



2025

**EXECUTIVE
SUMMARY**

20 25 EXECUTIVE SUMMARY



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Introduction

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

Agency Overview

Mission

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

Our Vision

It is our vision to be an effective 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 strengthened and supported.
- Children and their families are able to increase emotional strength and resolve personal and interpersonal issues.
- Community members have a sense of belonging and have access to resources that promote a healthy life free from harmful use of alcohol and other drugs.



Our Values

Model Diversity, Equity, Inclusion, and Belonging

We respect and embrace the diversity of our community and are committed to being an inclusive organization that values social equity and where all people can feel safe, respected, and valued.

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 services 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 intentions.

Have Fun

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

Our Philosophy

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

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 they 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.

Our Strategic Approaches

Strengths-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 strive 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.

Our Strengths

CHS:

- is CARF accredited for our mental health and substance use disorders programs.
- has a solid set of core values and we model these values.
- continues to value and invest in diversity, equity, inclusion, and belonging efforts despite administrative change.
- has a strong and active board of directors.
- is financially stable.
- has a strong investment in professional development, which enhances the commitment and confidence of its staff members to provide quality services and keeps best practices at the heart of the organization.
- can overcome adversity and continuing quality client care.
- is able to further review, refine, and develop policy and procedures and involve staff at all levels in providing feedback in decision making.
- values hiring people with lived experience and promoting from within when possible.
- has a strong infrastructure to support clean and successful audits.
- treats clients with dignity and respect.
- is a designated Trauma Informed Organization with Snohomish County.
- provides a benefits package for employees that exceeds the market norm.
- utilizes data to make wise and informed decisions.
- strategically plans and prioritizes program and services expansion as needed, included reflection on sustainability concerns.
- integrates our services and programs, serving as a one-stop shop for many.
- has a long and respected reputation with local and regional contractors/funders and other community organizations.
- has a forward-thinking vision and is ahead of the curve on most regional efforts.
- is committed to continuous quality improvement and assurance.
- is using an industry leading electronic health record called “Credible”, which is an EHR platform by Qualifacts.
- has several bilingual/bicultural program staff.

Our Challenges and Opportunities

CHS is challenged to:

- maintain up-to-date credentialing with the five Managed Care Organizations (MCOs).
- manage multiple contracts and grants, with complex and varied reporting requirements, and deal with subsequent increased administrative burdens.
- navigate changes in insurance rates, contract/grant changes.
- navigate environmental stressors such as homeland security concerns, gun violence, world affairs, that impacts sense of safety of clients and staff.
- navigate transition to Windows 11 and updating technology for compatibility.
- adapt staffing structures to grow with the expansion of the agency personnel.
- prevent staff burnout.
- compete with other organizations for resources and funding (Local, State, Federal).
- recruit and retain board members who represent the people we serve.
- face the increased costs of doing business.
- ingrain diversity, equity, inclusion, and belonging into all we do with a focus on anti-racism and social justice.
- find health insurance for employees that is affordable for part-time staff, and or includes dependent care options.
- earn incentives from King County Integrated Care Network (KCICN) for identified milestones.
- recruit qualified staff during behavioral health workforce shortage in an increasingly competitive market, especially candidates with management/leadership experience.
- streamline access to services for clients with co-occurring diagnosis.

Our Major Highlights & Accomplishments in 2025

CHS...

- increased utilization agency wide of business intelligence program called “Janet” designed by Mission Driven Data that replicates our data in the Credible Electronic Health Record system and gives us meaningful access to the data.
- had four staff graduate from the first cohort of the Y+Heritage University Masters in Mental Health Counseling program. Two staff continued engagement in the 2nd Cohort, and 1 started the 4th Cohort in the Fall of 2025.
- had a successful and fun auction, with a moving keynote speech by a staff member.

- sold the Silverlake Building and transitioned services to the Madison building.
- continued providing access to harm reduction supplies through support from King County Public Health, and have implemented supply cabinets as several office locations.
- sponsored an Overdose Awareness Day Event in Lynnwood.
- increased the number of staff who received licensed clinical supervision.
- honored our staff by giving them a full week off (paid) for the Winter holiday, and the board approved to write the time off into policy.
- supported several staff in access to professional development and conference travel opportunities. (See HR Section for BEAM utilization report)
- experienced a devastating fire at our Lynnwood building in July of 2025. Despite the disruption, the CBIS team maintained high level of services to clients and moved into the Castle building.
- hosted an All-Staff outing to the Everett Aquasox game.
- is one of the partner organizations with dedicated office space in the Lynnwood Neighborhood Center that opened in late 2025.
- Managers and Directors participated in training with Cultures Connecting.
- hired a Facilities Coordinator.
- launched the Access Department to support centralized access to Behavioral Health services.
- completed renovations of our 148th building.
- secured funding from North Sound ASO.
- made a successful transition from Winterfest to a Springfest event to acknowledge and appreciate staff.



Distributing CHS flyers and free Narcan at a community resource fair.

CHS Locations

CHS owns three buildings where we provided services in 2025.

CHS - 170th



**17018 15th Ave NE
Shoreline, WA 98155**

Location includes:

- King County Substance Use Treatment Services
- Access Department (BH Screening & Assessments)
- School-Based Mental Health leadership offices
- Family Support Center

CHS - 148th



**14803 15th Ave NE
Shoreline, WA 98155**

Location includes:

- King County Office-Based Mental Health
- Administration

CHS - Silverlake



**10315 19th Ave SE STE 112
Everett, WA 98028**

Location includes:

- Snohomish County Substance Use Treatment Services
- Limited Infant & Early Childhood Mental Health services

Building was sold in December 2025.

CHS - Madison



**2002 Madison St.
Everett, WA 98203**

Location includes:

- Snohomish County Substance Use Treatment Services

Building was purchased in December 2024. Services began in August 2025 after renovations. Silverlake SUD services transferred to this location.

We leased office space at the following locations in 2025.

CHS - Edmonds 21727 76th Ave. W., STE J, Edmonds, WA 98026

- Snohomish County Mental Health Office-Based Counseling
- Lease ended in December 2025. Service to relocate to Lynnwood Neighborhood Center in January 2026.

CHS - Bothell 12900 NE 180th St, STE 140, Bothell, WA 98011

- Mental Health Office-Based Counseling and Family Support
- Lease ended in March 2025 due to end of Bothell ARPA contract. Mental Health Counseling relocated to Shoreline and Edmonds office locations through 2025.

CHS - Everett 111 Everett Mall Way, STE E101, Everett, WA 98028

- Community Based Intensive Services

CHS - Lynnwood 3924 204th St. SW, Lynnwood, WA 98036

- Community Based Intensive Services
- Building experienced a fire that resulted in a total loss in July 2025. Services relocated to Castle Building

CHS - Castle Building 19730 64th Ave. W., Lynnwood, WA 98036

- Community Based Intensive Services
- Leased in August 2025 as relocation site due to fire at Lynnwood building.

CHS also provided services on a regular basis at schools in the Edmonds, Mukilteo, Shoreline, Northshore, Everett, and Seattle School Districts; Shoreline Recreation Center; and Ballinger Homes King County Housing Authority community.

We also provided SUD assessments at Carnegie Resource Center and Snohomish County Jail. Additionally, clients often receive services at other community locations of their choosing including their homes. All our locations had in-person services and virtual services available in 2025.

Board of Directors

Overview

At the end of 2025, CHS has 12 board members (21 is the maximum size of board). Board Officers in 2025 were Wesley Madsen (Board President), Marisa Pierce (Board Vice President), Katerina Plushko (Board Secretary), Ed Sterner (Board Treasurer). We added 2 new board members in 2025, Halima Lozano* and Olga Plushko* and two members exit the board at the close of 2024, Adam Ormonde and Shawn Karmil.

Board Member List

2025 Board Members and their affiliations

Diana Cadena-Sanner	Mountain Pacific Bank
Dave Calhoun	Northshore School District
Laurie Chapman	Copier Northwest
Lily DiPietro	Alliant Insurance Services
Halima Lozano*	Public Health - Seattle and King County
Heidi Ihde	Coldwell Banker
Ryan Madsen	Business Owner
Wesley Madsen	Alliant Insurance Services
Marisa Pierce	Skagit Valley College
Katerina Plushko	Kaiser Permanente

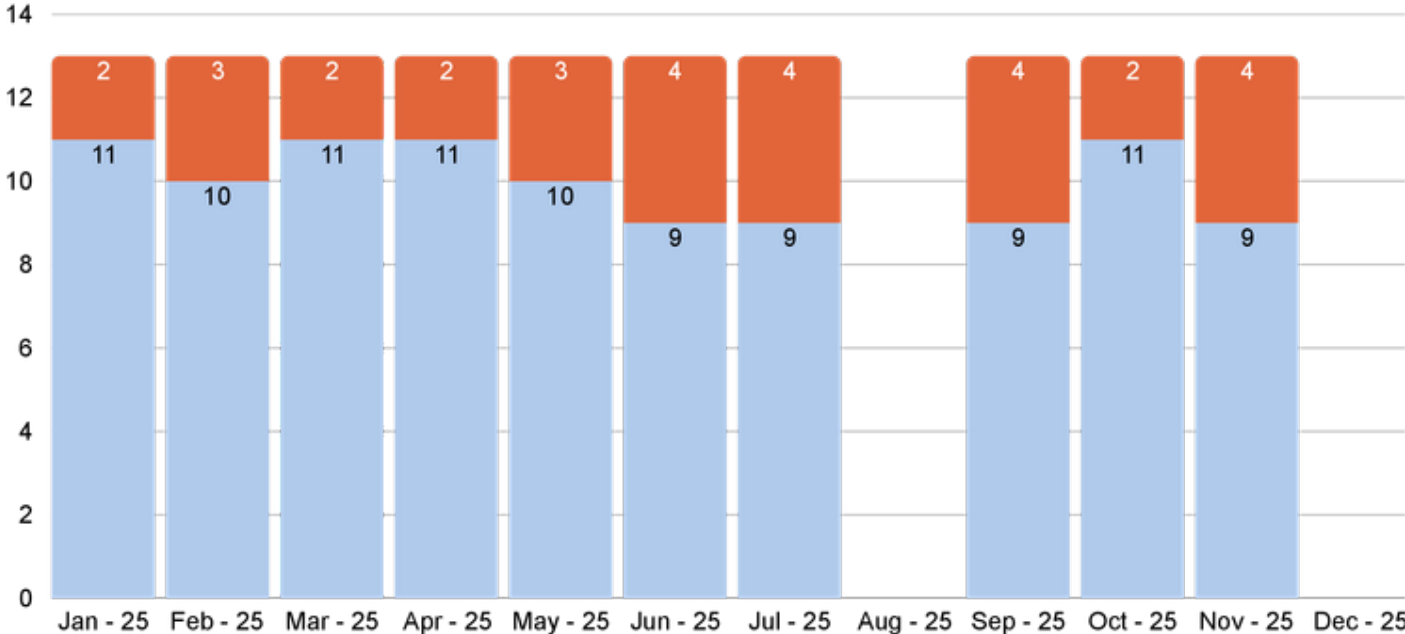
Olga Plushko*	Kaiser Permanente
Ed Sterner	Ed Sterner Law Office
Douglas Yormick	Project Manager

Board Committees

The active board committees in 2025 were the Executive Committee, Board Development Committee, Special Events Committee, Finance/Audit Committee, and Strategic Planning Committee.

Board Attendance

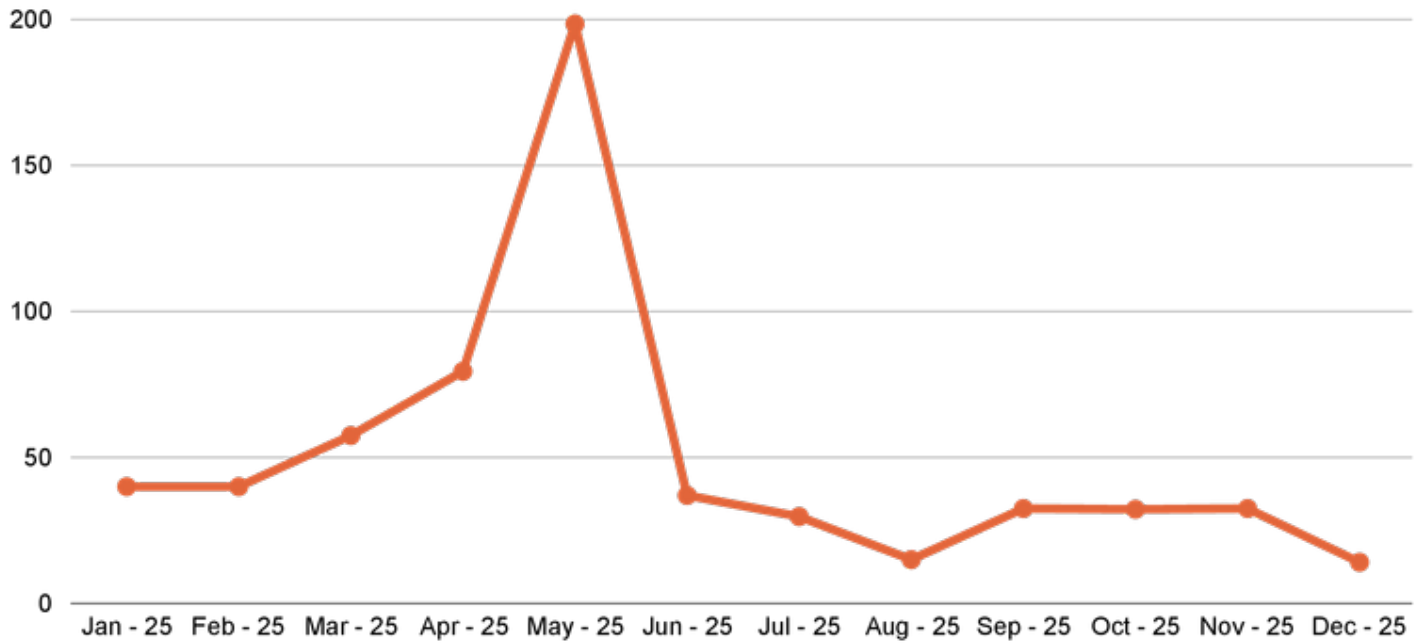
Board attendance in 2025 was excellent, averaging 9 members at each session for the year. See graph below.



The board did not meet in August and December. We had one member on sabbatical for a portion of the year.

Board Volunteerism

Board members reported the following number of volunteer hours at CHS in 2025. Board volunteer hours for CY 2025 = 608.58

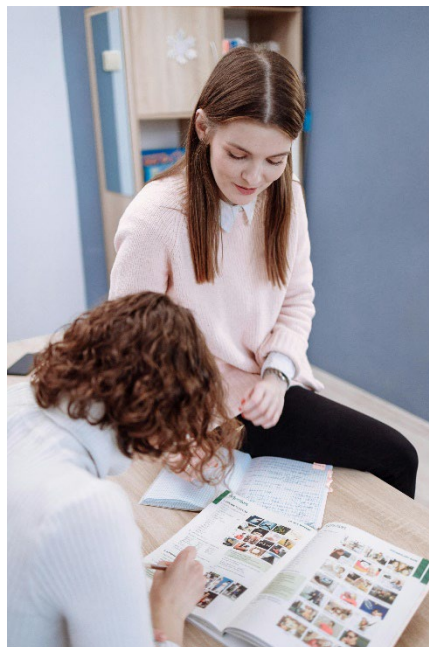


Volunteerism

In 2025 CHS had 117 volunteers who performed 7,883 hours. Volunteerism fair market value calculated at \$274,250 (\$34.79 per hour).

2025	1st QTR	2nd QTR	3rd QTR	4th QTR	TOTAL
Hours	1,723	2,253	1,856	2,051	7,883
Volunteers	24	35	34	24	117

Comparison by Year	2024	2025
Hours	7,644	7,883
Volunteers	102	117



Strategic Planning

Overview

Our Strategic Plan for 2024-2026 was developed by the Strategic Planning Committee, consisting of board members Ryan Madsen {chair}, Ed Sterner, and Shawn Karmil, along with 8 Directors on staff and approved by the board in 2023. To inform the development of the plan, the committee conducted an environmental scan. The scan included both an external component (identifying and assessing opportunities and possible problems in the external environment), and an internal component (assessing organizational strengths and weaknesses), and a needs assessment (reviewing existing relevant literature and other community assessments). The committee solicited and reviewed input by administering surveys to community interested parties, conducting SWOT exercises with staff, administering client surveys, and conducting focus groups. Additionally, they reviewed data collected throughout the previous three years obtained from clients' surveys, employee satisfaction surveys, fiscal audits, employee and client grievances, and other community input.

Strategic Plan Review

The 2024-2026 Strategic Plan and progress toward the goals in 2025 are below:

STRATEGY 1: Provide quality services that result in positive outcomes for clients/participants

GOAL 1: Implement practices that are proven

Objective 1: Offer rapid access to quality care

2024 - While we used Open Access same-day or next-day assessments, we spent much of 2024 planning for the development of an Access Program that would operate centralized screening services beginning in January 2025.

2025 - Access Department implemented to support centralized screening and assessment services for majority of behavioral health clients' resulting in more rapid access to care. Utilizing data from JANET, screenings in the Access department average of 3 business days between screening and assessment, and 32% of clients completed the assessment within 3 days.

Objective 2: Use best and promising practices in our service delivery.

2024 - All programs continue to use best and promising practice in delivery of services. Some of these practices include: Cognitive Behavioral Therapy (CBT); CBT+; Dialectical Behavioral Therapy; Moral Recognition (MRT); MRT Breaking the Chains of Trauma; Seeking Safety; Eye Movement Desensitization

and Reprocessing Therapy; Dyadic Infant and Early Childhood Mental Health; Parent-Child Psychotherapy (PCP); Prenatal Mental Health; RUBI (for parents of children with autism); Change Company Journaling; Circle of Security Parenting; Positive Discipline Parenting; Promoting First Relationships (PFR). Four additional therapists received training to provide EMDR; 22 staff were trained in DBT Skills; one was trained to provide MRT; and 8 mental health therapists were trained and certified as “Approved Supervisors”.

2025 - All programs continue to use best and promising practice in service delivery, and include: Cognitive Behavioral Therapy (CBT); CBT+; Dialectical Behavioral Therapy; Moral Recognition (MRT); MRT Breaking the Chains of Trauma; Seeking Safety; Eye Movement Desensitization and Reprocessing Therapy; Dyadic Infant and Early Childhood Mental Health; Child-Parent Psychotherapy (CPP); Perinatal Mental Health; RUBI (for parents of children with autism); Change Company Journaling; Circle of Security Parenting; Positive Discipline Parenting; Promoting First Relationships (PFR); Kaleidoscope Play & Learn. A mental health clinician was certified as an Inclusive Eating Disorder Specialist. The SUD Director trained 8 staff members in Trauma MRT in May 2025. One staff member became a certified approved supervisor.

Objective 3: Provide services that are relevant to clients and participants (including people of color, immigrants/refugees, LGBTQIA+, etc.)

2024 - Immigrants/refugees took advantage of mental health therapy being provided in various languages, with the most being Spanish. Both parenting classes and PFR were provided in Spanish. We provided programming specifically for Parenting and Post Partum Women (PPW). We also provided a Kinship Group for people who were parenting a family member’s child. The IEC program was for families with children birth to six. We conducted in custody SUD assessments as well as assessments at Carnegie Resource Center. Mental health staff provided two groups for LGBTQ+ youth. Family Support was on-site at Ballinger Homes low-income housing community. Plus, we have staff who are trained to work with transitional age clients; neurodivergent clients; perinatal women; and others.

2025 - Continued to provide services to a diverse client population as was provided in 2024. In 2025, mental health provided a group for those with Chronic Pain, a school-based group to promote community building, a music therapy group for special education students at Scriber High School, and school-based groups on self-harm, grief, and an LGBTQ+ art group for teens. Our Kinship Group increased enrollment, with 35% being over the age of 65. In SUD, a grief group was hosted for clients in response to the sudden death of a participant.

Objective 4: Maintain CARF Accreditation

2024 - Our last accreditation was for 3 years (the best awarded) and was to expire in October 2024, resulting in the need for a re-accreditation site visit. However, due to the shortage of CARF surveyors,

CARF extended our accreditation through January 2025 and scheduled the survey for the end of January. Much time was spent in 2024 in preparation for the re-accreditation survey.

2025 - Accreditation visit occurred in January 2025 and CHS received 3-year accreditation (the best awarded), that will expire in 2027.

GOAL 2: Promote holistic care through collaborative partnerships.

Objective 1: Expand co-location of services in schools, low-income housing communities, etc.

2024 - We added two more schools to the list of schools where we provide on-site mental health services. We placed a therapist at a low-income housing community for the summer. We are working on two co-locations for the future - one with Volunteers of America and the other with Housing Hope, both in Lynnwood.

2025 - Two additional schools were added to the list of schools we provide on-site mental health services: Cascade K-8 in Shoreline SD, and Spruce Elementary in Edmonds School District. We were able to continue having a mental health therapist on site at a low-income housing community over the summer. Continued partnership with City of Shoreline Parks and Recreation Teen Center with co-located therapist. December 2025 office-based mental health program opened at the Lynnwood Neighborhood Center. Other partners co-located at LNC include Volunteers of America, Child Strive, Boys and Girls Club, Latino Educational Training Institute (LETI), Korean Community Service Center, and Cocoon House.

Objective 2: Participate in networking opportunities to connect with other service providers.

2024 - Some of the many networking opportunities that we participated in included North Sound ACH convening meetings and learning collaboratives; Coordinated Care meetings; King County Integrated Network meetings; Coordinated Therapeutic Courts Project; RACER board; schools, King County Legislative Forum; Olympia Recovery Day; Heritage University + Y masters level program; Verdant Health community network meetings; King County PPW Network; State's sub-committee on Prenatal to 5 services; Lynnwood Human Services Commission; North Urban Human Services Alliance; King County Housing Authority; the Dale Turner; & CHS collaborative meetings; and Kaleidoscope Play & Learn Network.

2025 - Continued participation in same networking opportunities as in 2024 with the exception of the North Sound ACH meetings and learning collaboratives; Dale Turner and State sub-committee on Prenatal to 5 services. New networking opportunities in 2025 included the Lynnwood Neighborhood Center Networking Meetings; Positive Discipline and Promoting First Relationships Mentor Meetings; Career Pathways Quarterly Meetings; King County Learning Collaboratives; King County Clinical Advisory Board, National Council for Mental Well-Being 2025 Conference.

Objective 3: Excel within our scope and utilize cross-system referral to address social determinants of health.

2024 - CHS is recognized as a top provider of behavioral health and family support services. We make and receive cross-system referrals with Uber Business, Medi-transportation, Bus Ticket Programs, & Hopelink for transportation assistance for clients; food banks (primarily Hopelink); all the shelters in the region for individuals/families without homes; community health clinics for medical/dental referrals; etc.

2025 - Continued to make and receive cross-system referrals.

STRATEGY 2: Nurture and sustain a robust and skilled workforce.

GOAL 1: Recruit staff that reflect the diversity of our community.

Objective 1: Expand and formalize recruitment strategies.

2024 - CHS attended career fairs; participated in a University of Washington panel for social work students; and took advantage of many community events for recruiting. We stream-lined some recruitment materials and updated our job announcements. We offered paid internship positions. We intentionally put an emphasis of recruiting from within our organization and giving staff the support they need to work their way up in the human services fields (i.e., opportunities to sponsor staff to participate in two different programs that will pay for their masters program; training opportunities; etc.).

2025 - The Outreach and Engagement Manager attended two employee recruitment events in 2025. The US PSYCAP Virtual Employment Event and UW School of Social Work Career Fair. In addition to events, open positions were often shared with community partner organizations electronically. CHS continued our efforts to streamline and update job announcements and implement proven recruitment strategies. Continued paid internship positions.

Objective 2: Offer competitive salaries and benefits to employees.

2024 - We gave two all-staff raises in 2024. They were 5% each, which made our salaries very competitive. Additionally, we gave all staff a \$2,000 bonus. We maintained our excellent benefit package, including healthcare expenses for little or no cost to employees.

2025 - We gave one all-staff raise of 5%. In addition, we gave all staff a 1k bonus (pro-rated). We continued to offer a low-cost/no-cost health insurance plan, additional holidays, and personal days. Access to professional development resources were expanded through BEAM. Resources include: conference travel and accommodations, professional development workshops/trainings, licensure

reimbursement, and tuition support for educational programs. A benefit that we emphasized internally was our 3% employer match to 403b accounts for employees.

Objective 3: Invest in volunteers/interns for future employment opportunities.

2024 - 102 volunteers gave their time to us in 2024. They recorded 7,644 hours of volunteer work, valued at \$255,998. We also worked with 8 interns.

2025 - 117 volunteers gave their time to us in 2025. They recorded 7,883 hours of volunteer work, valued at \$274,250. We also worked with 7 interns.

GOAL 2: Develop and retain staff that deliver exemplary services.

Objective 1: Provide exceptional supervision and training to staff.

2024 - Each clinical staff member receives supervision on a weekly basis. They also participate in weekly group meetings to staff their cases with their team. Some clinicians with MSWs, still were having difficulty receiving enough one-on-one supervision from a LICSW, which is required for them to receive licensure. Therefore, we entered into a contract with a LICSW who provides them with additional supervision hours at no cost to them. Many supervisors also participated in trainings related to supervision during 2024.

2025 - Continued contract with LICSW to offer clinical supervision hours. To support training staff, we increased number of users in our Relias online training platform.

Objective 2: Provide staff with the tools they need to do their jobs.

2024 - Our efforts included upgrading our technology, replacing the cell phones in the mental health department, providing replacement furniture where needed, and provided toy kits for IEC therapists.

2025 - Continued replacing cell phones and laptops according to schedule. After fire of Lynnwood building, CHS replaced all the supplies and tools that were lost, such as the toy kits for IEC therapists.

Objective 3: Offer work sites that promote physical safety and are conducive to trauma-informed practices.

2024 - Early in 2024 we conducted a self-survey regarding TI space. We also conducted site safety checks twice for each site. Major renovations occurred to the 170th building and 148th building. All renovations and upgrades took into account safety and TI practices. These included painting the parking lots, adding lighting, installing a fence, etc. We also installed a new security system for 170th site. CHS purchased a new site for our SUD program currently at Silver Lake with the intent of providing staff with ample space that is safe and welcoming.

2025 - New building spaces, including Madison, Lynnwood Neighborhood Center, and Castle, were assessed to be TI and safe as part of the move in/renovation plans. Replaced security system at 148th.

Objective 4: Practice restorative leadership.

2024 - In March 2024, we provided a 3-day workshop for all management staff on Restorative Practices. A local expert conducted the training. Since then, staff have been able to participate in listening circles and follow the restorative leadership model for providing conflict resolution. We have also integrated the “relational window” in our decision-making.

2025 - Expanded training from 2024 to include training from Cultures Connecting regarding having Courageous Conversations. Continued to utilize principles from restorative practice to resolve employee conflicts, and listening circles to engage staff in challenging conversations.

STRATEGY 3: Appropriately respond to circumstances and events that impact our work.

GOAL 1: Be prepared to handle various possible scenarios that could impact our business, clients/participants, and staff.

Objective 1: Implement, revise as needed, and monitor the agency’s IT Security Plan.

2024 - The IT & Systems Plan was reviewed for relevance and updated with new goals and actions. This plan includes security needs. We also worked with our IT Vendor to test our security and vulnerability to a security breach.

2025 - Completed testing of our IT environment for vulnerability in July.

Objective 2: Keep the Disaster Preparedness Plan up-to-date and ready to be deployed.

2024 - Our Disaster Preparedness Plan was reviewed and is up-to-date and ready to be deployed if necessary.

2025 - CHS implemented Disaster Preparedness Plan in response to the fire at our Lynnwood site. Following this event, the plan was extensively reviewed, and minor adjustments were made to the plan.

Objective 3: Participate in meetings with funders/contractors, city/county/state leaders, and other relevant people to keep a pulse on what to expect in the future.

2024 - Our Executive Director attends monthly meetings with the King County Integrated Network (KCIN), the KCIN Clinical Operations Committee, the MIDD Advisory Committee, and the King County Youth and Family Services Network. Directors and Associate Directors attend clinical provider meetings with KCIN and Snohomish County. Our SUD Director attended a meeting with the Office of the Courts and Edmonds Community Court resulting in a contract. Leadership periodically met with Foundry 10 (a funder) and the Cities of Kenmore, Bothell, and Shoreline. Our Billing Manager meets with the IMCs monthly. We also had contacts with our King County Council Member, 3 cities' Councils, and our legislative representatives. With all this, we still have anxiety around what will happen with funding and legislation regarding human services in the future with the current national climate.

2025 - Continued participation in meetings noted above. Increased concern with the political climate and unknown impact on funding and legislation. The Executive Director worked with local State representative to secure capital funding.

Objective 4: Develop and implement a financial contingency plan.

2024 - The Board voted on a "Operating Reserve" policy and increased our minimum to two million dollars. As is seen in the Risk Management Plan, our revenue is exceeding our expenses. Still, it is vital for us to keep a pulse on our financial status. A major accomplishment in 2024 was that we began using "Janet" designed by Mission Driven Data that replicates our data in the electronic health record that we use (Credible/Qualifacts). JANET gives management the tools to track productivity, demographic, etc. with real live numbers and data visualizations. We also instituted a contract tracker that is monitored by the billing team and available for management to know exactly what our status is regarding contract fulfillment. All these processes are designed to help us not need to use a financial contingency plan.

2025 - We continue to carefully examine and monitor our financial situation due to unknown impacts federally on Medicaid. Efforts to systematize JANET as a tool to monitor billables has made significant progress. Due to the expected decrease in BH funding from Snohomish county, CHS entered into a contract with North Sound ASO to provide services to qualified low-income clients.

Objective 5: Maintain strong and transparent communication with appropriate interested parties.

2024 - We share information using our webpage and upon request. This extensive Executive Summary is published annually, posted on the web page, and openly discussed with all interested parties. We also use flyers and other outreach materials to share information about our services. We provide regular (typically monthly) reports to most funders describing how we are using their funding.

2025 - Continued communication methods mentioned above. In addition, due to the national political climate and the fear of clients and participants, CHS created guidance that was communicated agency wide in response to potential immigration enforcement presence at our office locations.

GOAL 2: Prepare for the transition of a new Executive Director in January 2028.

Objective 1: Build a dynamic succession plan for the Executive Director.

2024 - Early 2024, the Executive Director informed the Board of Directors and all of management of her intent to retire at the end of 2027. Succession planning work began.

2025 - In the Spring of 2025, Executive Director announced to all staff her intention to retire at the end of 2027. In Fall of 2025, board approved internal promotion of our Family Support Director to Associate Executive Director with the intention of assuming the Executive Director role in 2028.

Objective 2: Develop a communication plan for the community, including funders and key contacts.

2024 - This objective was intentionally delayed until closer to the actual retirement date.

2025 - On track with communication plan, and majority of communication will occur when Associate Executive Director position is effective in January 2026.

Objective 3: Build skills of directors and managers so they are prepared for the future.

2024 - We have seen significant growth on the part of our directors and managers this past year. They are using Janet and other data retrieval methods to track their services and decision making. Managers and directors were trained on Restorative Leadership. We gained significant knowledge about FMLA and PFML. We have several staff trained as trainers in the CAREs approach to trauma-informed practices. Our directors have gained skills to develop and track their department budgets.

2025 - Directors and managers increasing use of JANET and other data retrieval methods to plan for their departments. Continued training to support restorative practices. The Access Department Director position was revised and an external hire was made, and a new FS Director was hired internally. Both Directors have skill development plans in place.

GOAL 3: Maintain our commitment to being a Trauma-Informed organization that incorporates diversity, equity, inclusion, and belonging into all we do.

Objective 1: Maintain Compassion, Appreciation, Resilience, and Empowerment (CARE) designation.

2024 - Two more of our management staff attended CARE trainings, participated in discussions, and became certified in the CARE approach.

2025 - CARE designation maintained.

Objective 2: Support an active Trauma-Informed (TI) and Diversity, Equity, Inclusion, and Belonging (DEIB) team.

2024 - The objective was revised before it was implemented. Instead of maintaining a DEIB team, we created a CAREs Team which will work on both DEIB issues and TIC issues. A small team began in 2024 to discuss plans for the Team's work.

2025 - CARE Team focused on further developing framework and defining CARE Team objectives. Conversations with agency management was the focus to inform the development of CAREs Team structure and next steps. A revamp of the team will take place in early 2026.

Objective 3: Implement, revise, and monitor the agency's DEIB Plan at least once per year.

2024 - The DEIB Plan was reviewed and revised when the decision was made to have the CAREs team monitor this work.

2025 - DEIB Plan (Diversity and Cultural Competency) was woven into the CAREs Team framework.



Continuous Quality Improvement (CQI)

Our CQI Program consists of three distinct groups: Leadership CQI (All Directors, Associate Directors, and Managers), Systems CQI (relevant staff working on systems' improvements), and Management CQI (Associate Directors, Managers, and Executive Director). These three teams meet at least once a month to discuss and act upon CQI issues.

CHE uses our Leadership CQI Team to develop, review, and update our Accessibility Plan; Risk Management Plan; Diversity, Equity, Inclusion, and Belonging Plan; and our Quality Improvement Plan.

Accessibility Planning

Overview

A 2025 Accessibility Plan was the second year of the 2024 – 2026 Accessibility Plan. The plan was developed by the Leadership QI team and reviewed regularly in 2025. The Accessibility Plan and our analysis of the review of the plan are shared through 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 2025.

2025 Accessibility Plan Review and Analysis

Attitudinal

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Stigma toward individuals with behavioral health issues and ability to recover.	<ul style="list-style-type: none"> ● Educate staff ● Educate Public ● Promote a culture of recovery & resiliency 	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 2025 to improve accessibility that could be inhibited by attitude. <ul style="list-style-type: none"> ● CHS continued certification as a Trauma-Informed Agency by CARE. ● CHS allowed traditionally under-represented groups to hold support meetings or other
2. Stigma toward historically excluded/marginalized communities	<ul style="list-style-type: none"> ● Educate staff ● Educate public ● Promote a welcoming and inclusive environment. 	

		<p>activities at our locations. These included pregnant and parenting families, Adult Children of Alcoholics, Kinship Caregivers.</p> <ul style="list-style-type: none"> • Departments provided diversity and equity trainings for their staff.
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Physical & Architectural

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Need for more trauma-informed spaces to see clients.	Continual assessment & make suggested improvements to space as possible.	Madison remodel included providing a dedicated Recovery space for clients. Madison and 170th have Harm Reduction and Resources supply closets. Other locations can submit a request form for supplies to be delivered to their office location.
2. Vandalism & buildings need to be more secure.	Assess building security and implement solutions.	Security system installed at 148th. New location for CBIS (Castle building) has secure access. New location for MH-OB Snohomish County (Lynnwood Neighborhood Center) has security system and strict protocol for entry to the building.

Policies, Practice & Procedures

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. 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.	Executive Director explored new procedure for engaging staff at all levels in policy development. Revised and updated the Behavioral Health and Employee Manuals as needed.

2. Language barriers	Hire more staff; educate staff on use of interpreters and translators.	27% percent of staff are bilingual. In 2025 we used both telephone interpreters and in-person interpreters. Staff were provided details on how to request an interpreter.
3. Too much time between assessment and first on-going appointment.	Improve response time for assessment first on-going appointment.	Implemented Access Department to centralize assessment process and ways to schedule first on-going appointments. Used Business Intelligence to create reports to analyze data to inform process.

Communication

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Some agency cell phones need replacement	Purchase new cell phones on regular basis.	Cell phone replacement and upgrades continued as needed in 2025.
2. Not all program brochures are up to date	Update and print marketing materials.	All program brochures are up to date and printed by the Outreach and Engagement Manager.
3. Difficulty communicating by text with clients in WISe program.	Upgrade staff phones.	Accomplished. All staff cell phones are text-capable and compliant.
4. Sending reminder texts or making reminder phone calls to clients about appointment is labor intensive and time consuming.	Explore ways to automate appointment reminders texts/calls and implement if possible.	Clients can now opt for text reminders of appointments upon assessment. EHR and Business Intelligence software initiate texts from an automated system.

Technology

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Some computers need replacing.	Replace computers according to replacement rotation schedule	In anticipation of Windows 11 some computers were replaced and will continue in 2026.
2. Cost of computer replacement for staff.	Implement a Replacement Plan to replace all computers on a rotating basis.	Implementation plan required updating due to the anticipation of Windows 11 release.
3. Not utilizing Credible as effectively as we could.	Build reports and explore use of unused tabs.	Successful implementation of Business Intelligence (Janet) to support data retrieval. Continued improvement ongoing to create useful and accurate reports.
4. Some clients lack access to computers.	Explore having space and equipment available for clients to use at CHS.	Telehealth offices for clients are established at most sites.

Financial

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Need to increase billing.	Increase number of clients & service encounters. Assure that all encounters are billed, and payments received. Recoup state Medicaid direct billing.	Qualifacts continues to bill IMC/MCO Medicaid. Efforts to recoup state Medicaid direct billing was accomplished. Clinical clients decreased by 8% (366 clients), however overall service encounters increased by 1.5% (880 hours) in 2025.

2. Rates do not cover all costs for services.	Negotiate rates with MCOs and other contractors.	Medicaid rates stayed somewhat consistent in 2025. Dependent on the MCO's.
3. Some clients are not insured or have insurance deductibles so high that they discourage use of coverage.	Obtain more unrestricted funds to subsidize services.	Negotiated a contract with North Sound ASO for behavioral health services for low-income individuals without adequate insurance. Funding from Snohomish County continued.

Transportation

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Some clients have trouble accessing services due to lack of transportation.	Work with clients accessing various transportation options including the new light rail system.	Utilized Hopelink services; purchased ORCA cards when flexible funding was available; opened an Uber Business Account to support client transportation to services. In 2025 the Shoreline and Lynnwood Light Rail stations opened. New office locations are on bus lines.

Employment

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Poverty impacts a person's behavioral health. Some clients have difficulty securing and maintaining employment	Include employment goals in ISPs when appropriate; develop partnerships with employment programs.	We continue to work with employment goals in client's individual service plans.
2. Workforce shortage for clinicians affects quantity & quality of services.	Use Workforce Shortage special funds wisely.	Gave agency-wide raise, extra week off, and a bonus. Engaged in the BEAM professional development program. Executive Director working

	Educate legislators about improving Medicaid rates so a reasonable wage can be paid.	with 3 coalitions/networks to educate legislators.
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Community Integration

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Lack of knowledge of available community opportunities and resources.	<ul style="list-style-type: none"> • Educate clients and staff • Use Care Coordinators as source experts • Use Case Managers to explore resources and assist clients to access them • Screen clients for SDOH 	Use of Care Coordinators and Case Managers to stay up to date on available community resources is ongoing. SDOH screenings incorporated into treatment planning and case management.
2. Clients (particularly youth) are reluctant to become involved in pro-social activities.	<ul style="list-style-type: none"> • Educate clients on what is available to them • Include pro-social activities as part of ISP when appropriate. • Use flex funds when available 	Pro-social activities are being used in treatment plans as needed. Flexible funds used when it was available.
3. People of color are disproportionately represented in the criminal justice system	Advocate for and model racial equity.	Departments conducted trainings and facilitated/directed conversations regarding racial equity.
4. Lack of affordable housing	Utilize case managers and other staff to assist clients with finding housing	Case managers continued to assist clients with housing issues. Made referrals to shelters and low-income housing as needed.
5. Issues of racial justice and equity nationally	<ul style="list-style-type: none"> • Model inclusion and equity • Anti-racism work within our agency 	Leadership continued to explore ways to improve inclusion and equity agency-wide and engaged in a two part training with Cultures Connecting to strengthen skill sets for having

		courageous conversations about anti-racism and equity.
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Other Barriers

IDENTIFIED BARRIER	ACTION PLAN	STATUS - END OF 2025
1. Childcare is inaccessible for some clients and very expensive for staff	Offer as much free childcare as possible when clients are in session and promote its use. Continue to improve wages for staff.	This has been achieved for SUD clients at our Shoreline 170th location through PPW and Snohomish County funding in 2025. We provided an agency-wide raise.
2. High cost of living for both clients & staff were barriers in multiple ways.	Continue to help clients thrive and increase wages for staff.	Utilized all resources available for our clients and raised employees' wages.



Risk Management

Overview

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, and worker's compensation. 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.

We continued to monitor and address cyber security in 2025.

Additional risk management activities in 2025 included:

- All staff adhere to the confidentiality rules outlined in 42 CFR, part 2 and 45 CFR (HIPAA).
- Background checks were completed on all employees and volunteers.
- HR routinely 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 employees' credentials and received consent to obtain a driving record on the employee.
- All new employees signed our Substance Use Policy and our Ethical Codes at orientation.
- Accounting policies and procedures were reviewed and updated.
- Board members signed an attestation regarding no conflict of interest by serving on our board.

CHS sought and received input from clients, staff, and other interested parties 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 interested parties in a variety of ways such as through board reports, board minutes, all staff meetings, CQI minutes, this report, etc.

The Risk Management Plan identifies our loss exposure or risks. The Leadership CQI Team reviewed the potential loss categories regularly and 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.

In July 2025, a building we leased in Lynnwood experienced a total loss fire. It occurred on a weekend when business was not in operation, which reduced additional risks. Our security system alerted us to an incident on site and when we arrived, the fire department was already in

full force attempting to put it out. Our Emergency Response Plan was immediately engaged regarding communication with insurance, staff and other interested parties due to the disruption to our operations. Despite the loss, our staff with the WISe program that the building housed, did not have any disruption to services provided to clients and found alternative ways to connect with our clients. A new building location was secured within a couple of months, and the generosity of the community helped fill the gap as we addressed the loss of our office space and supplies.

The 2025 results of our risk mediation efforts follow.

2025 Risk Management Plan Review and Analysis

CHS Risk Management Plan for 2018-2025

FISCAL									
Loss Exposure/Risk	Analysis of Loss Exposure						Actions to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2025
	Low	Med	High	Low	Med	High			Baseline 2024
Loss of funding			X			X	Increase marketing and grant requests. Replace lost funding with new funding.	Funding base will be increased by 5%	Revenue was increased by 11% compared to 2024
							Apply for federal Payroll Protection Program (PPP) funding and other local or regional COVID-19 relief funding		Goal met in prior years.

Expenses exceed revenue		X				X	<p>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.</p>	<p>Costs will stay even with or less than revenue.</p>	<p>Our expenses were less than budgeted, primarily because of staffing vacancies and over-performance. Did not focus on private insurance billing and tried to maximize our Medicaid funding instead.</p> <p>We increased private insurance billing by 6% in 2025.</p> <p>Our Mental Health Department had 7 interns in 2025.</p>
Delay in payment			X		X		<p>Participate in conversations with decision makers regarding impact of new funding structures. Increase</p>	<p>Reserves will be ample to cover all expenses for 3 months.</p>	<p>All identified strategies to mitigate this risk occurred. Executive Director participated in Clinical Operations</p>

							communication with funders. Build reserves.		Committee of KCICN and other coalitions to strategize how to deal with the impact of the funding method in King County. We have maintained reserves that will cover a minimum of 4 months of expenses.
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HUMAN RESOURCES

Loss Exposure/Risk	Analysis of Loss Exposure						Actions to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2025
	Low	Med	High	Low	Med	High			Baseline 2024
Loss of key personnel		X				X	Open door policy for all supervisory staff members. Transparency in all business dealings. Retreat. Boost employee retention efforts.	Minimize "key staff" turnover	1 key position was vacated in March and filled in July. Implemented all strategies in our mitigation plan. Executive Director succession

							Maintain exceptional benefits.		plan is on track and an internal promotion to Associate Executive Director was announced.
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. Customizing and documenting training (new hires & on-going)	100% of required staff trainings will be offered. There will be a 95% completion rate for all training requirements.	We added a new mandatory training based on NSASO requirements. Continued to offer trainings in 2025. Did not meet completion rate as 70% completed all trainings, 30% partial completed. All identified strategies to mitigate this risk occurred.
High staff turnover			X			X	Utilize staff incentive programs. Utilize satisfaction surveys. Utilize exit interviews. If possible, increase salaries.	Reduce staff member turnover by 5%	Our turnover rate at the end of 2025 was 21.5%. This is a decrease of 3.4% from the prior year. Rate of staff turnover improved after

							<p>Maintain excellent employee benefits.</p> <p>Improve training programs.</p> <p>Involve line staff in decision-making when appropriate.</p> <p>Explore new ways to invest in employees.</p>		<p>implementing significant salary increases.</p> <p>However, there is simply a shortage of professional staff and there is an abundance of competition.</p> <p>We utilized all the identified methods to mitigate this risk.</p>
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SERVICE DELIVERY

Loss Exposure/Risk	Analysis of Loss Exposure						Actions to Reduce Risks	Projected Results	Actual Results 2025
	Likelihood of Occurrence			Seriousness of Risk					Baseline 2024
	Low	Med	High	Low	Med	High			
Improper service documentation			X			X	Increase staff training & improve professionalism. Standard utilization of collaborative documentation. Supervisors	Excellent clinical documentation	Documentation was an issue for several clinicians. We have seen improvements in our documentation. Our QA

							monitor case notes. Proactive clinical supervision. Keep training manuals up to date. Maintain professional liability insurance.		Manager provided numerous trainings on documentation. All identified strategies to mitigate this risk occurred.
Poor outcomes or outputs		X			X		Proactive clinical supervision. Use evidence-based practices. Staff training.	Excellent outputs and outcomes.	Continued to provide weekly clinical supervision. Maintained opportunity for MSW supervision. Use of EBP is recorded in clients' records and are reportable. Outcomes and outputs were very good in 2025. All identified strategies to mitigate this risk occurred.

HEALTH & SAFETY

Loss Exposure/Risk	Analysis of Exposure						Actions to Reduce Risk	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2025
	Low	Med	High	Low	Med	High			Baseline 2024
Serious on-site accident		X			X		Safety trainings for all staff members. Maintain proper insurance. Active Safety Team. Timely repair of hazards.	Avoidance of serious accidents.	Two -on-site accidents occurred when staff fell out of chair and a staff member got dizzy and stumbled down some stairs. No serious injury occurred and staff were seen by medical professionals.
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 or consider de-	Reduce number of annual traffic accidents.	Two traffic accidents in 2025. Fault was the other driver's in both incidents.

							commissioning agency van.		
Fire incident	X					X	Safety trainings for all staff members. Train staff members about safety plan. Maintain adequate property insurance.	No fires.	In July 2025, our leased office space in Lynnwood experienced a total loss fire. The fire occurred on the weekend, so no staff or clients were on site. Our property insurance was utilized to support relocating services to a new location and replacing the lost items.
Disaster			X			X	Educate staff regarding our Emergency Operations Plan. Contingency planning. Maintain adequate insurance.	As small an impact on our operations and continuation as possible.	Our Emergency Operations Plan is up to date and was utilized in response to the fire. We maintained the same level of insurance. All identified strategies to

									mitigate this risk occurred.
Potential of violence or harmful situations		X				X	De-escalation and 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	<p>The few cases of behavioral escalation by clients were controlled with de-escalation techniques. No remarkable situations occurred. All identified strategies to mitigate this risk occurred.</p> <p>In response to the increased regional presence of homeland security agents and political climate, staff were trained on guidance in the event of them entering CHS office spaces.</p>

LEGAL

Loss Exposure/Risk	Analysis of Loss Exposure						Actions to Reduce Risks	Projected Results	Actual Results
	Likelihood of Occurrence			Seriousness of Risk					2025
	Low	Med	High	Low	Med	High			Baseline 2024
Sexual harassment charges	X					X	Training during orientation and annually thereafter. Maintain proper insurance.	No sexual harassment incidents.	1 allegation was reported but the investigation did not substantiate the accusation. Both of the identified strategies to mitigate this risk occurred.
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	A few minor privacy incidents were reported and they had little consequence to the agency, and were resolved through education and training. Cyber insurance was maintained. Conducted our

									standard HIPAA Security audits with no major concerns found. Staff continued to receive a security awareness training and HIPAA compliance training on an annual basis. All identified strategies to mitigate this risk occurred.
Malpractice lawsuit		X				X	Educate staff on documentation techniques. Effective client grievance process. Regular supervision, performance coaching, and training. Maintain insurance.	0 lawsuits	No malpractice lawsuits were filed against us. Insurance was maintained. All identified strategies to mitigate this risk were implemented.
Waste, fraud and abuse		X				X	Have strong w/f/a policy. Education staff on what w/f/a is and how to	0 waste, fraud, or abuse.	No incidents of waste, fraud, or abuse were reported or suspected.

							report violations. Implement quality assurance measures to verify proper billing.		Staff received education and training on the process for reporting. All identified strategies to mitigate this risk were implemented.
Employment practice lawsuit		X			X		Effective employee grievance process. Regular supervision, performance coaching, and training. Management training. Maintain insurance.	0 lawsuits	An EEOC complaint was filed and agency responded with rebuttal. No resolution as of the time of this report.

TECHNOLOGY

Loss of Exposure/Risk	Analysis of Loss Exposure						Actions to Reduce Risks	Projected Results	Actual Results 2025
	Likelihood of Occurrence			Seriousness of Risk					Baseline 2024
	Low	Med	High	Low	Med	High			
Data breach or data loss (affecting confidentiality, integrity, or availability of EPHI)		X			X		Maintain strong back-up policies and procedures. Review back-up P&Ps annually. Regular testing by IT vendor. Maintain cyber insurance.	0 data breaches	No reportable data was breached. Tested per schedule. All identified strategies to mitigate this risk occurred.

Diversity, Equity, Inclusion & Belonging

(Cultural Competency and Diversity)

Overview

Effective January 2025, our Diversity, Equity, Inclusion, and Belonging (DEIB) Plan and practices are woven into every aspect of our work. CHS has developed an internal initiative called the CAREs Initiative, which is an acronym for Compassion, Appreciation, Resilience, & Empowerment. We are using this initiative to integrate content and best practices regarding Diversity, Equity, Inclusion, & Belonging (DEIB); Trauma-Informed Approaches, and Restorative Practices into our agency culture. Recognizing the intersection and alignment among these three practices and combining them into one initiative helps us strengthen our practices, policies, and procedures as an employer and a service provider.

The CAREs Initiative focuses on CHS being an agency that values diversity, equity, inclusion, and belonging, is trauma-informed, and uses restorative practices. The CAREs Team is responsible for the development of the DEIB Plan as well as assuring that the DEIB Plan is relevant, implemented, tracked, and analyzed on an annual basis. Input is considered from employees, clients, and other interested parties in the development and 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. The DEIB Plan and our analysis of the review of the plan are shared through minutes, all staff meetings, board reports, this executive summary, etc.

2025 DEIB Plan Review and Analysis

Diversity, Equity, Inclusion, & Belonging Plan Review of 2025 Action Plan (Also known as Cultural Competency Plan)
Guiding Principles of our DEIB Work <ul style="list-style-type: none">• Antiracism is our Guiding Light• Cultural Humility is the Path we walk• Decolonizing Behavioral Health is our Goal

In 2025, we restructured the DEIB position to a team approach we are calling the CARES Team. The CARES Team is responsible for implementation and monitoring of the DEIB Action Plan, including our Trauma-Informed and Restorative Practice approaches across the agency.

Action Steps	Strategies	Status - End of 2025
<p>Identify, recruit, select, and retain employees, board members, and volunteers that are reflective of the diverse population we serve</p>	<p>1. CHS will continue investing in internal training and professional growth opportunities for CHS staff.</p>	<p>Accomplished. Various internal trainings were offered; all staff had Relias learning; all staff had professional development funding internally and through BEAM.</p>
	<p>2. Outreach and Engagement Manager will strengthen relationship with WDI partners and other high education institutions through continued collaborative events.</p>	<p>Accomplished. The Outreach and Engagement Manager attended two employee recruitment events in 2025: US PSYCAP Virtual Employment Event and UW School of Social Work Career Fair.</p>
	<p>3. Executive Director will continue advocating for industry change on a legislative level.</p>	<p>Accomplished</p>
	<p>4. Directors and managers will encourage staff to utilize Professional Development Funds.</p>	<p>Accomplished. In April 2025, the funding support increased through BEAM. See BEAM utilization report in the HR section.</p>

<p>Review existing policies to ensure that they align with our core values and DEIB guiding principles</p>	<p>1. Staff will participate in trainings and events to stay up to date on DEIB best practices and share with other staff.</p>	<p>CAREs Team Members participated in Monthly Cohort meetings of the CARES organizations. Leadership engaged in part 1 of a Courageous Conversations training with Cultures Connecting.</p>
	<p>2. Directors and Managers will create feedback avenues for staff who identify gaps in existing policies and procedures or find gaps as new policies and procedures are implemented.</p>	<p>Leadership explored new procedure to provide staff with opportunities to suggest changes to policy, provide feedback on policies, and will formally launch process in 2026.</p>
	<p>3. CARES Team will plan for a formal review of all CHS policies</p>	<p>Leadership Team completed this task in place of the CARES Team</p>
<p>Create and maintain marketing and outreach materials that are easily updateable and reflective of our communities.</p>	<p>1. Department leadership will connect with Outreach and Engagement Manager to ask for changes in marketing materials.</p>	<p>Accomplished.</p>
	<p>2. Outreach and Engagement Manager will update marketing materials as needed or requested.</p>	<p>All marketing material is up-to-date. The responsibility was held by the Outreach and Engagement Manager in 2025.</p>

<p>Maintain a working environment that welcomes and supports diverse perspectives and lived experiences.</p>	<p>1. Management will ensure that all CHS locations are accessible and physically safe for all community members and staff.</p>	<p>Accomplished. Some maintenance and updates were required. A Facilities Coordination position was established and filled to support needs agency wide. The Castle building will undergo renovations in 2026 to make it ADA accessible.</p>
	<p>2. Supervisors and HR will ensure that CHS staff have the appropriate tools and supplies they need to do their work (and understand the process of how to report additional needs).</p>	<p>Staff have the tools they need to do their job.</p>
	<p>3. CQI Team will engage in restorative leadership/practices training to gain additional tools on how to navigate through moments of harm and move towards repair/resolution.</p>	<p>CQI Team continues to practice using restorative approaches to engage in courageous conversations. A two part training from Cultures Connecting began in November 2025 and concludes in January 2026.</p>
	<p>4. Department leadership will collaborate with CARES Team regarding any additional DEIB training needed. CARES Team will explore bringing in external trainers to do</p>	<p>Department Directors and Managers are implementing DEIB training and conversations internally with their teams based on staff and program needs. The training by Cultures Connecting was</p>

	more in-depth DEIB guiding principles training.	an external trainer that supported this goal.
Strengthen collaborative partnerships with external industry (CBA's, non-profits, human services, and behavioral health) and community partners.	1. Management will maintain and expand outreach efforts and collaborative relationships with partner organizations and external community partners.	Accomplished. Numerous collaborations with other organizations occurred.
	2. Executive Director will continue to convene, connect, and collaborate with local decision makers, leaders, and other industry professionals. The Outreach and Engagement Manager will support and participate in local resource fairs, community events, and legislative opportunities.	Accomplished by the Outreach and Engagement Manager in 2025, and other Directors/Managers depending on content area. CHS participated in over 26 events.
Build and maintain an agency culture that promotes transparency, open avenues of communication, and collaboration on all levels at CHS	1. HR will continue to implement annual anonymous staff satisfaction survey.	Survey was administered, however, the structure and format were updated to be more aligned with validated measurement strategies.
	2. HR and members of CARES team will review questions on satisfaction survey in effort to receive meaningful feedback.	Accomplished.

	3. Directors will continue to work collaboratively with rest of CQI Team to ensure transparency on how to deliver decisions to rest of CHS staff.	Continued conversations to enhance communication and transparency.
	4. CARES Team will collaborate on ways to celebrate CHS staff and highlight program achievements.	Springfest event was focused on staff appreciation. CARES Team is developing ways to acknowledge program achievements agency wide.
Begin building a foundation for the creation of a CHS Trauma Informed Leadership Team (TILT)	1. CARES Trained staff participate in monthly CARE Cohort meetings.	Accomplished
	2. Existing CARES trainers will suggest ways to involve other staff in the CARES team	An application process was designed and will be revisited in 2026.
Review and update the DEIB Action Plan as needed	1. CARES Team and Executive Director will review plan every 6 months and update accordingly.	Due to the staff transitions impacting the CARES Team, a new plan will be established in 2026. The Executive Director and a member of the CARES Team reviewed current plan.

Additional 2025 efforts related to Cultural Competency and Diversity are listed below:

- Outreach and Engagement Manager position replaced the DEIB Manager position.
- Staff were encouraged to attend trainings on DEIB and given paid time off to do so.
- All job descriptions had elements regarding our expectations regarding cultural humility.
- CHS used certified interpreters during sessions as needed.

CHS maintained its relationships with agencies that provide cultural-specific services (i.e., Consejo, Asian Counseling & Referral Services, SeaMar, International Community Health Services, LETI, Manos Unidos, etc.) and referred to these agencies when appropriate.

Play and Learn groups, Out-of-School Time tutoring, parenting classes, and information and referral services were provided in Spanish. Several clinical staff provided services in languages other than English.

For more information regarding the diversity of our clients and participants, please refer to “Persons Served Section” of this report. See information under “Human Resources” for diversity and cultural information about our employees.



care

BUILDING COMMUNITY
THROUGH COMPASSION

Technology Plan

Overview

Technology is an essential part of our business. We use an outside contractor (Real Impact) to help us navigate our technological needs. The Plan is reviewed annually by our IS (Information Systems) team and consultants.

The Information Systems (IS) Team includes the HR Director, IT Vendor, Finance Director, and Executive Director.

2025 Technology Plan Review and Analysis

Hardware

GOAL	PRIORITY	TECHNOLOGY ACQUISITION; MAINTENANCE; REPLACEMENT	RESOURCES NEEDED	STATUS - END OF 2025
Build our infrastructure for new Everett rental space	High	Acquisition: Purchase firewall; Install Internet; Purchase & install access point	\$4,000	Completed 7/2024
Build our infrastructure for the Madison building	High	Acquisition: Purchase firewall; Install Internet; Purchase & install access point	\$4,000	Completed 9/30/2025
Build our infrastructure for the Castle building	High	Acquisition: Purchase firewall; Install Internet; Purchase & install access point	\$4,000	Completed 10/31/2025
Build our infrastructure for LNC space	High	Acquisition: Purchase firewall; Install Internet; Purchase & install access point	\$4,000	Completed 12/23/2025

Provide ability of our IT Vendor to manage network	Medium	Acquisition: Purchase & install new smart switches	\$16,000	Completed 12/1/2024 and ongoing
Update existing monitors	Low	Acquisition & Replacement: Purchase & replace 20 old monitors	\$5,500 (10 in 2024 - \$3,000)	12/31/2026 on target
Update aged cell phones	Medium	Acquisition & Replacement: Purchase & replace 60 cell phones \$30k	\$30,000	Completed 12/31/2024
Update existing laptops	Medium	Acquisition & Replacement: Purchase & replace 20 aged laptops	\$40,000 (2026)	12/31/2026 on target

Software

GOAL	PRIORITY	TECHNOLOGY ACQUISITION; MAINTENANCE; REPLACEMENT	RESOURCES NEEDED	STATUS - END OF 2025
Maintain current software	High	Maintenance: Continued maintenance	None	Ongoing
Improve communication options for working with clients	Medium	Acquisition: Purchase & enable text capabilities	None	12/31/2026
Eliminate physical servers	High	Acquisition: Purchase & install software to expand existing software to allow for cloud services & storage	\$1,200 per month	12/31/2025 eliminated 5 and 3 remain.

				TBD if needed still by 12/31/2026
Implement maintenance software to improve tracking of maintenance requests	Medium	Acquisition: Acquire and implement a web-based ticketing system for submitting and tracking maintenance requests	Approximately \$60.00/per month for software licensing	Ongoing
Implement software that enables staff to obtain e-signatures and edit PDFs easily	High	Replace Adobe PDF with cost-effective, web-based solutions.	Licensing and configuration costs (TBD)	7/31/2026

Security & Confidentiality

GOAL	PRIORITY	TECHNOLOGY ACQUISITION; MAINTENANCE; REPLACEMENT	RESOURCES NEEDED	STATUS - END OF 2025
Dispose of media (drives) & software	High	N/A	\$2,000	Ongoing
Review back-up policies & revise as necessary	High	Maintenance: Maintain to current standards	IS Team Time	Completed
Review Disaster Recovery Plan & revise as necessary	High	Maintenance: Maintain to current standards and needs	Staff Time	Completed
Train staff on HIPAA security, security	High	Maintenance: Maintain training available in the Relias platform	Staff Time \$3,600 for	Annually

awareness, & compliance			testing IS Team; External Vendor; \$20,000	
Test our IT environment for vulnerability	High	Maintenance: Work with external vendor to complete penetration tests & vulnerability scan	\$15,000	Completed 7/31/2025
Assure that our IT environment is very low risk	High	Maintenance: Maintain the following: EndPoint detection response; Managed SOC; Microsoft 365 monitoring; SIEM	\$2,800 per month	Ongoing
Migrate all systems using SMTP basic authentication to a more secure authentication method to enhance security and maintain compliance with Microsoft requirements	High	Replace the current systems using SMTP and migrate them to more appropriate modern authentication for each system.	IS team time, and potential licensing cost (TBD)	4/30/2026 and ongoing monitoring

Virus Protection

GOAL	PRIORITY	TECHNOLOGY ACQUISITION; MAINTENANCE; REPLACEMENT	RESOURCES NEEDED	STATUS - END OF 2025
Continue use of internal firewall	High	Maintenance: Ongoing maintenance	Part of IT Vendor contract	Ongoing

Test & upgrade virus protection as necessary	High	Maintenance: Ongoing maintenance	Part of IT Vendor contract	Ongoing
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Assistive Technology

GOAL	PRIORITY	TECHNOLOGY ACQUISITION; MAINTENANCE; REPLACEMENT	RESOURCES NEEDED	STATUS - END OF 2025
None				

Miscellaneous

GOAL	PRIORITY	TECHNOLOGY ACQUISITION; MAINTENANCE; REPLACEMENT	RESOURCES NEEDED	STATUS - END OF 2025
Enable eFaxing capabilities for offices that currently do not have faxing capabilities	High	Acquire a HIPAA-compliant eFax provider	Licensing and configuration costs (TBD)	Will complete in 2026.

Corporate Compliance

2025 Critical Incidents Review & Analysis

Staff managed 628 Critical Incidents in 2025 which is a decrease of 20 from 648 in 2024. The incidents fell into the following categories:

Category of Incident	#	%
CPS report	454	62%
Other	156	21%
WISe program after hours crisis response	61	8%
Abuse, neglect and exploitation of a client including financial exploitation (does not include child abuse/neglect)	19	3%
Suicide/attempted suicide	18	2%
Credible threat to client's safety	13	2%
Incidents involving injury (on-site)	5	1%
Aggression or Violence (on-site)	3	0%
Major injury or major trauma to client	1	0%
Media Interest (if known or suspected)	1	0%
Unauthorized use or possession of legal or illegal substances (on-site)	1	0%

Use or possession of weapons (on-site)	1	0%
Violent acts allegedly committed by client; (attempted or completed) homicide, vehicular homicide, rape, sexual assault or indecent liberties	1	0%

Service Delivery

Services Provided & Department Highlights

(Jan. 1, 2025 - Dec. 31, 2025)

Mental Health Department

The Mental Health Department provided Individual Therapy, Family Therapy, Group Therapy, Conjoint Therapy, and Case Management. These services were provided mainly onsite and face-to-face in our offices, in schools, and in community settings. We also provided services through telehealth when clients requested. In our schools, we also provided Intake/Assessments on site. Throughout the year, we worked with both adults and children/youth (age 6 and older).

The Mental Health Department maintained staffing though we also experienced systems asking for more support. We have grown to be a department of over 70 staff which includes 7 leaders, 1 Case Manager, 2 Admin Specialists, 52 master level therapists and 9 master level interns. Our clinical staff provided trauma-informed, client-centered care across King and Snohomish Counties. Despite extenuating circumstances such as administrative changes, office transitions, and shifting program structures, the department upheld its mission of accessible, quality mental health services. Teams navigated these challenges with innovation, implementing new programs, expanding leadership, and continuing to strengthen team cohesion to meet the needs of the communities served.

2025 Mental Health Department Highlights

- Provided accessible care to clients through diverse services, including telehealth, community based, and group therapy.
- Expanded leadership roles across teams to help us better manage staff and respond to demands around productivity and billables. These adjustments are critical to sustaining our teams in light of Medicaid cuts, reductions in grant funding, and other financial pressures.
- During dedicated DEIB meetings, facilitated DEIB-focused learning opportunities occurred by discussing and reflecting upon a range of topics. The team read chapters of books, listened to podcasts, watched episodes of couples therapy, and viewed clinical webinars, all of which elicited reflective conversations on their own clinical styles and brainstorming to support their clients.
- We continued to prioritize low-barrier access to care by successfully applying for and being awarded several grants. These grants enabled us to provide school-based and office-based services at no cost to clients, ensuring equitable access to mental health support for our community.
- Provided community outreach efforts to bolster our visibility and trust, allowing us to offer services in six school districts and actively participate in community events. Notably, we presented in several parent and teacher group meetings providing psychoeducation and Q&A about the services we provide to support our schools and clients.

- The Mental Health Department celebrated the midpoint of the year in June with a relaxing afternoon in the park. The event included heartfelt acknowledgments of staff contributions, farewells to departing team members, and a celebration of graduating interns, recognizing their achievements and contributions to CHS.
- The Mental Health Department experienced several transitions following the closure of our Bothell office due to the end of grant funding. Therapists from that location were reassigned to other offices while we prepared for the opening of the Lynnwood Neighborhood Center.
- Throughout 2025, the Mental Health Director and Mental Health Office-Based Manager played key roles in planning and coordinating the transition, including overseeing logistics, furnishing the space, and relocating a team of nine staff members to the new building, which opened at the end of 2025.
- Several clinicians enhanced their service delivery through professional development experiences:
 - Two staff attended the annual play therapy conference in Houston to bolster their education on play therapy and renewed their certification.
 - Two staff were accepted into the Accelerator program that supports clinicians with associate licensures in their career growth and clinical training.
 - A staff member completed training on Inclusive Eating Disorder Education and is now IEDS certified.
 - Other professional development trainings attended were on art therapy, emotion focused therapy, nature and relational therapy, and best practices for sleep.
- In response to the SNAP food benefit crisis in the Fall of 2025, a case-manager started a food drive to create food bags for clients.

Community Based Intensive Services Department

Intensive services for children, youth, and families are provided in home, community, school, or office settings. While a small number of clients receive an outpatient level of care, the majority of clients served by CBIS are enrolled in WISE/Wraparound services. WISE provides a team-based approach to supporting families with the highest levels of need. Mental health therapists and counselors work individually and with caregivers, while Certified Peer Support Specialists provide both youth and caregiver support, and care coordinators facilitate team meetings, collaborate with identified natural supports and system partners, and maintain a robust family-driven plan to reduce behavioral health related risks. A small number of clients participate in a specially funded Wraparound program in King County, which includes much of the same services as WISE, but does not include mental health therapy. WISE and what was previously a stand-alone Infant and Early Childhood Mental Health Program combined efforts, providing most enrolled families with children birth to six with a wraparound approach. A small outpatient program continues to serve Perinatal mental health clients and young children who may not require the level of care WISE provides.

2025 CBIS Department Highlights

- CBIS experienced a significant fire, which resulted in the loss of the primary building that houses the department.
- The team focused on recovery from the fire, including establishing a new office at the Castle building.
- Celebrated two therapists completing the 18-month Child Parent Psychotherapy learning collaborative.
- Continued to expand the WISe team to increase representation of BIPOC and LGBTQIA+ staff.
- Continued to be known regionally as a leader in providing intensive services to LGBTQIA+ youth, particularly trans and gender non-conforming youth.
- Expanded collaboration with the Snohomish County Family Recovery Court to provide perinatal mental health treatment.
- Supported one employee to enroll in CHS sponsored clinical degree program.
- Provided RUBI (Parenting training to support children diagnosed with Autism) to more families.
- One employee completed the Y+Heritage Masters in Mental Health Counseling.
- Promoted qualified employees into leadership roles.

Substance Use Disorders Treatment Department

We provided our Substance Use Disorders (SUD) treatment as described in our Program Descriptions including Intake/Assessment, Intensive Outpatient services (9 hours of group therapy per week; a minimum 1 hour of individual/family/conjoint therapy per month; and Case Management Services when indicated), Outpatient Services (2 - 4 hours of group therapy per week; 1 - 2 hours of individual/family/conjoint therapy as needed/requested; and Case Management services as needed); and Monthly monitoring group. Additionally, we offered specialized groups for some, such as Adult Recovery Court clients and trauma survivors. SUD services were provided both face-to-face and remotely through telehealth (primarily using the Zoom platform). Most groups were held in person, with one group per week being held via ZOOM.

2025 Substance Use Disorders Department Highlights

- Services are primarily held in person, with occasional exceptions for individual services and one weekly group, Trauma MRT, being held via telehealth.
- Continued providing priority assessment times for Pregnant and Parenting (PPW) clients within the SUD Department while collaborating with the Access Department for all other SUD assessment needs.

- Continued with one full day of walk-in assessments at Carnegie Resource Center in Everett and consistently saw an average of three clients per day for services.
- Saw 9 participants successfully graduate from the Adult Recovery Court Program
- Continued our involvement with Shoreline Community Court and expanded our participation with Edmonds Community Court by hiring a clinician to act as a liaison.
- Our Snohomish SUD program moved from its Silverlake office into its Madison office. With this move, our program has been able to add another SUD clinician as well as continue to expand our Co-Occurring program with more space for therapy offices. We have a dedicated Recovery Space which is consistently used by clients for pro-social activities before group, to work on assignments, get support, and rest if needed. We have received positive feedback from clients about this space, and the quiet space they can use for telehealth sessions, appointments, or phone calls. "I have to take the bus and get here an hour early, now I have a place to relax". "I don't know what I would do without this place. I wouldn't eat, I know that." "I didn't know where else to go, but I knew I could come here."
- Continued to serve our PPW population with expanded services, childcare, parenting support, case management, and provided funding for emergency needs.
- Reduced barriers to services for Snohomish County clients by using grant funding to provide SUD treatment for low-income residents who were not otherwise eligible.
- Received a second grant from Snohomish County Emergency Management Funds to provide Opioid Overdose Awareness and Education to the community. With these funds, we focused on family and community education, specifically with our Hispanic Latino/x community members. We continued to provide transportation, basic needs, and recovery support for our clients in need.
- We were awarded an Overdose Prevention and Response Supply Distribution grant from Seattle and King County Public Health, which provided us with harm reduction supplies for clients and community members. We created no-barrier supply cabinets with hygiene supplies, wound care kits, cold weather supplies, food, and other harm reduction and basic needs. We also keep Narcan and fentanyl test strips available, as well as educational materials.
- We provided over 3000 Narcan kits along with education and training to staff, clients, and community members. Along with training for humans, a YouTube video was created that provided information and training on the safe and effective use of Narcan for pets.
- CHS partnered with Snohomish County Recovery Coalition to host our second annual International Awareness Day Event. We had a proclamation from the Mayor of Lynnwood, several personal stories of hope and healing from passionate speakers, and provided food and resources for over 100 people who attended.
- Offered SUD staff ongoing opportunities for professional development with trainings on Trauma-Informed Care, Breaking the Chains of Trauma training and fidelity calls,

Motivational Interviewing, Ethics and Boundaries, Opioid Epidemic, as well as continuing to learn about population-specific treatment while working with PPW, LGBTQIA+, Youth, Criminal Justice Involved, and BIPOC clients and community. Staff shared what they learned with the team by providing in-service training during weekly staff meetings.

- Continued to use contingency management as a way of increasing engagement, encouraging clients, and helping clients achieve their goals.
- Substance Use Department Director presented on Harm Reduction and Trauma-Informed Care at the Re-Imagining Behavioral Health, Race, Equity, and Social Justice Conference.
- One of our staff members completed a 40-hour Peer Specialist Program through the Health Care Administration and became a Certified SUD Peer Specialist.
- We received a grant through Public Health Seattle and King County to begin a pilot program, utilizing peer services, providing for basic needs, and reducing barriers for clients struggling with opioid use disorder, with a focus specifically on those in need of stable housing and who are at risk of revolving incarceration.
- Began accepting referrals from the Regional Crisis Responders as the treatment navigator program for Bridging the Gap Between Law Enforcement and Behavioral Health With Treatment Crisis Responders Project.

Family Support Department

The programming offered by Family Support (FS) are designed to decrease the isolation of families (particularly immigrants) and increase peer support and community connections and strengthen protective factors that build resilience. Specific programs provided in 2025 were:

Kaleidoscope Play & Learn - intergenerational early learning and parent education program for families with children 0-6 years old offered in Spanish and English. The model is deemed a Promising Practice through the University of Washington.

Positive Discipline Parenting Classes - weekly class series in Spanish and English for families with children of all ages. The curriculum is based on “Teaching Parenting the Positive Discipline Way” through the Positive Discipline Association.

Circle of Security Parenting Classes - weekly class series in Spanish and English for families with children 0-5 years old. Curriculum is an Evidence Based Practice.

Promoting First Relationships - one-on-one 10 session parent coaching model for a parent/caregiver and their child ages 0-6 years old. Model is an Evidence Based Practice out of the University of Washington.

Kinship Support Program - case management, support groups and family events for caregivers raising their relative’s children.

Out of School Time Program - afterschool and summer programming for youth K-12th grade that are residents of Ballinger Homes, a King County Housing Authority public housing complex in Shoreline. Also includes various case management and resource and referral services for adult residents including career and college planning and support.

2025 Family Support Department Highlights

- Successfully completed year 3 of capacity building funding from the Department of Children Youth and Families (DCYF) to implement effective program evaluation and analysis internally for our Promoting First Relationships Program.
- Due to success in our performance metrics of the DCFY contract, we were provided with a performance award.
- Successfully transitioned staff to our Shoreline location when the Bothell office was closed.
- Family Support staff supported the Outreach and Engagement Manager with representation at several community outreach events to engage Spanish speakers.
- The Family Support Department Director provided additional access to mental health counseling for family support participants through the Y+Heritage Masters program internship, and graduated from the program in December 2025.
- Parenting programs received continued investment from a private foundation to serve Snohomish County residents.
- Our Out of School Time Program was awarded the “Engagement Innovator” award through King County Housing Authority’s Youth Voice Challenge, a project to promote KCHA youth providing agencies engaging their participants in providing feedback and input toward future programming.
- The Out of School Time program strengthened partnership with the schools to host “Teacher Tutor” dates when local teachers volunteered to work with students at the afterschool program.
- Staff were able to support the sustainability of the Hunger Intervention Project by hosting the summer lunch site at Ballinger Homes after they lost funding for their Americorps members.
- In 2025, the Family Support Department Director participated in the Snohomish County Early Learning Leadership Council to inform a regional report on gaps in early learning across the region.
- The Family Support Program Manager attended Reflective Supervision Training.
- Several participants of the Promoting First Relationships program shared their experiences with DCYF staff at their April site visit.
- The Kinship Program launched a new evaluation tool to measure program outcomes.

Access Department

The Access Department was established in January 2025 to create a centralized entry point, and streamline access, to most CHS Behavioral Health services. Access clinicians conduct screenings, coordinate assessments, establish diagnostic impressions, recommend levels of care, and connect clients to ongoing Mental Health and SUD services.

In its first year, the department experienced significant growth while building the operational systems needed to support its expanded scope. Efforts focused on strengthening service delivery to ensure consistent, timely, and equitable access to care while improving documentation oversight and records management processes that promote quality of care.

In May, an additional assessment clinician was added to support increasing demand for screening and assessment services. In July, CHS welcomed a new Access Director who led operational improvements across workflows, staffing structure, and interdepartmental coordination. In October, the Quality Assurance (QA) and Medical Records processes transitioned from the Administration Department to the Access Department. This transition expanded the department's operational scope to include oversight of chart review, documentation standards, and medical records management. With new oversight and infrastructure to support growth, both QA and Medical Records are better positioned to expand their contributions to organizational quality, compliance, and operational improvement.

Additionally, Access began collaborating with the SUD Department and external partner Regional Crisis Response (RCR) through a funded initiative supporting crisis response in the community. As part of this collaboration, Access clinicians conduct intake screenings and provide clinical care recommendations for individuals served by RCR crisis responders.

2025 Access Department Highlights

- Access served 1,185 clients with 619 clients completing a screening/intake to access clinical services.
- Transitioned and integrated Quality Assurance (QA) and Medical Records into the Access Department from the Administration Department.
- Medical Records compliance and request management was strengthened by implementing a structured system for tracking and processing records requests.
- Through standardized workflows and improved communication between Access and ongoing clinical teams, resulted in an increased clarity around roles, expectations, and client transitions.
- Began development of Power BI dashboards and Excel-based tracking tools to monitor key Access metrics, including:
 - Screening completions and timeliness to scheduled assessment
 - Post-assessment timeliness to first routine appointment

- No-show and cancellation rates for assessments
- Client engagement vs. non-engagement following assessment
- Chart review metrics aligned with Quality Assurance standards
- Established foundational knowledge management resources by documenting department protocols, workflows, and policies to support staff training and operational consistency.
- Contributed to Systems Continuous Quality Improvement (CQI) initiatives, including improvements to assessment templates, documentation practices, and systemwide alignment on intake expectations.



Persons Served and Service Hours (Calendar Year 2025)

Numbers include billable and non-billable client services and interactions

Department	Clients Served	Client Service Hours
Mental Health	2,431	32,305
Community Based Intensive Services	514	16,356
Substance Use Disorders	664	26,901
Family Support	713	17,332
Access	1,185	904

Total Unduplicated Individuals Served 4,347 This number does not include many of the people who received only information/referral services, outreach and engagement, or prevention services.	Total Service Hours Provided 93,798 This number does not include telephone screenings, information/referral services, and most outreach activities. It is an increase of 10,862 compared to 2024.
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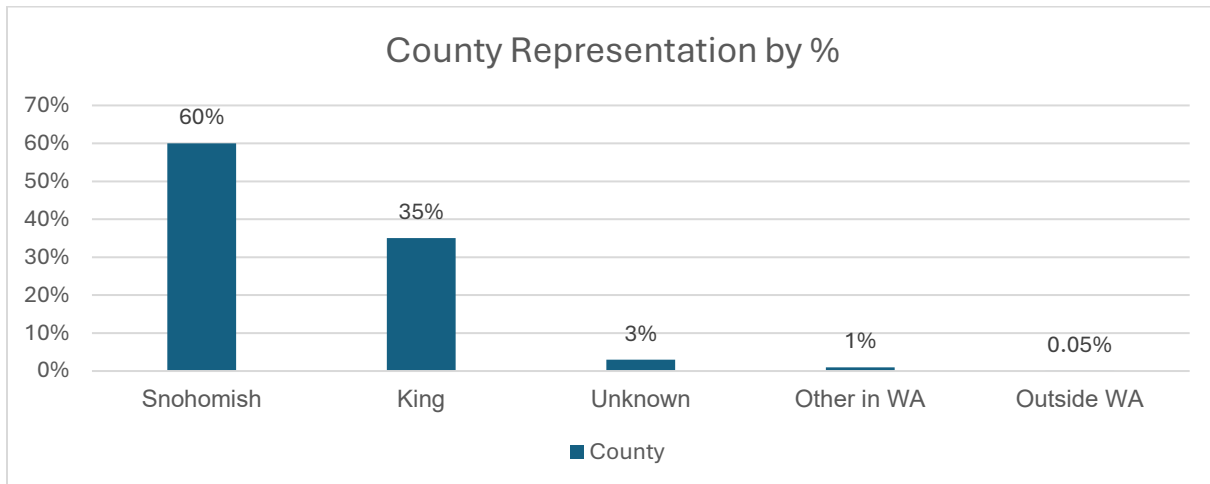


Characteristics of Persons Served

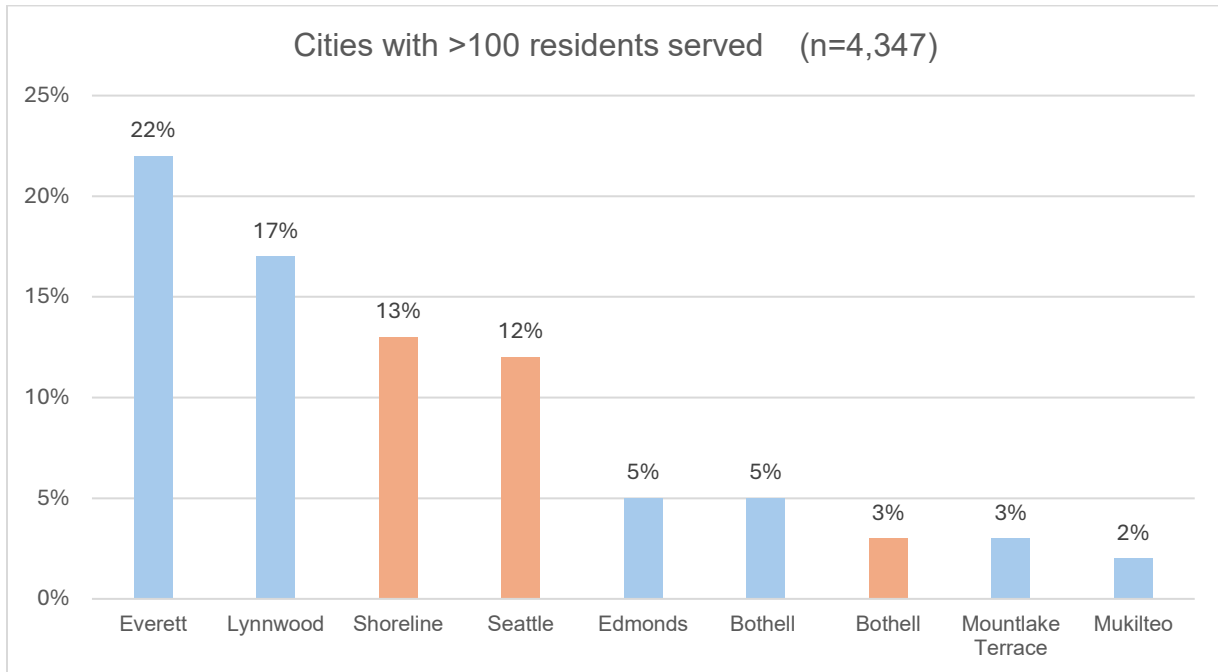
The following data tables and graphs depict demographics of the 4,347 individual clients that completed enrollment in our services in 2025. All client demographics are self-reported by the client.

Residence by County

Client County	Count of Clients (n=4347)
Snohomish	2621
King	1538
Unknown	120
Other County in WA State	62
Outside of WA State	6



Residence by City

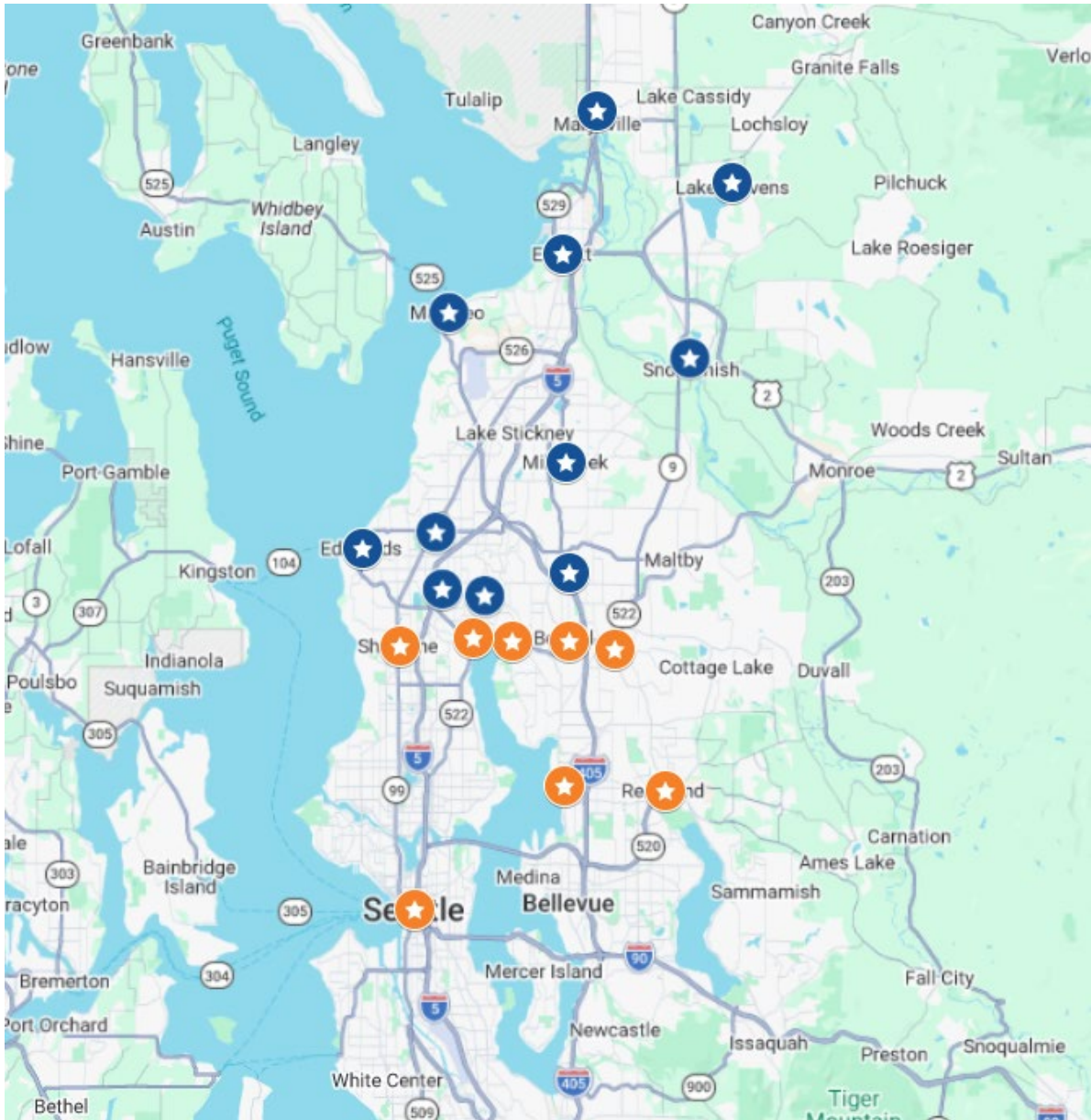


Client City (Snohomish County)	Count of Clients
Everett	948
Lynnwood	725
Edmonds	206
Bothell	205
Mountlake Terrace	131
Mukilteo	102
Marysville	70
Lake Stevens	59
Snohomish	49

Client City (King County)	Count of Clients
Shoreline	566
Seattle	505
Bothell	120
Kenmore	77
Lake Forest Park	65
Kirkland	47
Woodinville	48
Redmond	21

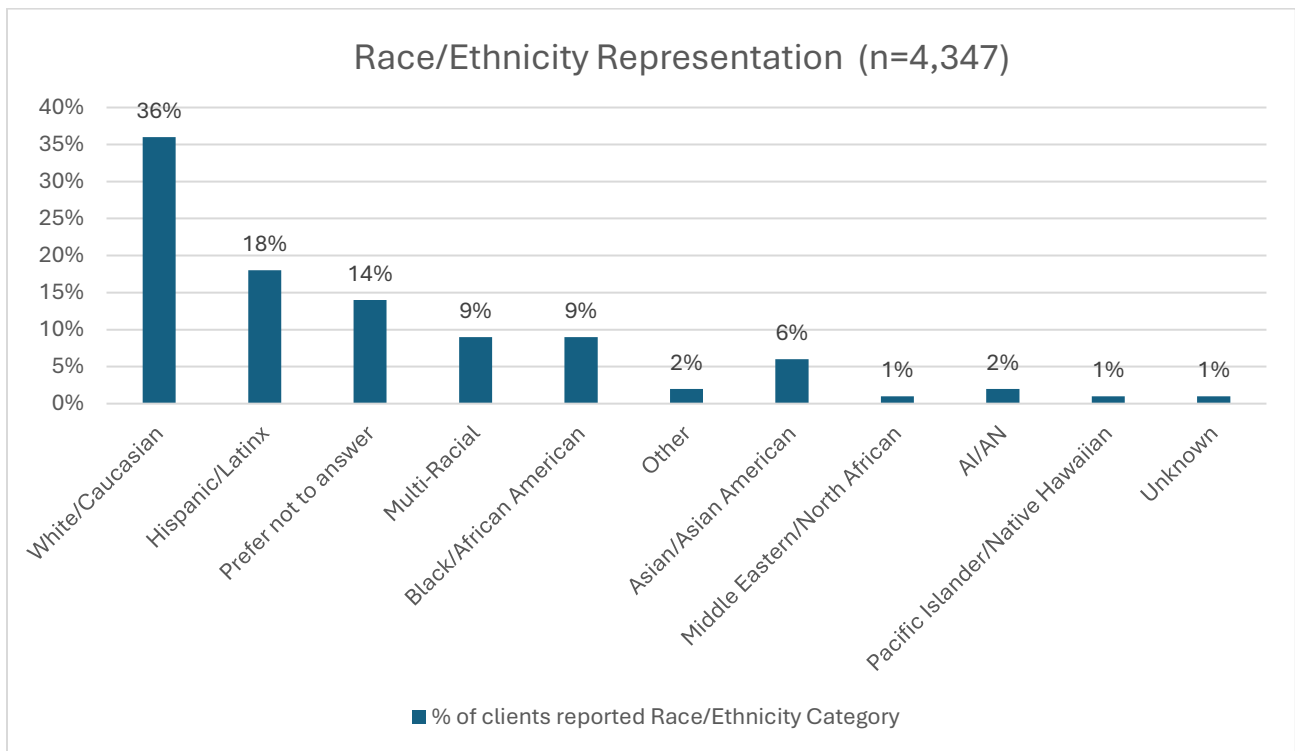
Mill Creek	39
Brier	23

Other cities across counties with <20	231	Unknown City regardless of County	110
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Race/Ethnicity

Client Race/Ethnicity	Count of Clients (n=4,347)
White/Caucasian	1582
Hispanic/Latinx	785
Prefer Not to Answer	624
Multi-Racial	402
Black/African American	379
Other Race/Ethnicity	96
Asian/Asian American	256
Middle Eastern/North African	53
American Indian/Alaskan Native	68
Pacific Islander/Native Hawaiian	47
Unknown	55



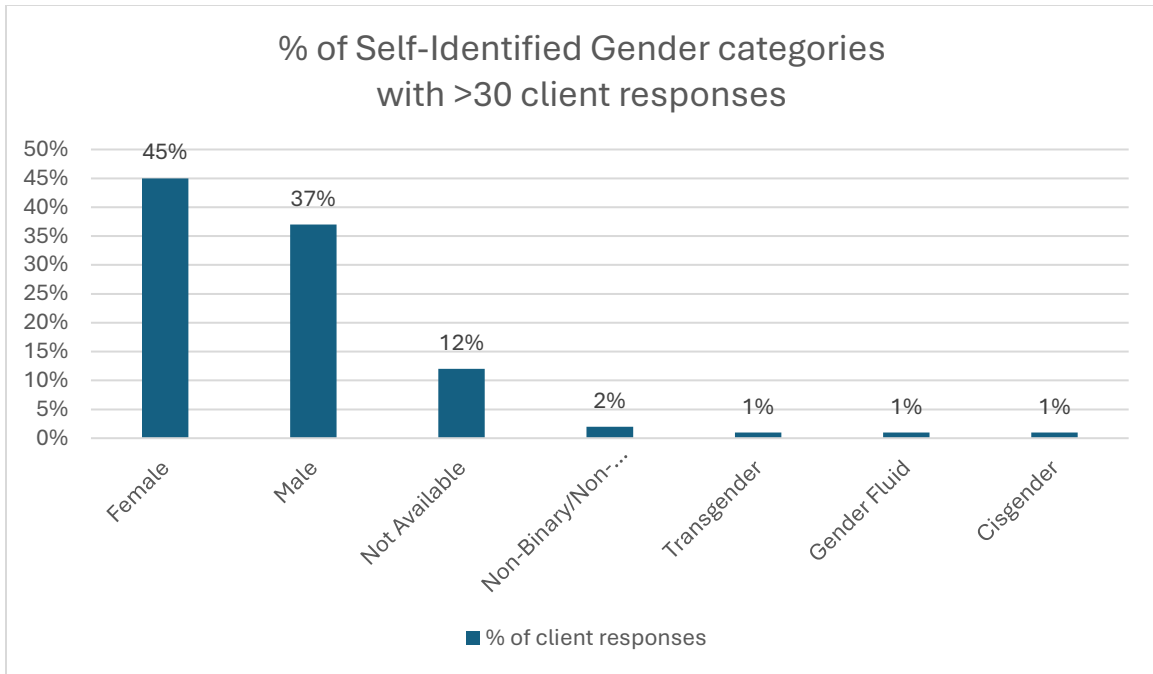
Sex and Self-Identified Gender

All clients are invited to self-report their sex and/or their gender identity. The following data includes how clients responded to both the Sex and Self-Identified Gender demographic portion of intake paperwork.

Client Sex	Count of Clients (n=4,347)
Female	1,584 (36%)
Male	1,402 (32%)
Unknown*	1,361 (31%)

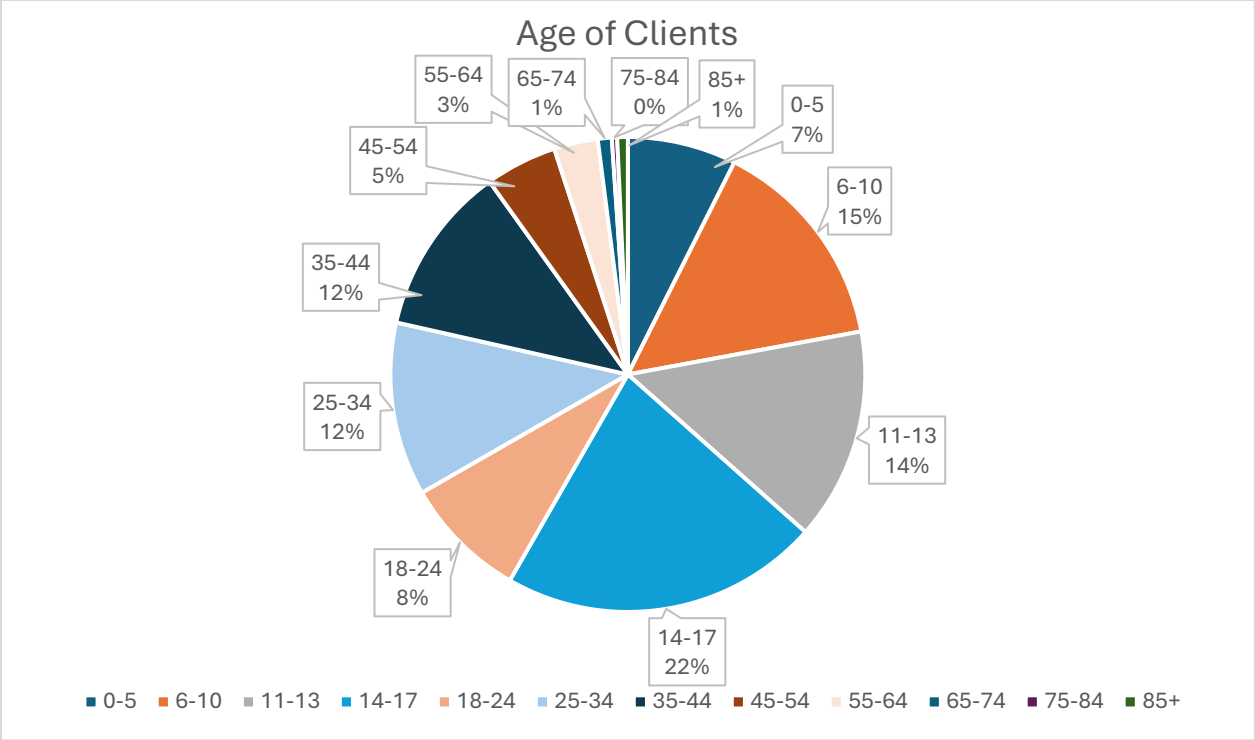
*Self-Identified Gender breakdown: Female (47%), Male (26%), Not available (23%), Transgender (1.33%), Non-Binary/Non-Conforming (0.96%), Cisgender (0.44%), Prefers Not to Answer (0.29%), Unsure (0.23%), Agender (0.11%), Two-Spirit (0.02%), Other (0.62%)

Client Self-Identified Gender	Count of Clients (n=4,347)
Female	1,950
Male	1,620
Not Available	541
Non-binary or Non-conforming	69
Transgender	42
Gender Fluid	39
Cisgender	32
Client prefers not to answer	13
Unsure	10
Unknown	9
Not listed	8
Gender Queer	7
Agender	5
Intersex: Born with characteristics of both	1
Two Spirit	1



Ages

Client Age Category	Count of Clients
	(n=4,995 due to client had services before and after a birth date)
0-5 years old	350
6-10 years old	694
11-13 years old	683
14-17 years old	1027
18-24 years old	398
25-34 years old	558
35-44 years old	547
45-54 years old	231
55-64 years old	141
65-74 years old	45
75-84 years old	17
85+ years old	34



Input from Interested Parties

Methods and Trends

Input from interested parties is crucial to our planning, program development, outcome evaluation, and overall sustainability. “Interested Parties” are clients/participants, family members, employees, funders, community members, etc.

Methods include:

- Anonymous survey to clients/families
- Focus groups
- Conversations or interviews between random clients/participants and manager/director
- Comment/suggestion boxes
- Solicitation of feedback through our web page and social media
- Solicitation of feedback at various community meetings management staff attend
- Employee exit interviews
- Employee satisfaction surveys
- Audits by funders/contractors

Trends included:

- Clients and participants are overall very pleased with and grateful for the services they are provided.

While there was not a lot of criticism given toward our services or the agency through any method, the Employee Satisfaction Survey in particular revealed information we had not measured in previous years and opportunities for improvement.

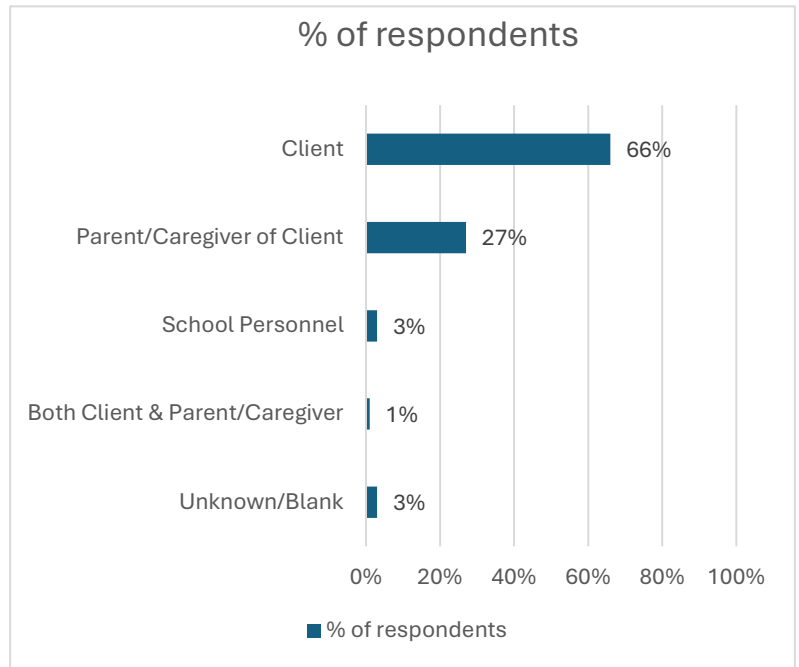
We analyze and use the input we received from all sources combined, in program planning, program development, strategic planning, advocacy, financial planning, resource planning, and workforce planning.

Client/Participant Feedback

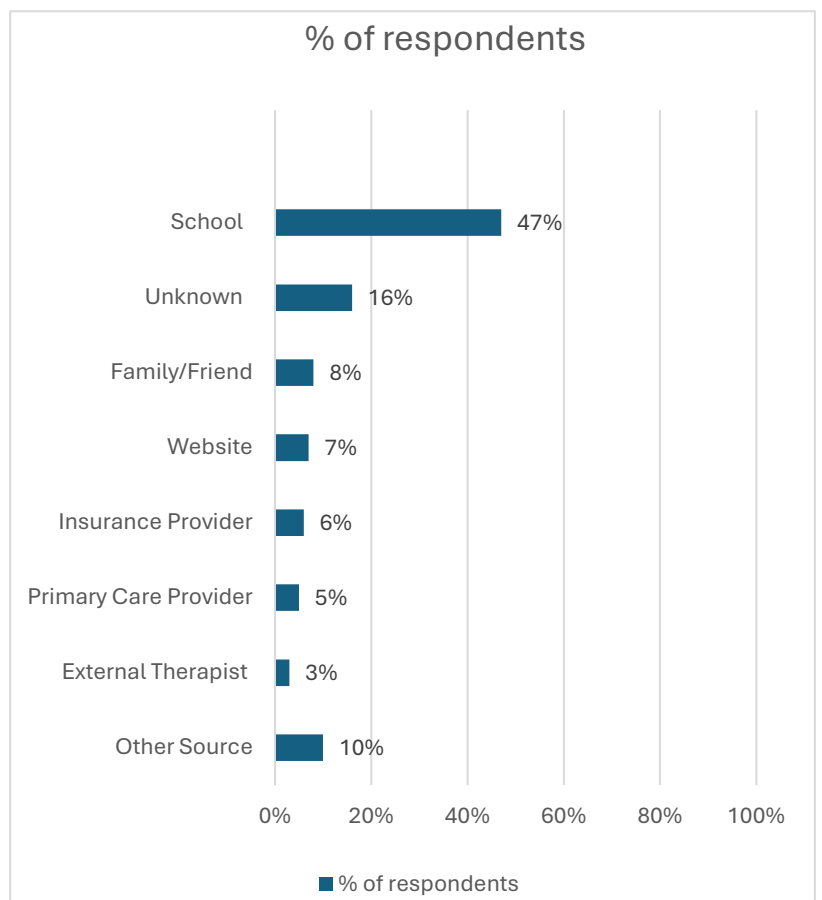
Mental Health Department

The Mental Health Department conducted voluntary client satisfaction and feedback surveys in the Spring/Summer and late Fall of 2025, receiving 162 responses. The following are results of the evaluation efforts.

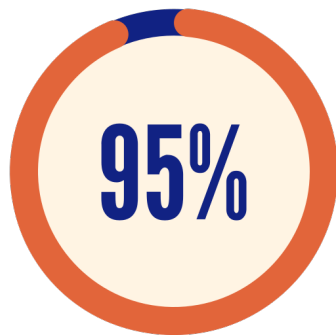
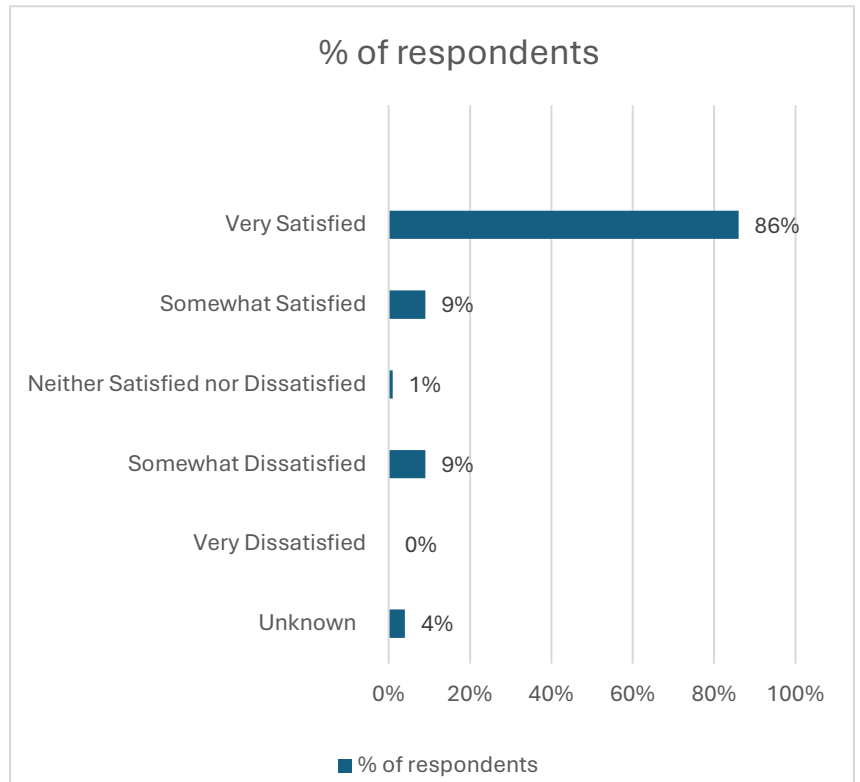
What is your relationship to CHS?	Count of Respondents (n=161)
Client	107
Parent/Caregiver of Client	43
School Personnel	5
Both Client & Parent/Caregiver of Client	2
Unknown	5



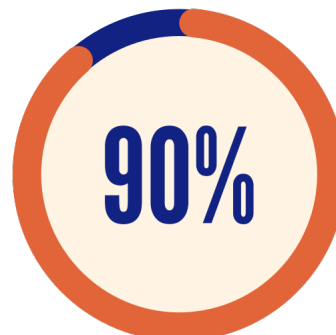
How did you hear about CHS?	Count of Respondents (n=161)
School	75
Unknown	25
Family/Friend	13
Website	11
Insurance Provider	9
Primary Care Provider	8
External Therapist	5
Other Source	16



How satisfied were you with your services at CHS?	Count of Respondents (n=161)
Very Satisfied	139
Somewhat Satisfied	14
Neither satisfied nor dissatisfied	2
Somewhat Dissatisfied	14
Very Dissatisfied	0
Unknown	6



Reported that CHS treats all clients with dignity and respect, no matter their race, ethnicity, gender, gender expression, sexual orientation, age, disability, or religious preference.

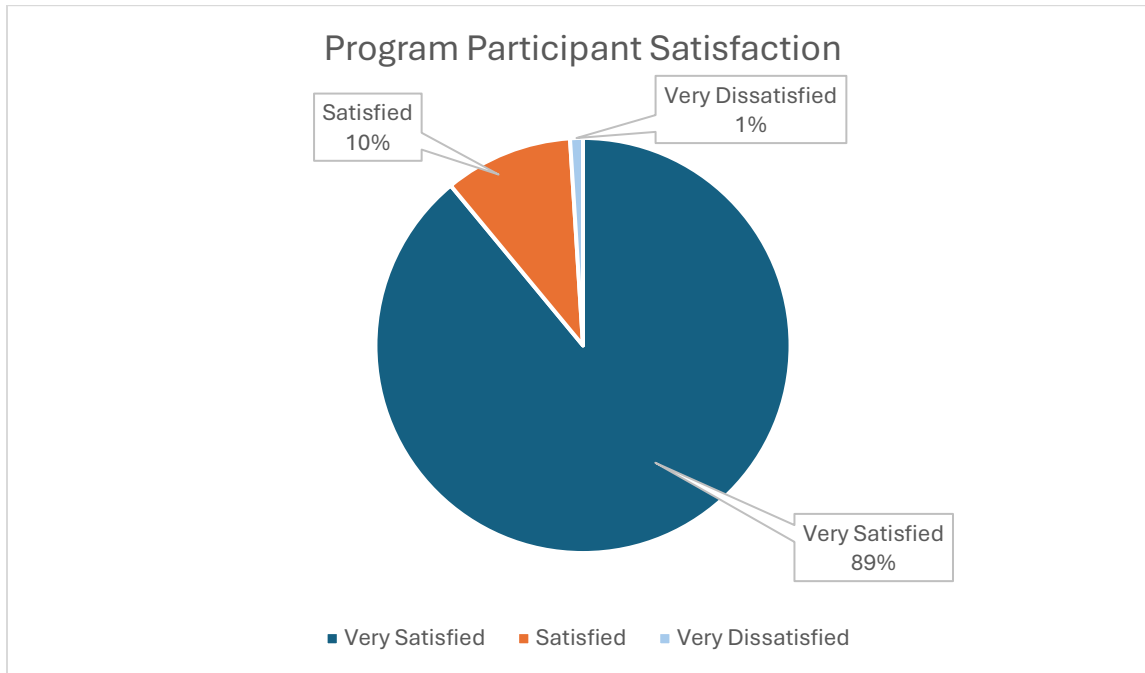


Reported that they did not experience any barriers to receiving services at CHS. For those that indicated barriers, transportation issues, location, and the timeliness of getting an appointment were the biggest barriers.

Family Support Department

Majority of the program evaluation methods used for outcome evaluation of programs also include a client satisfaction question using a 5-point Likert scale (Very Satisfied, Satisfied, Neutral, Dissatisfied, Very Dissatisfied), reflecting on their experience in the program/services.

In 2025, 76 participants responded to a satisfaction question and 89% were Very Satisfied, 10% were Satisfied and 1% were Very Dissatisfied.



Substance Use Disorders Department

ATOD Class Survey Results

The Access Department SUD intake specialist facilitated ATOD (Alcohol, Tobacco, Other Drug) education classes. Nine sessions were provided in 2025 and participants include both youth and a parent. The class is a one-time occurrence for 4 hours. Majority of referrals come from the Northshore School District. The following is a summation of the surveys completed by 33 participants (both youth and adults).

Remarks about the instructor included:

- Very knowledgeable and professional
- Very informative
- [the instructor] was kind, but firm
- Well informed and prepared
- Great job synthesizing student responses, good pacing, attentive to group needs

- Spoke in ways that teens can understand
- I was impressed with her ability to assertively encourage participation

Remarks about the class included:

- [I liked] all the different class materials, videos, handouts, and Narcan sample
- I liked the interaction and activity at the end of the course
- Good presentation of materials, good videos with good biological basis of drug use
- I liked the comprehensive discussion of various drugs, combinations, side effects, and dangers
- [I liked] how we were able to involve the teenage classmates in verbal contribution to prove that they are listening/paying attention.
- [Suggestion to include] a description of the legal implications - show it can impact school, scholarships, career, etc.
- Maybe let people give real life examples of situations to make it more real.
- Kids should have this class in elementary school, not after getting into it.

SUD Focus Group

A focus group was conducted on October 1, 2025 with an IOP group at the Madison location. Of the 14 clients on the group roster, 9 clients attended and participated in the focus group. The group was invited to provide feedback and the program and agency/environment.

Feedback received from participants included the following themes:

- Counselor Quality: participants consistently commented on the counselor's depth of teaching, engaging and interactive style, and genuine compassion.
- Supportive Staff & Environment: participants also acknowledge the administrative staff who provide a welcoming environment, are helpful and supporting, and how it contributes to their sense of belonging in the program.
- Recovery Space: participants value having a comfortable space to hang out in and several noted the food and resources available are meaningful.

Audits and Site Visits

Best Starts for Kids King County Fiscal Site Visit

On December 10, 2025, Public Health Seattle & King County (PHSKC) conducted a virtual fiscal monitoring site visit. The visit consisted of reviewing agency internal controls and compliance with the terms and conditions of the 2025 contract for Family Support's Kaleidoscope Play & Learn program. The summary letter from the BSK Fiscal Contract Monitor

noted that “In general, the internal control policies and procedures reviewed were satisfactory to achieve the results desired by the program through effective stewardship of public resources. The Center for Human Services team was very responsive and cooperative throughout the fiscal monitoring process.”

Snohomish County Human Services - Outpatient Mental Health Services

On September 30, 2025, Snohomish County Behavioral Health conducted its first monitoring visit since the contract was initiated for Outpatient Mental Health Services. The visit included a fiscal and clinical file review. The visit revealed no findings or concerns. Technical assistance was provided. Clinical file review focused on services provided in March 2025. The summary of the review noted the following strengths:

- our mental health evaluations were complete and supported recommendations
- progress notes were clear and individualized
- ROI's and other documentation was in the file and invoice with correct documentation is submitted in a timely manner
- policies and procedures were complete and submitted
- Trauma Informed Care has been integrated into the agency

Snohomish County Human Services - Community Outpatient Treatment Services (SUD)

On September 30, 2025, Snohomish County Behavioral Health conducted its first monitoring visit since the contract was initiated for Community Outpatient Treatment Services (SUD). The visit included a fiscal and clinical file review. The visit revealed no findings or concerns. Technical assistance was provided. Clinical file review focused on services provided in March 2025. The summary of the review noted the following strengths:

- assessments were complete and supported treatment recommendations
- individual and group session progress notes were clear and individualized
- ROI's and other documentation was in the file and invoice with correct documentation is submitted in a timely manner
- policies and procedures were complete and submitted
- Trauma Informed Care has been integrated into the agency

Snohomish County Human Services - School Based Mental Health Services

On September 30, 2025, Snohomish County Behavioral Health conducted a monitoring visit for School Based Mental Health Services. The visit included a fiscal and clinical file review. The visit revealed no findings or concerns. Technical assistance was provided. Clinical file review focused on services provided in March 2025. The summary of the review noted the following strengths:

- mental health evaluations were complete (as needed) and supported recommendations
- progress notes were clear and individualized
- ROI's and other documentation was in the file and invoice with correct documentation is submitted in a timely manner
- communication with school personnel was documented
- Trauma Informed Care has been integrated into the agency

MRT Fidelity Check

On September 17, 2025, an in-person MRT group was observed for a fidelity check. The group meets once a week, on Wednesdays, from 6:00pm-8:00pm. There were 11 clients present and 1 client absent. The summary noted the facilitator did a great job keeping to fidelity and clarifying the rules and the group seemed to trust the process and work well together. A few following recommendations were made as a result of the quality check; including reminding clients to listen for the essence of the step, not necessarily the content of what is being said; reminding group members of the difference between clarifying, curiosity, and counseling questions, and to be attentive to the tendency to process during certain times during presentations.

King County Department of Community and Human Services

On September 5, 2025, King County Department of Community and Human Services conducted a virtual fiscal monitoring visit that evaluated compliance with the terms and conditions of the Pregnant/Postpartum & Parenting Women and Youth and Family Services contracts for the period of CY 2024.

The fiscal review included evaluation of:

1. Agency financial policies and procedures, including review of internal controls over major accounting cycles;
2. Payroll processes, timesheets and other related payroll data for applicable staff;
3. Accounts payable process, which include underlying expenditures and supporting invoices;
4. Compliance over King County Ordinance 19762 and K.C.C. 2.94.000 implementing a Living Wage for covered employees.

The review resulted in a corrective action plan regarding segregating expenditures by funding source. DCHS required providing a corrective action statement detailing how expenditures would be segregated by funding source, program, or other method as appropriate. This was a new requirement and not expected in prior years of the contract.

On November 6, 2025 our Finance Director responded to the corrective action with measures to ensure compliance by:

1. Direct Cost Allocation
2. Personnel Billing Matrix to cross-reference with payroll system.

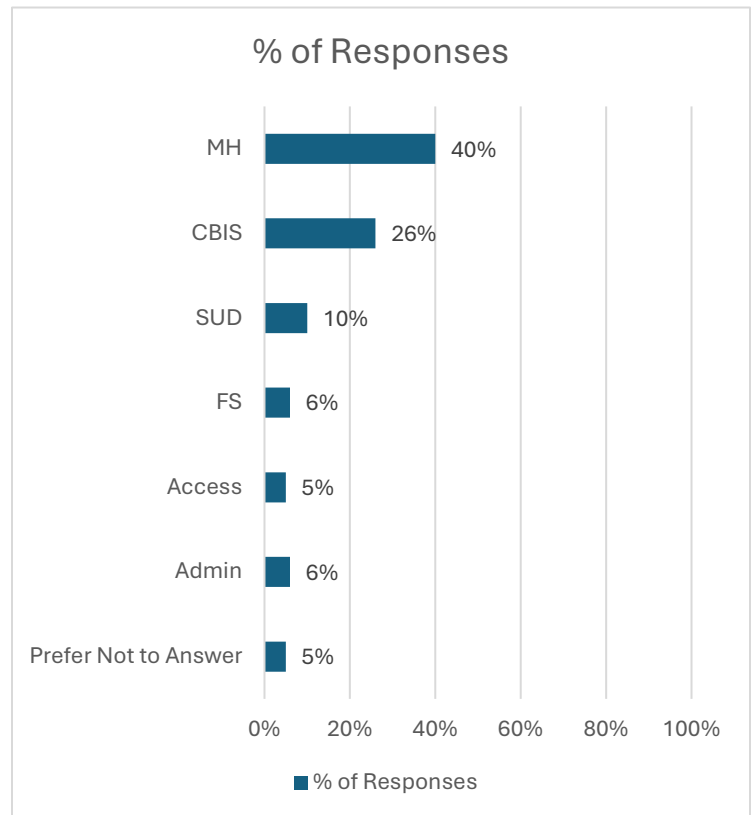
Employee Input

An Employee Satisfaction and Engagement Survey was launched on December 1, 2025 and closed on December 22, 2025. The survey responses were confidential and anonymous. 168 employees were invited to participate in the survey, and 94 responded. This is a 56% response rate which is considered a better than average response rate. Last year's response rate was 52%. This year's survey was redesigned and consisted of 36 questions that were informed by research of validated instruments. Helpful written comments were also received from those who took the survey. CHS management analyzed the results of the survey and was overall satisfied with the scores. Below is an analysis of the survey results.

Section 1: About You

Question 1. What department do you work in?

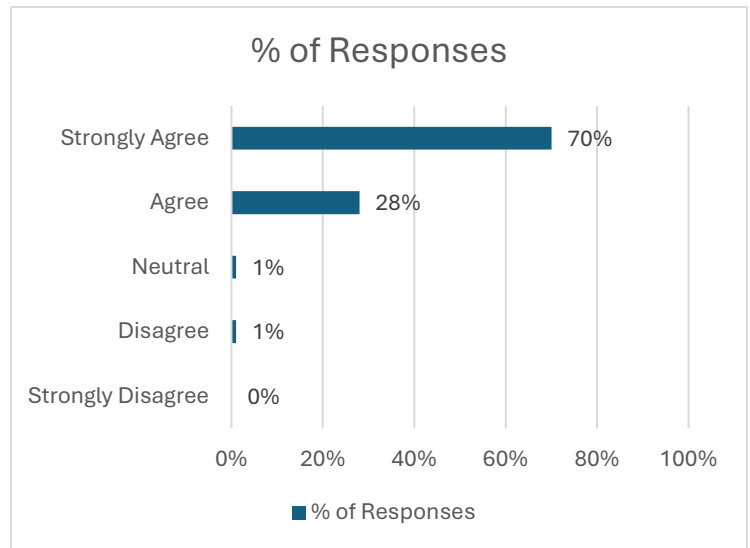
Department	Count of Respondents (n=94)
Mental Health (MH)	38
Community-Based Intensive Services (CBIS)	24
Substance Use Disorders (SUD)	9
Family Support (FS)	6
Access	5
Administration (Admin)	6
Prefer Not to Answer	5



Section 2: Mission and Engagement

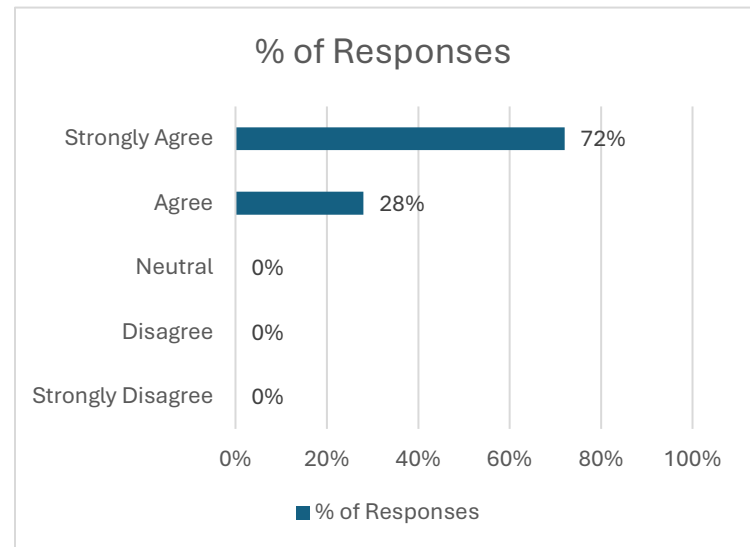
Question 2. I believe in the mission and purpose of Center for Human Services (CHS).

Scale	Count of Respondents (n=94)
Strongly Agree	66
Agree	26
Neutral	1
Disagree	1
Strongly Disagree	0



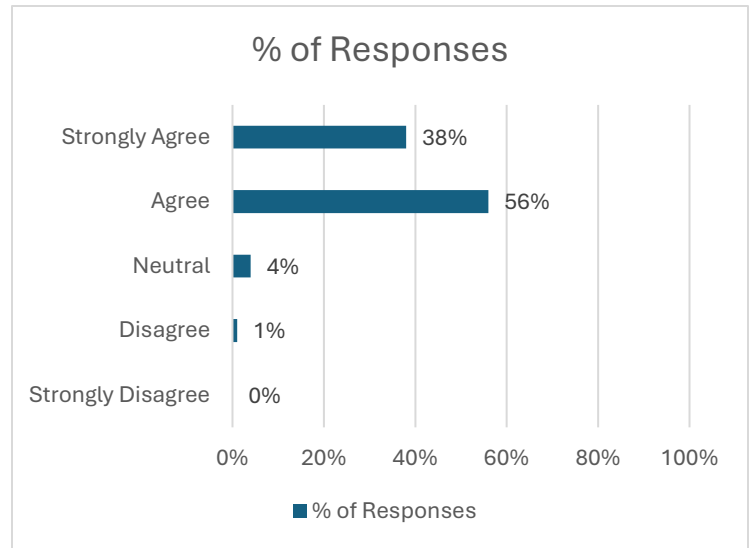
Question 3. I care about the future of CHS.

Scale	Count of Respondents (n=94)
Strongly Agree	68
Agree	26
Neutral	0
Disagree	0
Strongly Disagree	0



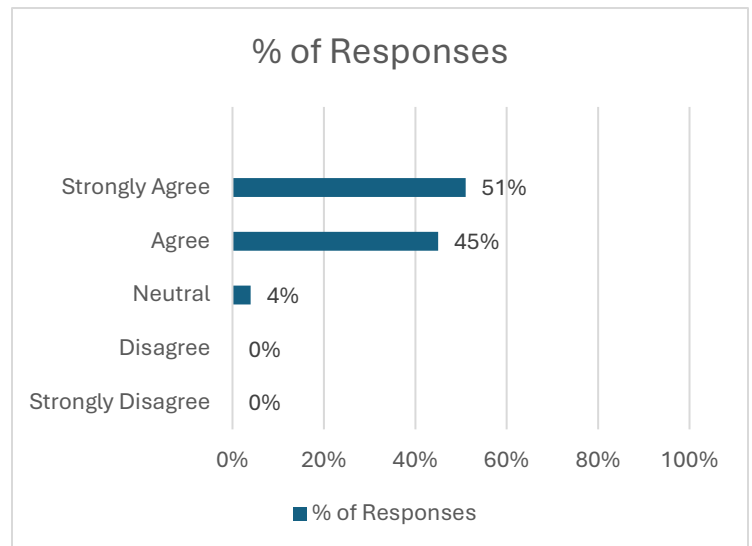
Question 4. I am really focused when I am working.

Scale	Count of Respondents (n=94)
Strongly Agree	36
Agree	53
Neutral	4
Disagree	1
Strongly Disagree	0



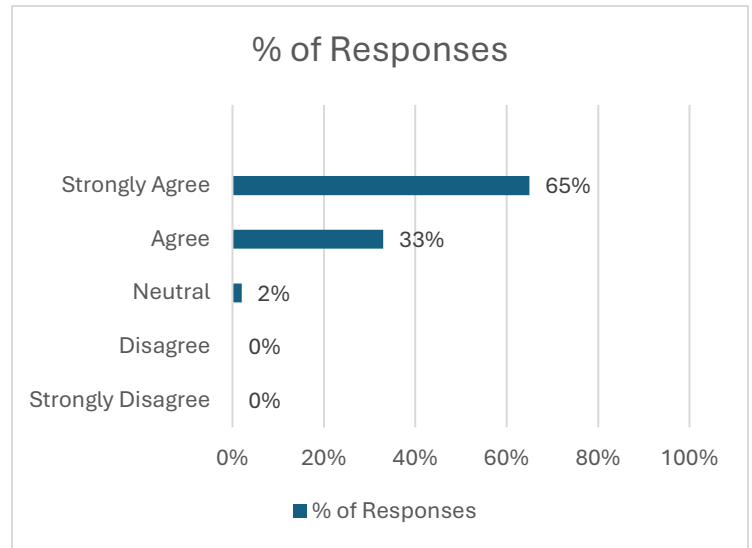
Question 5. I concentrate on my job when I am at work.

Scale	Count of Respondents (n=94)
Strongly Agree	48
Agree	42
Neutral	4
Disagree	0
Strongly Disagree	0



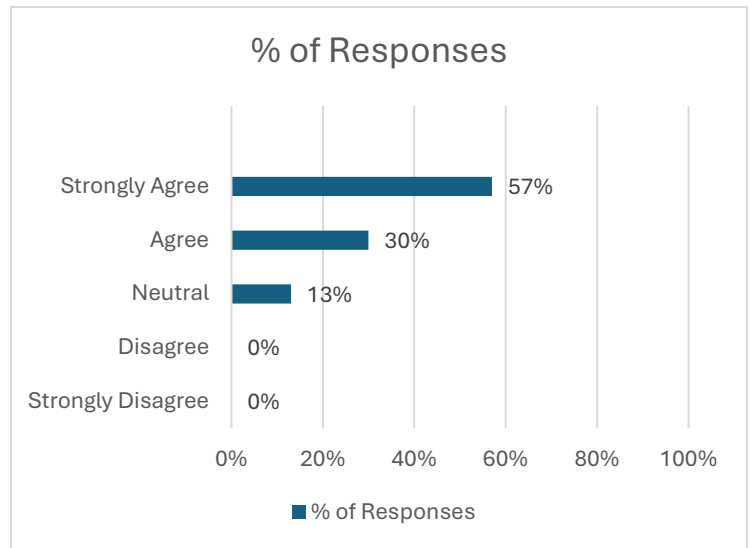
Question 6. I give my job responsibility a lot of attention.

Scale	Count of Respondents (n=94)
Strongly Agree	61
Agree	31
Neutral	2
Disagree	0
Strongly Disagree	0



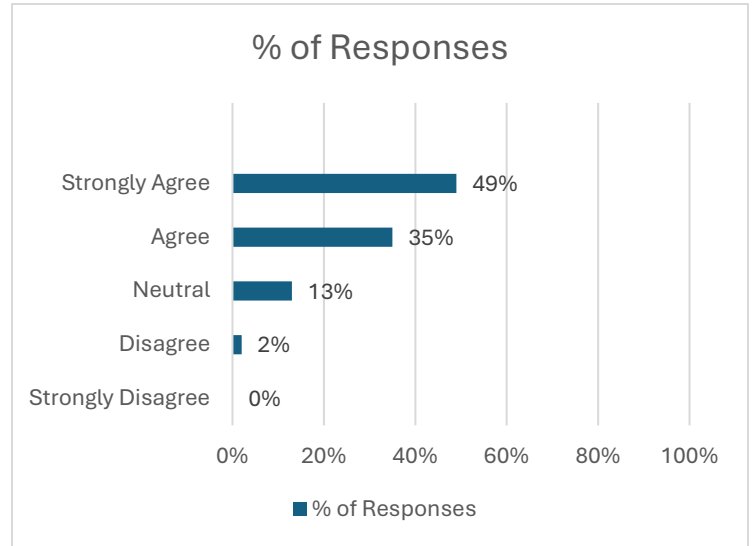
Question 7. Working at CHS has a great deal of personal meaning to me.

Scale	Count of Respondents (n=94)
Strongly Agree	54
Agree	28
Neutral	12
Disagree	0
Strongly Disagree	0



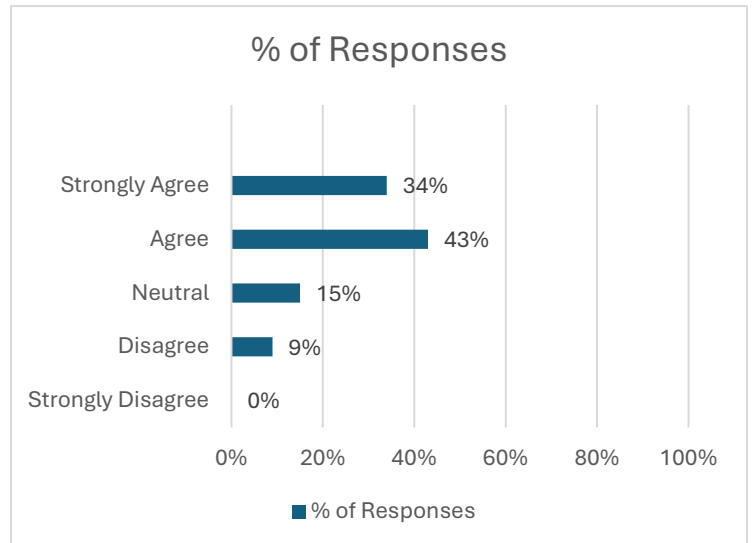
Question 8. I feel a strong sense of belonging at my job.

Scale	Count of Respondents (n=94)
Strongly Agree	46
Agree	33
Neutral	12
Disagree	2
Strongly Disagree	0



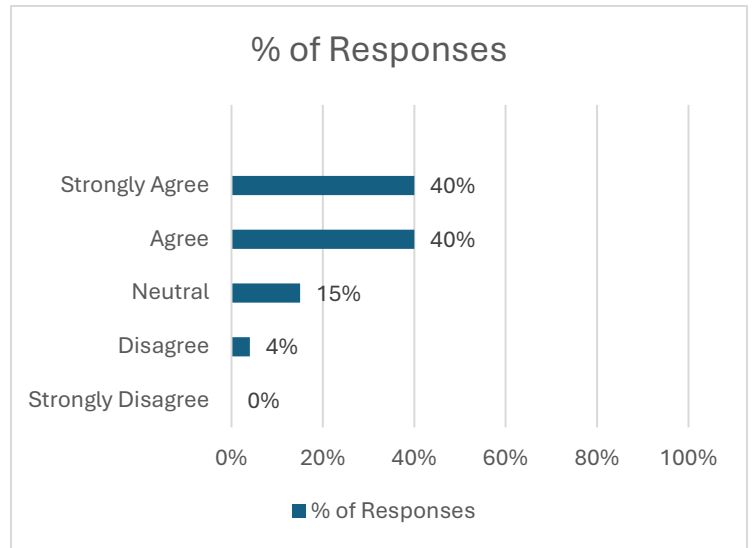
Question 9. I really push myself to work beyond what is expected of me.

Scale	Count of Respondents (n=94)
Strongly Agree	32
Agree	40
Neutral	14
Disagree	8
Strongly Disagree	0



Question 10. I am willing to put in the extra effort without being asked.

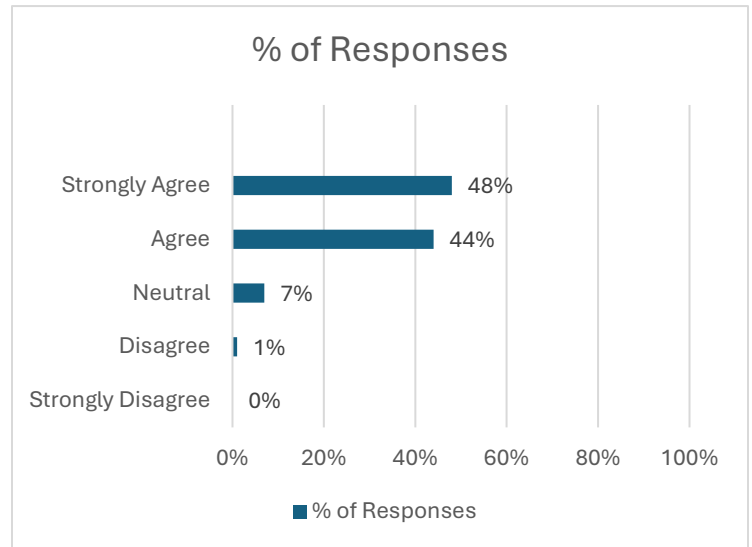
Scale	Count of Respondents (n=94)
Strongly Agree	38
Agree	38
Neutral	14
Disagree	4
Strongly Disagree	0



Section 3: Leadership and Development

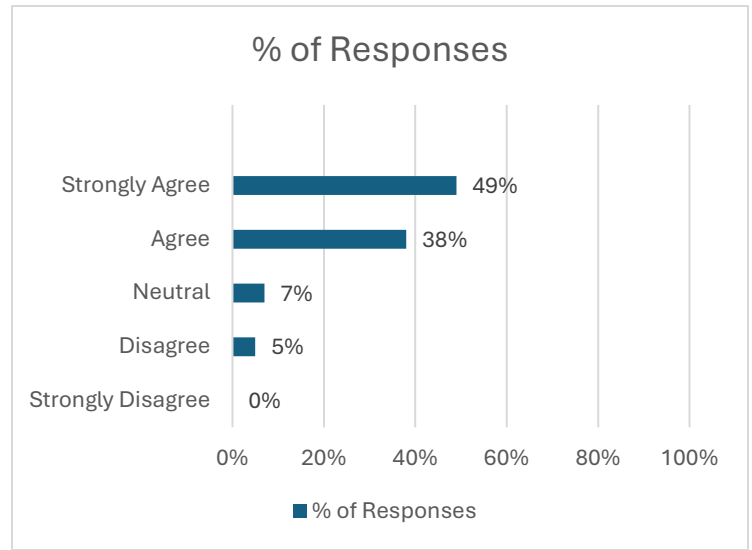
Question 11. My manager/supervisor is open to hearing new ideas.

Scale	Count of Respondents (n=94)
Strongly Agree	45
Agree	41
Neutral	7
Disagree	1
Strongly Disagree	0



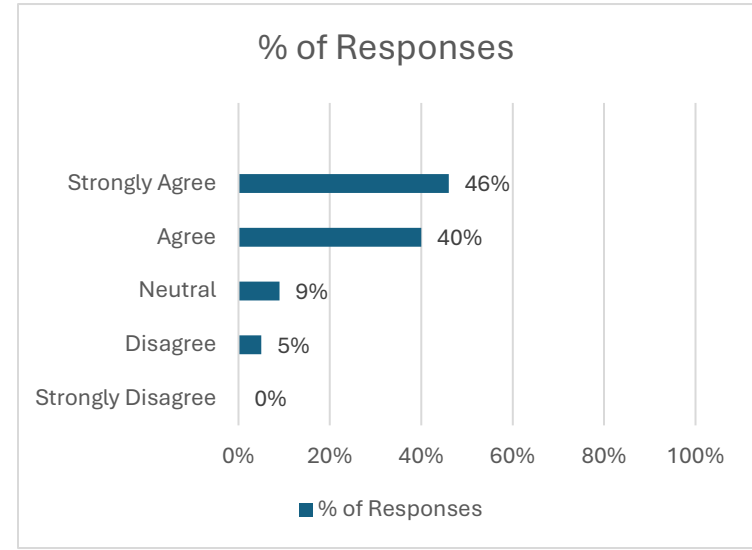
Question 12. My manager/supervisor is attentive to new opportunities to improve work processes.

Scale	Count of Respondents (n=94)
Strongly Agree	46
Agree	36
Neutral	7
Disagree	5
Strongly Disagree	0



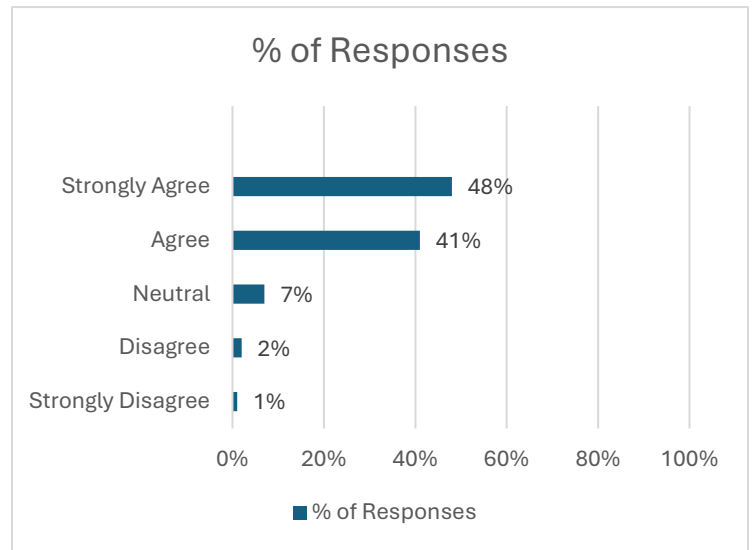
Question 13. My manager/supervisor is open to discuss the desired goals and new ways to achieve them.

Scale	Count of Respondents (n=94)
Strongly Agree	43
Agree	38
Neutral	8
Disagree	5
Strongly Disagree	0



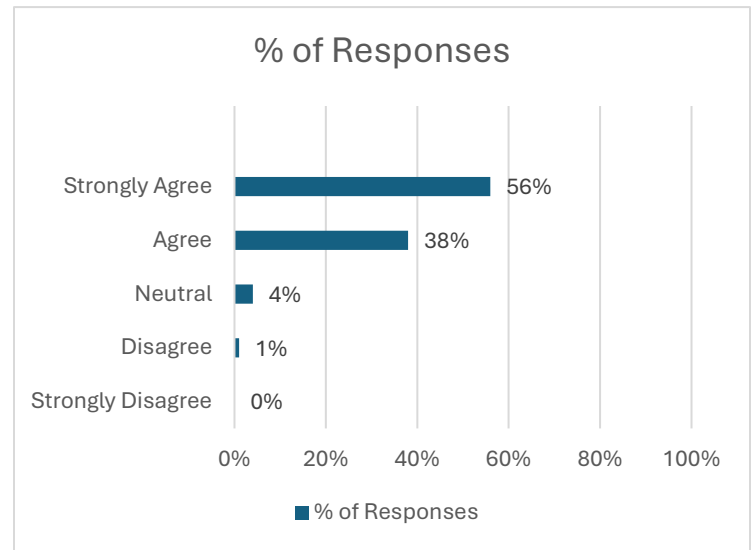
Question 14. My manager/supervisor is an ongoing presence on this team and is readily available.

Scale	Count of Respondents (n=94)
Strongly Agree	45
Agree	39
Neutral	7
Disagree	2
Strongly Disagree	1



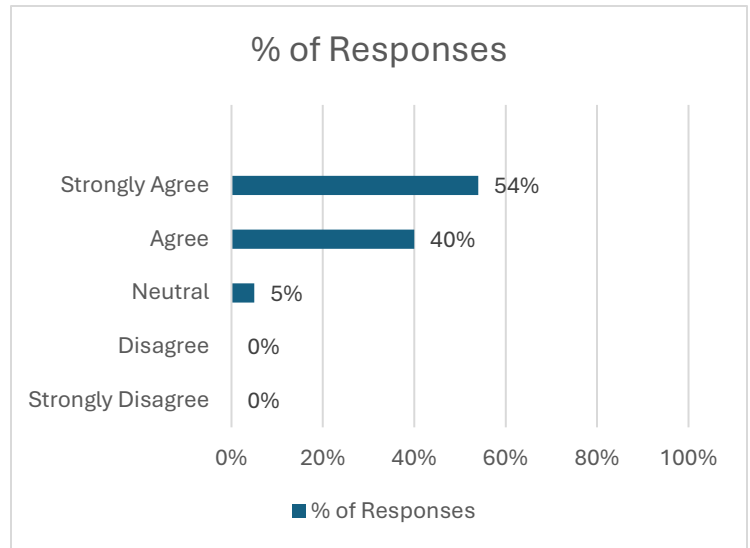
Question 15. My manager/supervisor is available for consultation on problems.

Scale	Count of Respondents (n=94)
Strongly Agree	53
Agree	36
Neutral	4
Disagree	1
Strongly Disagree	0



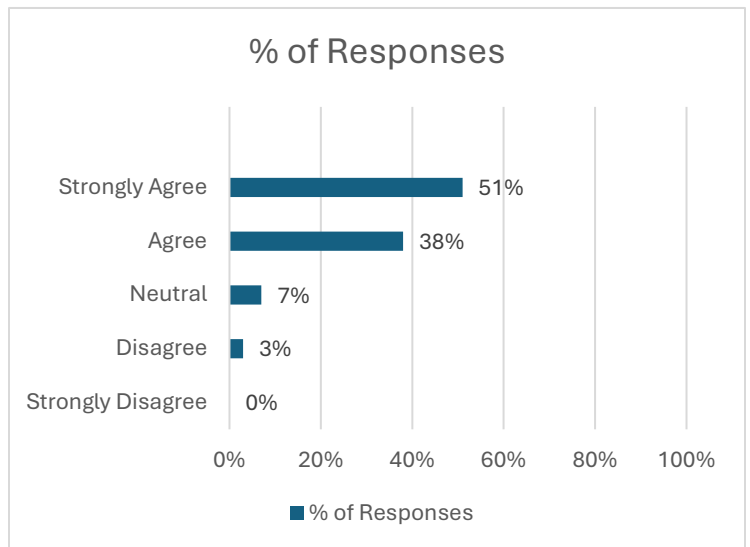
Question 16. My manager/supervisor is available for professional questions if I would like to consult with them.

Scale	Count of Respondents (n=94)
Strongly Agree	51
Agree	38
Neutral	5
Disagree	0
Strongly Disagree	0



Question 17. My manager is ready to listen to my requests.

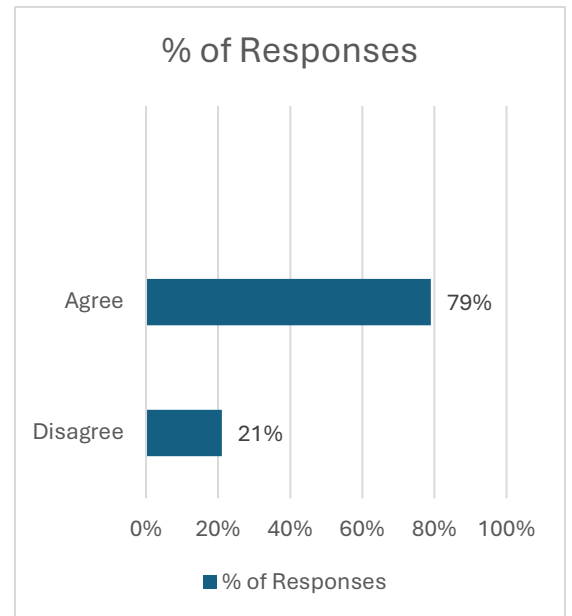
Scale	Count of Respondents (n=94)
Strongly Agree	48
Agree	36
Neutral	7
Disagree	3
Strongly Disagree	0



Section 4: Job Satisfaction

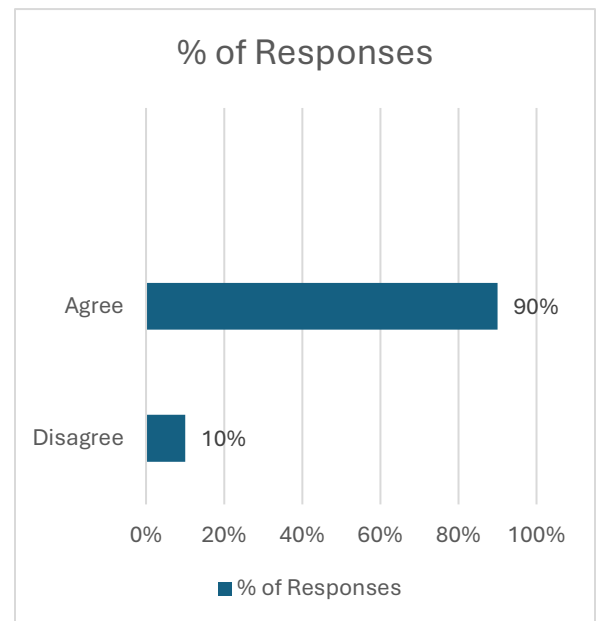
Question 18. I feel I am being paid a fair amount for the work I do.

Scale	Subscale	Count of Respondents (n=94)
Agree n=74	Agree Very Much	14
	Agree Moderately	32
	Agree Slightly	28
Disagree n=20	Disagree Slightly	13
	Disagree Moderately	4
	Disagree Very Much	3



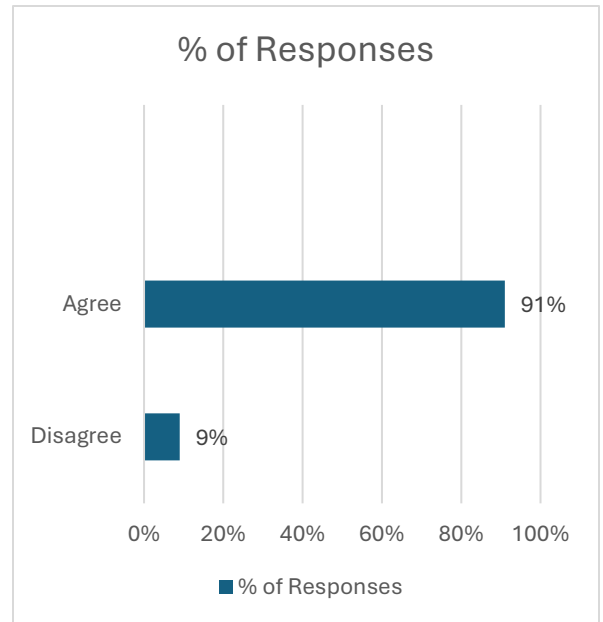
Question 19. I am satisfied with benefits I receive.

Scale	Subscale	Count of Respondents (n=91)
Agree n=82	Agree Very Much	45
	Agree Moderately	33
	Agree Slightly	4
Disagree n=9	Disagree Slightly	6
	Disagree Moderately	3
	Disagree Very Much	0



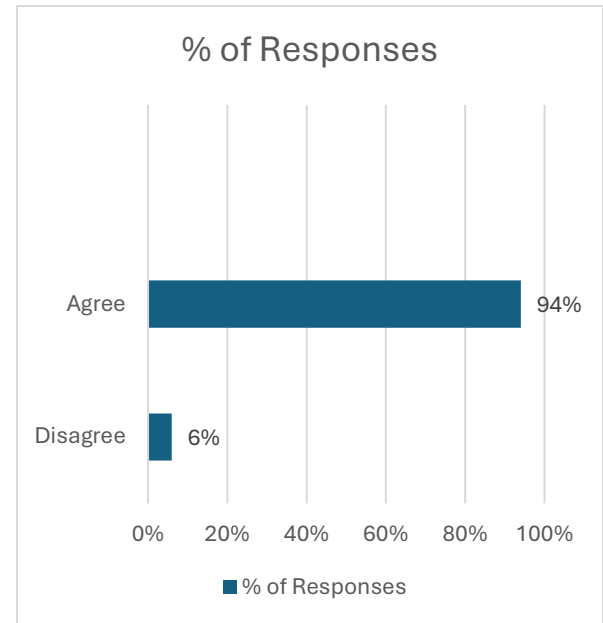
Question 20. My supervisor/manager is quite competent in doing their job.

Scale	Subscale	Count of Respondents (n=94)
Agree n=86	Agree Very Much	54
	Agree Moderately	23
	Agree Slightly	9
Disagree n=8	Disagree Slightly	5
	Disagree Moderately	3
	Disagree Very Much	0



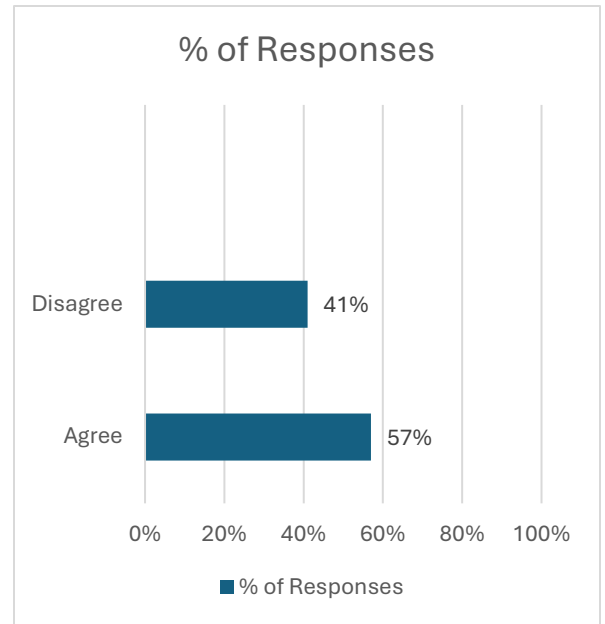
Question 21. My manager/supervisor is fair to me.

Scale	Subscale	Count of Respondents (n=94)
Agree n=88	Agree Very Much	66
	Agree Moderately	18
	Agree Slightly	4
Disagree n=6	Disagree Slightly	4
	Disagree Moderately	2
	Disagree Very Much	0



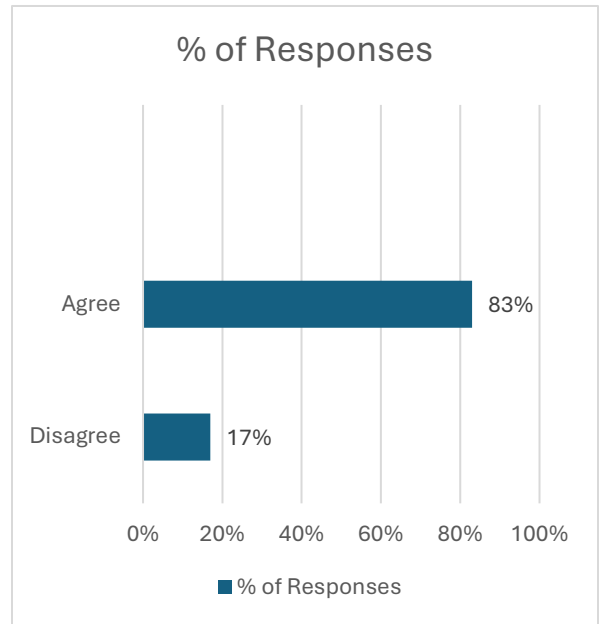
Question 22. There is really too little chance for a promotion in my job.

Scale	Subscale	Count of Respondents (n=93)
Disagree n=39	Disagree Very Much	3
	Disagree Moderately	12
	Disagree Slightly	24
Agree n=54	Agree Slightly	25
	Agree Moderately	21
	Agree Very Much	8



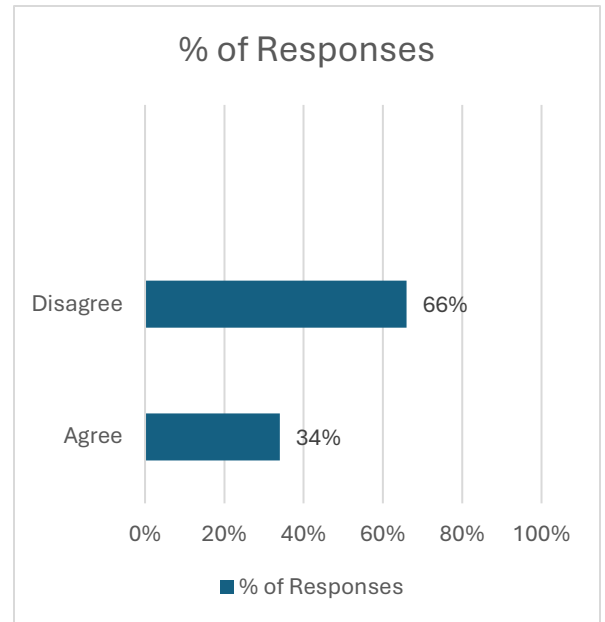
Question 23. When I do a good job, I receive recognition for it that I should receive.

Scale	Subscale	Count of Respondents (n=94)
Agree n=78	Agree Very Much	26
	Agree Moderately	29
	Agree Slightly	23
Disagree n=16	Disagree Slightly	9
	Disagree Moderately	6
	Disagree Very Much	1



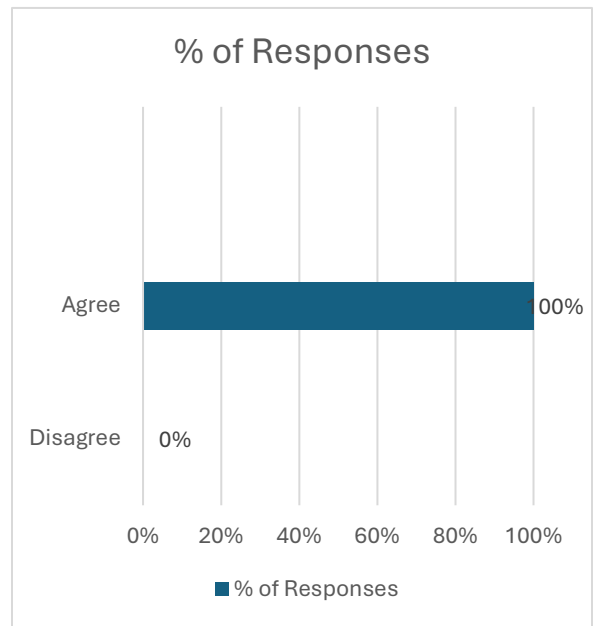
Question 24. Many of our rules and procedures make doing a good job difficult.

Scale	Subscale	Count of Respondents (n=94)
Disagree n=62	Disagree Very Much	19
	Disagree Moderately	23
	Disagree Slightly	20
Agree n=32	Agree Slightly	21
	Agree Moderately	10
	Agree Very Much	1



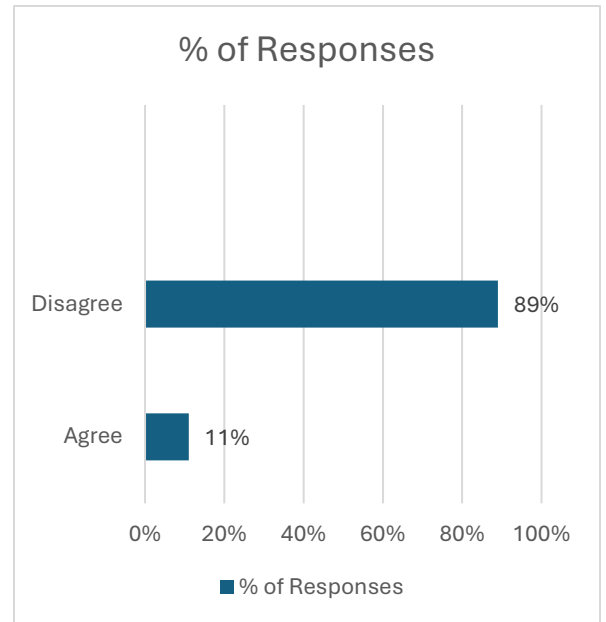
Question 25. I like the people I work with.

Scale	Subscale	Count of Respondents (n=94)
Agree n=94	Agree Very Much	61
	Agree Moderately	27
	Agree Slightly	6
Disagree n=0	Disagree Slightly	0
	Disagree Moderately	0
	Disagree Very Much	0



Question 26. The goals of this organization are not clear to me.

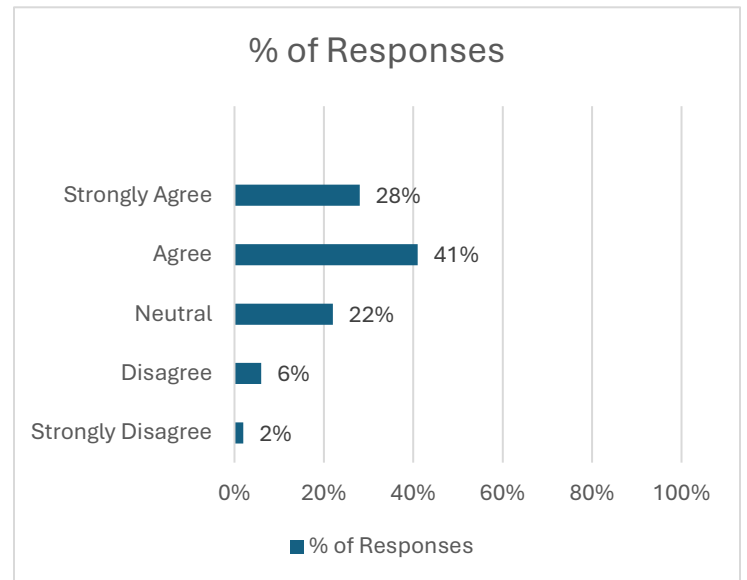
Scale	Subscale	Count of Respondents (n=94)
Disagree n=84	Disagree Very Much	47
	Disagree Moderately	28
	Disagree Slightly	9
Agree n=10	Agree Slightly	4
	Agree Moderately	2
	Agree Very Much	4



Section 6: Culture

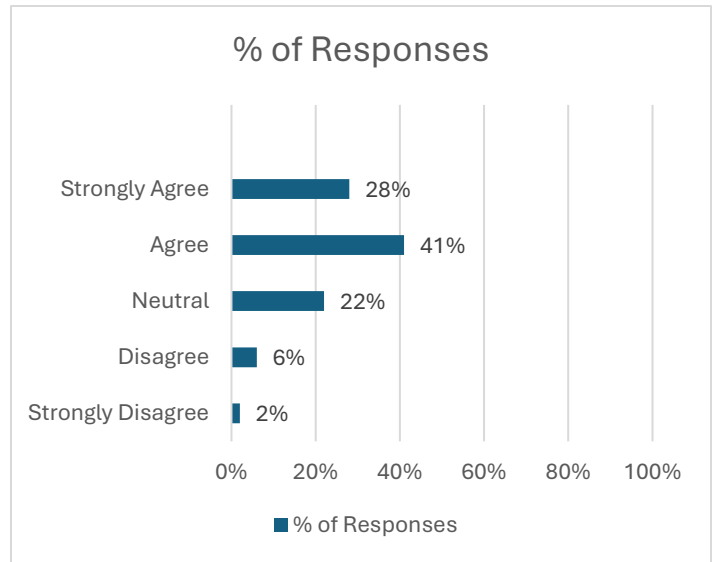
Question 27. If you make a mistake on this team, it is never held against you.

Scale	Count of Respondents (n=94)
Strongly Agree	26
Agree	39
Neutral	21
Disagree	6
Strongly Disagree	2



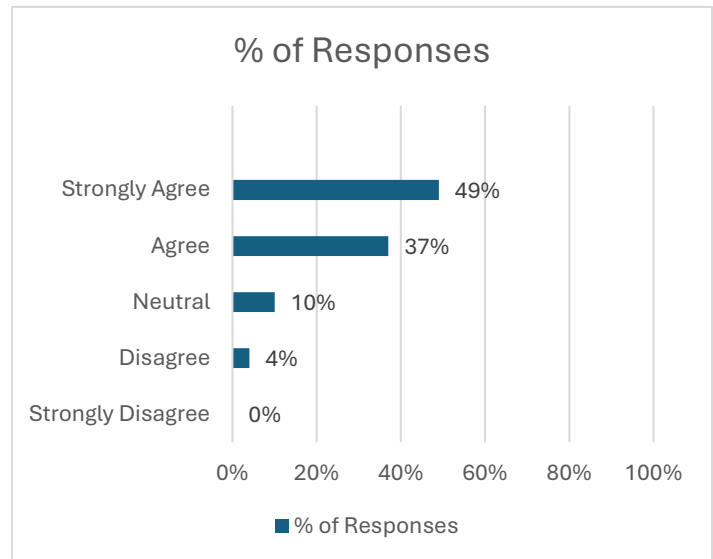
Question 28. Members of this team are able to bring up problems and tough issues.

Scale	Count of Respondents (n=94)
Strongly Agree	36
Agree	39
Neutral	13
Disagree	6
Strongly Disagree	0



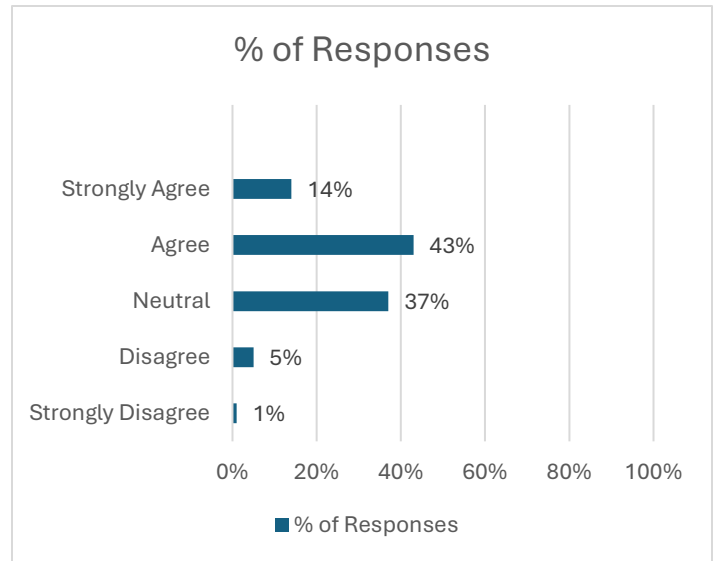
Question 29. People on this team don't reject others for being different.

Scale	Count of Respondents (n=94)
Strongly Agree	46
Agree	35
Neutral	9
Disagree	4
Strongly Disagree	0



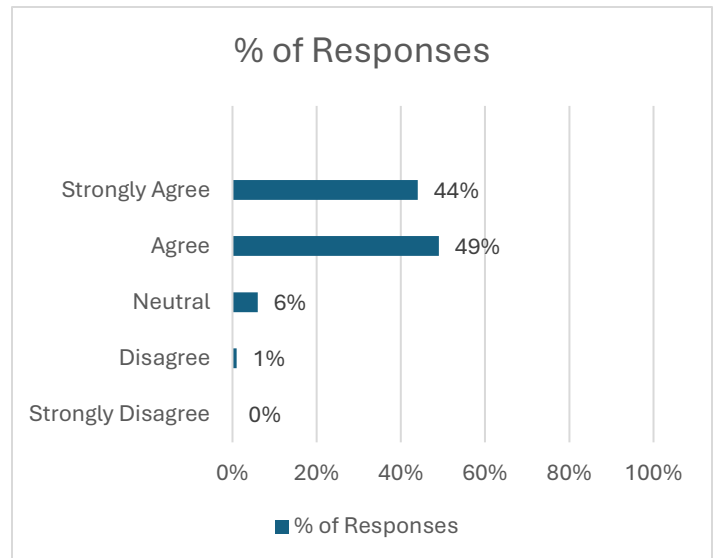
Question 30. It is safe to take risk on this team.

Scale	Count of Respondents (n=94)
Strongly Agree	13
Agree	40
Neutral	35
Disagree	5
Strongly Disagree	1



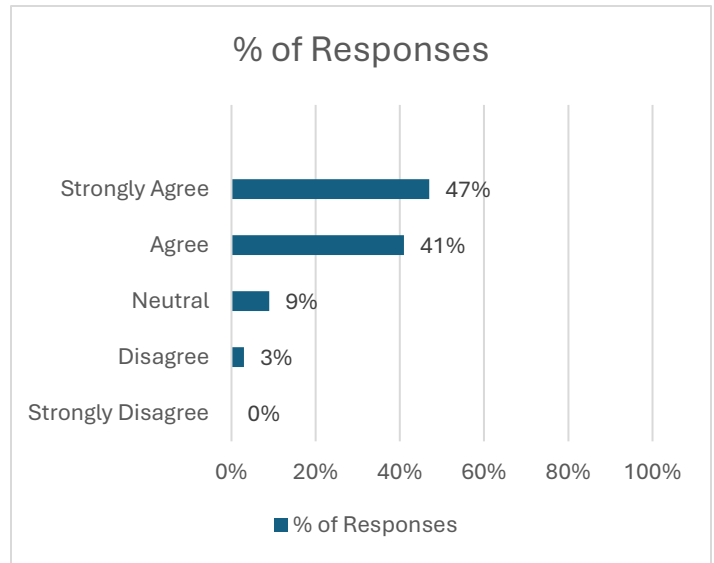
Question 31. It is not difficult to ask other members of this team for help.

Scale	Count of Respondents (n=94)
Strongly Agree	41
Agree	46
Neutral	6
Disagree	1
Strongly Disagree	0



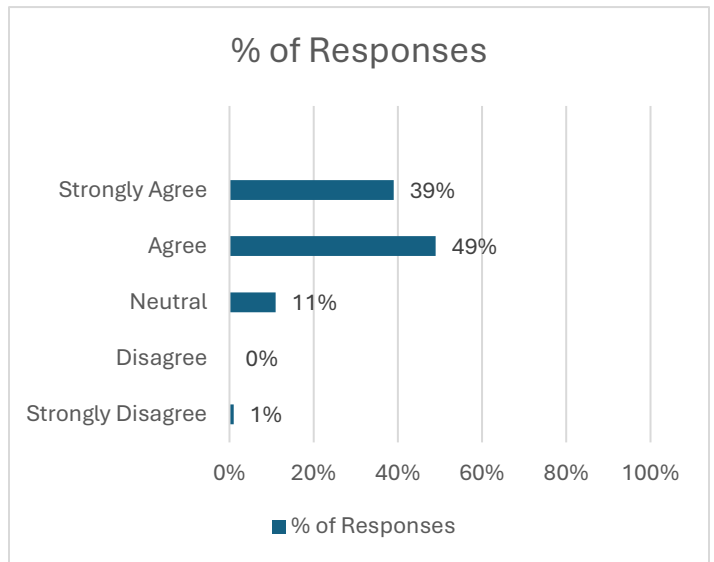
Question 32. No one on this team would deliberately act in a way that undermines my efforts.

Scale	Count of Respondents (n=92)
Strongly Agree	43
Agree	38
Neutral	8
Disagree	3
Strongly Disagree	0



Question 33. Working with members of this team, my unique skills and talents are valued and utilized.

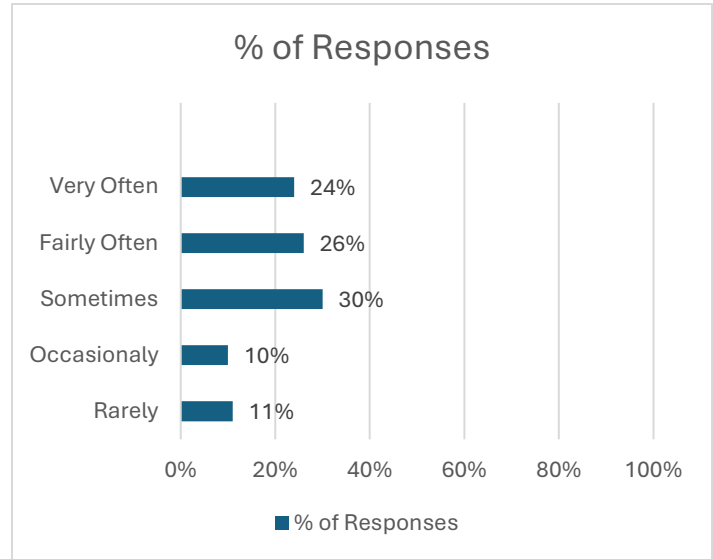
Scale	Count of Respondents (n=94)
Strongly Agree	37
Agree	46
Neutral	10
Disagree	0
Strongly Disagree	1



Section 7: Leadership Evaluation

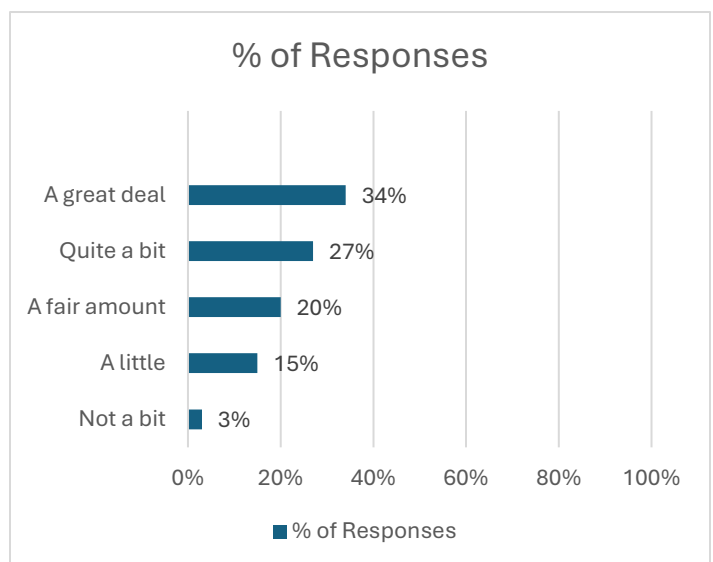
Question 34. Do you know where you stand with your Director? Do you usually know how satisfied your Director is with what you do? (note scale change)

Scale	Count of Respondents (n=93)
Very Often	22
Fairly Often	24
Sometimes	28
Occasionally	9
Rarely	10



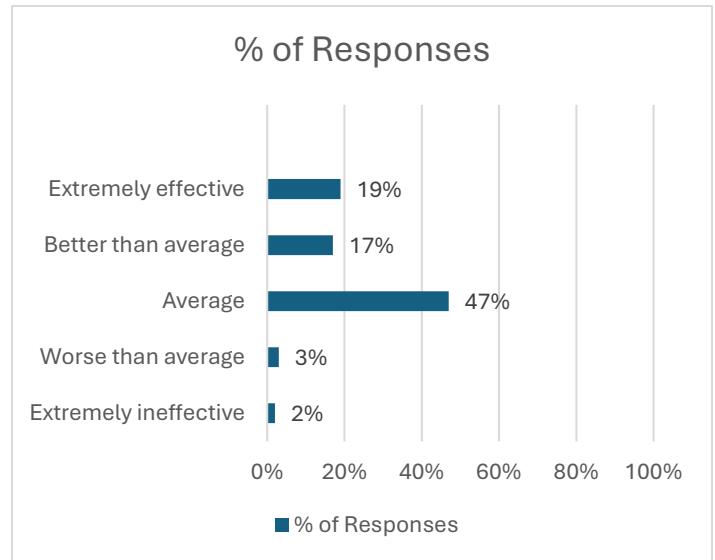
Question 35. How well does your Director understand your job problems and needs?

Scale	Count of Respondents (n=93)
A great deal	32
Quite a bit	25
A fair amount	19
A little	14
Not a bit	3



Question 36. How would you characterize your working relationship with your Director?

Scale	Count of Respondents (n=93)
Extremely effective	18
Better than average	26
Average	44
Worse than average	3
Extremely ineffective	2

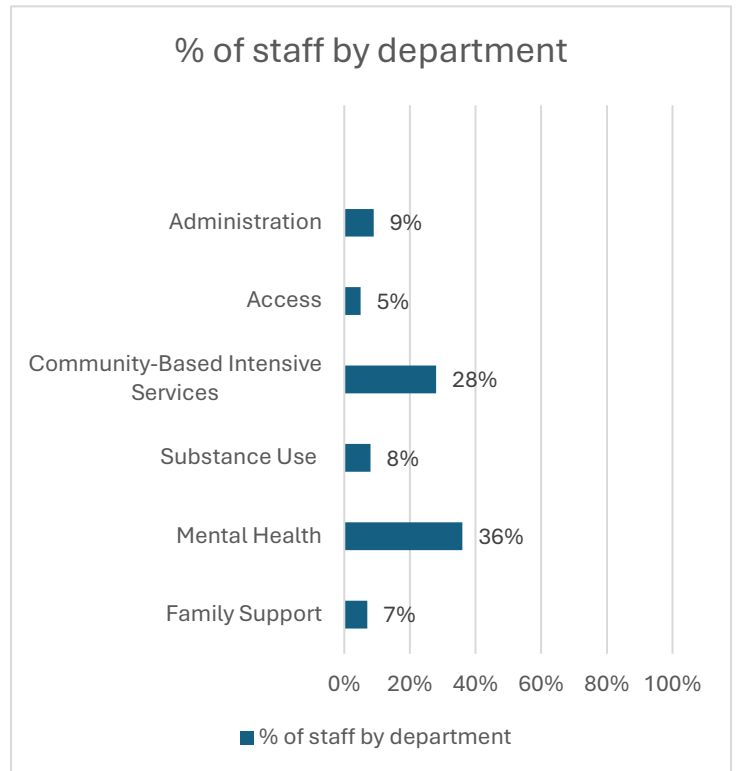


Human Resources

Overview

As of December 31, 2025, CHS had 166 active employees, reflecting a 6.4% growth rate. Of these, 127 were full-time (40 hours per week), 28 were part-time, and 11 were on-call or temporary. At the end of the year, there were 10 vacant positions. Excluding on-call and temporary staff, the total number of CHS positions was 155.

Department	Number of Employees
Family Support	11 (plus 11 on-call/temp staff)
Mental Health	60
Substance Use Disorders	14
Community-Based Intensive Services	47
Access Department	8
Administration	15
Total	166



Diversity of Staff

At the end of 2025, our workforce reflected strong diversity across multiple dimensions:

1. Generational Representation: Baby Boomers – 4%; Generation X – 16%; Millennials – 36%; Generation Z – 45%.
2. Race/Ethnicity: 36% of staff identify as non-white, including the 11 on-call employees.
3. Gender Identity: 26 males; 134 females (including 11 on-call employees); and 6 transgender staff.
4. Sexual Orientation: 37% of staff identify as LGBTQ+
5. Languages: Our staff demonstrates strong linguistic and cultural diversity, speaking a wide range of languages including Spanish, Portuguese, Japanese, Tigrinya, Arabic, Bosnian, Serbian, Croatian, Tagalog, Mandarin, Cantonese, Russian, Chechen, French, Vietnamese,

Korean, and German. Additionally, 27% of staff are bilingual, speaking English alongside one of these 17 languages, and several team members are fluent in up to four languages. Among on-call employees, six are people of color and six speak a language other than English, further strengthening our capacity to serve diverse communities.

6. Immigrant Status: 19% of staff identify as first- or second-generation immigrants.

2025 Human Resources Department Highlights

- We were able to provide another year of excellent employee medical benefits through Nonstop
- On-boarded 45 employees.
- Had 6.4% agency growth rate in 2025.
- Gave all staff a 5% pay increase in 2025
- Gave all staff a \$1000 bonus (per FTE).
- Gave all staff additional days off at Christmas
- Partnered with BEAM to support employees with training and license renewal costs (Professional Development), conference attendance, and tuition reimbursements

BEAM Program Utilization Report 2025

Participation and Utilization Recap

Eligible Employees = 148 Total number of applications = 96 Staff Participation rate = 65%

Total Benefit Requests = 121 Utilization = 82%

BEAM Funded Benefits 2025 (April - December 2025) Funded Benefits = 86 Still in Process = 35	Quarter 2	Quarter 3	Quarter 4
Professional Development - Paid	11	23	43
Conference Travel - Reimbursement	0	3	6
Tuition Assistance - Reimbursement/Voucher	0	0	0

Employee Retention

As the table below shows, turnover in 2025 was 21.5% overall, a reduction from 24.10% in from 2024

Department	Head Count	Open	12-month Turnover 2025	12-monthly Prior Year Turnover
Mental Health	60	3	23.14%	16.81%
CBIS	47	4	26.37%	37.04%
Substance Use Disorders	14	1	8%	36.36%
Family Support	22	1	14.63%	20.00%
Access	8	1	42.86%	42.86%
Administration	15	0	13.33%	6.45%
Total	166	10	21.5%	24.10%

2025 Retention Efforts

- One all-staff meeting was held in person.
- 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.
- Employee awards were given based on agency values.
- U-Rock was given at each CQI Meeting.
- Provided ongoing supervision (1 hour weekly per FTE).

- Provided specified supervision toward licensure.
- Vacation time for employees was one day per month plus an additional day for each year employed, up to 20 days per year. We allowed employees to carry over 1.5 times their annual allotment at the end of each year up to 20 days.
- 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.
- Employees received one extra day of leave per year as a “personal day.”
- Provided employees with 13 days of paid holiday leave, including 10 traditional holidays and 3 additional days during the Christmas period. The Board approved making the winter holiday week part of the annual holiday schedule, and this change has been implemented for future years.
- Pay adjustments were made.
- Continued offering a Professional Development Fund, in partnership with BEAM, to support employees with training and license renewal costs, conference attendance, and tuition reimbursement, reinforcing ongoing professional growth and career advancement within the organization.
- Conducted 17 exit interviews.
- Improved technology.

Terminations

In 2025, a total of 35 employees left CHS, either voluntarily or involuntarily, marking a slight decrease from 2024. Five employees were involuntarily terminated for various reasons. The remaining 30 employees resigned for the following reasons:

- Accepted a new job or transitioned to private practice: 14
- Personal reasons unrelated to the job: 9
- Relocated beyond a reasonable commuting distance or out of state: 4
- Family-related reasons: 2
- Returned to school: 1

Seventeen exit interviews conducted in 2025 revealed several consistent themes. Departing staff reported feeling well supported by their immediate supervisors and highly valued the relationships they built with colleagues and clients. Many expressed appreciation for the opportunity to serve communities in need and felt their work made meaningful contributions to community well-being.

At the same time, several staff identified opportunities for improvement, including limited cross-department collaboration, fewer opportunities for organization-wide connection, a desire for more field-specific training, and concerns related to employee recognition and appreciation.

ADA Requests

In 2025, we processed a total of six employee accommodations. Four of these requests were related to ergonomic adjustments, including specialized keyboard and mouse equipment to support proper workstation setup. The remaining accommodations primarily involved schedule modifications to allow for medical appointments, as well as chair adjustments to improve ergonomic support. Overall, the accommodations focused on ensuring employees had the necessary tools and flexibility to perform their roles effectively while addressing medical and ergonomic needs.

2025 Employee Award Winners

- Accountability Award: Miwa Easton
- Accessibility Award: Summer Rose
- Integrity Award: Denise Hotchkiss
- Diversity, Equity, Inclusion & Belonging Award: Britton Stewart
- Collaboration Award: Jesse DeFelice
- Fun Award: Cathy Assata

CHS Leadership

- Executive Director: Beratta Gomillion
- Substance Use Disorders Department Director: Cathy Assata
- Mental Health Department Director: Vanessa Villavicencio
- Community-Based Intensive Services Department: Katrina Hanawalt
- Access Department Director: Britton Stewart
- Family Support Department Director: Tanya Laskelle
- Finance Director: Max Sanchez
- Human Resources Director: Mirsada Kulovac

In early 2025, with the discontinuation of the Behavioral Health Integration Department, we lost a Director position. Also in 2025, the DEIB director position was reduced to a management level position and restructured as the Outreach and Engagement Manager, which resulted in a change to participating on the leadership team. A new Access Department Director joined the Leadership Team in July 2025.

Financial Operations

Summary

Center for Human Services leverages cross-departmental collaboration and well-established internal controls to support accurate and meaningful financial reporting. Control policies and accounting workflows are reviewed annually to mitigate the risk of fraud and financial reporting misstatements. The agency's financial position is analyzed monthly by management to ensure adequate resources and financial stability in support of the goals outlined in the strategic plan. Should unanticipated events materially impact operations, CHS will reassess its risk management plan and determine the appropriate course of action. As of December 31, 2025, the financial position of CHS remains strong with a favorable outlook for 2026. The metrics below were derived from the agency's balance sheet as of calendar year end.

Key Financial Metrics - As of December 31, 2025	
Liquidity	Ability to meet short-term financial obligations such as monthly agency expenses. Our quick ration is 10.08 , which is the proportion of liquid assets and receivables to claims tied to them.
Debt to Net Assets Ratio	Debt carried in proportion to net worth, demonstrating reliance on borrowed money. Our debt to net assets ratio is 1% , indicating extremely low reliance on borrowed money. The only debt currently recorded is through a forgivable loan set to expire in 2031.
Efficiency	Ability to obtain the maximum output possible for limited resources. CHS delivered 85,780 billable service hours , generating approximately \$17.72M in Medicaid and government contract revenue .
Net Asset Position	Total assets minus total liabilities. Our net asset position is \$16.98M , an increase of over \$3.1M from the prior year . Of this amount, \$119k is restricted for specific use, with the remainder available to meet cash needs for any expenditures deemed necessary for operations.

Governance & Compliance

Any appearance of conflict of interest will be identified and reported immediately to the Executive Director. **CHS maintains a clear conflict of interest policy**, and all active board members are required to review and sign off on this policy annually.

Finance Department Highlights for 2025

- Received a clean financial audit report from Jacobson Jarvis & Co., PLLC, with no material misstatements or control deficiencies identified.
- Improved the annual budget development process through increased communication and cross-collaboration between program leadership and the finance team and Executive Director.
- Facilitated the sale of the Silverlake property, resulting in a net gain of \$205k in the current fiscal period, and finalized the move to the Madison property.
- Awarded \$875k in new grant funding from sources including KC Career Pathways, Opioid Prevention, Regional Crisis Response, and DCHS funding for Access services.
- Implemented additional EHR dashboards, utilizing Power BI, providing management staff with valuable insights into clinical performance and client metrics. Additional dashboards include outcomes reporting, intake/assessment data, and expiring authorizations.
- Averaged 45 days for Medicaid payments to be processed through the RCMS partner, with a 3.8% denial rate in 2025.
- Sustained a strong employee participation in the retirement plan, with total plan assets growing by \$967k over the calendar year.
- Partnered with banking institutions to optimize cash investments, generating approximately \$251k in additional interest revenue.
- Conducted an annual staff compensation review, resulting in a 5% cost-of-living adjustment and a year-end bonus for all staff to keep pace with market demand and inflation.
- Completed King County-funded capital improvements at both Shoreline locations, including HVAC replacement and interior improvements such as carpeting, flooring, and painting.
- Reviewed and updated financial policies and procedures to adhere to current FASB standards.

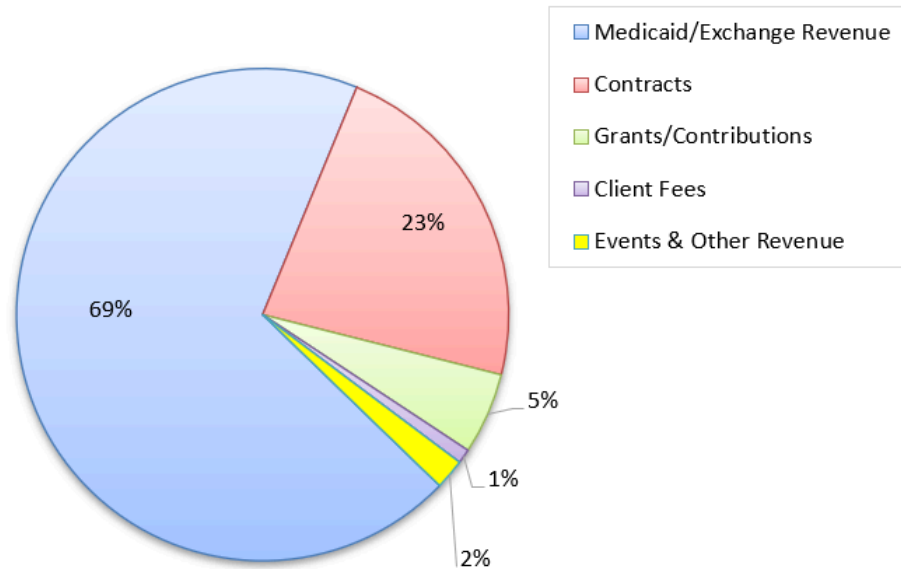
Financial Statement Ratios

Indicator	12/31/2025	Calculation	Description
Net Asset Position	\$16,980,867	Total assets minus total liabilities	Positive number indicates good performance
Working Capital	\$12,324,833	Current assets minus current liabilities	Liquid assets available for day to day expenses
Current Ratio	10.18	Current assets divided by current liabilities	Proportion of liquid assets claims tied to them
Quick Ratio	10.08	Cash + A/R divided by current liabilities	A more conservative estimate of above (less prepaids)
Cash on Hand to Current Liabilities Ratio	8.51	Cash divided by current liabilities	Strictly cash on hand to claims tied to them
Unrestricted Surplus/(Deficit)	\$2,805,495	Income less expenses	Positive Number indicates working within means
Debt/Net Assets Ratio	0.6%	Loans + notes payable divided by net assets	Debt carried in proportion to net worth (reliance on borrowed money)
Contributions to Total Revenue Ratio	6%	Contributed income divided by total revenue	Proportion of revenue generated strictly from grants and individual giving

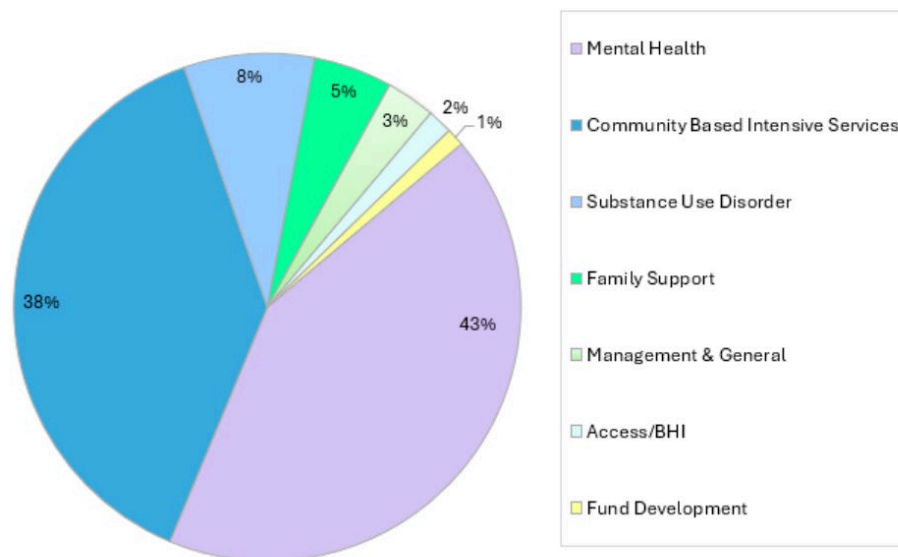
Program Expenses to Total Expense Ratio	90%	Program expenses divided by total operating expenses	Proportion of expenses used to support programming vs. admin/fundraising
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Revenue and Expenses (Actual)

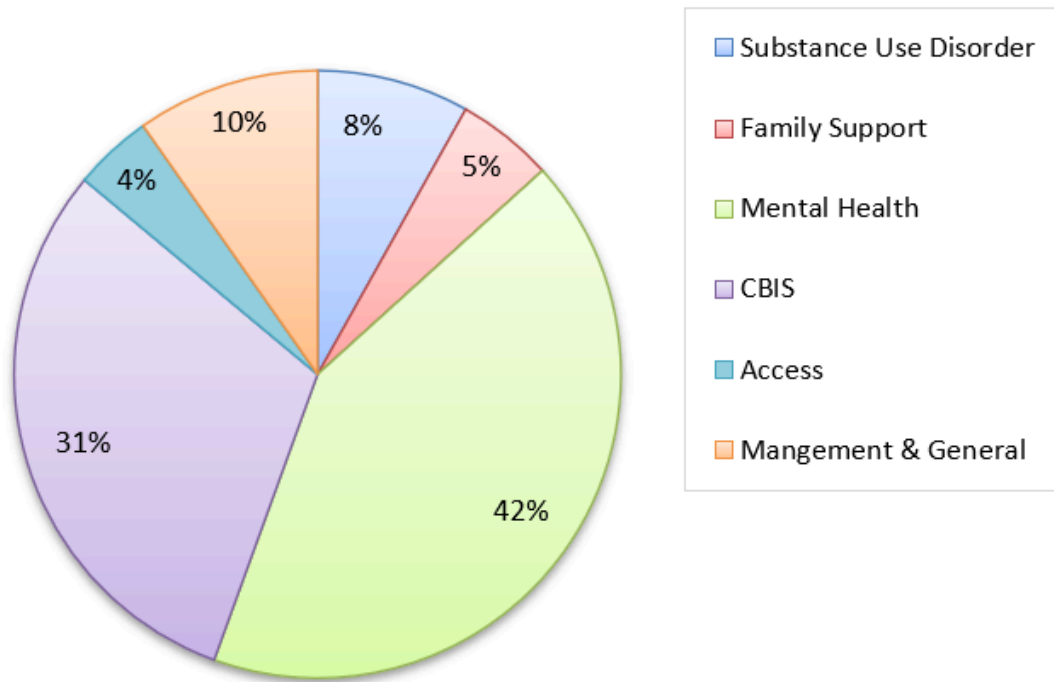
FY26 YTD REVENUE - Source



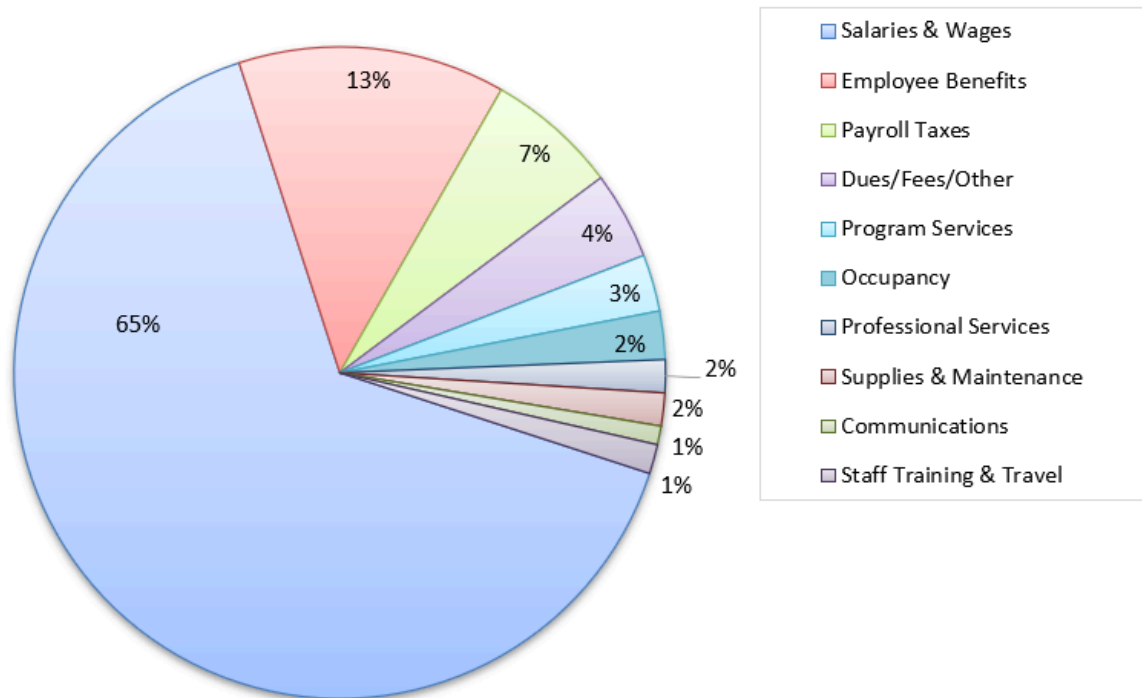
CY26 REVENUE - By Department



FY26 YTD EXPENSE - Area



2025 YTD EXPENSE - Area



Quality Improvement & Management

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 reports, from focus groups, from satisfaction surveys, from client and other interested parties' feedback, etc., to determine opportunities for improvement as well as 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.

Commitment to Quality

CHS is committed to the ongoing improvement of the quality of care our clients received, 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 available when needed (see Accessibility Plan).
- Risk to clients, staff, and others is minimized, and risk prevention is implemented (See Risk Management Plan).
- Client's individual needs and expectations are respected, and they have the opportunity to participate in decisions regarding their treatment and services provided (Refer to Client Feedback).
- Clients are treated with respect in a culturally informed and responsive manner (See DEIB 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.
- The agency remains trauma-informed and provide all services accordingly.

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. The overall outcome for the Family Support Department programs are for families to strengthen their protective factors and build resilience.

QI & Management Plan 2025 Analysis

Service Delivery Functions

Effectiveness of Services

The use of evidence based/informed and promising practices

- Applied to all programs.
- Data Source - EBP tracking in electronic health record (Credible).
- Person(s) Responsible for Data Collection - Managers and/or Directors
- Process - Clinicians have a place on each progress note to indicate with EBP was used. Credible Helpdesk will run a report periodically for Managers/Directors that show how many encounters indicate that an EBP was used, as well as which EBP was used for that particular session.
- Achievement Goal - All of our programs consistently use evidence-based/informed practices or promising practices, or elements thereof.
- Actual Results - Evidence-based Practices and Promising Practices that were used include: Cognitive Behavioral Therapy (CBT); CBT+; Dialectical Behavioral Therapy; Moral Recognition (MRT); MRT Breaking the Chains of Trauma; Seeking Safety; Eye Movement Desensitization and Reprocessing Therapy; Dyadic Infant and Early Childhood Mental Health; Child-Parent Psychotherapy (CPP); Perinatal Mental Health; RUBI (for parents of children with autism); Change Company Journaling; among several others.

Case record reviews

- Applied to all programs.
- Data Sources - Electronic Health Records
- Person(s) Responsible for Data Collection - QA Manager & Management
- Process - The QA manager reviews MH clinical records when a client has received services for 90 days. Randomly, the QA Manager reviews all new admissions within 30 days after admission. In both scenarios, individual results are shared with the clinician of record clearly outlining change expectations and a timeline for completion. They monitor the data to ensure it is corrected if it is something that can be corrected. The QA Manager addresses any coaching opportunities with the clinicians. The QA Manager utilizes trends to aggregate audit results and shares results with the Systems CQI Team. The intent of the process is to optimize clinical performance through remediation or sharing of best practices. The SUD QA process is being conducted internal to the SUD Department.
- Achievement Goal - Every new client record is reviewed at or around 30 days from admission. At least one record from each clinician is reviewed monthly, and every closed record is reviewed as part of the closure process.

- Actual Results - Our Mental Health client chart reviews in 2025 was 93 on 91 individual clients. The SUD department began QA monthly starting in May 2025 and completed 112 reviews, averaging 14 per month.

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 & QA Manager
- Process - The QA Manager looks for evidence of client/family access, voice, and ownership in the client's record. If deficient, QA Manager shares findings with the individual clinician (and manager, if appropriate). If a clinician consistently omits this information, a corrective action plan may be implemented by management and/or it may be noted in the clinician's annual performance review. The supervisor discusses this element of the way we do our work with supervisees regularly.
- Achievement Goal - 85% of our clinical records reviewed consistently document client//family access, voice, and ownership.
- Actual Results - Our internal QA chart reviews showed that we were consistently meeting this goal. Our forms and templates are designed to encourage documentation of client voice.

Client Outcomes

- Applied to all programs.
- Data Source - Outcomes surveys
- Responsible for the Data Collection - Supervisors, Clinicians, Family Support Management & Specialists
- Process = Outcome information is collected in clinical programs in June, December, and when a case is discharged or transferred. Family Support collects outcome data at minimum once per year or at the close of program sessions.
- Achievement Goal - Depends on program.
- Actual Results - We are very pleased with our results in each of our programs. See below:

Clinical Programs Outcomes 2025

Clinical programs are mental health (office-based, school-based, IEC) and substance use disorders treatment. In June, December, and whenever a client transfers to another program or is discharged, an Outcome service is completed. The results are:

- 87.3% of clients who received mental health services improved their mental stability/functioning.

- 88.2% of the clients who received mental health services made progress toward their treatment goals.
- 83.5% of the clients who received mental health services reduced symptomatic episodes
- 77.5% of the clients who received SUD treatment decreased or abstained from their alcohol or other drug use.
- 79.8% of the clients who received SUD treatment made progress of issues impacted by their alcohol and other drug use.

Family Support Department Outcome Summary 2025

Positive Discipline for Families Program:

Methodology: The outcomes below are based on a pre/post retrospective survey participants completed during the last session of the class series. Percentages reflect those that showed improvement in the following positive parenting strategies and techniques. In addition, we noted the percentage that positively maintained (scored in top 2 scale options).

- 66% improved in having people in their life they can talk to about parenting challenges, 23% positively maintained, (n=61)
- 61% decreased use of parenting techniques that threaten or criticize their child, 16% positively maintained, (n=61)
- 82% improved in warmly and consistently responding to their children's needs, 12% positively maintained, (n=60)
- 79% increased feeling supported in their role as a parent in the community, 13% positively maintained, (n=61)
- 82% improved in trying to understand the motivation behind their child's behavior, 16% positively maintained, (n=61)
- 67% decreased yelling or getting upset when they don't understand their child's behavior, 5% positively maintained, (n=61)
- 69% improved in identifying ways to take care of themselves (self-care), 28% positively maintained, (n=61)
- 72% increased saying positive, encouraging statements to their child about their behavior, 25% positively maintained, (n=60)
- 82% increased use of family meetings to improve communication in the family, 10% positively maintained, (n=61)
- 72% increased participation in community activities and services to help their family learn and be healthy, 20% positively maintained, (n=61)
- 69% improved in helping their child identify and express feelings, 21% positively maintained, (n=61)
- 74% improved in setting clear expectations and limits with their child, 23% positively maintained, (n=61)

- 84% improved in identifying when their own emotions interfere with their parenting, 15% positively maintained, (n=61)
- 77% improved in listening to/asking for the opinions, ideas and feelings of their child, 22% positively maintained, (n=60)

Circle of Security Parenting Classes:

Methodology: The outcomes below are based on a pre/post retrospective survey participants completed during the last session of the class series. Percentages reflect those that showed improvement in the following positive parenting strategies and techniques. In addition, we noted the percentage that positively maintained (scored in top 2 scale options). During 2025, we hosted only one class series of this program.

- 63% indicated high parenting stress that decreased as a result of participating in the parenting class, (n=8)
- 100% improved their parent/child relationship, (n=8)
- 88% improved in recognizing the behaviors that trigger their negative responses, (n=8)
- 100% improved in identifying and responding to their child's needs for support, (n=8)
- 100% increased their understanding of the importance of repair when they fail to respond to their child's needs, (n=8)
- 100% in understanding what their child's behavior is telling them about their needs, (n=8)
- 100% increased their confidence to meet their child's needs, (n=8)

Promoting First Relationships:

Methodology: The outcomes below are based on a pre/post retrospective survey participants completed following the 10th session. Percentages reflect those that showed improvement in the evidence-based strategies that increase bonding and attachment. In addition, we noted the percentage that positively maintained (scored in top 2 scale options).

- 86% improved their relationship with they child, 14% positively maintained (n=14)
- 86% increased understanding of their child's non-verbal cues, 14% positively maintained, (n=14)
- 79% improved responding warmly and consistently to their child's needs, 21% positively maintained, (n=14)
- 79% improved creating an environment in which their child feels safe to express their emotions, 21% positively maintained, (n=14)
- 85% improved in looking for ways to repair when they failed to respond to child's needs, 15% positively maintained, (n=13, 1 respondent did not complete the measurement)
- 86% improved in accepting their child's unique personality, 14% positively maintained, (n=14)

- 100% improved in recognizing the behaviors that trigger their negative parenting responses, (n=14)
- 100% improved in identifying when their own emotions interfere with their parenting (n=14)
- 100% improved in identifying self-care strategies, (n=14)
- 100% improved in understanding the motivation behind their child's behavior before reacting, (n=14)
- 93% increased identifying and responding to their child's needs for support to explore and for comfort, 7% positively maintained, (n=14)
- 79% increased their understanding of their parental role in building secure attachment with their child, 21% positively maintained, (n=14)

Kaleidoscope Play & Learn:

Methodology: A survey is conducted at minimum once per year with participants in the program. We utilize a survey created by the Kaleidoscope Play & Learn Network. The scale measures if participants increased/improved in areas 'A lot more', 'A little more' or 'about the same'. Internally, anyone that indicated 'A lot more', or 'A little more', met the outcome, however we have provided the separate scale percentages for extra context. We also included N/A if the respondent did not answer the question. In 2025, we collected 44 surveys from KPL participants.

- 89% increased their understanding that children develop school-readiness skills when they play (64% A lot more, 25% A little more, 11% About the same)
- 91% increased understanding of the role they have in helping the child in their care be ready for kindergarten (68% A lot more, 23% A little more, 7% About the same, 2% N/A)
- 95% increased understanding what to expect from children at different ages (61% A lot more, 34% A little more, 5% About the same)
- 93% increased understanding of the importance of having a nurturing relationship with the child in their care (77% A lot more, 16% A little more, 7% About the same)
- 93% increased describing things they do and see with the child in their care (66% A lot more, 27% A little more, 5% A little more, 5% N/A)
- 93% increased talking about numbers, shapes, and sizes with the child in their care (73% A lot more, 20% A little more, 5% About the same, 2% N/A)
- 86% increased reading, looking at books, or telling stories with the child in their care (68% A lot more, 18% A little more, 11% About the same, 2% N/A)
- 91% increased giving the child in their care opportunities to learn and try new things (77% A lot more, 14% A little more, 7% About the same, 2% N/A)
- 93% increased encouragement for the child in their care to keep trying even when it seems hard (64% A lot more, 30% A little more, 5% About the same, 2% N/A)

- 93% increased noticing times to help the child in their care learn throughout the day (73% A lot more, 20% A little more, 7% About the same)
- 91% increased talking about feelings with the child in their care (64% A lot more, 27% A little more, 7% About the same, 2% N/A)
- 89% increased use of community activities or services to help the child in their care learn and be healthy (68% A lot more, 20% A little more, 9% About the same, 2% N/A)
- 91% increased talking or sharing ideas about caring for children with another adult (70% A lot more, 20% A little more, 7% About the same, 2% N/A)
- 89% increased feeling supported as a parent/caregiver in the community (73% A lot more, 16% A little more, 11% About the same)

Kinship Support Program:

Methodology: A survey is conducted at minimum once per year with participants in the program. In 2025, a new survey tool was created and piloted. The survey is a pre/post retrospective that supports the client reflecting on how they felt/behaved prior to participating in the support group and then after receiving the support. Through the pilot of the survey we identified the need for additional education on the retrospective structure to increase complete and meaningful data. The data below reflects those that noted improvement or positive maintenance of the outcomes, as well as includes the data pertaining to respondents that did not complete the measurement as designed and therefore could not be measured.

- 50% increased feelings of resilience, 50% positively maintained (n=8)
- 62.5% increased their support network, 25% positively maintained, 12.5% maintained neutral in their response (n=8)
- 37.5% increased their social connections, 50% positively maintained, 12.5% maintained neutral in their response (n=8)
- 50% increased awareness of sources of stress in their lives, 37.5% positively maintained awareness, 12.5% maintained neutral in their response (n=8)
- 75% increased tools to help with stress, 25% positively maintained (n=8)
- 57% increased understanding of their child's developmental age and stage, 43% positively maintained (n=7, 1 respondent did not complete the measurement)
- 71% increased awareness of when their own emotions interfere with parenting/caregiving, 29% positively maintained (n=7, 1 respondent did not complete the measurement)
- 62.5% increased self care strategies, 25% positively maintained, 12.5% maintained neutral in their response (n=8)
- 75% improved in exploring motivation behind their child's behavior, 12.5% positively maintained, 12.5% maintained neutral in their response (n=8)
- 62.5% improved in identifying and responding to their child's need for support and comfort, 37.5% positively maintained (n=8)

- 62.5% increased understanding about neurotypical/neurodivergence and response to their individual needs, 25% positively maintained, 12.5% maintained neutral in their response (n=8)

Out of School Time Programming:

In 2025, the OST program did not engage youth in a formal participant survey as we acknowledge the need to redesign and redevelop our evaluation efforts for this program. The following outcome/indicator results are informed by attendance and anecdotal evidence collected and reported to King County Housing Authority and illustrates our effectiveness in promoting positive youth development outcomes.

- An average of 57% of youth attended programming quarterly 70% or more of the time.
- 94% of youth report being satisfied and engaged in programming
- 99% of youth served in 2025 participated in academic enrichment programs and services

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 - All critical incidents from 2025 were reviewed. See Critical Incidents summary and analysis in this report.

Client complaints and grievances

- Applied to clinical departments
- Data Source - Grievance reports
- Person(s) Responsible for Data Collection - Executive Director
- Process - Complaints attempt 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 all 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 - There were no client grievances filed in 2025.

Efficiency of Services

Utilization management (appropriateness of admissions and services provided)

- Applied to clinical programs
- Data Source - Client records & 30-day review form
- Person(s) Responsible for Data Collection - Managers & Directors
- Process - Charts are reviewed randomly. The reviewer determines if the client was appropriate for admission and was assigned to the appropriate level of care. Reviewer uses ASAM (SUD) and Locus/CALocus (MH) scores as reference points.
- Achievement Goal - 100% of clients whose charts are reviewed meet medical necessity and are placed in the appropriate level of care.
- Actual Results - Goal met. All clients admitted for services were appropriate admissions.

Utilization management (number of clients being served)

- Applied to clinical programs
- Data Source - Credible Report
- Person(s) Responsible for Data Collection - Clinicians
- Process - Number of clients put in our database for the current year is compared to the number of clients indicated in the previous year.
- Achievement Goal - 15% (or more) increase in participation over previous year.
- Actual Results - We did not meet this goal, and served less individuals than 2024 by a 3.6% decrease (164 clients). However, the service hours increased, meaning we are serving less people but with higher dosage.

Encounter data validation

- Applied to clinical programs
- Data Source - Electronic Health Record
- Person(s) Responsible for Data Collection - Billing Specialists
- Process - Billing Specialists compare services to coding and billing. The Billing Specialist provides individual results to the clinician of record and their supervisor, clearly outlining change expectations and timeline for completion. The Billing Specialist monitors the data to assure it is corrected. The clinical element of the encounter is monitored by the

supervisor and QA Manager. 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 - 100% data reviewed & corrected when necessary. Encounters submitted for billing should show an accuracy of 95% or higher.
- Actual results - The CHS 2025 EDV TA review resulted in 71.4% accuracy (75 % MH, 68.4% SUD). The 2024 EDV resulted in 50% accuracy (90% MH, 10% SUD). This is a 21.4% overall increase from 2024. Of the services reviewed by King County staff, the following items are of note:

Center for Human Services (CHS) continues to improve their electronic health record (EHR) template ensuring many of the required data elements are present in every note.

SUD notes accuracy increased by 58.4%. It is evident CHS has worked hard to ensure clinician's intervention used was included which is what improved much of the overall SUD score.

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 positions 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 - 60% of clients engaged in SUD treatment (had 3 sessions or more) remain in treatment for at least 90 days.
- Actual Results - For the SUD clients seen in 2025 who received at least 3 sessions of any kind, 65% of them remained in treatment for at least 90 days, exceeding our goal.

Billable hours of clinical staff

- Applied to clinical programs.
- Data Source - Electronic Health Records
- Person(s) Responsible for Data Collection - Supervisors, Department Director, Program Managers
- Process - Supervisors and/or staff in management positions run a report in our Business Intelligence software that pulls data from the electronic health record, that indicates direct service hours per clinician. If a clinician's direct service hours do not meet expectations on 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 consistently meets their billable expectations
- Actual Results – We continue to be challenged on hitting this goal. Using data for the month of October 2025, 29% met or exceeded their billable expectations. Of those that did not meet the expectation however, 68% were within 10% of their goal.

Show & No-Show Rates

- Applied to clinical programs
- Data Sources - Electronic Health Record
- Person(s) Responsible for Data Collection - Supervisors, Department Director, Program Managers
- Process - A Credible report is run after the end of the year, to show how many no-shows we had compared to all appointments scheduled per department. Additionally, 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 - Each program and the agency as a whole will have a no-show rate of less than 30% for the year.
- Actual Results - Overall, the agency as a whole had a no-show rate of 15%.

Program	Attendance Rate (% Show)	% No Show
MH	73%	16%
SUD	75%	18%
WISe	73%	11%
IEC	72%	15%

Service Access

Accessibility and timeliness of access

- Applied to Access Program
- Data Source - Electronic Health Record and Business Intelligence Software “Janet”
- Person(s) Responsible for Data Collection - Screeners, Assessors, and Access Director
- Process - Screeners in the Access Department indicate on the following in the screening service in the EHR:
 - the date of the original screening call
 - the date of the first available scheduled visit or open access time block for an assessment
 - the date client agrees to attend assessment (could be the same as offered)
 - reasons for NOT scheduling an assessment

After assessment is completed, the date of the first on-going appointment data is noted in the MH Summary.

- the date of first available ongoing appointment
 - the date of the scheduled ongoing appointment
- Reports generated through Business Intelligence Software and the EHR provide analysis of the date comparison.
- Achievement Goal - 90% of assessment appointments and first ongoing appointments are within the time frames allowed by state law and/or MCO/ICN contracts (i.e. assessment is conducted within 7 days of request for services). Services are accessible to people needing our services.
 - Actual Results – Business Intelligence reports are in the process of review for accuracy and quality of data entry is being reviewed for accuracy. This is in part due to screening forms being used for access to other services that do not include an assessment appointment and/or ongoing care.

Penetration of services

- Applied to clinical programs
- Data Source - Electronic Health Record
- Person(s) Responsible for Data - Supervisors, Department Director, Program Managers
- Process - Designated staff run a report from the electronic health records 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 - In 2025 we had a 3.7% increase in assessments. To determine increase in admissions, we utilized data based on first billable service since screening which resulted in a 13.7% increase in admissions over 2024.

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 interested parties, 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 - Goals 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 the Department Directors and Executive Director.
- Achievement Goal - Overall client satisfaction is at least 80%.
- Actual Results - This goal was met. Based on 238 respondents to a satisfaction question, 87% were Very Satisfied with the services they received.

Satisfaction of Other Interested Parties (Other than Clients/Participants & Employees)

- 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 Directors and Executive Director

- Process - Input from other interested parties (in addition to client input and employee input) is solicited regularly. Surveys through Microsoft Forms, formal interviews, and informal conversations are used to collect stakeholder input. Audit and site visit reports are used as well.
- Achievement Goal - Input is received from interested parties in addition to client and employee input.
- Actual Results - This goal was accomplished through conversations, meetings, suggestion boxes, web page comments, etc. See Input from Interested Parties section of this report.

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
- 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 result 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. All drills and inspections occurred according to schedule and CARF standards for health and safety were met. Risk Management Plan reviewed - See Plan review in this report.

Employee Satisfaction

- Applied to entire agency
- Data Source - Satisfaction survey
- Person(s) Responsible for Data Collection - Executive Director
- Process - In the fall of each year, Human Resources distributes a confidential web-based satisfaction survey to all staff. The survey is not mandatory, although it is encouraged. The

tool we use anonymously compiles the data for management to review. Results are shared with Leadership CQI.

- Achievement Goal - 50% of staff completed a satisfaction survey.
- Actual Results - Goal Met. The response rate for the 2025 survey was 56%. See Employee Input section of report for more data.

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.

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 for at least 40 weeks per year; 100% of all clinical staff have training plans, with at least 75% of the training plans being achieved.
- Actual Results - Goal met. All clinical staff received supervision as scheduled. All clinical staff have a training plan. Training plans were reviewed regularly and progress was recorded. Additional supervision hours were purchased by CHS for the purpose of helping our MSWs receive their supervision hours.

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 and compliance is monitored closely with the particular employee. Managers/Directors monitor deliverables per contract. At the end of the contract, managers/directors see if we met our goals regarding deliverables.
- Achievement Goal - Any compliance issues or problems with deliverables are corrected. All audits and site visits are deemed as satisfactory by the auditing body.
- Actual Results - All audits and site visits had acceptable results.

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. We continue to follow all relevant CARF standards and received 3-year CARF accreditation in early 2025.

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 with 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 occurred.
- Actual Results - In 2025, there were a few HIPAA related concerns, but none of them were reportable. All were classified as low risk.

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 Assistance; 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.
- Achievement Goal - Less than a 35% turn-over rate. 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 - This goal was met. In 2025, our turn-over rate was 21.5%.

Other Quality Improvement Efforts

CHS recognizes that service performance is also influenced by many factors. Therefore, we have implemented the following strategies as routine components of our Quality Improvement efforts:

- Each clinician is to be provided one hour of weekly individual supervision by a qualified supervisor (some part-time staff's supervision time was reduced). This time is to be utilized to coach, train, support, and model quality improvement. Supervisors will maintain supervision logs for each supervisee. Clinical staff are to receive group supervision (typically on a weekly basis) for the purpose of staffing cases and receiving consultation from peers and supervisors. Clinical supervision should support and enhance services and assure adherence to clinical policies and procedures.
- Managers and/or directors are to be responsible for monitoring compliance with WACs, state and federal rules and laws, CARF standards, and contract requirements as applicable.

- CHS will maintain its certification as a Trauma-Informed Agency. We will have staff members who are trained as trainers on trauma-informed approaches, and we intend for these TIA practices and approaches to inform everything we do.
- Our CAREs Initiative is expected to impact all areas of service delivery.
- Staff members are to receive and participate in a performance evaluation annually, but we expect for supervisors to provide continuous performance feedback throughout the year.
- Each clinician will develop an annual training/enhancement plan in consultation with their supervisor.
- Clinical staff will have 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 will offer support to staff in obtaining training based on current trends in treatment and/or to meet training requirements for licenses or certification.
- CHS will maintain our CARF accreditation as a way to assure our commitment to quality and performance improvement by adhering to an international set of standards.
- Evidence-based practices (EBPs) or promising practices are to be implemented in the provision of services. In many circumstances, CHS will continue to have trainers of evidence-based practices on staff when possible, so we have convenient, in-house training available. Documentation of an employee's certification to use EBPs will be kept in personnel files if applicable.
- Supervisors will assure that EBPs are implemented with fidelity as appropriate. This should occur through observation, supervision, and chart review.
- The Corporate Compliance Committee will analyze any critical incidents, extraordinary occurrences, grievances, or HIPAA violations that occur, and make recommendations for quality improvement as applicable.

Extenuating or influencing factors that affected our work in 2025

The primary extenuating or influencing factors in 2025 were:

- Cost of living – The cost of living in our area is high. It negatively impacted both clients and staff.
- Workforce shortage – The workforce shortage continued to impact our work. In some situations, it took months to find an appropriate hire for vacant positions, particularly those with management level skill requirements. We are offering competitive salaries and

excellent benefits in attempt to improve this situation. While that is working, we cannot compete with private practice, government positions, or private hospitals.

- Private practice internships – Schools are allowing Masters level interns to complete their internships at private practice groups where the work is not as intense and is often mostly remote. This has made accepting interns that are apt to want to be hired at the end of their internship fewer than in the past.
- Trauma – There were many incidents across the nation and globally that had lasting effects on our staff and clients. These included school shootings, mass shootings, politics and elections, wars, wildfires, flooding, hurricanes, and other devastating occurrences. Racism, Xenophobia, transphobia, homophobia, Islamophobia, Judeophobia, and sexism were often prominent. Trauma was not only a huge issue with our clients, but also had a strong effect on our staff. In many situations, CHS was unable to relieve staff's stress over these matters, but we continued to focus on self-care and trauma informed practices.
- Agency facilities – In 2025, our Lynnwood location that housed over 50 staff in the CBIS program was burnt down. The loss of the building and its contents had a significant impact on our staff as they pivoted to continued client care while grieving their shared space with colleagues. While we recovered quickly from this loss, the team had to adapt to a new space and navigate starting over.
- The increased presence of homeland security and law enforcement regarding immigration response had a significant impact on the sense of safety and security in the communities we serve and among staff. Significant time and effort to research policies and advocate for guidance to support safety began at the end of 2025 to prepare for the potential of incidents at our office locations.

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