Executive Summary 2018

Center for Human Services

Building a stronger community…one family at a time.

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CENTER FOR HUMAN SERVICES
ANNUAL EXECUTIVE SUMMARY
2018

Introduction

Center for Human Services (CHS), a community-based, non-profit organization, exists to meet the needs of residents of North King County and Snohomish County in the areas of outpatient mental health, outpatient substance use disorders (prevention, intervention, and treatment), behavioral health integration, and family support.

Our Vision

It is our vision to be the community's leading provider of social services to children, youth, adults, and families. CHS strives to help create a strong community in which:

- Thriving children, vital individuals, and stable loving families are created and supported.
- Children and their families are able to increase emotional strength and resolve personal and interpersonal issues.
- People recover from behavioral health problems.

Agency Overview

Mission

To strengthen the community through counseling, education, and support to children, youth, adults, and families.

Belief Statement

CHS believes that the most critical element for strengthening a community is to strengthen its members and their families through preventive and responsive programs. This is accomplished by taking an approach that is strength-based,

family-focused, client-centered, trauma-informed, integrated with other services, and culturally responsive.

Our Values

- **Embrace Diversity**

We respect and honor the diversity of our community and are committed to weaving that diversity into our programs, actions, and results.

- **Provide Accessibility**

We provide services that are easy to find, use, and understand.

- **Champion Collaboration**

We foster collaborative relationships that promote creativity, innovation, and teamwork.

- **Demand Accountability**

We assess and coordinate our programs and systems to assure that we meet high standards of service and care.

- **Personify Integrity**

We value the strengths and assets of our clients, community members, and co-workers and are honest, respectful, and ethical in our interactions.

- **Have Fun**

We are passionate about the work we do and use humor to promote a positive workplace.

Our Philosophy

It is our philosophy that all people have gifts and strengths and our role as a human service provider is to create opportunities for them to use these talents and skills to strengthen themselves and their community. Our premise is that change will occur only when we firmly believe in our clients/participants and when we collaborate with them to positively use their aspirations, perceptions, and strengths. We believe that anyone who seeks our services at CHS deserves the best quality services possible. Our approach is holistic in that we try to understand the whole person or whole family rather than a dissection of parts. Not one therapeutic approach works for all people or in all situations, so various techniques are applied. However, general themes of emotional/physical safety,

respect, and cultural sensitivity are consistent. Intra-agency referrals are made when we see that a combination of our program services will best serve the client's/participant's needs; when services are needed which CHS cannot provide, referrals outside the agency are made. Staff have a commitment to provide effective services, thus engage in an on-going process of evaluation, education and self-care. CHS is striving to be a leader in the human services community by providing preventive and responsive services and using our identified strategic approaches.

Strategic Approaches

- **Strength-based**

Providing services from a strength-based perspective is based on the belief that every individual has strengths and that the role of a human service provider is to create opportunities for individuals to use these talents and skills to strengthen themselves, their families and their community. When working with a child or an adult, CHS acknowledges and responds to their needs, while also identifying their strengths and capacity for growth. This approach empowers participants to draw upon their own strengths in order to move toward creating change within themselves.

- **Client-centered**

We strive to provide services that are congruent and responsive to our clients' strengths and needs. When clients receive services that are tailored to their individualized needs, they are more likely to achieve positive outcomes. This process promotes client choice, voice, and resilience.

- **Family-focused**

The CHS approach is family-focused and holistic in that staff and volunteers try to understand the whole person or whole family rather than a dissection of parts. CHS defines family in the broadest sense of the word and staff are dedicated to supporting all families. Genuinely understanding each family's uniqueness, CHS recognizes grandparents, friends, extended family and other individuals together as playing a significant role in the family design.

- **Trauma-informed**

CHS realizes the widespread impact of trauma and actively resists re-traumatization of our clients and participants. Trauma-informed care is grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and the prevalence of these experiences in persons who seek and receive behavioral health services.

- **Integrated with Other Services**

Recognizing that no single approach works for everyone or in all situations, CHS programs include a variety of services and techniques. These include prevention-based and other services that respond to the immediate needs of the community. Intra-agency referrals are made between programs when a combination of services would best serve individual needs. External referrals are made when additional services are needed outside the agency's scope. Our most recent and current efforts toward integration are with primary care clinics.

- **Culturally Responsive**

CHS understands, respects, and honors cultural differences. We practice our work through a lens of cultural humility. We bring people together in community while celebrating everyone as unique individuals. CHS maintains an atmosphere of openness and appreciation of cultural differences, while continuing to assess our agency's own culture. CHS promotes ongoing development and knowledge of various cultures and relevant resources and affirms and strengthens the cultural identity of individuals and families, while enhancing each client's/ participant's individual abilities to thrive in a multi-cultural society.

Strengths

CHS:

- is CARF accredited for our mental health and substance use disorders programs.
- has a stable leadership team with significant longevity.
- values diversity and has minority representation on the board, leadership team, management team, and in direct service and support positions.
- has improved our infrastructure by adding additional positions.
- provides progressive advocacy within the local community and greater region.
- has one of the best employee benefit packages of similar non-profits in the area.
- has an experienced and respected leadership team that values the organization's employees and clients.
- has employees who exhibit compassion and enthusiasm for the mission of the organization and the services provided.
- has a strong commitment to training, which enhances the commitment and confidence of its staff members to provide quality services and keeps best practices at the heart of the organization.
- treats clients with dignity and respect.

- routinely uses and tracks the usage of evidence-based practices.
- Has been using an industry-leading electronic health record (EHR) and has been for the past 5 years.
- has an excellent health insurance package for employees.
- has a forward-thinking vision and is ahead of the curve on most integration efforts.
- provides services in primary care clinics, schools (5 school districts), clients' homes, and other community locations as well as in six agency locations.
- is dedicated to developing and maintaining partnerships with other community agencies.
- uses data to make wise (management and service) decisions.
- has a willingness and ability to expand services.
- has an experienced Executive Director (23+ years of experience at the Center for Human Services & over 40 years in non-profit behavioral health).

Challenges and Opportunities

CHS is challenged to:

- maintain CARF accreditation and State licensures.
- be credentialed with the five Managed Care Organizations (MCOs).
- abide by complex reporting requirements and increased administrative burdens.
- obtain Best Start for Kids funding.
- recruit and retain qualified staff in an increasingly competitive market;
- operate within a state that has a workforce shortage of CDPs.
- recruit and retain excellent and engaged board members.
- face the increased cost of doing business.
- compete with other organizations for resources and funding (Local, State, Federal).
- successfully integrate behavioral health and primary care (physical health).
- respond to the loss of all United Way funding for the first time in over 40 years (due to their change of focus for funding).
- effectively use technology in helping us meet our goals.
- operate under a funding model for IEC Mental Health that is not adequate because of the added expenses of home visiting.
- survive the current national political climate that has changed and could present numerous risks to human services.

Highlights of 2018 Accomplishments

CHS:

- had a CARF survey that was excellent and resulted in another three-year

accreditation. There were no recommendations or suggestions in our program areas.
- moved from the over-crowded Mountlake Terrace location to a larger location in Edmonds.
- our Family Support Counselor in Training program received the Outstanding Human Services Award from the North Urban Human Services Alliance.
- sent our Executive Director to the National Council's Behavioral Health Conference.
- expanded our WISe Wraparound Program in Snohomish County from one team to three teams.
- began contracting directly with King County for mental health services (we had been sub-contracting through Navos for over 20 years).
- completed major improvements to some locations, making our sites more welcoming and professional.
- had a clean financial audit with no management letter.
- took significant steps, working with a consultant, to improve our HIPAA Security & Privacy policies and practices.
- added new locations for our Wraparound Program.
- began using Pre-Manage to track our client's hospitalizations and emergency room visits.
- worked with consultants from Qualis Health on our readiness for fully integrated managed care and made significant improvements to our systems and processes.
- made significant investments in employees through retention incentives.
- completed our process of working with MTM Consultants to fully implement Treatment of Demand protocol.
- was selected by Best Starts for Kids to participate in an Early Childhood Learning Collaborative.
- sent two staff members to the 0-3 National Conference in Denver.
- increased the number of clients served and hours of services provided compared to 2017.
- had a successful and fun annual auction fundraiser.
- trained thirty-two adults in Youth Mental Health First Aid.

Locations

Our Locations

We have office space at the following locations:

- CHS- 170th
  17018 15thAve. NE Shoreline, WA 98155 (for primarily Substance Use Counseling, plus Mental Health Counseling)
- CHS - 148th Shoreline
  14803 15th Ave. NE Shoreline, WA 98155 (for Mental Health Counseling)
- CHS – Silverlake

10315 19th Ave SE, STE 112 Everett, WA 98208 (for Substance Use Counseling)

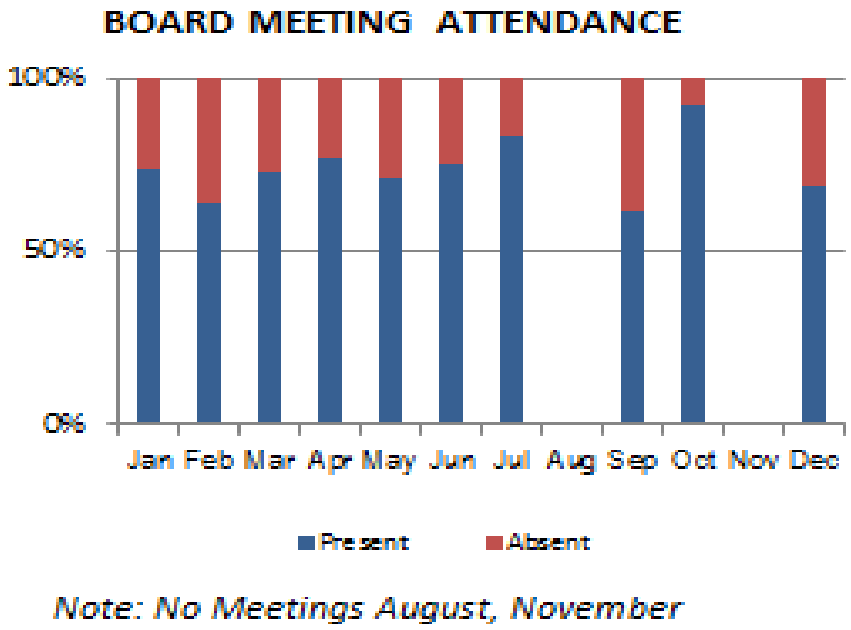
- Bothell United Methodist Church
  18515 92nd Ave NE Bothell, WA 98011 (for Family Support programming)
- CHS - 147th Shoreline
  14708 15th Ave. NE Shoreline, WA 98155 (for Wraparound program)
- CHS South Everett
  11314 4th Ave W, STE 209 Everett, WA 98204 (for WISe Snohomish County)
- CHS - Edmonds
  21727 76TH Ave. W, STE J, Edmonds, WA 98026 (primarily Mental Health, plus limited Substance Use Disorders Program)

CHS also provides services on a regular basis at schools in the Northshore, Edmonds, Mukilteo, and Seattle School Districts; Third Place Commons; and two King County Housing Authority communities (Ballinger Homes in Shoreline and the Greenleaf Community in Kenmore). We provide on-site services at the Virginia Mason Medical Clinic in Edmonds (formerly Edmonds Family Medicine) and at the Community Health Center of Snohomish County in Lynnwood, Edmonds, and Everett. Additionally, clients often receive services at other community locations of their choosing including their homes.

BOARD OF DIRECTORS

At the end of 2018, CHS had 13 board members (21 is maximum size of board). Board Officers were Karen Fernandez, President; Rick Henshaw, Vice-President; Kim Karmil, Secretary, and Dave Calhoun, Treasurer. We added two new board members in 2018. Our Board of Directors, at the end of 2018, represented a diverse representation of age range, males and females, sexual minorities, and races.

The following graph indicates the board attendance for 2018:



Note: No Meetings August, November

The Grace Cole Award for 2018 Volunteer of the Year was awarded to Susan Ramstead at the dinner gala and auction in April 2019.

At that time, the Board of Directors also presented the 2018 Dorrit Pealy Awards for Outstanding Community Support to the King County Housing Authority (business/organization) and to Neal & Linda Ottmar (individuals).

STRATEGIC PLANNING

CHS is in the third year of its Strategic Plan. Our strategies have not been modified since they were first presented. An annual review of the goals and objectives of the 2016-2019 Strategic Plan was conducted with notations made in **purple** font to illustrate progress made in 2018.

STRATEGY 1

Provide exceptional, value-based services to promote a thriving Community.

GOAL 1: Preserve quality personalized services that consistently target community needs and meet or exceed standards of best practice.

Objectives:

1. Apply evidence-based practices throughout our programming to achieve superior outcomes.
   2018 – Various staff were trained in Cognitive Based Therapy, Cognitive-Based Therapy +, Dialectic Behavioral Therapy, Motivational Interviewing, Parent-Child Psychotherapy, Moral Reconation Therapy, and more. We are now tracking (in our EHR) which evidence-based practice (EBP) we use in each client encounter.

2. Maintain CARF International accreditation for substance abuse services and mental health services.
   2018 – We had our CARF survey in November and received a very positive 3-year accreditation. There were no recommendations in the Program sections of the accreditation survey.

GOAL 2: Provide strengths-based services and best/promising practices that fill gaps in our community and align with our mission.

Objectives:

1. Increase clinician trauma informed practices and community supports to address adverse childhood experiences (ACEs).
   2018 – Continued to train new staff in trauma-work and ACEs. Began planning to work toward becoming a Trauma-Informed agency.

2. Conduct research among groups with clients/participants to obtain their perceptions of gaps in services.

2018 – SUD conducted 1 focus group; MH, SUD & BHI conducted surveys. Family Support conducted one-on-one interviews.

STRATEGY 2

Expand collaborative partnerships that address the whole person.

GOAL 1: Increase partnerships with entities such as school districts, community-based organizations, healthcare providers, courts, funders, and promoters.

Objectives:

1. Develop a role and contribute to integrating systems of care regionally (King and Snohomish counties) to address the needs of the whole person.
   2018 – Continued to be active in integration efforts. Negotiations occurred with Swedish Hospital health clinics to integrate our services in their clinics. Worked with Qualis Health (consultants) on integration-readiness. Participated in targeted webinars and trainings. Executive Director served as an Executive Committee member of the newly formed Integrated Care Network (ICN) in King County. Began talking to Managed Care Organizations about contracting with us for Medicaid services.

STRATEGY 3

Achieve sustainable growth by increasing agency capacity and diversifying funding sources.

GOAL 1: Participate in the implementation of the Healthier Washington Medicaid waiver and Health Care Reform.

Objectives:

1. Engage community efforts related to the Medicaid Waiver and ACA implementation.
   2018 – Several staff have attended meetings regarding Medicaid Waiver, implementing fully integrated managed care, and working with Managed Care Organizations (MCOs). We completed our work with a consultant (MTM) on Same Day Access implementation. We participated in Fully Integrated Managed Care Readiness consultation from Qualis Health. We continued to participate in the Treatment on Demand Initiative with King County BHO. Worked with Healthier Here in its Medicaid transformation efforts in King County and worked with North Sound Accountable Care

Community in its transformation efforts.

2. Refine our operations to accommodate for client rapid access to care.
   2018 – Completed our work with MTM (consultant) to develop and implement Same Day/Next Day Assessments based on previous data. Significantly improved our Treatment on Demand efforts.

3. Promote operational best practices and efficiencies through change teams.
   2018 - Implemented centralized scheduling in King County. MH Systems team & SUD Systems team continued its regular meetings and activities as change teams. Created a new Change Team to address our Managed Care Readiness.

GOAL 3: Continue to improve infrastructure.

Objectives:

1. Adapt billing systems and procedures to work with funders using EHR and data that integrates clinical, quality, and financial information. *
   2018 – Continued to work with Credible and the BHOs to adapt our EHR system for Medicaid billing. Made numerous improvements to our forms and tracking in our EHR so we will have rapid access to data that is needed. Next, we will need to update our systems as they relate to Managed Care Organizations.

2. Improve data visibility to help with better decision making.
   2018 – Worked to assure that our systems have and retrieve the right data. Hired a Database Specialist to help with these processes.

3. Strengthen infrastructure to support continued compliance with regulatory and/or contractual requirements. *
   2018 – Hired a new Billing Specialist, hired an assistant for the Billing Manager (new position), hired a Database Assistant. We still need to hire an insurance biller.

GOAL 4: Recruit, develop, and retain a workforce that delivers exemplary services.

Objectives:

1. Recruit staff and volunteers that reflect the diversity of our community.

2018 – Employees at the end of 2018 had the following characteristics: 25% identify as bi- or multi-cultural; 20% identify as LGBT. They spoke 16 different languages.

2. Continue to develop staff competencies specific to work skills at all levels, e.g., train staff in best/promising practices.
   2018 – Staff have been trained to use a variety of EBPs. We have now developed a tracking mechanism and procedure that accurately reflects when EBPs are used.

3. Evolve staff's and volunteers' cultural competency to meet the needs of our diverse community.
   2018 – Followed Cultural Competency Plan. Plan was reviewed with a few revisions. Staff are required to participate in at least one cultural competency or related training each year.

4. Develop and implement creative strategies to recognize staff who excel at their job.
   2018 – Department or program level groups gathered with recognitions given; recognitions were part of the all-staff meetings; we gave our annual Employee Awards based on our values; and made a greater effort to say "thank you" informally. Salary adjustments were made in several situations.

5. Provide Employees with tools/support they need to do their job.*
   2018 – Implemented additional phases of replacing computers. Improved and expanded office space. Moved Wraparound to another building; moved Mountlake Terrace office to bigger office in Edmonds; rented additional space in Everett for WISe Wraparound expansion.

6. Continue to provide a competitive benefit package appealing to current and potential employees.
   2018 – NonStop Wellness continues to give us an excellent health insurance benefit – no out of pocket expenses for our employees. The claim submission process was improved in 2018. Our benefits are well above average, and we used this fact to recruit new employees.

7. Enhance communications between departments increasing teamwork, engagement, and satisfaction.
   2018 – Some efforts were successful in addressing this issue, but there remains an overall lack of understanding of what each department does, and this limits the opportunities for working together. Plan to continue addressing this issue.

8. Increase employee retention and satisfaction year over year.
   2018 – Retention continues to be a problem for CHS, as it is for most other local non-profit agencies. This is largely due to inadequate pay and strong competition from for-profits and others who pay more wages for professional staff. 47 employees left CHS in 2018 (either voluntarily or involuntarily) and 25 of those employees had been with us less than a year. Staff are very satisfied with our benefit package. We implemented several different retention strategies and incentives (see "Employee Retention" section of this report).

9. Engage potential employees through a comprehensive announcement and orientation.
   2018 – Orientation process continued to be improved and job announcements were comprehensive.

GOAL 5: Implement strategies to diversify funding sources to promote sustainable growth.

Objectives:

1. Increase revenue year over year. *
   2018 – Goal met for 2018

2. Prioritize new services based on contribution to bottom line (See Strategies 1 & 2). *
   2018 – Focused expansion efforts in Snohomish County, where rates were better. Also expanded WISe services, which is funded well.

3. Locate/identify/evaluate new sources of funding.
   2018 – Several new sources of funding were explored, and we were successful in obtaining additional grant funds as well as Best Start for Kids funding.

4. Expand marketing to social media outlets as well as electronic and hard copy materials.
   2018 – Regularly & frequently posted on Facebook. Some hardcopy publications were created but more is to be done in this area.

5. Explore being a provider for EAP services (Boeing, VERA).
   2018 – This goal is being pursued by the Consortium to which we belong.

CONTINUOUS QUALITY IMPROVEMENT (CQI)

CHS uses our Continuous Quality Improvement (CQI) Team to develop, review, and update our Accessibility Plan, Risk Management Plan, Cultural Competency and Diversity Plan, and our Quality Improvement Plan. The CQI Team usually meets every month and addresses other quality improvement issues or initiatives.

Accessibility

Accessibility Plan

The 2017-2019 Accessibility Plan was reviewed by the CQI team regularly in 2018. The Accessibility plan and our analysis of the review of the plan are shared with stakeholders in a variety of ways such as through board reports, board minutes, CQI minutes, all staff meetings, this report, etc.

The following is a review of the barriers and action items and their status at the end of 2018. All actions on the original Accessibility Plan with target dates before 2018 had already been accomplished. Additions or deletions made to this plan in 2018 are listed in **purple** font. Status is reflected through 2018. Previously completed goals are omitted.

Accessibility Plan - 2018 Review

Attitudinal

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Stigma toward individuals with behavioral health issues and ability to recover Stigma toward minority cultures & different socio-economic groups.	• Educate staff • Educate public • Promote a culture of recovery & resiliency • Educate staff • Educate public • Promote a welcoming and inclusive environment.	Attitude and stigma remain barriers for some people who are seeking and receiving services. This category needs to be continually addressed. The following steps were taken in 2018 to improve accessibility that could be inhibited by attitude. • Staff participated in cultural competency and sensitivity trainings and other learning opportunities. • CHS allowed traditionally under-represented groups to hold support meetings or other activities at our locations. These included battered women, kinship

		caregivers, and Arabic Language School. • The mental health department held regular equity trainings for their staff. • One staff member conducts Youth Mental Health First Aid courses which educate people about behavioral health issues and debunk myths. Two trainings were conducted by here-in 2018.

Physical & Architectural

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Limited space for clinicians at the Mountlake Terrace, 170th and 148th sites.	Look for a larger location when lease expires at MLT; consider remodel options; consider adding space.	MLT barrier was negated by moving to a larger space in Edmonds. This portion of this action plan will be removed. 170th space needs were improved significantly when Wraparound moved to a different location. This portion of this action plan will be removed. 148th remains tight for space, but it is functionable. **We consider this action plan accomplished for the time being and will remove it from the overall Plan.**
Stairs at 170th (fire escape) need to be more secure.	Assess situation and restrict use if necessary. Secure funding to fix stairs.	Access has been restricted, but the stairs need to be replaced.
HVAC problems at 170th.	Explore option with our HVAC contractor.	Temperature remains difficult to manage at 170th. **This barrier will be removed from plan since we no longer are working on solving it.**
170th site looks unappealing.	Replace carpet/tile; repaint throughout; replace worn furniture.	Major remodel occurred which included new carpet/ tile, some new furniture, repainting, new bathrooms, etc. **This action plan was accomplished and will be removed from the plan.**

Policies, Practice & Procedures

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Development, revisions, updates, and combinations of existing or non-existing clinical policies & procedures need to be made.	Integrate new policies & procedures in relation to WACs/RCWs, BHO requirements, county requirements, & CARF. Finish Behavioral Health Manual.	Some revisions were made, and some new policies were established to follow BHO requirements and in anticipation of MCO or ICN new policies. More is changing in behavioral health so many revisions are anticipated in 2019 and will be ongoing.
Language barriers.	Hire more staff; educate staff on use of interpreters and translators.	Twenty-four of our staff are bilingual. In 2018 we used both telephone interpreters and in person interpreters. Beginning in 2019 in King County all Medicaid interpretation must by in-person and through a specific vendor.
Too much time between screening to assessment, and assessment to first on-going appointment.	Implement same day/next day assessments using open access.	Open access was implemented, and we put measures in place to improve the amount of time for first appointments. The only problems are with school-based and home-based services, and these serv-ices do not fit in the model. We will track and monitor these time expectations closely in 2019.

Communication (Information & Technology)

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Some computers need replacing.	Replace computers and implement replacement rotation schedule.	Computers were replaced in 2018 according to the schedule.
Not utilizing Credible as effectively as we could.	Build reports.	We hired another staff member who can build additional reports. We began working on which reports we need.
Not able to bill mental health services directly to King County (currently subcontracting with Navos).	Work with Credible to build capabilities for us to direct bill for Mental Health.	We began billing King County directly for all services effective December 2018. **This goal was accomplished.**

Financial

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Need to increase billing	Increase number of clients & service encounters. Assure that all encounters are billed, and payments received.	We will be in a better position to reconcile our billing in King County since we are now billing the county directly for mental health services.
Rates do not cover all costs for services	Negotiate rates with MCOs and other contractors	Rate negotiation will begin in 2019.
Some clients are not insured or have insurance deductibles so high that they discourage use of coverage	Obtain more unrestricted funds to subsidize services; Educate legislators	Since this action goal was added, our concerns about un-insured and under insured people have continued to increase due to the current federal political trends. We will keep this action plan open since the mandatory requirement for insurance has changed and the future is uncertain.

Transportation

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Agency van is aging.	Regular van maintenance.	Regular maintenance was completed in 2018. This is monitored by the site coordinator at the 170th site.
Anticipated disruption caused by construction of light rail near 148th location.	Keep informed of light rail plans and when construction will begin. Make plans for any disruptions it may cause.	Staying informed. No significant disruption occurred in 2018 but construction seems closer. **We will need to prepare for inadvertent consequences such as an increase in rodents.**

Community Integration

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Lack of knowledge of available community opportunities and resources.	Educate clients and staff.	Worked on educating clients about available community resources. Work is on-going.
Clients (particularly youth) are reluctant to become involved in pro- social activities.	Educate clients on what is available to them; include pro- social activities as part of ISP when appropriate.	Worked on educating clients about pro-social activities. Work is on-going.
People of color are disproportionately represented in the criminal justice system.	Advocate for and model racial equity.	Conducted trainings and facilitated/directed conversations regarding racial equity. Several staff attended equity trainings. We regularly posted messages on our Face-book Page related to equity. Researched anti-biased interviewing and hiring practices.

Employment

IDENTIFIED BARRIER	ACTION PLAN	STATUS - End of 2018
Some clients have a difficult time finding and keeping a job.	Include employment goals in ISPs when appropriate; Develop partnerships with employment programs.	Work on this barrier will continue.

Other Barriers as identified by persons served, personnel, or other stakeholders

The need for childcare was a barrier for many of our clients/ participants. We will continue to offer as much free childcare for our SUD clients as possible. The workforce shortage for SUD professionals caused us to be under-staffed much of the year. The difficulty in hiring Mental Health staff with competitive pay also left some Mental Health and Behavioral Health Integration positions open longer than desired.

Risk Management

Center for Human Services has insurance coverage that adequately protects all the agency's assets including coverage for professional liability, directors and officers, buildings, equipment and inventory, worker's compensation and our vehicle. Center for Human Services maintains coverage against claims from persons served, personnel, visitors, volunteers and other associates.

When, upon investigation, issues of risk to persons served, personnel, visitors and the organization are found to exist, CHS acts as quickly as possible to take corrective actions and make changes so the identified risk is minimized (or removed) and the potential for loss is decreased. Corrective actions are reviewed to ensure that the actions are or will be effective.

In 2018, we used a consultant to conduct a HIPAA Security Assessment of CHS. While our current policies and procedures were good, we saw a need for some improvement. With the help of the consultant, we developed and implemented an action plan to further improve our cyber security.

Additional risk management activities in 2018 included:

- All staff adhere to the confidentiality rules outlined in 42 CFR, part 2 and 45 CFR (HIPAA).
- We worked with a consultant to do a HIPAA risk management assessment and implemented an action plan to further our HIPAA security.
- Background checks were completed on all employees and volunteers
- HR regularly checked the LEIE Exclusion List to look for any of our employees who may be on the list. None were found.
- At orientation with new employees, Human Resources verified the employee's credentials and received consent to obtain a driving record on the employee. Copies of driver's licenses were filed in personnel files. Our insurance company obtained the driving records of employees.
- All new employees received and signed our Substance Use Policy and our Ethical Codes at orientation.
- Accounting policies and procedures were updated.

CHS sought and received input from clients, staff, and other stakeholders regarding perceived risks to create and update the Risk Management Plan. All risks continue to be assessed and updated on a regular basis. In all instances, CHS has done everything within reason to ensure that all risks to the agency are minimized. The Risk Management Plan and our analysis of reviews of the plan are shared with stakeholders in a variety of ways, such as through board reports, board minutes, all staff meetings, CQI minutes, this report, etc.

In 2018, the Continuous Quality Improvement (CQI) Team reviewed the Risk Management Plan and made revisions. The plan identifies our loss exposure or risks. In each of the potential loss categories the CQI team analyzed the loss exposure (likelihood of occurrence and seriousness of risk), identified how to rectify identified exposures, implemented actions to reduce risks, and reported results of these actions.

Some additional risks and mediations were added early 2018. Changes to the Risk Management Plan are indicated in **red font**. Our 2018 findings regarding the results of our actions to reduce risks were as follows:

CHS Risk Management Plan for 2018-2020

2018 Review

Loss Exposure/ Risk	Analysis of Loss Exposure						Actions to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2018
	Low	Med	High	Low	Med	High			Baseline 2017
FISCAL									
Loss of funding			X			X	Increase marketing and grant requests. Replace lost funding with new funding.	Funding base will be increased by 5%.	*Funding* increased by $701,669, an increase of 9.7%.
Costs exceed revenue			X			X	Maintain internship relationships with schools. Maximize available billing hours. Bill more insurance. Monitor monthly budget to identify trends of excess costs or under-billing. Increase revenue. Find ways to lower costs.	Cost will stay even with or less than revenue	Costs were less than income. We billed more hours than in the previous year. Our internship program remained strong. Several cost savings measures were implemented
Delay in payment			X		X		Participate in conversations with decision makers regarding impact of early adoption of integrated managed care. Build reserves.	Reserves will be ample to cover all expense for 3 months.	We have built reserves that will cover 3 months of expenses.

Loss Exposure/ Risk	Analysis of Loss Exposure						Actions to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2018
	Low	Med	High	Low	Med	High			Baseline 2017
HUMAN RESOURCES									
Loss of key personnel			X			X	Open door policy for all supervisory staff members. Transparency in all business dealings. Retreat. Boost employee retention efforts. Maintain exceptional benefits.	Minimize "key staff" turnover	No key staff left in 2018.
Increase in training requirements			X		X		Simplify access to training. Use of Relias web-based training. Review and update training curriculum. Stay up to date with training requirements. Customize and document training (new hires & on-going).	100% of required staff trainings will be offered. There will be a 95% completion rate for all training requirements.	Over 95% of staff completed required training.
High staff turnover			X			X	Utilize staff incentive programs. Utilize satisfaction surveys. Utilize exit interviews. If possible, increase salaries. Maintain excellent employee benefits. Improve training programs. Involve line staff in decision-making when appropriate. Explore new ways to invest in employees.	Reduce staff member turnover by 10%.	Staff turnover has not improved although we implemented all of the identified actions and more. There is simply a shortage of professional staff and an abundance of competition.

Loss Exposure/ Risk	Analysis of Loss Exposure						Action to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2018
	Low	Med	High	Low	Med	High			Baseline 2017
SERVICE DELIVERY									
Improper service documentation			X			X	Increase staff training and improve professionalism. Standard utilization of collaborative documentation. Supervisors monitor case notes. Proactive clinical supervision. Keep training manuals up to date. Maintain professional liability insurance.	Excellent clinical documentation.	We have excelled in this area. All staff are using collaborative documentation. Outside audits of our documentation have been good, and CARF raved over our documentation during the CARF survey.
Poor outcomes or outputs		X			X		Proactive clinical supervision. Use evidence-based practices. Staff training.	Excellent outputs and outcomes.	We had over-estimated some of the outputs with our City contracts. However, overall, our outputs and outcomes were within acceptable ranges.
HEALTH & SAFETY									
Serious on-site accident		X			X		Safety trainings for all staff members. Conduct Fire Drills routinely at each site. Maintain proper insurance. Active Safety Team. Timely repair of hazards.	Avoidance of serious accidents.	A staff member had a box fall on her head leaving her with a concussion. Otherwise, there were no serious accidents in 2018.

Loss Exposure/ Risk	Analysis of Loss Exposure						Action to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2018
	Low	Med	High	Low	Med	High			Baseline 2017
HEALTH & SAFETY (Cont.)									
Traffic accident			X		X		Properly orient staff members who are drivers. Staff training. Minimize travel. Ask City for flags at cross walk at 148th. Maintain vehicle insurance.	Reduce number of annual traffic accidents.	No traffic accidents occurred.
Fire incident	X					X	Safety trainings for all staff members. Train staff members about safety plan. Maintain adequate property insurance.	No fires.	No fires occurred.
Disaster	X					X	Educate staff regarding our Emergency Operations Plan. Contingency planning. Maintain adequate insurance.	Educate staff regarding our Emergency Operations Plan. Contingency planning. Maintain adequate insurance.	All staff received disaster preparation training and were educated about our EO Plan & Contingency Plan. Maintained same level of insurance.
Potential of violence or harmful situations		X				X	De-escalation & other safety trainings; safety drills; safety inspections; implement safety protocols for new situations.	No violence or threat of violence occurs at CHS, or if it occurs, harm is minimized.	The few cases of behavioral escalation by clients were controlled with de-escalation techniques. No remarkable situations occurred.
LEGAL									
Sexual harassment charges	X					X	Training during orientation and annually thereafter. Maintain proper insurance.	No sexual harassment incidents.	No sexual harassment incidents were reported.

Loss Exposure/ Risk	Analysis of Loss Exposure						Action to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2018
	Low	Med	High	Low	Med	High			Baseline 2017
LEGAL (Cont.)									
HIPAA or 42 CFR violation		X				X	Training in confidentiality. Maintain insurance (including cyber insurance). Training about HIPAA security. HIPAA security audit.	0 reportable incidents.	No violations were reported. Cyber insurance was maintained. We used a consultant to conduct a HIPAA Security Assessment of our agency and help us develop an improvement plan.
Malpractice lawsuit.		X				X	Educate staff on documentation techniques. Effective client grievance process. Regular supervision, performance coaching, & training. Maintain insurance.	0 lawsuits.	No lawsuits were filed against us.
Waste, fraud & abuse.		X				X	Have strong w/f/a policy. Educate staff on what w/f/a is and how to report violations. Implement quality assurance measures to verify proper billing.	0 waste, fraud, or abuse.	No incidents of waste, fraud, or abuse were reported or suspected.
Employment practice lawsuit.		X			X		Effective employee grievance process. Regular supervision, performance coaching, & training. Supervisor training. Maintain insurance.	0 lawsuits.	No lawsuits were filed against us.

Loss Exposure/ Risk	Analysis of Loss Exposure						Action to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2018
	Low	Med	High	Low	Med	High			Baseline 2017
TECHNOLOGY									
Data breach or data loss (affecting confidentiality, integrity, or availability of EPHI)		X			X		Maintain strong back-up policies & procedures. Review back-up P&Ps annually. Regular testing by IT vendor. Maintain cyber insurance.	0 data breaches.	No data was breached or lost.

Cultural Competency & Diversity

In 2018 our CQI Team reviewed our Cultural Competency and Diversity Plan. Input was considered from employees, clients, and other stakeholders in the analysis of this plan. The plan is based on the consideration of culture, age, gender, sexual orientation, gender identity, gender expression, spiritual beliefs, socioeconomic status, and language.

Cultural Competency & Diversity Plan

2018 Review

GOAL: CHS seeks to improve the quality of life of all staff members, clients, and other stakeholders by providing a dynamic and diverse environment. Through cultural competency initiatives, employees will enhance their understanding and sensitivity to cultural differences associated with race, age, gender, gender identity, gender expression, sexual orientation, religious preference/spiritual beliefs, socio-economic status, language, ethnicity, and other cultural factors. CHS will strive to model cultural competency with all stakeholders.	
Action Steps	**2018 Status**
1. Identify, recruit, select and retain employees, board members, and volunteers that are reflective of the diverse population we serve.	At the end of 2018, 25% of our employees identify as non-white; one employee uses ASL.
2. Conduct a cultural competency self-assessment.	We began work on this step, but it has not been completed.

3. Review existing policies to ensure that they support the development and implementation of a culturally and linguistically competent system of care.	All policies and procedures were reviewed. Minor revisions were made.
4. Assess for cultural consultation needs.	Cultural consultation was received when needed on a case-by-case level.
5. Identify cultural needs of clients and train clinicians to incorporate them into treatment/service planning.	Equity Trainings in MH included working with native populations, the school to prison pipeline, implicit bias, systemic racism, white fragility. Special education and racially disproportionate IEPs, and others.
6. Assess and modify the physical facility and tools to reflect the population we serve, and to be welcoming, clean and attractive by providing cultural art, magazines, culturally relevant toys, etc.	When furnishing our newly leased buildings we carefully chose appropriate culturally inclusive or neutral art and toys.
7. Include at least one cultural competency or diversity training in all staff members' annual training plans.	Accomplished.
8. Offer at least one in-house cultural competency or diversity training for staff.	Accomplished.
9. Provide an equity training in the Mental Health Department each month.	Accomplished. This goal will be changed to Quarterly rather than monthly in 2019.
10. Assess the linguistic capabilities of our staff and establish a clear protocol for using interpreters.	Included a question at orientation that asks for new employee's linguistic abilities. Used both telephone and face-to-face interpreters with clients. Protocol for requesting interpreters in 2019 for Medicaid clients was updated by the state, so our internal protocol was revamped with this in mind.
11. Review and update the Cultural Competency and Diversity Plan.	Accomplished.

- Additional 2018 efforts related to Cultural Competency and Diversity are listed below:
- Staff were encouraged to attend trainings on Cultural Competency/Diversity and given time off to do so.
- All job descriptions had elements regarding our expectations regarding cultural sensitivity.
- CHS used certified interpreters during sessions as needed.

- CHS maintained its relationships with agencies that provide cultural-specific services (i.e., Consejo, Asian & Pacific Islanders Counseling, Seattle Counseling for Sexual Minorities, etc.) and referred to these agencies when appropriate.
- Remodel of restrooms at 170th were made to be ADA compliant.
- We offered Play and Learn groups, Out of School Time tutoring, parenting classes, information and referral services, and mental health sessions were in Spanish. Mental health services were also offered in Arabic.
- We serve as host for a Women and Infant Children (WIC) site where staff speak Spanish, Korean, and Vietnamese at our 170th Shoreline location.
- An Arabic Language School used our 170th Shoreline location on weekends for their classes.
- Through our collaboration with the Northshore School District's Transition Program, several disabled people volunteered with us.
- Our PI Program conducted LGBT Support Groups (with amazing participation) in Northshore schools.

For information regarding the diversity of our clients and participants, please refer to the "Persons Served" section of this report. See information under "Human Resources" for diversity and cultural information about our employees. See information under "Board of Directors" for diversity and cultural information about our board of directors.

CORPORATE COMPLIANCE

Critical Incidents

2018 Critical Incidents Review & Analysis

The Corporate Compliance Committee reviewed all the critical incidents from 2018. The definition of "reportable events" from the Behavioral Health Organizations changed resulting in many fewer categories of what should be reported. Therefore, annual comparisons will not be relevant.

In total, 8 Critical Incidents were reported. Seven were in the Substance Use Disorders Department and one was in the Mental Health Department.
The incident reports documented the following:

- Death of client 2
- Violent act committed by client 4
- Attracted media attention 2
- Acts by client reported to police 1
- Unauthorized possession of substances 1
- Communicable disease/infection control 1
- Completed suicide 1

Note that some incidents fit in more than one category. Debriefing occurred on the program level in each incidence. Obviously, some incidents (such as the suicide by a 12-year-old) required more debriefing and employee-care than others.

The Corporate Compliance committee reviewed and analyzed the 2018 critical incidents and found the following:

- Cause of each incident – None of the causes of the incidents were out of the ordinary. The incidents were categorized in the according to the event as listed above.
- Trends or emerging themes – None, although the death of two clients, and one by suicide, had a profound impact of staff.
- Action plans for improvement – None noted; our responses to each incident were all appropriate.
- Results of performance improvement plans – N/A
- Education and/or training of personnel needed – We agreed that we need to provide staff with a training to update them on the changes in Critical Incident reporting for 2019.
- Prevention of recurrence – None of the incidents were within our control.
- Internal reporting requirements – All internal reporting requirements were met, and all incidents were reported in a timely manner.
- External reporting requirements – In two incidents, staff were required to report the incident to the BHO and did so.

SERVICE DELIVERY (JAN.1, 2018 – DEC. 31, 2018)

Persons Served:

Mental Health Clients

1,850 people received Mental Health services.

- Adults - 319
- Children/Youth - 861
- Children between six and eighteen - 769
- Children younger than six – 92
- Received CHS Clinic-Based services -1,005
- Received School-Based services – 572 youth
- Received Home-Based services – 129 families

Substance Use Disorders Clients

846 people received Substance Use Disorders services

- Received treatment services - 585
- Adults - 403
- Youth - 182
- Received School-Based Treatment services - 64 youth
- Received Prevention/Intervention services – 355 youth
- Received Wraparound services – 82 families

Behavioral Health Integration Clients

1,300 people received BHI services

- Received SBIRT services in Medical Clinics – 484
- Received Screening services – 115
- Received Health Home services – 235
- Received School-Based Prevention/Intervention services in schools – 9

Family Support Participants

1,536 people participated in family support programs or classes.

- Received Out-of-School-Time program services – 90 youth
- Participated in parent/child activities – 1,222 parents & children
- Received Adult Education – 268 adults
- Received Child Care – 111 children

Total Served in Programs – 5,532

(Total does not include telephone screenings, universal prevention, & some outreach)

Characteristics of Persons Served

N = 4,974 - (only individuals who completed demographic forms)

Service Locations	
867	Shoreline
443	Everett
456	Lynnwood
512	Bothell
548	Seattle
185	Edmonds
229	Kenmore
124	Woodinville
134	Mountlake Terrace
118	Kirkland
134	Lake Forest Park
44	Snohomish
51	Other King County
148	Other Snohomish County
981	Information Withheld
4,974	**Total**

Races/Ethnicities	
79	American Indian/Alaska Native
332	Asian/Pacific Islander
348	Black/African American
882	Latinx/Hispanic
1,897	White/Caucasian
256	Other Race
1,180	Race Not Disclosed
4,974	**Total**

Gender	
2,303	Female
1,887	Male
15	Transgender
5	Intersex
764	Gender Not Disclosed
4,974	**Total**

Ages

835	0-5
535	6-12
1,167	13-17
570	18-24
645	25-34
879	35-54
317	55-74
26	75+
4,974	**Total**

Service Hours

A total of 62,354 service hours were provided in 2018. Below is a breakdown of the individual department hours.

Mental Health Clients – 13,296
Substance Use Disorders Clients – 16,787
WISe – 3,679
Behavioral Health Integration Clients – 1,986
Family Support Participants – 26,606

The above service hours do not include telephone screening, information & referral, and many outreach activities.

STAKEHOLDER INPUT

Methods and Trends

Stakeholder input is crucial to our planning, program development, outcome evaluation, and overall sustainability. Stakeholders are clients/participants, family members, employees, funders, community members, etc. In addition to a procedure being in place for client and/or employee grievances, we solicited feedback from stakeholders using a variety of methods:

- Client/participant feedback was solicited using focus groups.
- Client/family feedback was solicited using an anonymous survey.
- Managers/Directors talked with random clients/ participants individually about the services they were receiving.
- Substance Use Disorders treatment program conducted M-90 follow-up assessments on all clients in treatment.
- Comment/suggestion boxes were placed at each site.
- Feedback was encouraged on our web page.
- Staff attended various community meetings and sought comments and suggestions about our services from attendees.
- A Staff Satisfaction Survey was administered to agency employees.
- Employee exit interviews were conducted by Human Resources if the departing employee consented.

Trends included:

- Without a specific effort (such as a focus group or survey) to obtain input, very little feedback is received from clients, employees, or other stakeholders.
- Clients are for the most part very pleased with the services they are provided.
- Our sampling of clients for surveys were much larger than last year's.
- Staff satisfaction results were very similar to 2017 results.

CLIENT INPUT

Satisfaction Survey Summaries

Substance Use Disorders Treatment Satisfaction Survey:

A satisfaction survey was administered randomly to SUD treatment clients in 2018. 36 clients participated in the survey. The results are as follows:

Q.1. How satisfied are you with CHS services?

Very Satisfied	27
Somewhat Satisfied	6
Neither satisfied or dissatisfied	2
Somewhat dissatisfied	1
Very dissatisfied	0

Q.2. In your opinion, does CHS treat all clients with dignity and respect?

Yes	36
No	0

Q.3. Have you experienced any barriers to receiving CHS services?

Yes	4
No	32

Barriers identified:

Transportation problem	9
Could not get an appointment quick	3
Can't afford services	4
Location not convenient	3
Other	2

There were no changes made based on the above survey, however, staff were reminded of our expectations.

Mental Health Satisfaction Survey:

A satisfaction survey was administered randomly to mental health clients and/or their families in 2018. 215 people participated in the survey; 202 were clients; 9 were parents/caregivers; 4 did not identify. The results are as follows:

Q.1. How satisfied are you with CHS services?

Very Satisfied	171
Somewhat Satisfied	38
Neither satisfied or dissatisfied	6
Somewhat dissatisfied	0
Very dissatisfied	0

Q.2. In your opinion, does CHS treat all clients with dignity and respect?

Yes	214
No	0

Q.3. Have you experienced any barriers to receiving CHS services?

Yes	14
No	201

Barriers identified:

Transportation problem	9
Could not get an appointment quick	2
Can't afford services	4
Other	10

There were no changes made based on the above survey, however, staff were reminded of our expectations.

Mental Health & Substance Use Disorders Accessibility Survey

Because accessibility to our services was a primary area of focus for us in 2018, we conducted a series of Access to Care Surveys for King County clients. There were only three questions and the clients/caregivers in the two departments were asked to complete them immediately after their

initial intake/assessment appointment. 129 clients completed this survey. The results were as follows.

Q.1. I was satisfied with the time I had to wait between asking for help and my first meeting with clinic staff.

Yes	125
No	4

About how long did you wait between asking for help and your first meeting with clinic staff?

Less than 15 minutes	59
15-60 minutes	30
1-4 hours	8
1 day	15
2-4 days	9
5 or more days	5

Q.2. Services were available at times that were convenient.

Agree	120
Disagree	7
Did not answer	2

Q.3. The staff members I spoke with treated me with respect.

Agree	128
Disagree	1

There were no changes made based on these survey results. We anticipate that with "Open Access", our time will continue to improve.

Family Support Surveys

The various programs in the Family Support Department administered surveys to participants. All the results were positive. Below is a sampling from each program.

Play & Learn:

Q.1. What skills has your child has gained because of participating in KPL?
"The group participation and cooperative play with same aged children. Singing songs as a group & following a "teacher's" directions. School readiness skills"
"Confidence"
"We've learned that each child learns at different paces. It's okay to be different."
"I've seen the biggest difference in their fine motor skills."

Q.2. What are 2-3 things you do differently at home with the child in your care/since participating in KPL?
"Different ideas for activities and understanding of how to encourage learning. Noticing stages of learning & development and promoting reaching to the next level"
"Play more! talk more, work together on letter recognition, fine motor, etc."
"actively play, find opportunities to learn/count everywhere"

"I see more opportunities for teaching and connecting when we are out and about."
"Connecting with the families from the group"
"More patient with them when they are trying something new - explain more how's & why's we do what we do"
"I have definitely learned to value "play" more greatly and taken several of the activities, songs, and ideas into my home."
"We try to make every activity we do a learning opportunity for our son. We are very careful with what we watch on TV and what we talk about around him, because we are his model."

Other Comments:
"Of all the different KPL groups I have attended, yours are the best!"

Parenting Classes in Spanish:

Q.1. Please describe how Positive Discipline has influenced your family.
"When we are all in the same harmony, things flow better, and we all learn that our family lives better in all aspects."
"To not shout so much with them and love more."
"The class has influenced me to feel closer to my children and understand the needs of them."
"I have to listen to them more instead of imposing my ideas and telling them that I am right because I am the mother."
"Now we speak more of feelings, that there is respect for all. We negotiate and choose agreements."
"The strategies learned here have been the best tools that as a parent I can use. Just seeing the results of applying them is proof of them. And even more will be the long-term results."
"Be more united and strengthen family love."
"Positively influenced and my son has improved a lot in school and at home."

Out of School Time Program: (Spring 2018 school year program)

Q.1. What was your favorite experience in the afterschool program this year?
"I get to hang out with friends." – 4th grader
"I loved everything" – 5th grader
"Computers" – 3rd grader
"When I get a snack and we made fluffy slime." – 3rd grader
Q.2. Please tell us why you want to come to the afterschool program
"I come here to get help on homework" – 4th grader
"So I can get food and learn new stuff" - 3rd grader
"Because its useful and they help me with my homework" – 5th grader
"I come here as a break from everything and to be with my little brother." – 8th grader

Out of School Time (Camp Ballinger 2018 CIT feedback)

Q. 1. What did you like best about the program and being a CIT?
"being able to connect with kids"– 12th grader

"meeting new kids/people" – 11th grader
"being a leader on the field trips" – 9th grader
"gaining the respect of the kids" – 12th grader

Q.2. What was the most important thing you experienced or learned as a CIT this summer?
"I learned more leadership skills" – 11th grader
"how all kids don't work and learn the same" – 12th grader
"how to control my temper with kids" – 12th grader
"how to help young children solve problems" – 9th grader

Focus Groups Summaries

The Substance Use Disorders Department conducted three focus groups in 2018. In total 25 current clients participated in the focus groups. The focus groups were facilitated by a Program Manager rather than the clients' clinician or group leader. One focus group was conducted in April with 10 adult Drug Court clients at the Silver Lake location. The primary concern expressed by this group was the inconsistency of counselors for the group. They noted that they particularly liked the Silver Lake office and the group times and days. In August another focus group was held with 6 IOP day group clients. They expressed that they would like a larger group but were pleased with having a group in the daytime, the attentiveness of their counselor, and fact that they felt respected. A final focus group was held with 9 clients from the MRT group. The only thing they expressed as wanting to be different was that they wanted more women in the group. They also expressed that they like their counselor, the MRT process, and the respect they receive from staff.

Employee Input

An employee satisfaction survey was administered to staff in November 2018, using Google Forms. We were very pleased with the response rate, in that 69 employees completed the survey. 9 are from Administration; 22 are from the Mental Health Department; 24 are from the Substance Use Disorders Department; 7 are from the Family Support Department; and 7 were from the Behavioral Health Integration Department. The survey included 33 statements that were ranked on a scale of 1 -5 with "1" meaning "not true at all" and "5" meaning "extremely true". The specific statements and average scores are on the next graph:

Staff Satisfaction Survey 2018

1. I have a good understanding of the mission of CHS.	4.32
2. I understand how my work directly contributes to the overall success of CHS.	4.30
3. I am satisfied with my job.	3.66
4. I am highly committed to this organization.	3.85
5. I feel personally driven to help this organization succeed and will go beyond what's expected of me to ensure that it does.	3.96
6. I am proud to tell people that I work for this organization.	4.20
7. I receive useful and constructive feedback from my supervisor.	3.94
8. Teamwork is encouraged at CHS.	4.04
9. I receive the training I need to do my job well.	3.35
10. My supervisor encourages and supports my development.	4.01
11. We maintain very high standards of quality at CHS	3.84
12. CHS is focused on clients' needs.	4.12
13. The amount of work I am asked to do is reasonable.	3.54
14. I am treated fairly by my supervisor.	4.22
15. To the best of my knowledge, everybody is treated fairly at CHS.	3.68
16. My job does not cause unreasonable amounts of stress in my life	3.30
17. My supervisor treats me with respect.	4.30
18. CHS respects its employees.	4.50
19. My coworkers care about me as a person.	4.22
20. I have the tools and resources I need to do my job well.	3.59
21. My workplace feels safe.	3.92
22. CHS tries to address accessibility issues for our clients and the community.	3.98
23. Information and knowledge are shared openly at CHS.	3.49
24. Communication is encouraged at CHS.	3.77
25. CHS leadership is genuinely interested in employee opinions and ideas.	3.54
26. CHS works to attract, develop, and retain people with diverse backgrounds.	3.41
27. People with diverse backgrounds and experiences are given respect and valued in CHS's work environment.	3.91
28. My salary is competitive with similar jobs I might find at similar organizations.	2.71
29. I am satisfied with my employee benefit package.	4.17
31. I respect the managers and directors at CHS.	4.04
32. CHS Directors know what they are doing.	3.84
33. The Executive Director demonstrates strong leadership skills.	3.91

The results of the survey were very similar to the results from the previous year. There were no scores with a significant difference from 2017. Only one question received an average score of less than 3. We considered scores of 3 or above to be acceptable, although not

always implying that it was an area that does not need addressing. The question of lowest satisfaction is: "My salary is competitive with similar jobs I might find at similar organizations." (2.71) The question with the highest average satisfaction score (4.5) is "CHS respects its employees".

Employee Grievances

There was one employee grievance in 2018. It was in regard to communication between a supervisor and a supervisee. It was settled informally to the satisfaction of both employees.

Other Stakeholder Input

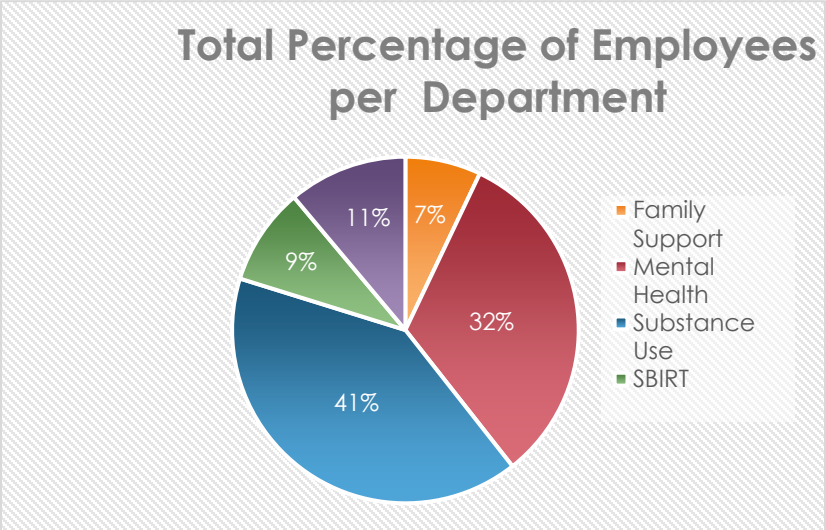
No other input from community members through the web page or other means available was analyzed.

HUMAN RESOURCES

Overview

On December 31st, 2018, CHS had a total of110 employees, an increase of 8 compared to the previous year. Of the 110 employees, 78 were full time employees; 21 were part-time employees, and 11 were on-call/temporary employees. We also had 16 vacant positions at the end of 2018.

Department	Number of Employees Per Department
Family Support	7 (plus 11 on-call/temporary staff)
Mental Health	32
Substance Use Disorders	40
Behavioral Health Integration.	9
Administration	11

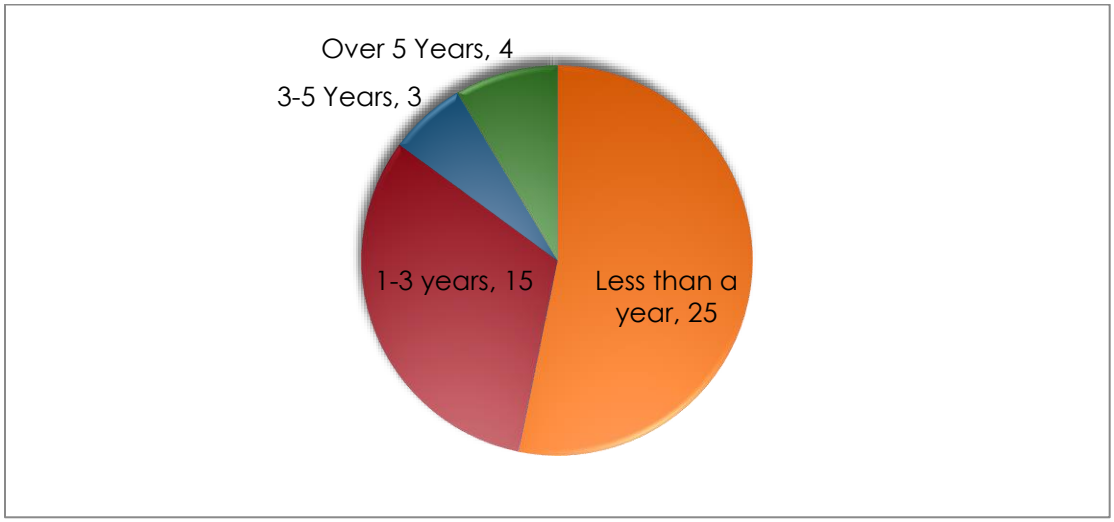


At the end of 2018, the diversity of our staff included:
(The numbers below do not include on-call or temporary employees.)

1. Age – 5 are over the age of 60; 9 are 51-60 years old; 20 are between 41-50 years old; 35 are between 30-40 years old; 30 are under 30 years old
2. Race – 25% of our staff identify as non-white
3. Gender – 30 males; 68 females; 2 transgender/queer
4. Sexual Orientation – 20% of our staff identify as LGBT
5. Languages – In addition to English, the following languages are spoken by our staff: Amharic, Oromo, Spanish, German, Tagalog, Bosnian, Serbian, Croatian, Chewa, Hebrew, Japanese, Conversational A&L, Chinese, Cantonese, Mandarin. 21% of our staff are bilingual speaking English and one of 15 other languages, with several of them speaking up to four languages. Additionally, we had interns at the end of 2018 that are bilingual.

Employee Retention

Longevity of Employees who Left CHS in 2018



25 employees left before their 1-year anniversary,
15 employees left between 1 to 3 years of their employment with CHS,
3 left between 3 to 5 years of their employment and
4 left between 5 or more years of their employment with CHS.

Terminations for 2018

In 2018, 47 people were either voluntarily or involuntarily terminated from CHS. Five people were involuntarily terminated due to agency policy violations. The reason for other 42 employees resigning included:

- Accepted new job: 16
- Retirement: 2
- Health reasons: 5
- Personal reasons: 9
- Moved outside of reasonable commute/state: 6
- Went back to school: 4

In total 30 exit interviews were completed: The most common responses received indicated that staff enjoyed working with their co-workers, the culture at CHS is very open and everyone is very friendly, staff appreciate the benefits provided at CHS; staff values how much management realizes that social and political aspects of life can influence the job and appreciates the open-door policy. Have better clinical trainings, establish boundaries for the clinicians, processes and procedures for the new programs, more engagements between staff from different departments, making sure that satellite programs are more connected to other programs and offices.

2018 retention efforts included:

- 4 all-staff meetings were held including a summer picnic.
- All staff had training plans that were used for staff growth.
- CHS continued to pay 100% of a full-time employee's health insurance costs with no out-of-pocket expenses for the employee.
- Employee awards were given based on agency values.
- U-Rock was given at each Manager's Meeting.
- Employee evaluations were conducted regularly.
- Vacation time for employees was one day per month plus an additional day for each year employed, up to 20 days per year. Employees were allowed to carry over 1.5 times their annual allotment at the end of each year up to 20 days.
- CHS gave employees 11 days of paid leave for holidays for the year. (9 traditional holidays, one discretionary day identified by the Executive Director and one "personal" day chosen by the employee).
- New orientation process and on-boarding process was better defined.
- Pay adjustments were made for several employees who were paid less than average wages for their positions.
- 30 exit interviews were conducted.
- Technology was improved.
- Improved work conditions for Snohomish County WISe Wraparound staff by renting a new office space.
- End of the year bonuses were given using Workforce Development funding from the State (through NSBHO).
- Sick time was accrued at the rate of one day per month. Accrual is carried over each year up to a maximum of 60 days per year.

ADA Requests

We received 2 ADA requests in 2018. One request was for an external monitor and keyboard to enforce posture for neck and back, and the second request was for a lighter computer to help decrease a chronic pain in hands. Both ADA requests were accommodated in timely manner for employee.

2018 Employee Awards Winners

Employee awards are based on the agency's values. Nominations come from staff and the winners are selected by the Board of Directors. Awards were presented at our Winterfest celebration with board and staff. The staff awards went to:

- **Accountability**
  Stan Iraola – Intake Specialist
- **Accessibility**
  Josh Gilbert – Intake Specialist & Health Homes Coordinator

- **Diversity**
  Mirit Markowitz – Behavioral Health Integration Therapist
- **Integrity**
  Hannah Dickinson – Mental Health Therapist
- **Collaboration**
  Tekle Bushen – Director of Administration & Finance
- **Fun**
  Kayla Rees – Mental Health Therapist

CHS Leadership

Beratta Gomillion	Executive Director
Tekle Bushen	Director of Finance & Administration
Ramona Graham	Substance Use Disorders Department Director
Katrina Hanawalt	Mental Health Department Director
Paula Thomas	Behavioral Health Integration Department Director
Tanya Laskelle	Family Support Department Director

Volunteerism

In 2018 CHS had 352 volunteers who performed 8,134 hours (an increase of 1,189 hour compared to 2017) of volunteerism valued at $200,828.46 (based on IRS volunteer value of $24.69 per hour for 2018). Many CHS staff also volunteer for other causes.

FINANCIAL OPERATIONS

Overview

Financial operations consist of policies and procedures that ensure the continued financial success of Center for Human Services through prudent financial management. Financial management is the process of controlling and utilizing resources to best achieve agency goals. This type of management consists of the following principles, and was analyzed as indicated:

1. Liquidity
   (ability to meet short-term financial obligations such as monthly agency expenses) - As of 12/31/2018, our quick ratio (also known as acid test) is 5.5 – meaning that we have 5.5 times the amount of cash and receivables needed to meet our current obligations. There is no significant difference from the prior year ratio. This is because the increase in both current assets and liabilities are proportionate. Also, we have maintained our liquidity ratio, in spite of the major investments in IT infrastructure and some building renovations and expansions.

2. Debt service coverage ratio
   (the ratio of cash available for debt servicing to interest, principal and lease payments) – As of our fiscal year-end June 30, 2018, our debt service coverage ratio was 4.93, meaning that our current income was enough to cover our debt payments. The ratio improved, meaning that when compared to last year, the coverage ratio is higher by 0.61.

3. Efficiency
   (ability to obtain the maximum output possible from our limited resources) – Our outputs (numbers of people served; number of hours served) compared to our revenue shows efficiency.

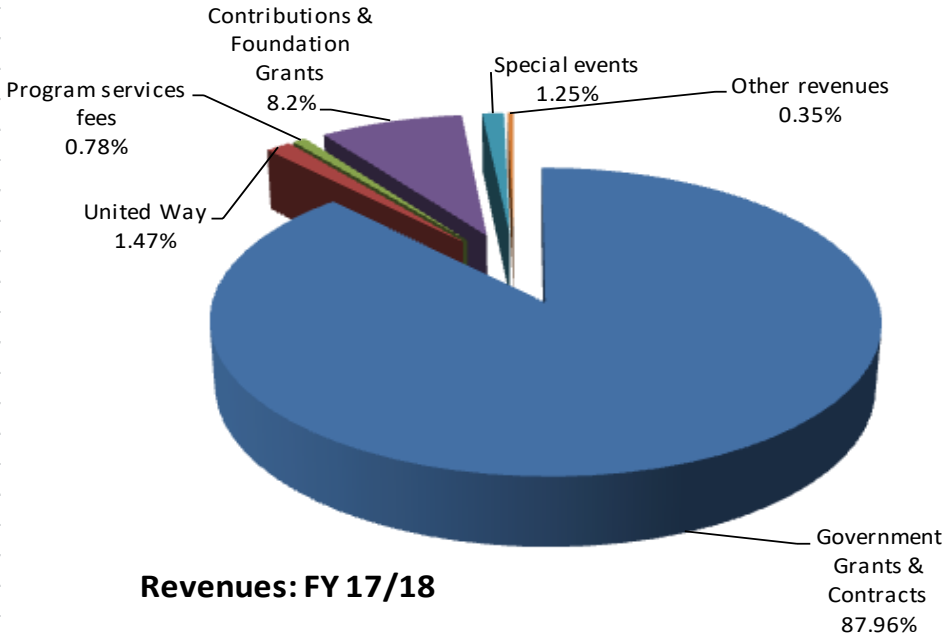
4. Fidelity
   (any appearance of conflict of interest will be identified and reported immediately to the Executive Director). CHS has a clear conflict of interest policy that addresses this.

In 2018:

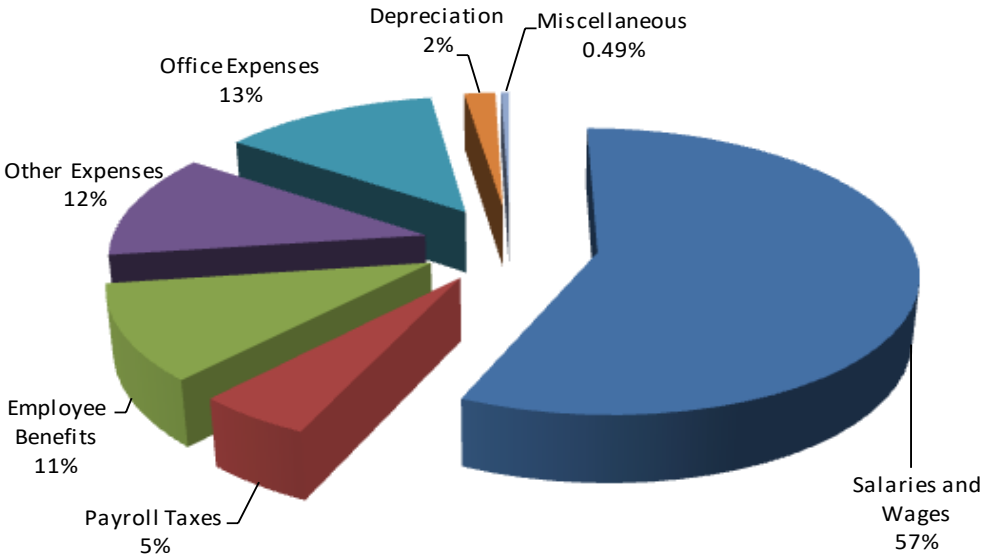
a. CHS received a clean audit with no findings from Jacobson Jarvis & Co., PLLC.
b. The Credit Line of $200,000 was not used at all in 2018.
c. Financial policies and procedures were reviewed and updated.

2017/2018 Fiscal Year Revenue and Expenses per Category (Actual)

FINANCIAL REPORT JULY 1, 2017 Through JUNE 30, 2018



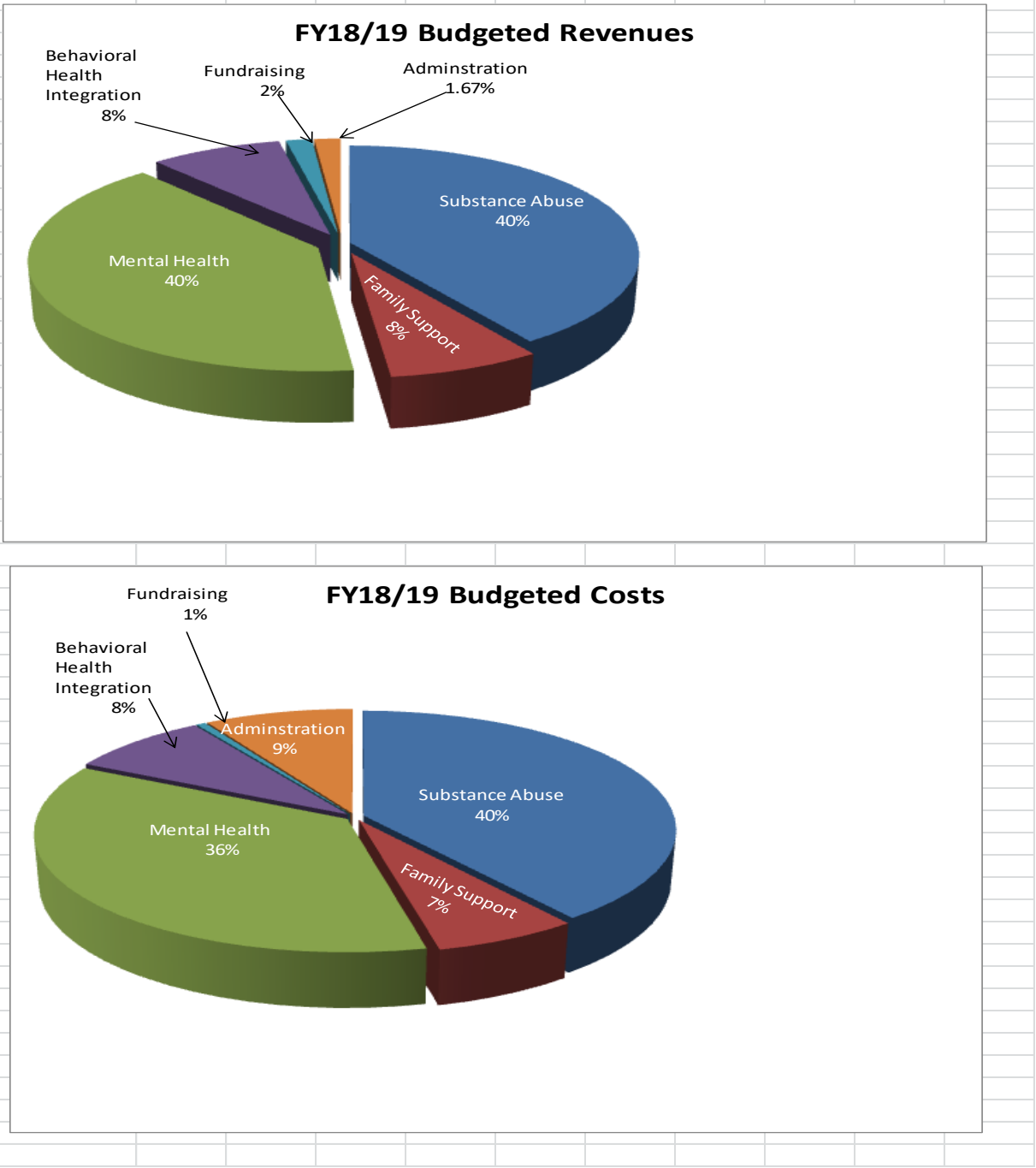
Revenues: FY 17/18



Expenses: FY 17/18

Revenue and Expenses per Department

Budgeted for Fiscal Year 2018/2019



PERFORMANCE IMPROVEMENTS

Overview

Center for Human Services is committed to continually improving our organization and service delivery to the clients served. We analyze and manage the data we collect in Credible (our her), reports, from focus groups, from satisfaction surveys, from client and stakeholder feedback, etc., to determine opportunities for improvement and opportunities for celebration. We expect our performance management processes to set us apart from other organizations when reviewed or surveyed by licensing bodies, contract monitors, and CARF.

CHS is committed to the ongoing improvement of the quality of care our clients receive, as evidenced by the outcomes of that care. CHS continuously strives to ensure that:

- The treatment provided incorporates evidence-based practices;
- The treatment and services are appropriate to each client's needs and are available when needed (see Accessibility Plan);
- Risk to clients, staff, and others are minimized, and risk prevention is implemented (See Risk Management Plan; See Health & Safety Plan));
- Client's individual needs and expectations are respected, and they have the opportunity to participate in decisions regarding their treatment and services provided (See Client Feedback Policy);
- Clients are treated with respect in a culturally informed manner and in a diverse environment (See Cultural Competency Plan).
- Services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.

CHS tracks effectiveness, efficiency, accessibility, and satisfaction in a systematic manner that can be distinct for each program and/or counselor, as well as in the aggregate.

The overarching outcome for all CHS behavioral health programs is for people with behavioral health issues to have access to integrated care and maintain optimum health including recovery.

QUALITY IMPROVEMENT & MANAGEMENT PLAN: 2018 Analysis

Service Delivery Functions

Effectiveness of Services

- **The use of evidence based/informed and promising practices**
  - Applied to all programs
  - Data Source – Inventory of EBPs and promising practices used
  - Person(s) Responsible for Data Collection - Managers and/or Directors
  - Process – Managers/Directors keep inventory up to date and provides the inventory to the Executive Director who analyzes our progress toward offering more programming using evidence-based/informed practices and/or promising practices.
  - Achievement Goal – 90% of our programming includes evidence-based/informed practices or promising practices.
  - Actual Results – This goal was met.

- **Case record reviews**
  - Applied to clinical programs
  - Data Source – Electronic Health Records
  - Person(s) Responsible for Data Collection – Supervisors
  - Process – Supervisors conduct clinical audits of records assigned to each clinical supervisee. They provide individual results to the clinician of record clearly outlining change expectations and timeline for completion. The supervisor monitors the data to assure it is corrected. The supervisor addresses any coaching opportunities with the clinicians. The Department Director and Program Manager utilizes trends of aggregate audit results to optimize clinical performance through remediation or sharing of clinician best practices.
  - Achievement Goal – At least one record from each clinician is reviewed monthly, and every closed record is reviewed as part of the closure process.
  - Actual Results - This goal was met.

- **Services and treatment planning maximize child and family access, voice and ownership**
  - Applied to all programs
  - Data Source – Results from clinical records reviews.
  - Person(s) Responsible for Data Collection – Supervisors
  - Process – Supervisor looks for evidence of client/family access, voice, and ownership and documents findings on review form. Results are shared with Program Manager or Department Director as appropriate. When a clinician consistently omits this information, a corrective action plan may be implemented and/or it may be noted in the clinician's annual performance review.
  - Achievement Goal – 85% of our clinical records reviewed consistently documents client/family access, voice, and ownership.
  - Actual Results - All our outside audits and reviews showed that we were consistently meeting this goal.

Client participant outcomes

Family Support Progress

- **Parenting Classes**
  - 95% of participants who attended our Positive Parenting classes improved their family relationships.

- **Out-of-school Time Programs**

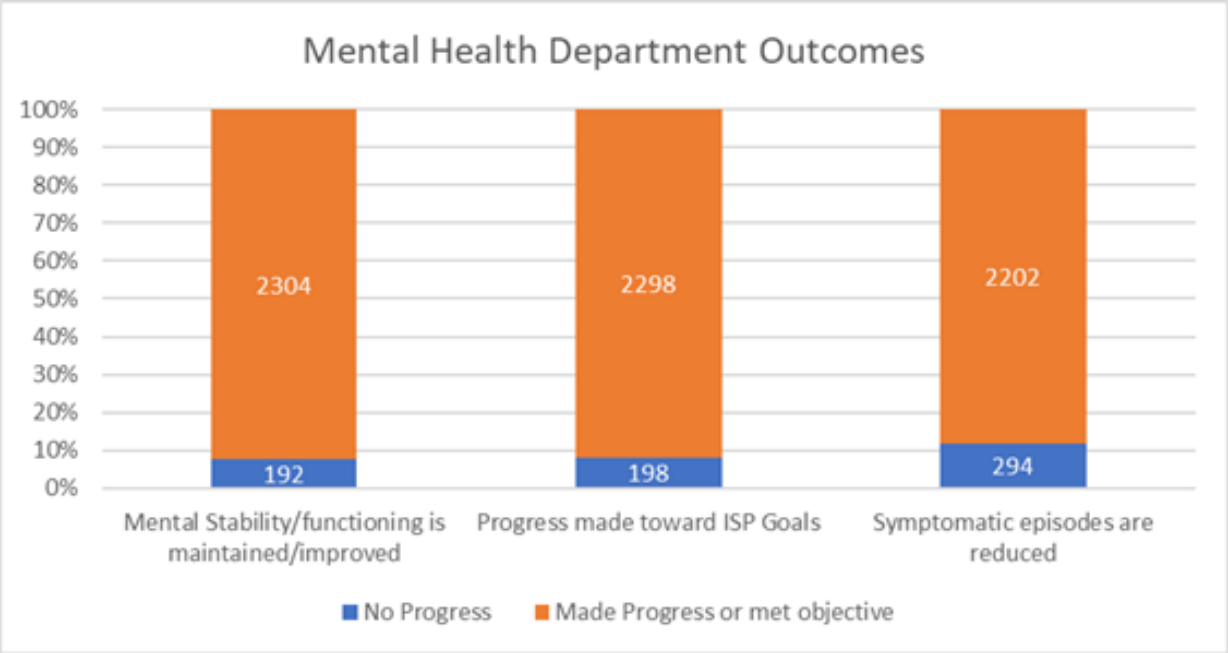
After School Program (September 2017 – June 2018):

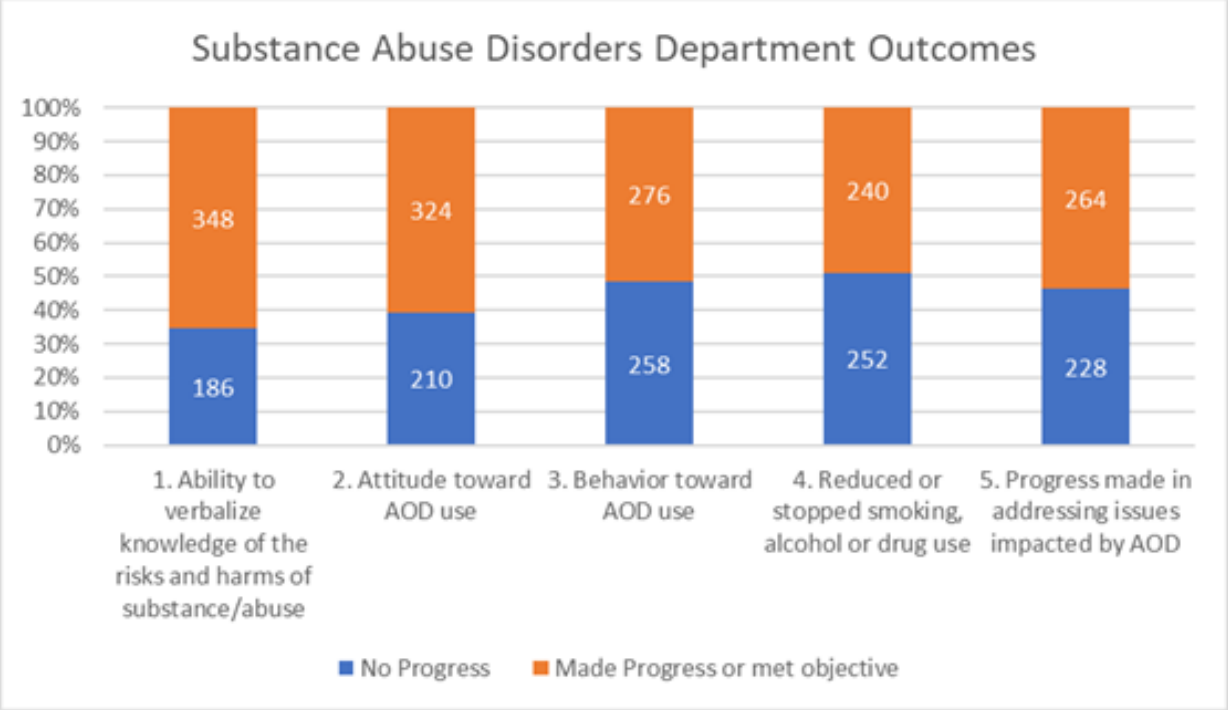
  - 92% of K-8th developed/strengthened their positive conflict resolution and/or problem-solving skills
  - 83% demonstrated personal responsibility and/or leadership
  - 91% reported a sense of belonging and engagement in the community

  - 92% of K-8th graders reported they maintained/increased their enjoyment and interest in science and STEAM activities.
  - 21 local youth (9th – 12th grade) fulfilled the role of Counselors in Training during the summer camp program for a total of 1,431 hours
  - 823 free lunches were provided to youth 5-18 years old during the summer

- **Play & Learn**
  - 91% increased their understanding that children develop school readiness skills when they play
  - 89% increased their understanding of the role they have in helping the child in their care be ready for kindergarten
  - 86% increased their understanding of what to expect from children at different ages
  - 86% increased how of often they read, look at books or tell stories with the child in their care
  - 91% increased providing opportunities for their child to learn and try new things
  - 91% feel more supported as a parent/caregiver in their community

- **Clinical Programs:**
  - 93% of the clients who received mental health services improved their mental stability/functioning.
  - 48% of clients who received substance abuse treatment services reduced or stopped their alcohol, tobacco, or drug use.


Mental Health Department Outcomes
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2304
192
2298
198
2202
294
Mental Stability/functioning is maintained/improved
Progress made toward ISP Goals
Symptomatic episodes are reduced
No Progress
Made Progress or met objective


Substance Abuse Disorders Department Outcomes
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
348
186
324
210
276
258
240
252
264
228
1. Ability to verbalize knowledge of the risks and harms of substance/abuse
2. Attitude toward AOD use
3. Behavior toward AOD use
4. Reduced or stopped smoking, alcohol or drug use
5. Progress made in addressing issues impacted by AOD
No Progress
Made Progress or met objective

- **Critical incidents**
  - Applied to entire agency
  - Data Source – Critical incident reports
  - Person(s) Responsible for Data Collection – All staff involved in any incident (as defined in policy)
  - Process – When an incident has occurred, staff involved complete an incident report. Incident reports regarding clients are completed in the electronic health record. Other incident reports are completed using a "Critical Incident Form" and given to the Executive Director within the time frame identified in policy.
  - Achievement Goal – 100% of the critical incidents reported are analyzed for quality improvement opportunities.
  - Actual Results – Goal met. See Critical Incidents summary and analysis in the report.

- **Client complaints and grievances**
  - Applied to clinical departments
  - Data Source – Grievance reports
  - Person(s) Responsible for Data Collection – Executive Director
  - Process – Complaints are attempted to be resolved in an informal matter. When a client files a grievance, they complete a grievance form (staff or others may assist clients in completing the form). Each step of the grievance process is conducted per policy and recorded along with any resolution that is agreed upon. The Executive Director keeps the grievances in a secure area.
  - Achievement Goal – 80% of the grievances submitted are resolved to the client's satisfaction. 100% of all filed grievances are analyzed for quality improvement opportunities.
  - Actual Results - Goal met. See results in "Client Complaints and Grievances" in this report.

Efficiency of Services

- **Utilization management (appropriateness of admissions, continued service and service closure)**
  - Applied to clinical programs
  - Data Source – Utilization Reports
  - Person(s) Responsible for Data Collection – QA Specialists
  - Process – Utilization Reports are generated on a regular basis. Results are reviewed by supervisors, managers, and directors and corrective action is taken as appropriate.
  - Currently this process is not refined.
  - Achievement Goal – A process is developed to measure utilization management.
  - Actual Results - Goal met. A process has been developed, but we are not yet consistently using this data yet.

- **Encounter data validation**
  - Applied to clinical programs
  - Data Source – Electronic Health Record
  - Person(s) Responsible for Data Collection – QA Specialists
  - Process – QA Specialists compare services to coding and billing. The QA Specialist provides individual results to the clinician of record and their supervisor, clearly outlining change expectations and timeline for completion. The QA Specialist monitors the data to assure it is corrected. The supervisor addresses any coaching opportunities with the

clinicians. The Department Director utilizes trends of aggregate audit results to optimize clinical performance, through remediation or sharing of clinician best practices.
  - Achievement Goal – 90% data accuracy
  - Actual results - Encounter data validation is being measured by the BHOs now. We spent 2018 modifying our record collection and reports to supply the appropriate information.

- **Client retention rates**
  - Applied to Substance Use Disorders
  - Program Data Source – Electronic Health Record
  - Person(s) Responsible for Data Collection – Supervisors, Department Director, Program Managers
  - Process – Supervisors and staff in management position run a report in the electronic health record that indicates retention rates (by program and/or by clinician). Trends are analyzed by the supervisors and coaching opportunities are identified.
  - Achievement Goal – 80% of clients engaged in SUD treatment remain in treatment for at least 90 days.
  - Actual Results – Because of a glitch in our reporting system, we are unable to measure the results for 2018.

- **Direct service hours of clinical staff**
  - Applied to clinical programs
  - Data Source – Electronic Health Record
  - Person(s) Responsible for Data Collection – Supervisors, Department Director, Program Managers
  - Process – Supervisors and/or staff in management positions run a report in the electronic health record that indicates direct service hours per clinician. If a clinician's direct service hours do not meet expectations one or more of these actions may apply: (1) systems are analyzed and process improvement steps taken (i.e., clinician is given more clients, clinician's hours are reduced, or no-show rates are examined), (2) employee is coached as to how to improve direct service hours, (3) a corrective action plan for the employee may be developed, (4) discipline, up to termination, may occur.
  - Achievement Goal – 80% of all clinicians have a direct service rate of at least 50% each month.
  - Actual Results – Because of reporting problems, we are unable to capture 2018 numbers at this time.

- **Show-rates**
  - Applied to clinical programs
  - Data Source – Electronic Health Record
  - Person(s) Responsible for Data Collection – Supervisors, Department Director, Program Managers
  - Process – Supervisors and/or staff in management positions run a report in the electronic health record that indicates show rates per clinician. If a clinician's show rates do not meet expectations one or more of these actions may apply: (1) systems are analyzed and process improvement steps taken (i.e., reminder calls are used, clinician's hours are changed, etc.), (2) employee is coached as to how to retain clients and/or improve attendance of clients, (3) a corrective action plan for the employee may be developed, (4) discipline, up to termination, may occur.
  - Achievement Goal – 80% of all clinicians have a show rate of at least 65% each month.
  - Actual Results – Our show-rates improved significantly, and we met this goal.

- We implemented a "Client Engagement Policy" in 2018 with strategies to decrease our no-show (i.e., reminder calls, promptly closing cases when needed, modifying client treatment plans to reflect a goal of showing up for appointments, follow-up calls to clients who miss appointments, ensuring clients understand our expectations, etc.).

Service Access

- **Accessibility and timeliness of access**
  - Applied to clinical programs
  - Data Source – Electronic Health Record
  - Person(s) Responsible for Data Collection – Screeners, Department Directors, Program Managers
  - Process – Screeners indicate on the screening form in the EHR the date of the original screening call. They also record the assessment date that is offered to the prospective client. After assessment occurs, the date of the first on-going appointment is noted. The electronic health record is able to track and compare each of these dates. Directors and Managers can pull a report from the electronic health record that shows each of these dates and timeliness of service. Accessibility is analyzed annually.
  - Achievement Goal – 90% of assessment appointments and first on-going appointments are within the time frames allowed by state law and/or BHO contracts (i.e. assessment is conducted within 14 days of request for services).
  - Actual Results – The one program that had trouble achieving this goal was the Infant & Early Childhood Mental Health Program. These assessments must be conducted by someone trained to work with the birth to six population and are often scheduled as home visits. The IEC Program is in high demand, and we did not have enough clinicians to always meet our time frame goals. Most programs have successfully implemented "Open Access" which assures timely assessment. We also implemented centralized scheduling in most programs so on-going appointments could be made in a more efficient manner. Other accomplishments regarding our services being accessible include: The Mental Health and Substance Use Disorders Departments both offer after work-hours appointments to help improve accessibility for our clients. We also provide a variety of services in the community (such as in schools, health clinics, homes, etc.) to improve accessibility. All of our sites are either on or near a bus stop.

- **Penetration of services**
  - Applied to clinical programs
  - Data Source – Electronic Health Record
  - Person(s) Responsible for Data Collection – Supervisors, Department Director, Program Managers
  - Process – QA Specialists and or Directors run a report from the electronic health record that shows the number of assessments each year and admissions each year.
  - Achievement Goal – 5% increase in assessments each year; 3% increase in admissions each year
  - Actual Results – Assessment numbers for 2018 remained very similar to last year's numbers.

- **Agency's accessibility planning**
  - Applied to entire agency
  - Data Source – Accessibility Plan Review

- Person(s) Responsible for Data Collection – Executive Director and CQI Team
- Process – With input from clients, staff, and other stakeholders, the CQI develops an Accessibility Plan and/or reviews/updates it annually.
- Achievement Goal – Accessibility Plan is current and reviewed at least once a year.
- Actual Results - Goal met. See review of Accessibility Plan in this report.

Service Satisfaction

- **Client satisfaction**
  - Applied to all programs
  - Data Source – Satisfaction summaries from satisfaction surveys, focus groups, suggestion boxes, grievances, incident reports, and outcome data at discharge.
  - Person(s) Responsible for Data Collection – Department Director and Program Managers
  - Process – Client input is solicited regularly. Clinicians may ask current or closed clients to complete a satisfaction survey; clients may participate in a state-wide satisfaction survey; a focus group may be conducted with clients; suggestion boxes are available at every site with input being collected regularly; client grievances are analyzed annually by the Executive Director; incident reports are analyzed by the Executive Director; and outcome data is collected in the EHR and analyzed by Department Directors and the Executive Director.
  - Achievement Goal – Overall client satisfaction is at least 80%.
  - Actual Results - This goal was met. See Client Input section of this report

- **Stakeholder input**
  - Applied to entire agency
  - Data Source – Summaries of stakeholder input collected from a variety of sources including funder audits or site visits.
  - Person(s) Responsible for Data Collection – Department Director and Executive Director
  - Process – Stakeholder input, in addition to client input and employee input, is solicited regularly. Surveys through Survey Monkey, formal interviews, and informal conversations are used to collect stakeholder input. Audit and site visit reports are used as well.
  - Achievement Goal – Stakeholder input is received from clients, employees, and other stakeholders.
  - Actual Results – This goal was accomplished through client/family satisfaction surveys, employee satisfaction surveys, focus groups, interviews, suggestion boxes, web page comments, etc.

Business Functions

- **Risk prevention/safety of clients/participants and staff (includes Risk Management Plan)**

- Applied to entire agency
- Data Source – Risk Management Plan Review; Internal Safety Inspections; External Safety Inspections; Safety Drill Reports; CARF surveys
- Person(s) Responsible for Data Collection – Safety Coordinator; Site Coordinators, Safety Drill Results; and CQI Team
- Process – Site Coordinators conduct safety inspections on each facility twice a year; external safety inspections are conducted by outside professionals on each facility at least once a year (arranged by site coordinators); Safety Drills for fire, bomb threats, natural disasters, utility failures, medical emergencies, and violent or other threatening situations are conducted annually at all sites. Safety Team analyzes the results of all inspections and drills, identifies areas for improvement, and improvements are made as needed. The CQI Team develops and/or reviews/updates our Risk Management Plan annually.
- Achievement Goal – Risk Management Plan is developed and/or reviewed annually by the CQI team; drills and inspections occur as required by CARF standards; CARF Health & Safety standards are met
- Actual results – Goal met. See review of Risk Management Plan in this report.

- **Employee grievances**
  - Applied to entire agency
  - Data Source – Grievance reports
  - Person(s) Responsible for Data Collection – Executive Director
  - Process – Complaints are attempted to be resolved in an informal matter. When an employee files a grievance they complete a grievance form. Each step of the grievance process is conducted per policy and recorded along with any resolution that is agreed upon. The Executive Director keeps all grievances in a secure area. Annually, the Executive Director compiles a summary report of all grievances received and the results of the grievances.
  - Achievement Goal – 80% of the grievances submitted are resolved to the employee's satisfaction. 100% of all filed grievances are analyzed for quality improvement opportunities.
  - Actual Results – There was one grievance filed in 2018 and it was resolved to the satisfaction of all involved. Therefore, this goal was accomplished

- **Staff credentialing and development**
  - Applied to entire agency
  - Data Source – Personnel Files and HR records; Supervision Logs
  - Person(s) Responsible for Data Collection – Human Resources Specialist; Supervisors
  - Process – Staff submit copies of evidence of required credentials upon hire and as each credential is renewed. HR Specialist keeps a record of when credentials expire and conducts verifications of credentials as necessary. Supervisors identify areas for development with supervisees and develop a plan with the employee to attain what is needed. Work toward staff development is recorded in Supervision Logs & in performance reviews. A performance review is conducted with each employee on a regular basis. Performance reviews are kept in personnel files and the HR Specialist assures that the reviews are current.
  - Achievement Goal – 95% of staff are current with their credentials with evidence being in their personnel file. 95% of staff will have development goals established by the employee and supervisor.
  - Actual Results – Goal met. All staff are current with their credentials with proof being in their personnel files. All staff had development goals. CHS was also successful in obtaining NPI numbers for all clinical staff which was a new billing requirement for

Medicaid.

- **Staff supervision and training**
  - Applied to entire agency
  - Data Source – Supervisor logs; training plans; personnel files
  - Person(s) Responsible for Data Collection – Supervisors; HR Specialist
  - Process – Supervisors provide weekly 1:1 clinical supervision per FTE (prorated for some part time employees) and keep a supervision log on each employee; a training plan is developed by supervisors and clinical staff annually; progress toward completing the training plan is recorded in the employee's personnel file.
  - Achievement Goal – 100% of all clinical staff receive weekly supervision over 40 weeks per year; 100% of all clinical staff have training plans; 90% of staff achieve at least 75% of their training plan goals.
  - Actual Results – Goal met.

- **Contract and WAC compliance/deliverables**
  - Applied to all programs
  - Data Source – Audits and Site Visits; Clinical Reviews
  - Person(s) Responsible for Data Collection – Department Directors
  - Process – All staff are expected to comply with contracts and WACs as well as negotiated deliverables. Supervisors regularly review the clinical files of each supervisee to assure compliance. If found not in compliance, training is provided; if the issues are not corrected a corrective action plan may be developed and/or discipline, up to termination, is considered. Additionally, audits from the BHOs and the state DBHR indicate our compliance or lack of compliance with state laws and relevant contracts. If necessary, a corrective action plan will be instituted to resolve any issues.
  - Achievement Goal – No more than 20% of staff are put on a corrective action plan due to lack of WAC or contract compliance (including not meeting deliverables) each year. All audits and site visits are deemed as satisfactory by the auditing body.
  - Actual Results – Goal met.

- **CARF Standards compliance/deliverables**
  - Applied to clinical programs administration
  - Data Source – CARF Survey Report
  - Person(s) Responsible for Data Collection – Department Directors, Executive Director Process – All staff are responsible for CARF standards compliance. Supervisors monitor this at every opportunity and initiate change when needed.
  - Achievement Goal – 3-year CARF accreditation. CARF standards are institutionalized at CHS.
  - Actual Results – Goal met. Received another 3-year accreditation in 2018.

- **Fiscal controls and efficiency**
  - Applied to administration.
  - Data Source – Annual Fiscal Audit; Results of LEAN management implementation.
  - Person(s) Responsible for Data Collection – All managers and directors.
  - Achievement Goal – Fiscal audit requires no management letter; cost and time savings occur as a result of Lean management.
  - Actual Results – We had a clean audit (no management letter).

- **HIPAA & confidentiality compliance**
  - Applied Agency Wide.
  - Data Source – Corporate Compliance Minutes
  - Person(s) Responsible for Data Collection – Executive Director
  - Process – If a HIPAA or confidentiality violation is suspected or confirmed, the department director discusses it during a Corporate Compliance Team meeting. Opportunities for improvement are suggested by the Team as well as any disciplinary action if needed.
  - Achievement Goal – Zero HIPAA or confidentiality violations occur
  - Actual Results – No HIPAA violations were noted.

- **Employee retention**
  - Applied to entire agency
  - Data Source – Retention reports; Employee Satisfaction Summary Report
  - Person(s) Responsible for Data Collection – Department Directors, Executive Director, Executive Assistant; HR Specialist
  - Process – Retention rates and data from employee satisfaction surveys are used to develop a retention plan each year if needed. Retention rates are calculated by the HR Assistant. We administer an anonymous survey to staff periodically (every 2 to 3 years). The data is compiled by the Executive Assistant and summarized by the Executive Director. The Executive Director and Department Directors analyze the data to determine opportunities for quality improvement and then implement plans that will help us achieve quality improvement.
  - Achievement Goal – Retention of staff in community behavioral health is an issue across the state due to a number of factors such as low pay, high caseloads, paperwork requirements, etc. Therefore, we analyze our retention of employees each year by documenting how many employees left CHS and the reasons why. However, our employee satisfaction survey often gives us better data regarding our employee's feelings and thoughts about the agency.
  - Actual Results – See "Employee Retention" section of this report and the specific results of the employee satisfaction in this report.

The one **extenuating or influencing factor** that affected our work last year was the State's shift to Integrated Managed Care in January 2019. With this fact, a tremendous amount of energy, time, and work was put into developing new protocols, practices, and procedures.

- **Other Quality Improvement Efforts:**

CHS recognizes that service performance is also influenced by several other factors such as quality supervision, clinical training, cultural sensitivity and competency, use of evidence-based and promising practices, compliance with applicable state and federal rules and laws, compliance with requirements from entities that govern licensure and certification, as well as compliance with CARF standards. Therefore, the following quality assurance activities occurred in 2018:

- Each clinician was provided one hour of weekly individual supervision by a qualified supervisor (based on FTE). This time was utilized to coach, train, support, and model quality improvement. Supervisors maintained supervision logs for each supervisee. Clinical staff received group supervision (typically on a weekly basis) for

the purpose of staffing cases and receiving consultation from peers and supervisors.

- Clinical supervision supported and enhanced services and assured adherence to clinical policies and procedures.
- Staff members received and participated in a performance evaluation.
- Each clinician developed an annual training/enhancement plan in consultation with his/her supervisor.
- Clinical staff had unlimited access to Relias, a web-based learning system developed for our field.
- Each staff member is expected to participate in at least one cultural competency/equity/diversity training during the year.
- CHS offered support to staff in obtaining training based on current trends in treatment and/or to meet training requirements for licenses or certification.
- CHS participated in the Navos training consortium.
- CHS maintained our CARF accreditation as a way to assure our commitment to quality and performance improvement by adhering to an international set of standards.
- Managers and/or directors were responsible for monitoring compliance with WACs, state and federal rules and laws, CARF standards, and contract requirements as applicable.
- Evidence-based practices (EBPs) or promising practices were implemented in the provision of services. In as many circumstances, CHS has trainers of evidence-based practices so we had convenient, in-house training available. Documentation of certification to use EBPs are kept in personnel files if applicable.
- Supervisors assure that EBPs were implemented with fidelity as appropriate. This occurred through observation, supervision, and chart review.
- The Corporate Compliance Committee analyzed any critical incidents, extraordinary occurrences, complaints, or grievances that occurred, and made recommendations for quality improvement as applicable.

Comments or questions about this report can be sent to BGomillion@chs-nw.org.

Appendix

Acronyms

ACA – Affordable Care Act

BHI – Behavioral Health Integration

BHO – Behavioral Health Organization

CARF – Commission or Accreditation of Rehabilitation Facilities

CQI – Continued Quality Improvement

DBHR – Department of Behavioral Health and Recovery

EBP – Evidence Bases Practices

EHR – Electronic Health Record

EPHI – Electronically Protected Health Information

ICN – Integrated Care Network

IEC – Infant and Early Childhood

IEP – Individual Education Plan

IOP – Intensive Outpatient Program

ISP – Individualized Service Plan

KPL – Kaleidoscope Play and Learn

LEIE – List of Excluded Individuals/Entities (Office of Inspector General)

MH – Mental Health

MRT – Moral Recognition Therapy

NSBHO – North Sound Behavioral Health Organization

PI – Prevention and Intervention

SUD – Substance Use Disorder

WISe – Wraparound Intensive Service