MECKLENBURG COUNTY

COMMUNITY SUPPORT SERVICES

ANNUAL

PERFORMANCE IMPROVEMENT

PROGRAM EVALUATION

Assessment of Fiscal Year 2020

INTRODUCTION

Substance Use Services became a component of Community Support Services (CSS) July 1, 2015. Prior to that, the services reported in this document were a part of The Provided Services Organization (PSO), a Mecklenburg County Department from July 1, 2012, to September 2, 2015. On October 7, 2014 the County Manager announced plans to divest some substance use services and reorganize others within the County. The substance use treatment programs were redistributed as follows: the detention and shelter programs began operating under the Community Support Services Department as of July 1, 2015 and the detox and residential programs were contracted out to The Anuvia Prevention and Recovery Center, a local non-profit provider effective September 2, 2015.

This report includes performance improvement information regarding the CSS Substance Use Services programs that were accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) first October 2008, August 2011, October 2014 and August 2017.

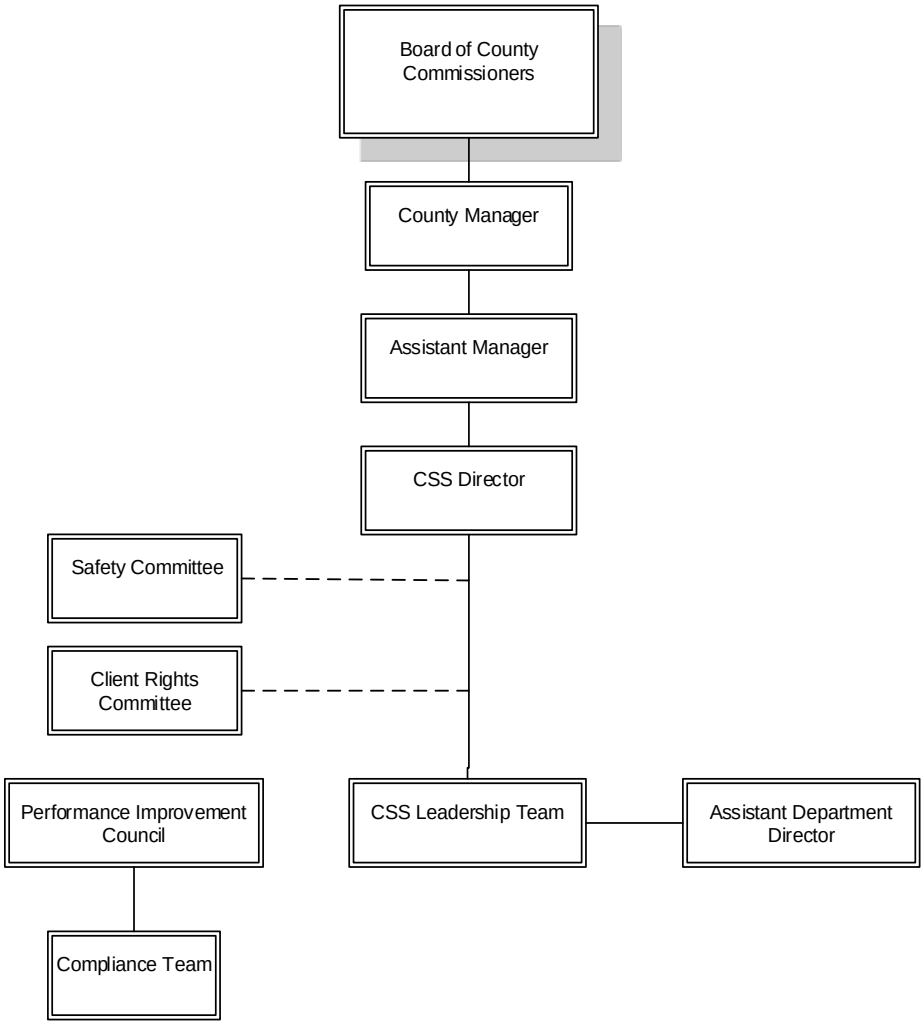
CSS conducts an ongoing Performance Improvement (PI) program and an annual evaluation of the PI Program to measure progress, highlight the activities that resulted in meaningful improvement and identify activities that need ongoing attention. The assessment looks at the fiscal year twelve-month period (July through June) and summarizes progress toward meeting performance goals.

CSS Sr. Quality & Training Specialist Ginger Little, QP prepared the FY20 Performance Improvement Program Evaluation. The evaluation was (will be) reviewed and approved by the Community Support Services Performance Improvement Council (PIC) September 24, 2020. The findings are provided below.

This Performance Improvement Program Evaluation reflects the continuing commitment of CSS to quality care. The evaluation includes a review of completed and ongoing quality activities, trended data, and an assessment of barriers to improved performance when performance goals are not met. Conclusions about the overall effectiveness of the program, including assessments of the adequacy of resources and the appropriateness of committee structure, are integrated into the program evaluation.

COMMITTEE STRUCTURE AND EFFECTIVENESS

In 2005, a Performance Improvement Council structure was initiated to support the development, implementation, and evaluation of the PI Program. When a portion of the substance use services was absorbed by CSS in July of 2015, the structure as noted below was adjusted from previous years. The same PI activities occur, but due to a smaller staff composition, these activities have been collapsed into fewer committees. The Mecklenburg County Board of County Commissioners serves as the governing body for the agency and is ultimately responsible for oversight of the PI Program. A copy of the CSS Committee organizational chart is below.



The Performance Improvement Council (PIC) solicits input from the subcommittees to identify issues, suggest strategies for improvement, and to implement activities. The CSS's Client Rights Committee, a client-led group, advises CSS on Performance Improvement (PI) activities including customer satisfaction, accessibility, incident management, complaint management and readability and usefulness of the department's website and some CSS publications.

This section of the PI evaluation examines the effectiveness of services provided.

Table 1. Effectiveness of Client Services

Program	Measurement	Target	FY18	FY19	FY20
Day Tx –SU Detention Program at Central & North	# program grads returning to detention w/in 12 months of release (decreasing measure)	<55%	37%	36%	%39
SAIOP- SU Program Men's Shelter	% Successfully Completing Program during the entire month	≥60%	*21%	*31%	*23%
SAIOP-SU Program Women's Shelter	% Successfully Completing Program during the entire month	≥60%	*27%	*43%	*35%

Table 1a. Effectiveness of Client Services

Program	Measurement	Target	FY18	FY19	FY20
Day Tx –SU Detention Program at Central & North	Percentage difference between the average scores on the Initial BSCQ and Follow-up BSCQ during the quarter	≥40%	83%	71%	%62

* Target not met.

Analysis of Performance:

In FY20, the Detention Center met the recidivism target. A historical concern in the past for this data has been how the Detention Center counts individuals that return. The individuals that enrolled in our program yet did not complete the program may have been included in this count. There are other complexities that may not accurately reflect the effectiveness of the SU program. For this reason, in 2013 the Detention Center began presenting the residents the Brief Situational Confidence Questionnaire at the beginning and end of treatment. The target has been met the past three years. Beginning FY21, the BSCQ will be reported out in place of the recidivism.

The Men's Shelter SU Program and the Women's Shelter SAIOP Program did not meet the effectiveness measure of program completion. Due to the number of beds available at the Men's and Women's Shelter, the number of potential clients served (capacity) for both the men's and women's shelter was 16 this fiscal year. Because SAIOP is provided at the homeless shelters and only to those clients that actually live on-site, the programs have little to no control over how many clients are referred for services, complete treatment, or continue to live at the shelters. Housing rather than treatment is the reason our clients are at the shelter. Obviously, since the base portions of Maslow's Hierarchy of Needs is a priority for most of our clients, the need for housing comes before treatment. In addition to other reasons, once housing is obtained, clients leave the Shelter and are discharged from our Shelter Program before treatment is

completed. In addition, due to the continuing push for Housing First, we continue to see a decline in referrals, and treatment is no longer required when a treatment issue has been identified. Also, due to COVID-19, we were unable to serve clients in the treatment program the last quarter of this year. Staff completed check in calls with individuals that were in service at the time of the pandemic.

It is important to note that if a client breaks a shelter rule and is discharged, they are automatically discharged from treatment and cannot complete the program. Shelter staff members do what they can to work with the shelter's leadership but, because we are a "guest in their house", they make the final decision on who stays or who goes. On occasion, staff have negotiated so the client can complete treatment.

Table 1.1 Effectiveness of Client Services –Plans for FY21

Program	Measurement	Target	FY20	Action Plans
SAIOP Men's Shelter	Successfully Completing Program during the entire month	60%	23%	Program Leadership continues to work with leadership at the Shelters to identify clients in need of services and collaboratively coordinate a course of treatment. During the multi-disciplinary team meetings will continue to discuss strategies and interventions that support long term recovery. Leadership will continue to negotiate with the shelter where feasible so a client can finish the treatment episode after shelter discharge.
SAIOP Women's Shelter	Successfully Completing Program during the entire month	60%	35%	Program Leadership continues to work with leadership at the Shelters to identify clients in need of services and collaboratively coordinate a course of treatment. During the multi-disciplinary team meetings, we will continue to discuss strategies and interventions that support long term recovery. Leadership will continue to negotiate with the shelter where feasible so a client can finish the treatment episode after shelter discharge.

This section of the PI evaluation examines the efficiency of services provided.

Table 2. Efficiency of Client Services

Program	Measurement	Target	Actual FY18	Actual FY19	Actual FY20
Day Tx -SU Detention Program	% occupancy	≥95%	*76%	*73%	*76%
SAIOP-SU Program Men's Shelter	% occupancy	≥75%	*65%	*67%	*51%
SAIOP-SU Program Women's Shelter	% occupancy	≥75%	*45%	*57%	*58%

* Target not met.

Analysis of Performance:

In FY20, the Detention Center Substance Abuse Treatment Program did not meet the efficiency measure of occupancy, but did increase slightly from last year. Several factors continue to contribute to not meeting our occupancy goal for Men's and Women's programs this year. One, in the past we only used data from the male pod, and in 2018, the male and female data was averaged. Due to the low volume of females admitted, this has lowered our numbers. This past year, we've had a turnover in staff which resulted in a reduction of the number of individuals admitted during certain periods. Other contributing factors include: refusal of residents to remain in the program, safety and security takes precedent over treatment needs which can lead to resident removal from the program. There are numerous program options for residents to elect which can have an impact on census. The process to move the residents is cumbersome, so a high turnover due to the reasons noted above makes it difficult to maintain the targeted occupancy rate. We will continue collaborative efforts by providing training to MCSO Detention Officers and program staff. As noted above, COVID-19 impacted our ability to have clients in our pod at the beginning of quarter 4.

In FY20, the IOP Program at the Men's Shelter did not meet the efficiency measure of occupancy, and there was a significant decrease from FY19. Due to COVID-19, we were unable to serve individuals in the shelter all of 4th quarter. Program Leadership continues to work with leadership of Shelter to blend treatment programming with community initiatives in an effort to meet client needs and promote community reintegration. Staff and management have initiated being more visible to the client population served and sharing information about available services and how to access them. We continue to provide walk-in services for assessments which can lead to quicker access to services.

In FY20, the IOP Program at the Women's' Shelter did not meet the efficiency measure of occupancy; however, there was a slight increase from FY19. Program Leadership continues to work with leadership of Shelter to blend treatment programming with community initiatives in an effort to meet client needs and promote community reintegration. Staff and management have initiated being more visible to the client population served and sharing information about available services and how to access them. We've continued to provide walk-in services for assessments which can lead to quicker access to services.

Table 2.1 Efficiency of Client Services-Plans for FY21

Program	Measurement	Target	Actual FY 2020	Action Plans
Day Tx-SA Program in Detention Center	% occupancy	95%	*76%	The women were moved from Detention North to Detention Central, consolidating residents and staff, which should make staff coverage easier. Program leadership recently worked with Detention leadership to allow our male staff to provide services to the female residents in certain circumstances. The program supervisor will work on managing clinician's schedules so coverage will be less of an issue, thus being able to admit more females. Clinical process changes were made to better assess client needs related to length of stay, allowing for more opportunity for admissions. Assessment of this process will continue.
SAIOP Men's Shelter	% occupancy	75%	*51%	Program Leadership continues to work with leadership of Shelter to increase the likelihood that clients will stay with the program on a contiguous basis. CSS Leadership is reassessing services provided at the shelters to determine what will be most effective and plans to implement integrated behavioral healthcare in programs that serve the homeless.
SAIOP Women's Shelter	% occupancy	75%	*58%	Program Leadership continue to work with leadership of Shelter to decrease the likelihood that clients are discharged with the Shelter for rules violations and to increase likelihood that the Shelter Program staff can meet with clients prior to these discharges to provide assistance with SU issues. CSS Leadership is reassessing services provided at the shelters to determine what will be most effective strategies to implement integrated behavioral healthcare programs that serve the homeless.

* Target not met.

This section of the PI evaluation examines the accessibility of services provided to our clients.

Table 3. Accessibility of Client Services

Program	Measurement	Target	Actual FY18	Actual FY19	Actual FY20
Day Tx – Detention Center	Average # Days Clients are on the Waiting List	≤5 FY19 ≤30	*21	27	*49
SAIOP Men's Shelter	Average days to complete admission	≤3	*4.8	*5.8	*4.4
SAIOP Women's Shelter	Average days to complete admission	≤3	2.7	2.2	3

* Target not met.

Analysis of Performance:

In FY20, the Day Treatment SU Detention Program did not meet the goal for Accessibility of client services. In March of 2018, we developed a method to capture accurate data regarding client referrals and wait time. Our capacity in all programs combined is 56, and residents can remain in the program up to 42 days. Based on this data and given we have over 2,000 residents request services per year, a more realistic wait time from screening to admission is 30 days; thus, our target beginning FY19 was amended to ≤30 days. Due to COVID-19, clients wait time for screening and admission increased. In FY20, the SU detention program screened approximately 814 clients, a decrease from 2019 of 1,158 residents screened.

In FY20, the IOP Program at the Men's shelter did not meet the goal for Accessibility of Client Services. The Men's Shelter developed alternative housing options for individuals needing shelter. Unfortunately, being offsite can be a barrier as it relates to transportation and access to services provided at the main location. The pandemic has also impacted clients located at alternative housing and our inability to transport due to the restrictions implemented because of COVID-19.

Table 3.1 Accessibility of Client Services – Plans for FY21

Program	Measurement	Target	Actual FY 2020	Action Plans
Day Tx-Detention Center	Average # Days Clients are on the Waiting List	≤30	*49	It is believed the length of time on the waiting list will continue remain over 30 days for the next foreseeable future due to the pandemic.
SAIOP Men's Shelter	Accessibility	≤2	*4.4	The shelter continues to make improvements to their facilities and

				efficiency of their lottery system. We will continue to collaborate with the shelter to identify clients in need of our resources. We will continue to identify alternative resources for transportation.

This section of the PI evaluation examines satisfaction among clients and stakeholders with the services provided.

Table 4. Client and Family Satisfaction with Client Services

Program	Target	Actual FY18	Actual FY19	Actual FY20
Day Tx – Detention locations	85%	99%	97%	99%
SAIOP - Men's Shelter	85%	95%	100%	95%
SAIOP - Women's Shelter	85%	100%	100%	93%

* Target not met

Analysis of Performance: The FY20 results for the programs exceed the target for client satisfaction.

5. Stakeholder Satisfaction Survey (*2020 Community Partner Survey)*

Key Quantitative Results for 2020:

- **The response rate is 12%. Of 50 contacts for the Substance Use Program, 6 responded. Due to the low response rate, these are not statistically significant. In addition, sample sizes differ from year to year, which makes trend comparisons challenging. In light of these caveats, use caution, when reviewing these results.**
- **The aggregate of the "Strongly Agree" and "Agree" of 96 potential responses, 95 were positive, resulting in 99% positive.**
- **Of 6 total SU respondents, 6 provided answers to all questions**
- **Comments: Because we are permitted to work within a non-county facility, we don't have control over all aspects of facility processes. This sometimes leads to misunderstandings with our community partners regarding what we can change to address issues. The Detention SU Manager has been meeting with Wellpath to discuss mutual clients and how we can each better support the individual. Obtaining clarification with the Sheriff's Office who the point person is should improve communication. New HIPAA guidelines surrounding sharing of clinical information will help to address or mitigate barriers.**

Q1 - Substance Use provides valuable services to the jail and/or shelters.

#	Answer	%	Count
1	Strongly Agree	50.00%	3
2	Agree	50.00%	3
3	Disagree	0.00%	0
4	Strongly Disagree	0.00%	0
	Total	100%	6

#	Answer	%	Count
1	Strongly Agree	50.00%	3
2	Agree	50.00%	3
3	Disagree	0.00%	0
4	Strongly Disagree	0.00%	0
	Total	100%	6

Q2 - Substance Use staff communicates clearly about the programs it provides in the jail and/or shelters.

#	Answer	%	Count
1	Strongly Agree	50.00%	3
2	Agree	50.00%	3
3	Disagree	0.00%	0
4	Strongly Disagree	0.00%	0
	Total	100%	6

Q3 - Substance Use staff is sensitive to client needs.

Q4 - Substance Use staff responds appropriately in sensitive situations.

#	Answer	%	Count
1	Strongly Agree	33.33%	2
2	Agree	50.00%	3
3	Disagree	16.67%	1
4	Strongly Disagree	0.00%	0
	Total	100%	6

Q5 - My concerns are heard by Substance Use staff.

#	Answer	%	Count
1	Strongly Agree	16.67%	1
2	Agree	83.33%	5
3	Disagree	0.00%	0
4	Strongly Disagree	0.00%	0
	Total	100%	6

- **Q6 - Substance Use staff responds to all inquiries in a timely fashion.**

#	Answer	%	Count
1	Strongly Agree	33.33%	2
2	Agree	66.67%	4
3	Disagree	0.00%	0
4	Strongly Disagree	0.00%	0
	Total	100%	6

Q7 - Substance Use staff responds to my emails within a reasonable time-frame.

#	Answer	%	Count
1	Strongly Agree	50.00%	3
2	Agree	50.00%	3
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q8 - Substance Use staff returns my telephone calls within a reasonable time-frame.

#	Answer	%	Count
1	Strongly Agree	50.00%	3
2	Agree	50.00%	3
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q9 - Overall, Substance Use staff's level of response meets my needs.

#	Answer	%	Count
1	Strongly Agree	16.67%	1
2	Agree	83.33%	5
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q10 - Substance Use staff treats me with respect.

#	Answer	%	Count
1	Strongly Agree	16.67%	1
2	Agree	83.33%	5
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q11 - Substance Use staff demonstrates integrity in their partnerships with the jail and/or shelters.

#	Answer	%	Count
1	Strongly Agree	33.33%	2
2	Agree	66.67%	4
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q12 - Substance Use staff is knowledgeable about the issues faced by clients in the jail and/or shelters.

#	Answer	%	Count
1	Strongly Agree	50.00%	3
2	Agree	50.00%	3
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q13 - My experience with Substance Use staff meets my needs.

#	Answer	%	Count
1	Strongly Agree	33.33%	2
2	Agree	66.67%	4
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q14 - My agency's partnership with Substance Use is beneficial.

#	Answer	%	Count
1	Strongly Agree	50.00%	3
2	Agree	50.00%	3
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q15 - My agency's relationship with Substance Use is collaborative.

#	Answer	%	Count
1	Strongly Agree	33.33%	2
2	Agree	66.67%	4
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Q16 - Overall, I am satisfied with the services provided by Substance Use staff.

#	Answer	%	Count
1	Strongly Agree	33.33%	2
2	Agree	66.67%	4
6	Disagree	0.00%	0
7	Strongly Disagree	0.00%	0
	Total	100%	6

Table 6. Client Complaints: FY 19/20

FY 17/18	Men's Shelter SU Services	Women's Shelter SU Services	Detention	Within 10 days	Complaints to LME/MCO
1st Qtr	0	0	0	NA	0
2nd Qtr	2	0	0	Yes	0
3rd Qtr	0	0	0	NA	0
4th Qtr	0	0	0	NA	0
Total	**2**	**0**	**0**	**NA**	**0**

In previous years, approximately 99% of complaints were generated from clients accessing our residential program, which as stated in this introduction, is now with another agency. FY 19 resulted in no complaints; however, two complaints were received FY20. Both complaints originated from the same individual and were resolved successfully within our identified timeframe of 10 days. Due to the low level of incidents, there are no systematic improvements recommended, nor follow-up required. Staff make clients aware of the input process during orientation, and information is posted in programs regarding how to reach the client advocate should they want to consult with someone other than program staff. Staff in the Detention Center have access to a kiosk where complaints or issues can be documented.

Table 7. Accessibility

The following serves as the Mecklenburg County Community Support Services (CSS) Accessibility Plan Assessment for fiscal year 2019-20. The purpose of this document is to provide a means to facilitate continual quality improvement in the area of accessibility.

CSS is committed to providing an organizational setting that seeks to accommodate the needs of all clients, employees, and stakeholders. Central to this commitment is the removal of architectural, attitudinal, employment, and other barriers that may impede full access to the services and programs of the organization.

This Accessibility Plan is developed in response to the CSS's internal evaluation of barriers through the use of facility inspections, assessments of need, and feedback from clients, employees, and other stakeholders.

The Elements of the Accessibility Plan are as follows:

1. ARCHITECTURAL:
Architectural barriers have been identified through internal and external inspections, assessments of need, and employee, stakeholder and client feedback. Mecklenburg County Asset and Facilities Management and the Safety Committee provide ongoing monitoring of conditions within the organization that serves to improve access. The organization's leadership conducts long and short-range planning meetings that routinely include assessment of architectural needs and related costs analysis.

2. ENVIRONMENTAL:
CSS believes that the environment in which services are provided reflect the culture and cultural customs of the clients, and in addition are conducive to providing a comfortable and confidential setting for clients and employees to achieve their highest potential.

3. ATTITUDINAL:
The organization seeks to reduce the stigma associated with persons who have mental illness, and substance abuse problems, and to promote their inclusion within the community.

4. FINANCIAL:
CSS, within in the structure of Mecklenburg County, seeks to support appropriate programming to provide support and resources to those clients most in need.

5. EMPLOYMENT:
CSS strives to maintain a diverse workforce sensitive to the unique needs of clients and representative of the community it serves. In addition, CSS strives to hire and maintain the highest of quality of employees available in the labor market.

6. COMMUNICATION:
CSS seeks to provide open channels of communication that allow clients, employees, and stakeholders to access information that accurately represents the status of the organization's systems and outcomes. The Mecklenburg County Balanced Scorecard System is used by CSS to provide information regarding CSS to the Mecklenburg County Board of County Commissioners. In addition, CSS seeks to facilitate communication among clients and employees, providing a basis for personal and professional growth, and well-being.

7. TECHNOLOGY
CSS seeks to utilize technology to gain efficiency, communicate information, and market the Department's services to staff, clients and other stakeholders. The annual Technology and Systems Plan and assessment of the plan detail goals and progress made toward them.

8. TRANSPORTATION:

CSS seeks to ensure that clients are not limited by a lack of personal transportation options or by options that may not accommodate their disabilities, and that transportation systems fully accommodate any community member seeking to access services.

9. OTHER AREAS:

In addition to the above specific accessibility goals and objectives, CSS is involved in many ongoing activities and procedures that enhance the accessibility of clients, employees, and members of the community. Examples include personnel policies (employee climate survey, balanced scorecard measures, and exit interview process), ongoing outreach activities in all program areas, the utilization of client feedback/input processes such as satisfaction surveys, psychosocial assessments, and individual planning, participation in client advocacy groups, outcome studies, cultural competency education, and other activities that directly facilitate the enhancement of accessibility.

ANNUAL REVIEW:

The Community Support Services Performance Improvement Council develops and approves a revised Accessibility Plan each year. The plan is reviewed and approved by the CSS Director, and is made available to clients, employees, and stakeholders on the CSS website.

1. ARCHITECTURAL:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date
County to develop standard operating procedures enterprise wide to assure all facilities are ADA compliant. *Plans to promote social distancing and to install barriers where needed to enhance safety of clients and staff in all county and non-county spaces where CSS provides services.	CSS to develop departmental standard operating procedures to be in compliance with county requirements	Review and approval by County Executive Team	County Manager's Office and CSS Leadership	TBD	6/30/20
Assessment: This goal is ongoing and will be carried over to FY21. The county identified a project that will include reducing the number of entry access to county buildings and installing scanning equipment. This will be added to the FY21 plan.					

2. ENVIRONMENTAL:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date

Mecklenburg County Land Use and Environmental Services Agency (LUESA) Goals Per Strategic Business Plan, work green initiatives are identified	Adhere to environmentally preferable purchasing (EPP) guidelines. Educate staff regarding work green initiatives; Continue with the Green Stream Dream Team and Sweep Street Peeps volunteer programs.	Dollars spent on recycled paper/ Dollars spent on environmentally preferable office supplies, Dollars spent on remanufactured printer cartridges	Noah Brierton	TBD	6/30/20
Mecklenburg County Environmental goal to improve air quality	County proposed incentive to use tax free dollars to encourage use of the transit systems – purchase CATS tickets pre taxed	Track number of employees accessing this benefit	TBD	TBD	TBD
Mecklenburg County rolled out the "Work Green Initiative "to encourage staff to limit use of resources	County initiated the "Clean Commute Challenge"				
Assessment: CSS continues to encourage employees to be mindful of all work green initiatives.					

3. ATTITUDINAL:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date
Involve clients in accessibility planning	Include annual review of the CSS accessibility plan on the CSS Client Rights Committee (CRC) agenda	CSS Client Rights minutes indicate the members reviewed the accessibility plan	Yvonne Ward	$50 CSS Admin Budget	October 2020

In partnership with SAMSA, CSS Veteran's launched new initiative	To reduce the stigma of Mental Illness		Ronnie Devine		
Assessment: CSS management staff continue to partner with other agencies in the community to reduce stigma and promote wellness within the populations we serve.					

4. FINANCIAL:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date
Medicaid Billing	Set up and maintain contract, credentialed staff and access to systems	Billing occurs timely and completely-Medicaid or IPRS funding per successful event	Yvonne Ward, Chinita Craighead Davis & ?	Utilize existing Health Dept. staff for this function	June 1, 2020
Medicaid/IPRS Billing	Finalize succession planning, in preparation for Christine Payseur's retirement. Some of	Billing occurs timely and completely-Medicaid or IPRS funding per successful event	Yvonne Ward and Chinita Craighead-Davis		9/30/19
Assessment: Christine's position and job functions have been reassessed and various duties executed by Christine were divided between a variety of individuals. Yvonne Ward assumed the monitoring and updating of Provider Direct. Chinita Craighead-Davis assumed entering initial authorizations into Echo, entering Cardinal authorizations into Echo and monitoring authorizations and follow-up of denied billing.					

5. EMPLOYMENT:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date

Employ the best staff	Locate qualified people, have the ability to afford them, maintain staffing that is representative of the persons served	On average during the year have 90% of positions filled	Stacy Lowry	TBD	Average 90% of positions filled during FY19
Employee Longevity Recognition Event	Improve staff morale	Present years of services pins at CSS quarterly meetings, Continue Morale Committee	Stacy Lowry	TBD	6/30/19
County Equity and Inclusion Trainings					4/2020
Assessment: Equity and Inclusion Trainings were made available for all staff to attend. When the pandemic struck in March, some of these training were cancelled and will be rescheduled.					

6. COMMUNICATION:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date
Give clients access to the CSS's county Key Performance Indicator Data (KPI)	Publish KPI outcomes for Substance Use Services in the CSS Client newsletter when it is published	KPI report in the newsletter and on the CSS External Website	Carole Ward	$200 CSS Admin Budget	Fall 2019
Give clients access to CSS news updates, including surveys	Publish Client newsletter twice a year, Spring and Fall on the CSS internet and intranet	Publish twice a year	Ginger Little		Fall 2019 Spring 2020
Assessment: The external website continues to be a source for clients. CSS also now has a facebook page that posts frequent information regarding services.					

7. TECHNOLOGY:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date
Replace CSS staff PC's every four fiscal years	Acquire and install faster and more reliable machines	TBD	IST staff	TBD County Funds	6/30/20
Assessment: CSS remains on target with computer replacements.					

8. TRANSPORTATION:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date
Maximize county vehicle use	Monitors vehicle usage to assure equity in mileage	Safety and Compliance monitoring	Rashida Hudson	Unknown	June 30, 2019

9. OTHER AREAS:

Goal	Objectives	Measure	Responsible	Cost/Source	Target/Status Date

Table 8. FY 19/20 Annual Incident Analyses

FY17/18 Total = 3
Fy18/19 Total = 9
FY19/20 Total = 7

	M.Shelter			W.Shelter			Detention			Level I Total	Level II Total	Level III Total	GRAND TOTAL
FY 18/19 Annual Report	I	II	III	I	II	III	I	II	III				
Injury-Aggressive Behavior													
Self-Injury													
Trip or Fall													
Auto Accident													
Injury - Other													
Alleged abuse													
Alleged neglect													
Alleged exploitation													
Suicidal Behavior	1			1	1								

Inappropriate/Illegal/Sexual behavior													
Illegal acts													
Other behavior – Aggressive acts													
Diversion Drugs/Overdose		1											
Suspension													
Expulsion													
Fire													
Absence > 3 hrs													
Absence > 3 hrs *													
Search & Seizure													
Conf. breach	1						1						
Death									1				
Restrictive Intervention													
Sub-Total	2	1	0	1	1	0	1	0	1				
Total	3			2			2						

For CARF accredited programs, we had 5 DHHS Shelters incidents and 2 Detention Center incidents. The Detention Center death actually occurred in the previous year, but was reported to us FY20. The number of individuals served FY20 in Day Treatment or SAIOP total approximately 1077, not counting screenings and evaluations. Less than 1% of these individuals were involved in a reportable incident. There were no trends noted nor follow-up required.

Table 9. Risk Analysis

In June 2020, the Substance Use Services leadership conducted a risk assessment. What follows are the items in each area given the highest score and strategies to mitigate issues identified.

	Focus Area	Weakness, Threat	Reduction Strategy
1.	Information Technology	System downtime issues connectivity at offsite locations (Jail and Shelter Program Locations)	Per staff report, it has been a little more consistent since switching to Time Warner Cable. Because it's an out-posted site, this is not unusual. The issues are not with the Echo DB itself, but the connectivity. In 2018, we moved from the DB being hosted by us to hosted by the Echo Development team. In 2019 we moved to a web version, which has helped some with connectivity. We will

		Client database that supports our business and clinical need & length of time for updates	continue to monitor and adjust as strategies become available. Echo, our electronic medical record is used by our department as well as several other services with the Public Health Department. Features and updates must be aligned with not just the business needs of CSS, but the needs of Public Health. The projection of moving from our current Echo system to Echo Vantage is 2021. EchoVantage will present many upgrades for clinicians.
2.	Financial Stability	Gaps in billing – not billing for all services possible Limited number of clients	We will continue to work with our finance department and our liaison with the LME/MCO to ensure that we are capturing all services per our contract and that staff are providing all the necessary clinical documentation required to receive reimbursement for services rendered. We continue to work with our collaborative partners to blend desired treatment outcomes with the goal of the collaborative partners we work with, whose goal is to provide temporary housing and transitions clients into the community. This community goal limits the number of potential clients as they are not required to access our services even when there is an identified need for the service. We continue to explore and refer clients to resources that can meet their needs in the community.
3.	Health & Safety	Clearing of facilities	We continue to work with staff and provide with the resources to ensure their workspace is clean and safe. We are also in constant communication with our collaborative partners to jointly identify resources to ensure that the workspace is clean and safe. During this time of the pandemic supplies and cleaning resources have been increased

			to eliminate the potential spread of the virus. Protocols have been put in place by the governor and county leadership that have been shared with staff.
		Staff knowledge of appropriate protocols for staff injuries	We have implemented the process of periodically reviewing our operational procedure with our staff that includes a procedure on what steps should be taken if the client sustains an injury on the job. Staff are encouraged to reach out to supervisors with any questions or assistance they need if they encounter such an incident.
4.	Buildings & Grounds	Climate control of buildings Building maintenance issues	The Women's Shelter is an older building that has fairly inefficient systems of maintaining a steady temperature. The Men's Shelter completed a full renovation August of 2018 which has addressed the above problem. In 2019, the administrative offices of CSS moved to a renovated site at Freedom Drive. It's taking some time to get this large facility regulated adequately.
5.	Staff Conduct and Performance	Not knowing policy, rules & regulations and not following Policy, Rules and Regulations	Supervisors have added a standing agenda item on their monthly staff meeting agenda to inquire if there are any questions or concerns regarding updated policies received via email Policies are discussed and questions answered during staff meetings. Additional information is provided as needed during individual staff supervision, providing guidance and direction on expectations regarding job performance and expectations.
6.	Succession Planning for Senior Leadership	Mid-management mentoring for succession/leadership/promotion	The succession planning process is underway and has begun with upper management in CSS. There is a plan to implement succession across CSS. Staff

		Time available to develop staff	have the opportunity to complete an Individual Development Plan that has components of a succession plan tied to it that supervisors then use to help staff achieve those goals through supervision, outside training, and mentorship.
7.	Stakeholder Input	Clients don't get 'stationary' case managers (often switched)	Unfortunately, the assignment of, or access to case management services in the facilities of our collaborative partners are out of our control. While there are many services in the community, the indigent population with mental health and substance use challenges still tend to fall through the cracks. Our services are currently focusing on collaborating with internal customers in our division where we may be serving mutual clients, better discharge and transition planning, in an effort to assist in connecting discharged clients to outside resources.
		Too few resources to address the needs of too many clients	Staff continues to be innovative in working with internal and external partners to identify and coordinate resources for clients. We also help providers advocate for resources with state and county legislators by encouraging them to speak out at public forums that ask for feedback on services provided to vulnerable populations.

Health & Safety

CSS operates one shift, and email drills were conducted across three separate dates between the hours of 8am – 5pm. Due to COVID-19, two of the five drills were not completed, as several of the substance use employees did not have the resources to respond when the offices closed. Of the three drills conducted, the average number of employees having the opportunity to respond to the drill was 124, which resulted in overall response rate of 50%. Overall percentage of accuracy was 74%. The Bomb threat drill percentage of accuracy was the highest at 83%, followed by Medical Emergency at 72%, and Violent/Threatening situation at 68%. Initially email responses were received only by the sender, and the response rate was 43%. Reviewing results at the Safety Committee resulted in the recommendations of having staff copy their supervisor as they responded to the drill, in hope to prompt an increased response rate. This improved the response rate from 43% to 50%. After each drill, results are emailed to every employee with the correct responses, and supervisors are encouraged to review drill information during staff meetings. For FY21, a drill for each situation will be combined in one email, to see if this improves results.

Performance Improvement Team

During FY20, the Sr. Q&T specialist conducted a Performance Improvement Team for the Detention Programs, that initially consisted of seven individuals. The Team Charter identified the business case of developing a comprehensive single process for the Detention Center's Discharge Planning process. This was a carryover from a previous FY, and the team met until 11/29/2019. Due to previous staff turnover and difficulty to acquire qualified staff, the team dissolved. With the information gathered, the supervisor of the detention center carried out identified changes within the program to streamline several of their processes.

SUMMARY of PERFORMANCE IMPROVEMENT PROGRAM

Throughout the year, the staff implemented a number of improvement activities. Some were clearly successful, and some did not result in expected level of performance. Certainly, the COVID-19 pandemic had a profound impact on our services the last quarter of FY20. For FY21, renewed emphasis will be applied to important activities to rebuild our programs and move toward business as usual within the approved guidelines. We will continue to assess areas we have not yet reached the targeted level of performance, and in cases where performance levels meet the goals, ongoing monitoring will continue.

The CSS Substance Use Sr. Quality and Training Specialist worked closely with CSS Leadership, Managers and Staff to maintain high standards of compliance. We continue to work diligently as we've prepared September 2020 Digitally Enabled Site Survey (DESS) by the Commission on the Accreditation of Rehabilitation Facilities (CARF). We anticipate our continued work and dedication will result in a successful 2020 accreditation.