a strong effort to get individuals requesting services opened as soon as possible. Overall we have experienced good success in getting this process completed well within the 60 days noted in the objective. Psychological evaluations have continued during this fiscal year to be the main reason for a delay in determining eligibility. Intake staff continue to work with community psychologists to ensure that reports contain all of the required data and maintain an updated list of professionals in the community for those interested in our services to choose from.

Performance Improvement: For the next fiscal year, we have begun the process of developing a relationship with the VCU Psychology department who will be able to send doctorate level students to our main location to conduct evaluations for individuals who do not have insurance coverage.

Objectives for the Coming Year

Effectiveness Objective: 90% of individuals referred to the agency for services will have a face to face intake meeting within 10 business days of the first contact.

Access Objective: 90% of individuals receiving intake for ID Services will have eligibility resolved within 60 days from initial face-to-face visit..

CSS Day Services

Outcomes

Effectiveness Objective: 30 different individuals will participate in activities of their choice within another unit of day services each quarter.

Results: Average 52

Recommendations/ Action Taken: The purpose of this objective was to allow individuals to participate in a large variety of activities including work and volunteering that may or may not be offered in the unit for which they are enrolled. Many individuals love to work, but like to get out in the community and like to participate with others than those they see every day. The objective was to use the Person Centered Plan information and assist individuals in achieving some of their choices while helping them reach higher levels of performance and build their capacity. We averaged over 100 activities serving an unduplicated count of over 50 participants each quarter. The split between the units was equivalent to the numbers of enrollees: the Workshop averaged 58%, the LEP unit averaged 13%, and the STEP unit averaged 23%.

Performance Improvement: This objective was well received by consumers and staff and will be continued with an increase in the number of people to be served each quarter.

Effectiveness Objective: 50% of the individuals enrolled in Enclaves will be provided a “Work World Assessment” and/or a complete benefit analysis.

Results: 29%

Recommendations/ Action Taken: A total of 9 of 31 have accepted this service for 29% of the enrolled enclave participants. Overall, we offered the service and received a response back from 20 of the 31 individuals. This service was not as well received as we had anticipated. For the immediate future, we will refer people to those funded by the WISA grant if there are questions of their benefits in the future. For the long term, we are enrolling a staff member in the training so we have an expert in house.

Performance Improvement: We will continue to encourage enclave participants to explore their work options and increase their earning potential. Next year’s outcome will move individuals to the choice of individual supported employment.

Effectiveness Objective: Utilization Peer Review scores on the DATA section will reflect an average of 95% compliance for all waiver charts over the course of the year.

Results: 89.5%

Recommendations/ Action Taken: There was a good improvement in the data sections of the Utilization Review in Day Services over the year. We started with a baseline compliance rate of under 80% our first quarter and improved to over 93% in our last quarter. Staff received training throughout the year and efforts were made to provide extensive supervision and discussion during staff meetings to help in ensuring that accurate data collection occurred throughout the year.

Performance Improvement: We will continue this objective in the next Fiscal year, with continuing efforts to improve and exploring ways of ensuring accurate and quality data collection.

Access Objective: 90% of individuals referred will start the program within 90 days of the date of referral.

Results: 33%

Recommendations/ Action Taken: We had three individuals begin a Day Services program in FY 2011. Of those only one was able to start within the 90 days. There are multiple factors that impact when a person can start including gathering the paperwork needed from the family for a person to get on the payroll system, the need for extended assessments to ensure the placement is one that will benefit the person, and the availability of work in which to assess the skills of the individual.

Performance Improvement: Next year, we will adjust the objective to capture the time from referral to the start of the assessment. This is a more accurate measure of a person's access to our secondary service.

Objectives for the Coming Year

Effectiveness Objective: 40 different individuals will participate in activities of their choice within another unit of day services each quarter

Effectiveness Objective: 10 Individuals enrolled in the enclaves will visit a different enclave or community work site

Efficiency Objective: Utilization Peer Review scores on the DATA section will reflect an average of 95% compliance for all waiver charts

Access Objective: Individuals will start their assessments within 30 days from the date the referral is received

CSS Case Management

Outcomes

Effectiveness Objective: Enhance service provision to individuals with a dual diagnosis of ID and MI through targeted staff training

Results: 1 training

Recommendations/ Action Taken: The training provided to HAMHDS staff gave providers in both Community Support Services and Clinical and Prevention divisions information about the diagnosis and treatment for individuals with intellectual disabilities who also have a mental illness or are experiencing a behavioral challenge. Concrete information was shared about how to enhance services to meet treatment goals.

Performance Improvement: This objective will be continued in FY12 with a follow up training made available to all Agency staff.

Access Objective: Individuals will be seen within 15 business days of receipt of chart by Team Leader

Results: 10.71 average

Recommendations/ Action Taken: This objective was met. The process developed at the beginning of the year continues to expedite meetings. This process involves sending the individual a letter outlining information about the name and contact number of the Support

Coordinator/Case Manager and the timeframe for scheduling the first meeting so that services can begin.

Performance Improvement: This process will continue in the new fiscal year.

Objectives for the Coming Year

Efficiency Objective: Enhance service provision to individuals experiencing behavior challenges through ESP staffings

Efficiency Objective: Enhance service provision to individuals with a dual diagnosis of ID and MI through targeted training

Access Objective: Individuals will be seen within 20 business days of assignment to “Eligibility Complete” unit

CSS Individual Supported Employment

Outcomes

Effectiveness Objective: 50% of unemployed individuals in the Individual SE program will receive an offer of employment within 2 months of requesting a job

Results: 24%

Recommendations/ Action Taken: The overall job market was challenging this past year and had an effect on the ability of individual’s being successful in job searches. In addition to challenges with the job market, a number of people experienced personal issues that affected their interest in pursuing prolonged searches for employment. Sharing the potential challenges without decreasing motivation may help individuals adjust expectations based on current economic conditions.

Performance Improvement: Continue to use all tools available to improve employment outcomes for individuals including increasing submission of applications as individuals allow. Next year’s outcomes include a goal around number of applications submitted per month.

Efficiency Objective: 90% of SE staff who attend best practice training will articulate how they used this information in their practice.

Results: 100%

Recommendations/ Action Taken: The time spent in training was beneficial to SE staff who readily engaged in discussion around the topic of supporting individuals on the job site. All staff were able to take away techniques to put in practice and some identified specific examples of how they would use the information with particular individuals they currently support.

Performance Improvement: All SE staff were able to articulate how they can use best practice techniques in their work.

Access Objective: Individuals will be seen within 6 business days from the time of acceptance to the employment program to the first face to face meeting with the Job Coach

Results: 4.3 days average

Recommendations/ Action Taken: This objective was met with an average of 4.3 days from the date of acceptance to SE to the date of the first face to face. The most number of days was 14 (1 person in July 2010) and the least was an individual seen the same day as accepted (in March of 2011).

Performance Improvement: This objective will remain unchanged in the coming year.

Objectives for the Coming Year

Effectiveness Objective: 95% of unemployed individuals will complete and submit 4 job applications per month for positions related to their employment goal

Efficiency Objective: All SE staff will answer 9 of 10 questions correctly after training on the delivery of SE best practice services through ID Waiver

Access Objective: Individuals will be seen within 6 business days from the time of acceptance to the employment program

CSS Residential

Outcomes

Efficiency Objective: 100 % of service delivery verifications forms will meet criteria. Criteria: initials and signature (first initial and last name) will be included for all staff who worked during that month.

Results: 55%

Recommendations/ Action Taken: This outcome was based on some recommendations following an audit last year. The program redesigned a form and created new procedures to make sure that reviewers could match a person's initials with their signature. We did not meet this outcome for this year, but staff have made a concerted effort to make this a routine activity and supervisors have learned strategies to provide improved oversight and feedback for staff.

Performance Improvement: This outcome will continue into the next fiscal year

Objectives for the Coming Year

Efficiency Objective: 100 % of service delivery verifications forms will meet criteria. Criteria: initials and signature (first initial and last name) will be included for all staff who worked during that month.

Parent-Infant Program

Outcomes

Efficiency Objective: 100% of (randomly selected 25) cases discharged between 8/1/2010 and 12/1/2010 will have all steps and services completed on the transition pages of the IFSP.

Results: 62%

Recommendations/ Action Taken: According to final results from the state, only 62% percent of 22 charts chosen in the 3rd quarter audit met compliance for the local results. Although results slightly improved from last year, Henrico did not meet compliance around the area of transition. Compliance is 100%.

Performance Improvement: Based on the results, more training is required around transition. Program Manager has requested an informal training and audit to be conducted by the Part C monitoring consultant and technical consultant. Program Manager will have to complete a Corrective Action Plan regarding non-compliance. Results also indicate a need for more frequent chart reviews (peer and supervisory) around the area of transition.

Access Objective: Meet or exceed the child count state target of 22 (for infants and toddlers birth to 1).
Results: Target was not met for the December 1 child count

Recommendations/ Action Taken: The 0-1 child count was not met on December 1st of 2010 and will result in a Corrective Action Plan for our locality. Although our system did not meet this indicator, we did exceed the child count number in July, September and November. For the new fiscal year, the system manager will be coordinating Early Intervention referrals with a new Premie Follow-up Clinic (St. Mary's) in our area. Henrico will also partner with the Virginia Department of Health's New Born Screening Department. This department collects data on all babies born with diagnosed conditions in the state of Virginia. Due to new eligibility criteria implemented this year by the state Part C office (NICU stay over 28 days and/or prematurity), our system is hopeful that we will meet or exceed our child count.

Performance Improvement: The goal for the new fiscal year is to partner and educate referral sources about Early Intervention and the new eligibility criteria.

Objectives for the Coming Year

Efficiency Objective: 100 % of children discharged from Early Intervention Services will have all of their transition steps and services completed on their IFSP.

Access Objective: 100 % of children found eligible for Early Intervention services will have an IFSP developed within 45 days of the date of referral

Access Objective: The Infant and Toddler of Connection of Henrico, Charles City and New Kent Counties will meet or exceed the December 1 child count determined by the Part C state office.

5. POST DISCHARGE INFORMATION FOR CARF SERVICES

Post discharge information is collected for all CARF accredited programs. The post discharge surveys are mailed approximately 30- 60 days after discharge from a CARF service. At least two questions were asked in each survey, including a satisfaction question and a question that refers back to the service's effectiveness objective. Survey questions are reviewed and updated on an annual basis to correspond with the current goals and objectives. In order to complete a timely annual report, the reporting period covers the period of April 1, 2010 through March 31, 2011.

During this fiscal year, ten (10) separate services were tracked. A total of 305 surveys were mailed to the ten HAMHDS programs and 29 were returned. The response rate for programs ranged from 0% to 66.7% with an average response rate for all of the CARF services of 10%. This is a slight increase compared to FY10's

average response rate of 09%. Individual comments were forwarded to the respective program. Additional detail is available in the FY 2011 Post-Discharge Survey Report.

HAMHDS	CARF	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Response Rate%
Survey Response Rates (Apr 2010 - Mar 2011)															
CM&A	MH Case Management	0	2	0	0	2	3	2	1	0	1	0	0	11	5.0%
PACT	Assertive Community Treatment	1	0	0	2	0	0	0	0	0	0	0	0	3	27.3%
MH Day Support	MH Community Integration	1	0	2	1	2	0	0	1	0	0	0	0	7	24.1%
MH Residential	MH Community Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
MH Vocational	MH Community Employment	0	0	0	0	0	0	1	0	0	0	0	0	1	7.1%
MH Supported Svcs	MH Supported Living	0	1	1	0	0	0	0	0	0	0	0	1	3	20.0%
LEP	ID Community Integration	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
ID Supp Employ	ID Community Employment	0	0	0	0	0	0	1	1	0	0	0	0	2	16.7%
Sheltered Employ	ID Organizational Employment	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
ID Group Supp Empl	ID Community Employment	0	0	0	1	0	1	0	0	0	0	0	0	2	66.7%
		2	3	3	4	4	4	4	3	0	1	0	1	29	10%
Response Rate		9%	17%	9%	18%	12%	13%	12%	13%	0%	11%	0%	3%	10%	

6. SATISFACTION

ADULT SERVICES- MHSIP

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) conducted a survey of consumers with serious mental illness who received outpatient mental health and substance abuse services. The Adult, Mental Health Statistical Improvement Program (MHSIP) survey was used to assess five aspects of

the public mental health service system and is recommended by the Center for Mental Health Services for reporting state data for the federal mental health block grant.

HAMHDS contributed 312 to the Virginia state sample and 63 valid MHSIP surveys were completed. The overall response rate for the agency sample was 20%. Table 1 displays the five performance indicators as compared to the Health Planning Region (HPR) and the state sample.

Indicator: Percentage of caregivers who report:	HMHDS (N=55)	HMHDS (N- 63)	HPR 4 (N-455)	State (N-3084)
	2010	2011	2011	2011
General satisfaction	94%	84%	86%	86%
Access to services	94%	82%	81%	81%
Appropriate treatment	94%	87%	84%	83%
Positive outcome	84%	67%	62%	70%
Functioning	75%	62%	58%	60%
Treatment participation	78%	81%	73%	67%
Social connectedness	NA	62%	62%	65%

YOUTH SERVICES- YSSF

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has not conducted a survey of caregivers of youth with serious emotional difficulties this fiscal year, but will resume this survey next fiscal year.. The Youth Services Survey for Families (YSSF) is used to assess five aspects of the public mental health service system and is recommended by the Center for Mental Health Services for reporting state data for the federal mental health block grant..

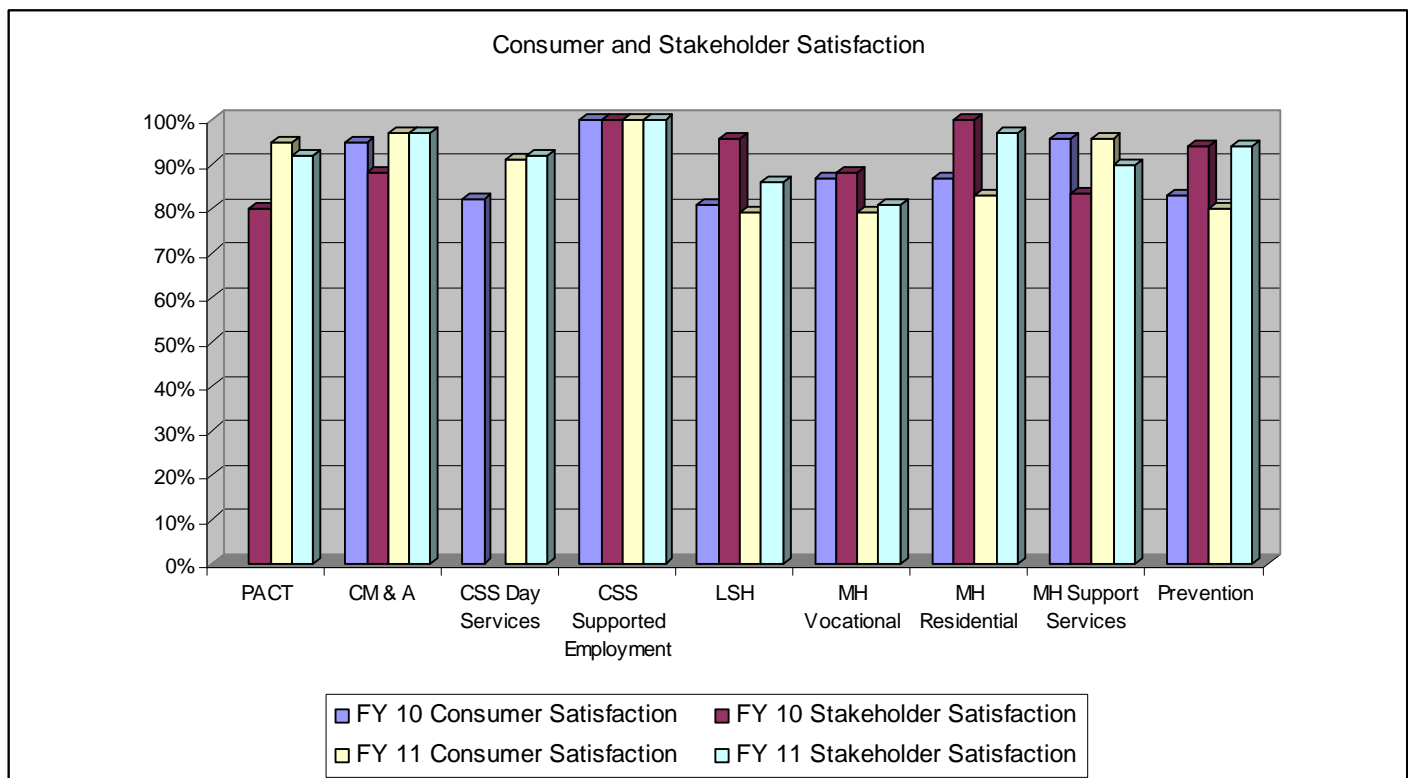
INTELLECTUAL DISABILITY SERVICES- FAMILY SATISFACTION SURVEY

The Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Developmental Services administered its tenth annual statewide survey of family satisfaction with Community Service Boards and other Intellectual Disability (ID) service providers. The family satisfaction survey was designed to measure family perceptions in five areas; family involvement, case management services, choice and access, healthy and safe environment, and service reliability. The 37-item questionnaire based in part by surveys developed by the National Core Indicators Project (NCI) was handed to family members during the time of the consumer’s annual review. Respondent’s replies included strongly agree, agree, strongly disagree, disagree or does not apply. Respondents mailed the completed surveys directly to the Office of Intellectual Disability Supports in the provided post-paid return envelope. Forty-six (46) surveys were returned representing a 10.9% return rate. The percentages below include the Strongly Agree and Agree responses. The survey in its entirety can be found at <http://www.dbhds.virginia.gov/documents/ODS/OMR-FamilySurvey2009.pdf>.

1. 93% feel where the person with ID goes during the day is a healthy and safe environment
2. 96% feel where the person with ID resides is a healthy and safe environment
3. 81% feel that services provided to the person with ID helped to relieve stress on the family
4. 81% stated staff respect family choices and opinions
5. 82% received information in a reasonable time from their case manager
6. 84% feel they receive enough information to help them participate in planning services for their family member
7. 86% report participation in the development of their family member's yearly service plan

AGENCY SATISFACTION SURVEYS

HMHDS also directly conducted Consumer and Stakeholder satisfaction surveys in some programs, in addition to the surveys administered by the Department of Behavioral Health and Developmental Services (DBHDS). Results below indicate all responders report at least a 79% satisfaction rate with services, with four services demonstrating an increase in the satisfaction rating.



7. FY 12 MANAGEMENT, ADMINISTRATIVE AND PROGRAM INITIATIVES

MANAGEMENT

- ❖ Prepare for Health Care Reform

ADMINISTRATION

Reimbursement

- ❖ Implement administrative billing for VICAP
- ❖ Implement Medicaid changes for billing Early Intervention Targeted Case Management

- ❖ Transition 4010 electronic billing format to the 5010 format which provides electronic data exchange enhancements that will assist with verification of eligibility, claim status, service authorizations and remittance advice
- ❖ Convert fee structure for Court Evaluations flat fee
- ❖ Implement crisis intervention billing for ARS, Youth and Family and PACT Units
- ❖ Implement Gateway EDI for claims management, eligibility, and electronic remit advice for Medicare and commercial payers
- ❖ Transition from IEXCHANGE to Atrezzo for managing Medicaid Service authorizations

Information Services

- ❖ Implement new functionality in Anasazi that will capture client signatures electronically and document scanning in order for the agency to become completely paperless
- ❖ Facilitate the implementation of the Doctor's Homepage, which includes e-prescribing capabilities, tracking drug-to-drug, drug-to-food and side effect interactions, as well as patient allergies and pregnancy/lactation warnings
- ❖ Begin the process of implementing Client Notifications for secondary programs
- ❖ Continue adding key performance measures to the user friendly Dashboard on the intranet
- ❖ Assess the agency's readiness for federal meaningful use requirements under the HITECH Act and assist with the development of an implementation plan
- ❖ Devise and begin implementing a mobility plan that will bring 175 users into a mobile world and eliminate their desktops

Facilities

- ❖ Opening a new facility in December 2011 at Bremo Road, consolidating Radford, the West teams and business support at Hermitage, and DBT in one building
- ❖ Install generators for 2 server rooms at 2 main facilities and for 6 group homes (East Center, Woodman, Sherbrooke, Gayton, Green Run, Walton Farms, Danray, Shurm Heights)

Human Resources

- ❖ Continue to review and certify agency job descriptions

Business Support

- ❖ Continue to formalize key quality assurance processes to ensure smooth and efficient front desk and front end activities (including Chart Tracker accuracy)
- ❖ Successfully implement VICAP
- ❖ Merge business staff into new Bremo location

Health Information Management

- ❖ Plan and begin implementation of Scanning in 3 locations
- ❖ Clear the Closed Chart room of FY08 and 09 closed records and establish a routine method for sending charts to Archive
- ❖ Enhance Chart Tracker to add Archive as a location and designate thousands of records to that location
- ❖ Work with MH/SA programs on trainings related to findings in the Record Reviews

CLINICAL AND PREVENTION SERVICES

Access

- ❖ Implement Access services East for 16 hours/week

Adult Substance Abuse/ Adult Mental Health Services

- ❖ Increase use of Evidence Based Practices

Adult Recovery Services

- ❖ Implement Crisis Intervention Services for adults
- ❖ Implement more flexible service model to meet the needs of consumers

Emergency Services

- ❖ Increase use of Peer Counselors
- ❖ Conduct pilot mobile crisis team with CIT staff and MH Clinician responding to crises in the community

Youth & Family

- ❖ Implement more flexible service model to meet the needs of consumers in the Eastern part of Henrico County
- ❖ Implement Crisis Intervention Services for youth

Prevention

- ❖ Increase focus in the Connect after-school program on enhancing early reading skills for grades 1 -3
- ❖ Work collaboratively with schools and community to reduce incidences of under-age drinking and other substance use

COMMUNITY SUPPORT SERVICES

Residential Services

- ❖ Complete transition to use of EHR (Anasazi)

Parent Infant Program

- ❖ Complete implementation of System Transformation

Case Management Services

- ❖ Implement Intellectual Disability On-Line System (IDOLS)

Day Services

- ❖ Implement innovative ways of providing employment services in conjunction with Employment First Statewide Initiative.

8. QUALITY HEALTH INFORMATION

OUTCOMES

Record reviews were completed on approximately 20% of Medicaid and 10% of non-Medicaid charts;

1009 Quality reviews and 390 Administrative reviews were done in FY 2011. ID outcomes were over 90% compliant in all but 1 of their programs and outcomes were similar to last year. MH/SA made dramatic improvements with half of the programs reviewed improving by more than 5 percentage points and all but 2 programs improving by 1% or more.

OBJECTIVES FOR THE COMING YEAR

- ❖ Continue improvements of the Utilization Review process
- ❖ Establish and implement improved agency-wide QHI reporting
- ❖ Continue training to ensure documentation meets all requirements

FY 2010 CSS RECORD REVIEW RESULTS SUMMARY

	FY 2011 YTD	FY 2010	FY2009
NORTH 1 WAIVER	96%	95%	88%
EAST 1 WAIVER	94%	92%	74%
EAST 2 WAIVER	95%	93%	77%
WEST 1 WAIVER	95%	93%	90%
WEST 2 WAIVER	94%	96%	93%
NORTH 1 SPO	96%	93%	97%
EAST 1 SPO	97%	91%	91%
EAST 2 SPO	95%	95%	94%
WEST 1 SPO	95%	98%	92%
WEST 2 SPO	98%	97%	94%
NORTH 1 SE	98%	90%	99%
EAST 1 SE	94%	94%	95%
EAST 2 SE	95%	99%	87%
WEST 1 SE	96%	100%	96%
WEST 2 SE	96%	88%	84%
HERMITAGE VOC	93%	90%	84%
CYPRESS VOC	96%	94%	89%
ENCLAVES	86%	84%	88%
LEP	97%	94%	93%
STEP	95%	93%	95%
RESIDENTIAL	89%	88%	89%
ID ADMINISTRATIVE	91%	85%	80%

Percentage represents compliance with standards reviewed

Represents area in compliance 90% or better

Represents areas that improved by more than 5 percentage points

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

Represents areas that dropped (not done in 90%+ range)

FY 2011 MH/SA RECORD REVIEW RESULTS SUMMARY

	FY 2011 YTD	FY 2010	FY2009
ESP/OUTPATIENT	91%	81%	
ESP/PRESCREENING	97%	97%	91%
YOUTH & FAMILY EAST	84%	82%	78%
YOUTH & FAMILY WEST	81%	80%	78%
MHOP EAST/WEST	88%	80%	81%
MHOP/SA/YOUTH PF	77%	78%	74%
SA EAST	83%	66%	75%
SA RADFORD	70%	68%	73%
DBT OP	97%	91%	92%
DBT CM	87%	84%	83%
LAKESIDE CENTER	91%	84%	89%
LAKESIDE CTR VOC	77%	84%	83%
PACT EAST	86%	62%	84%
PACT WEST	83%	73%	72%
CM&A EAST	77%	71%	75%
CM&A WEST 1	83%	77%	81%
CM&A WEST 2	85%	77%	81%
CM&A PF	74%	78%	76%
MH SUPPORTED SVS	83%	82%	82%
MH RESIDENTIAL	79%	87%	90%
MH ADMINISTRATIVE	87%	84%	80%

Percentage represents compliance with standards reviewed

Represents area in compliance 90% or better

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

Represents areas that improved by more than 5 percentage points

Represents areas that improved by 1-4 percentage points

Represents areas that dropped

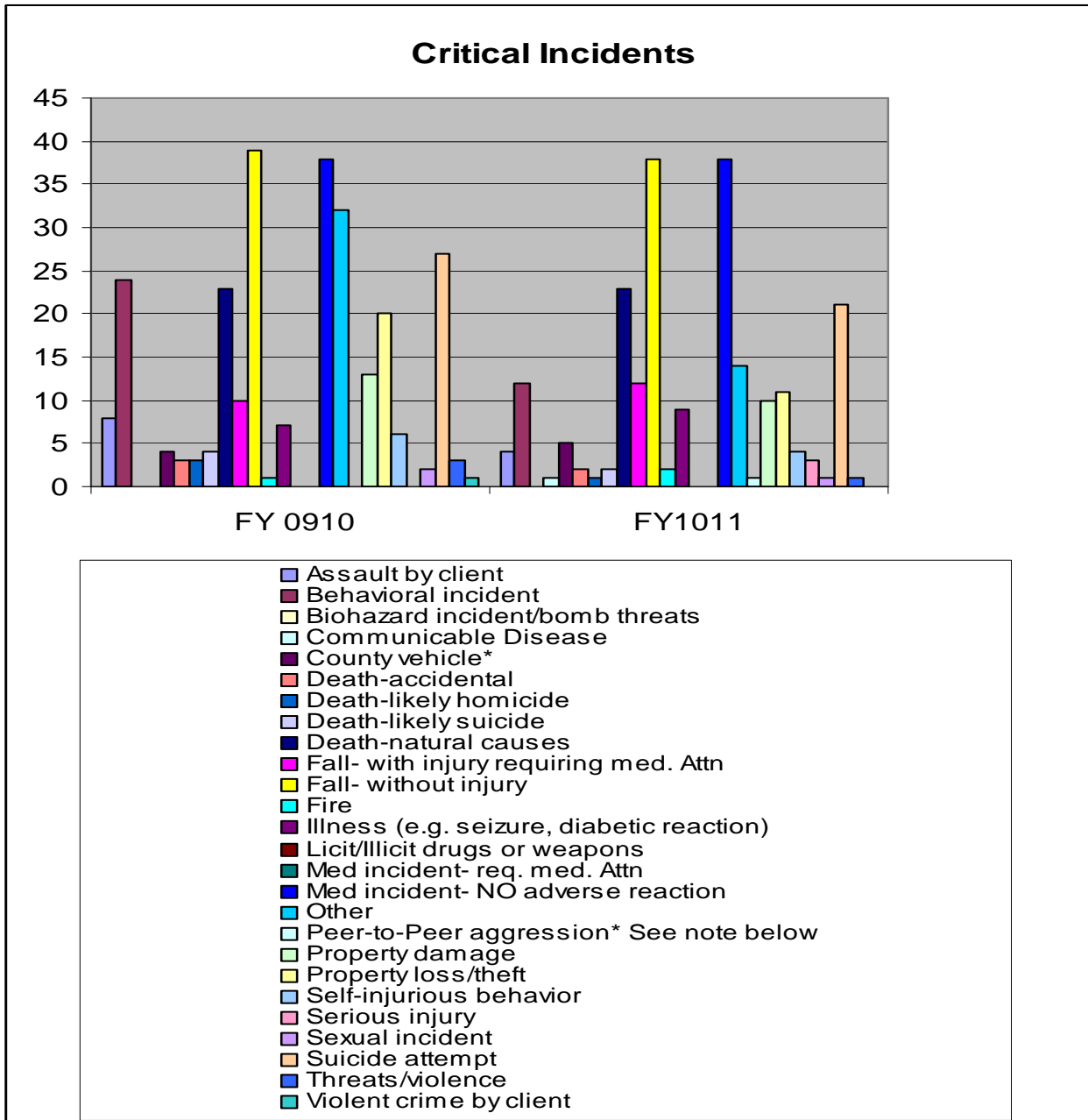
9. RISK MANAGEMENT / INCIDENTS AND COMPLAINTS

OUTCOMES

During this past year, all objectives within the agency's Risk Management Plan were addressed. Highlights included: assurance of quality services through an improved orientation process; successfully achieving a 3 year CARF accreditation for 8 programs; further planning and implementation of the agency's electronic

health record; additional training on confidentiality; implementation of changes within the Local Human Rights Committee; increased access for reporting Fraud, Waste and Abuse to the County; ongoing health and safety checks and drills ; as well as testing and updating the agency’s disaster preparedness.

Critical incidents were regularly reviewed, analyzed and addressed as appropriate. No specific trends were noted requiring significant or organization wide interventions.



OBJECTIVES FOR THE COMING YEAR

- ❖ Maintain compliance with all regulations and standards related to health and safety
- ❖ Incorporate revised disaster procedures into emergency procedures

10. STAFF TRAINING

OUTCOMES

The Agency values staff training as a way to assist staff in remaining current in their field or area of expertise and it is consistent with the agency's continuous improvement efforts. All staff is aware of required training and obtain training in a number of venues; the options include attending training provided directly by the agency, on-line through the agency Intranet, County of Henrico, self study or outside of the agency and County.

The Agency maintains a group of 24 staff trainers that provides mandatory training in a variety of areas such as First Aid, CPR, Prevention of Violence, Therapeutic Options, and Prevention of Infectious Diseases. On-line training courses available to staff include: the Code of Ethics, Fraud Awareness, Pharmacy Fraud, Waste and Abuse, Fire Suppression, Agency Compliance, Prevention of Violence annual refresher course, HIPPA Breach Notification, Confidentiality and Professional Ethics Training. On-line competency based training is provided for all staff annually in the areas of Human Rights and the Reporting of Critical Incidents. A self study course is available for Prevention of Infectious Diseases. Waste Management instruction was added to Prevention of Infectious Diseases classes as a requirement from the County. A major change for next year includes the course changes for the American Red Cross for all CPR and First Aid classes. Cultural Awareness training is provided through the Cultural Awareness and Competency Committee. Staff obtained additional professional training through in-house workshops, in-services, brown bags and by attending conferences and training that occurred in the community. County of Henrico's Department of Human Resources, Employee Development and Training Division also offers classes to all county employees in the areas of customer service, leadership/professional development, management, and technology. In addition, the County of Henrico's Risk Management Department requires new employees who drive a county vehicle to take the 8 hour defensive driving course, and a four hour refresher defensive driving course every 3 years thereafter.

OBJECTIVES FOR THE COMING YEAR

- ❖ Implement changes in the American Red Cross curriculum for First Aid and CPR by October 1, 2011
- ❖ Add Medical Waste training module to the Intranet to assist staff in fulfilling their Prevention of Infectious Diseases training

11. CULTURAL AWARENESS AND COMPETENCY

OUTCOMES

The agency conducted an agency-wide linguistic assessment, translated several agency documents into Spanish and provided language guidance folders for staff. The agency maintained a diverse workforce in leadership, management, direct service and support service positions and maintained a comfortably diverse environment through the display of diverse art work, children's play area, and the availability of wheel chairs and automatic doors. CACC participated in agency orientations of new staff, continued the expectation for all staff to participate in at least one cultural awareness activity per year, conducted two sensitivity and awareness classes for new staff, developed a new class which includes more in-depth discussion of the CLAS standards, held fourteen diversity events, held special activities for African American History Month, participated in joint community training efforts with Colaborando Juntos, and supported the Area Planning and Services Committee for Individuals Aging with Lifelong Disabilities (APSC). CACC also maintained three

diversity bulletin boards, included monthly Diversity information in the Agency newsletter, provided staff membership to the State Department of Behavioral Health and Developmental Disabilities Cultural and Linguistic Awareness Steering Committee, posted Audio Podcasts on the Intranet from the State Board of Social Services (SBSS) on the impact of poverty throughout the Commonwealth, and continued to host Network of Care which provides translation for resources to persons served and their families.

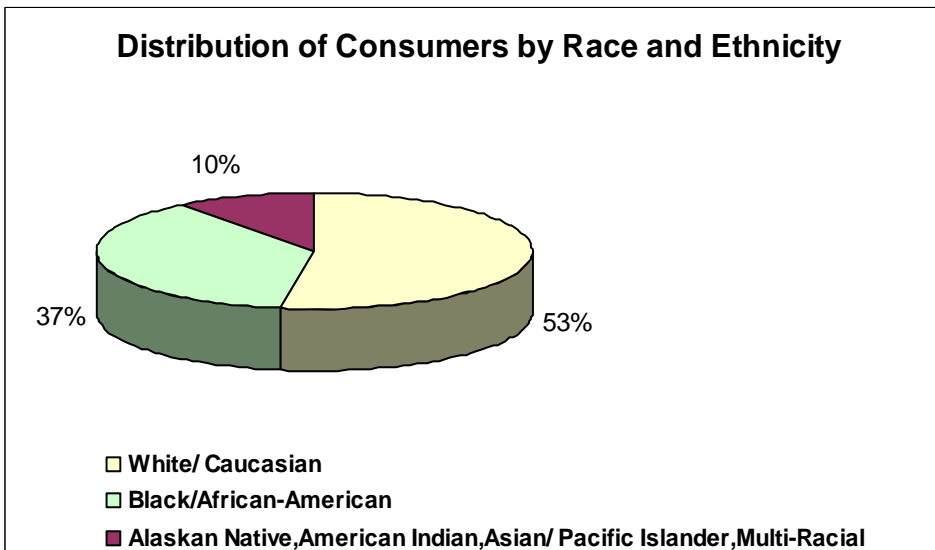
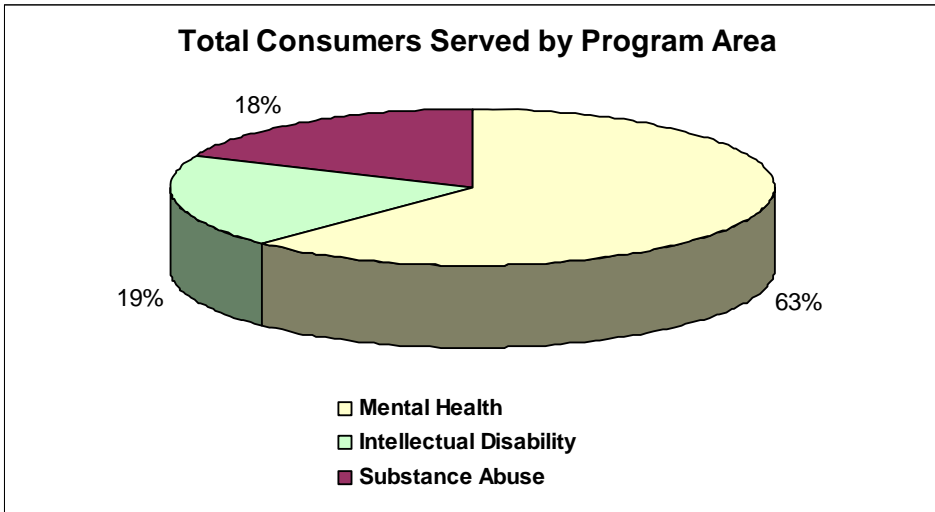
Race & Ethnicity	FY11 Average 3- County %	FY11 Persons served	FY10 Persons served	FY09 Persons served	FY11* HAMHDS Employees	FY10* HAMHDS Employees	FY09 HAMHDS Employees
White/Caucasian	60.60%	52%	53%	54%	58%	57%	57%
Black/African American	30.46%	39%	37%	38%	39%	39%	41%
Alaskan Native, American Indian, Asian/Pacific Islander, Multi-Racial	7.38%	9%	10%	8%	2%	3%	2%
Persons served who identify themselves as Hispanic	2.73%	5%	4%	4%	1%	1%	<1%

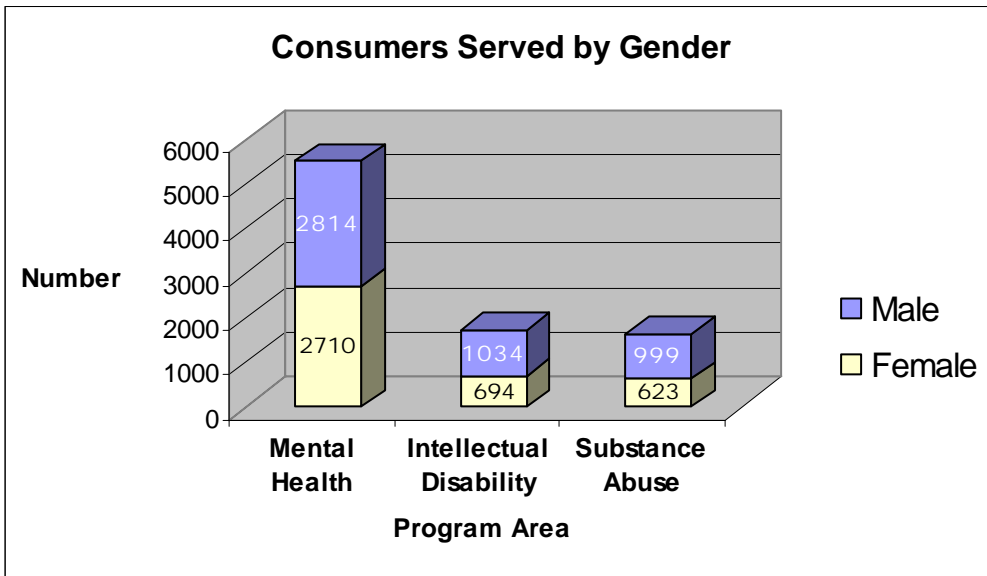
* HAMHDS data for FY11 and 10 includes Hispanic employees; FY 09 does not

OBJECTIVES FOR THE COMING YEAR

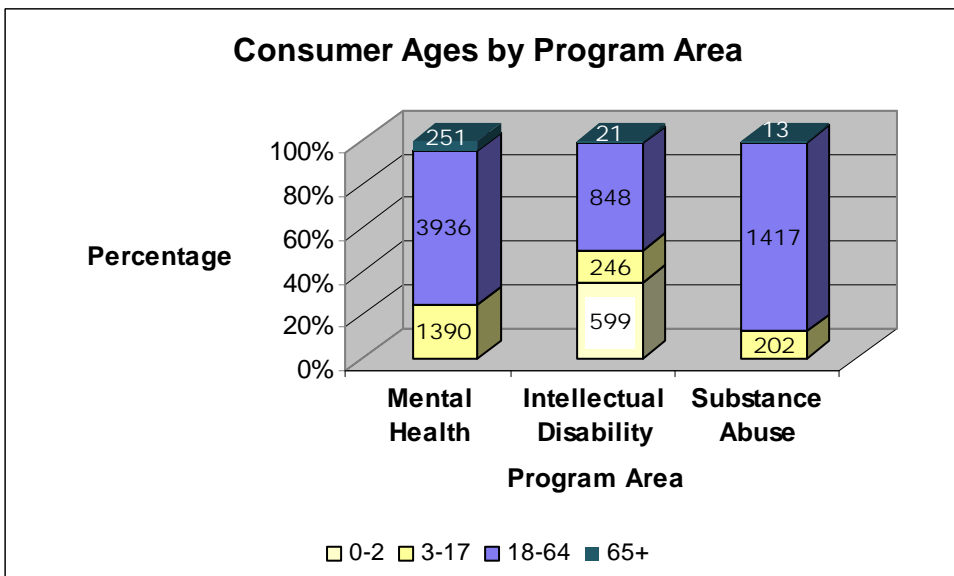
- Increase awareness and adherence to CLAS standards and increase cultural and linguistic awareness
- Complete Agency Language Access Survey and implement recommendations from Language Subcommittee
- Promote information sharing with the Board; provide information to the Board regarding work on language access and provide information about the Board members to agency staff
- Provide education about agency's value and commitment to cultural competency at every agency orientation
- Provide Sensitivity and Awareness training to all new employees, provide activities to celebrate Diversity month (April 2012), recognize Minority Mental Health month (July 2011), and offer additional educational activities during Black History Month
- Increase awareness of all staff regarding changing demographics of the community served (CC,NK, HC)
- Support Virginia Department of Behavioral Health and Developmental Services (DBHDS) Office of Cultural and Linguistic Competence and the CLC Steering Committee efforts and continue to partner with community organizations
- Maintain diversity bulletin boards in at least three locations and support displaying consumer art work in agency locations
- Support needs and awareness of services to the aging and to the deaf, hard of hearing and latent deaf populations
- Increase staff networking to support agency value of partnering and sharing

12. DEMOGRAPHICS





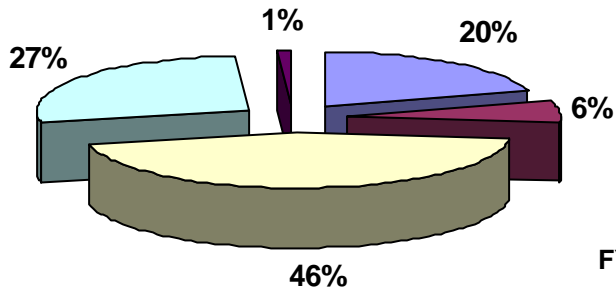
Fifty-one (51) percent of individuals served in the Mental Health program area were male, and 49% served were female. In the Intellectual Disability program area, 60% of individuals served were male, and 40% served were female. In the Substance Abuse program area, 62% of individuals served were male, and 38% served were female.



Seven (7) percent of individuals served were ages 0 – 2; 21% were ages 3 – 17; 69% were ages 18- 64; and 3% were ages 65+.

13. BUDGET

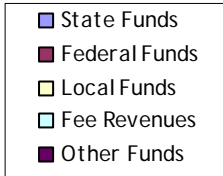
REVENUE



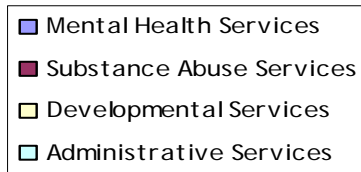
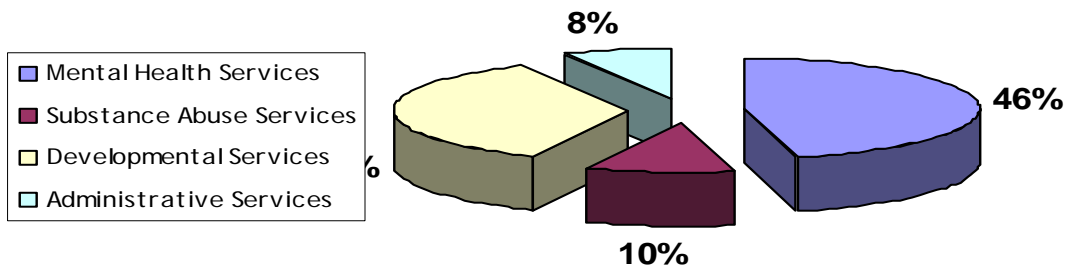
FY2011 per the Year End Performance Contract Report

Revenue by Source

State Funds	\$	6,515,171	20%
Federal Funds	\$	2,068,012	6%
Local Funds	\$	14,787,606	46%
Fee Revenues	\$	8,964,475	27%
Other Funds	\$	357,691	1%
Total	\$	32,692,955	



EXPENSES



FY2011 per the Year End Performance Contract Report

Expenses by Disability

Mental Health Services	\$	13,594,779	46%
Substance Abuse Services	\$	3,009,738	10%
Developmental Services	\$	10,522,839	36%
Administrative Services	\$	2,206,472	8%
Total	\$	29,333,828	