EXHIBIT NO. 1

11
9-10-02

City of Alexandria, Virginia

MEMORANDUM

DATE: SEPTEMBER 5, 2002

TO: THE HONORABLE MAYOR AND MEMBERS OF CITY COUNCIL

FROM: PHILIP SUNDERLAND, CITY MANAGER PS

SUBJECT: CONSIDERATION OF THE ALEXANDRIA COMMUNITY SERVICES BOARD'S (1) AMENDED FY 2003 PLAN OF SERVICES, WHICH INCLUDES THE FY 2003 PERFORMANCE CONTRACT WITH THE STATE, (2) FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN, AND (3) STATUS OF THE FY 1999-2003 HOUSING PLAN

ISSUE: City Council consideration of the Alexandria Community Services Board's (1) FY 2003 Plan of Services, which includes the Performance Contract with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, (2) FY 2003 Quality and Performance Improvement Plan, and (3) status of the FY 1999 - FY 2003 Housing Plan.

RECOMMENDATION: That City Council:

(1) approve the Board's amended FY 2003 Plan of Services, which includes approval of the Performance Contract with the State, and a net decrease of $286,561 in the Department's budget; and

(2) approve the Board's FY 2003 Quality and Performance Improvement Plan.

BACKGROUND: The Community Services Board (CSB) is required by state law to prepare a plan of services and have this plan approved by the local governing body. City Council approved the Board's FY 2003 Plan of Services on May 6, 2002, as part of the City's Department of Mental Health, Mental Retardation and Substance Abuse annual budget. The FY 2003 Plan of Services provides for maintenance of current service levels across the Department, including outpatient, supported residential (including group homes and supervised apartments), case management, vocational, day support and early intervention and prevention activities. Because the CSB received notification of State and federal funding amounts after City Council adopted the FY 2003 budget, the Board is presenting a revised budget and plan for Council review and acceptance. In addition, the Board is presenting its proposed evaluation plan for FY 2003.

DISCUSSION:

FY 2003 Plan of Services

The budget on which the approved Plan of Services is based is incorporated in the Board's FY 2003 "Performance Contract." The Performance Contract is an annual agreement with the State that serves as the primary accountability and funding mechanism for the relationship between the Board and the State. It specifies levels of State and federal funds that are disbursed to the CSB through the State, and sets service and reporting requirements for the Board. The FY 2003 Performance Contract is available for review at the Board's administrative offices at 720 North St. Asaph Street.

City Council approved the Board's FY 2003 Plan of Services on May 6, 2002, as part of the Department of Mental Health, Mental Retardation and Substance Abuse annual budget. The initial budget amount for the approved Plan of Services included State and federal funding estimates based on information available at the time the budget was developed. Subsequently, the Board received notification from the State of actual funding levels. Below is a summary of changes made to the budget for the Plan of Services.

- A reduction of $167,672 in general funding from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). The Board will recoup $67,672 of this reduction through an increase in the State Medicaid reimbursement rates for mental health and mental retardation case management. On May 6, 2002, City Council approved the addition of $100,000 in City general fund monies to offset possible State reductions, and these funds will be transferred from the City's Non-Departmental account to the Department of Mental Health, Mental Retardation and Substance Abuse, resulting in no net decrease to the Department.

- The transfer of $153,813 in City General Funds approved by City Council on May 6, 2002, to replace lost State Substance Abuse Reduction Effort (SABRE) funding. The transfer is from the City's Non-Departmental account to the Department of Mental Health, Mental Retardation and Substance Abuse, and results in no net decrease to the Department.

- The freezing of 5.0 FTEs in the Homebased program. Due to a lower than expected and budgeted demand for intensive homebased services, fee revenue is not available to fund these positions. This will result in a decrease of $286,298 in the Department's FY 2003 budget. One of the FTE's frozen here (Therapist III) will be transferred to the Drug Court Program, described on the next page.

- A funding reduction from DMHMRSAS of $41,142 for an HIV Counselor position. This will result in a decrease of $41,142 in the Department's FY 2003 budget.

- The addition of $30,879 to reflect earned grant revenue transferred from the Department of Human Services to partially fund a program which combines intensive case management and judicial supervision, mandatory drug testing, treatment and escalating sanctions to families involved in the Alexandria Drug Treatment Court. This program is a partnership among the Courts, the Department of Human Services, attorneys, treatment providers, the Department of Mental Health, Mental Retardation and Substance Abuse, and the Alexandria Public School System and was approved by City Council on December 15, 2001, as part of the allocation of Reasonable and Necessary Funds received by the Department of Human Services from the State in FY 2002. MH/MR/SA will use a 1.0 FTE Therapist III position currently located in its budget (transferred over from the homebased program). The $30,879 transferred from DHS will pay for approximately one-half of the salary and benefits of this position (Therapist III, grade A with benefits totals approximately $62,000). The remainder of the position will be funded by MH/MR/SA reallocating funding from an existing part-time therapist position currently located in the SA outpatient division, which will be eliminated. The transfer from Department of Human Services will result in an increase of $30,879 to the Department's budget for FY 2003.

- The addition of $10,000 in State funding for adolescent smoking prevention and education.

- The addition of a 0.5 FTE Fiscal Analyst, to be funded by an existing grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The 3.0 full-time temporary positions funded by this grant were approved by City Council on January 8, 2002, but this part-time position was inadvertently omitted. Funding for this grant was received in FY 2002 and is on-going. This grant-funded position will terminate upon expiration of the grant, and the individual who fills this position will be notified of this condition of employment.

These additions and deletions result in a net decrease of $286,561 to the Department's FY 2003 budget. As the majority of this decrease is due to the freezing of grant-funded positions due to lack of demand for homebased services, no other service levels within the department will be impacted.

There will likely be additional cuts in State funding of CSB services ranging from 7% to 15% ($268,708 to $575,803) in FY 2003. We will keep Council informed as we receive additional information on State aid reductions in this and other areas of the City government.

Quality and Performance Improvement Plan

Each year the CSB adopts a Performance Improvement Plan to assess its programs and activities. The plan sets expected performance standards and defines specific performance indicators for

each Board program or activity. The FY 2003 Community Services Board Performance Improvement Plan is attached as Attachment A.

Status of FY 1999-2003 Housing Plan

Every five years the Board conducts a City-wide review to determine housing needs for Alexandrians with mental illness, mental retardation or substance abuse problems and to establish a five-year housing plan. The current housing plan, covering FY 1999 through FY 2003, was approved by Council on June 23, 1999. The plan identified three types of housing needed to serve these Alexandrians: group homes, condominium or apartment units, and Section 8 certificates.

The plan called for the addition of five group homes, seven supervised condominium or apartment units, and 30 Section 8 certificates. The target for additional supervised apartments has been met. At the time the plan was approved, the Board had an allotment of 22 Section 8 vouchers, and the plan called for an additional 30 vouchers. In the years after the plan approval, the vouchers allotted to the Board declined from 22 to 17. Recently, however, the Alexandria Redevelopment and Housing Authority Board has approved the transfer of 25 Section 8 vouchers to the Board. Five of these vouchers will now be used to replenish the Board's original allotment (to 22), and 20 will be applied to the plan's target of 30 additional vouchers. The plan also called for five additional group homes. Funding for these homes has not been obtained. However, the Board is pursuing proposals for a group home for homeless persons.

The following table summarizes the numbers of additional housing units originally targeted in the FY 1999 - FY 2003 Housing Plan, and the number of units and beds that have not yet been delivered.

FY 1999 - 2003 Housing Plan

Type of Residence	Number of Authorized Housing Units	Number of Housing Units Authorized but not yet Delivered	Remaining Number of Beds Authorized but not yet Delivered
Group Homes	5	5	35
Supervised Apartments	7	0	0
Section 8 Certificates	30	10	10
Total	42	15	45

No action is requested at this time. The Board will submit a new five-year housing plan for FY 2004 - FY 2008 for Council consideration in the spring of 2003.

FISCAL IMPACT: On May 6, 2002, City Council approved the Department of Mental Health, Mental Retardation and Substance Abuse's FY 2003 budget. Incorporating the FY 2003 Performance Contract into the FY 2003 Plan of Services results in a net decrease of $286,561 to the Department's budget for reduced homebased program revenues and expenses.

ATTACHMENT:

Attachment I: The Alexandria Community Services Board FY 2003 Quality and Performance Improvement Plan

STAFF:

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ALEXANDRIA COMMUNITY SERVICES BOARD
QUALITY AND PERFORMANCE IMPROVEMENT PLAN

For FY 2003, the Board's Performance Improvement Plan has been integrated with the Quality Improvement Plan, creating one overall plan addressing both quality and performance improvement titled the Quality and Performance Improvement Plan. This was done to combine the overlapping requirements of the two plans and to simplify adherence to all external authorities and departmental directives.

This *Quality and Performance Improvement Plan* is divided into three sections, determined primarily by the locus of the Quality Improvement Requirement. These sections are:

A. **External Reviews:** This category includes sources of review that are external to program staff, such as State licensing agencies; personnel from other service agencies (both public and private) with whom Board staff regularly interact; consumers and their families or authorized representatives; and professional consultants.

B. **Internal Reviews:** This category includes formal staff reviews designed to assess many factors that contribute to program quality and success, such as analysis of predetermined program outcome indicators; evaluation of direct care provided by clinical staff and the accuracy of consumer records; review of the adequacy of supervision; and inspections of all Board facilities.

C. **Staff Reviews:** This category encompasses personnel policies, which ensure that qualified staff are hired and retained; provide for ongoing staff training as required and the routine verification of employee credentials; and set standards for employee performance.

Within each of these sections, there exist program performance indicators categorized as one of three general evaluation categories corresponding to CARF (Committee on Accreditation of Rehabilitation Facilities) outcome measure categories. The categories are: (1) efficiency measures, which are usually administratively oriented, such as access to care, productivity, occupancy rates and cost per unit; (2) effectiveness measures, which address the quality of care and often measure change over time; and (3) satisfaction measures, which are usually oriented toward consumers, family, personnel, community or funding sources. Each outcome indicator is numbered consecutively within the following plan and is labeled with its corresponding outcome measure category. In addition, a matrix of program outcome measures is included on the last page to assist in understanding required performance indicators.

Performance indicator results are reported in 1) Division Monthly Reports; 2) Four Month, Eight Month and Annual Board Evaluation Reports; 3)Annual Division Reports; 4) State Performance Contract reports; or 5) stand alone Board items.

Alexandria Community Services Board
FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN

SECTION I. External Reviews of Board Programs

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF EXTERNAL REVIEW AND RELATED OUTCOME INDICATORS	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
I.a.	**OUTSIDE LICENSING AGENCIES** ensure that Board programs are adequate and in compliance with Federal and State funding requirements			
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services	Site reviews by licensing personnel include examination of administrative requirements, policies and procedures, personnel practices, fiscal protocols, fee policy standards, staffing requirements, building and environmental considerations, client rights, treatment plan requirements, admission and discharge procedures, special procedures for medications, emergencies and case coordination, consumer care records, occupancy permits and other relevant documents.	Every three years and unscheduled	Issuance of license or site visit letter	State licensing is required by law for State funded programs. Applies to both directly operated and contract programs.
Virginia Department of Social Services		Annually and unscheduled		
Virginia Department of Medical Assistance		Annually and unscheduled		
I. b.	**PERFORMANCE CONTRACT** is a required agreement between the Board and the State that sets forth the responsibilities of parties to ensure the delivery of public-funded services to Alexandrians with mental illness, mental retardation or a substance abuse problem.			
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.	This contract specifies regulatory, reporting and administrative requirements; sets funding levels for State funds and Federal funds that are disbursed through the State; and sets minimum service requirements for Board programs.	Revised Annually	Semi-annual reporting requirements are specified in the Performance Contract	State Statute Applies to both directly operated and contract programs.
All programs	**Indicator 1.** (efficiency) Consumers Served: Number and percentage of consumers served for each program as a function of the predicted number of consumers served. Benchmark = 100%	Reviewed Monthly	Monthly, Four month Board reports, Semi-annual State report	
All programs measured by staff hour	**Indicator 2.** (efficiency) Units of Service Provided: Number and percentage of staff hours of service provided as a function of predicted hours of service as projected in State Performance Contract. Benchmark = 100%	Reviewed Monthly	Monthly, Four month Board reports, Semi-annual State report	
All day support and residential programs	**Indicator 3.** (efficiency) Units of Service Provided: Number and percent of consumer days, consumer hours and bed days provided as a function of predicted consumer days, consumer hours, and bed days as projected in State Performance Contract. Benchmark = 100%	Reviewed Monthly	Monthly, Four month Board reports, Semi-annual State report	
All Acute Care and Extended Care programs	**Indicator 4.** (efficiency) Priority Population Consumers Served: Number and percentage by core service area of 'priority population' consumers served as determined by number of consumers served with a priority population assessment compared to total consumers served in each service area. Benchmark = 95% for Extended Care programs and 75% for Acute Care programs	Annually	Twelve month Board report	

Alexandria Community Services Board
FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF EXTERNAL REVIEW AND RELATED OUTCOME INDICATORS	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
All programs	**Indicator 5.** (efficiency) Program Costs: Total program costs compared to predicted costs by core service area. Benchmark = 100%	Reviewed Monthly	Monthly, Four month Board reports, Semi-annual State report	
I. c.	**BOARD REVIEW** provides an opportunity for the Board to examine program missions and the extent to which programs meet fulfill missions.			
Board Committees	Each Board Committee chooses one program to be the focus of an in-depth study each year. This ensures that all programs are reviewed over time. Committee evaluations could include an examination of the program's long term mission and short term goals as well as a review of its operations. Special consideration of the program from a citizen perspective is also undertaken.	Annually	Board Committees submit a report on program evaluations to the full Board.	State Statute Applies to Acute Care, Extended Care and Prevention Div.
I.d.	**FORMAL FEEDBACK BASED ON INTERAGENCY COLLABORATION** provides useful perspective on program quality			
Other agencies (both public and private) with whom Board programs regularly interact	**Indicator 6.** (satisfaction) Agency and Needs Assessment Survey: This evaluation is a report card from our peers. It consists of a written questionnaire that asks recipients to respond to questions about their experiences with Board Programs. Examples of topics addressed include: quality of services, appropriateness of referrals, staff responsiveness and cooperation. Also includes input from and unmet needs in the community at large. Benchmark = 80% positive responses to questions on the survey	Annually	Staff reports to Board on survey results	State Statute This applies to both direct and contract programs.
I.e.	**FORMAL CONSUMER FEEDBACK** provides first-hand information about consumer satisfaction, which is an indication of program quality.			
All Acute and Extended Care programs	**Indicator 7.** (satisfaction) Consumer Satisfaction: Formal satisfaction survey conducted annually using State satisfaction survey instrument. Reported as satisfaction in four domains; (a) general satisfaction with services, (b) accessibility to services, (c) appropriateness or quality of services and (d) outcomes of services. Compared to previous year results and Statewide results. Benchmark = 85% satisfaction as determined by positive responses to survey questions. Exceptions to State instrument include: PIE program (uses Part C Family Survey), MR Case Management (MR Family survey conducted at time of annual service plan meeting), MH Youth and Family (MH Family Services survey conducted by State)	Annually	Board item	
Prevention and Early Intervention	**Indicator 8.** (satisfaction) Consumer Satisfaction: Ongoing satisfaction surveys conducted by Prevention staff conducting one-time or time limited presentations to the public or to early intervention consumers. Benchmark = 85% satisfaction as determined by positive responses to survey questions	Continuously throughout year	Prevention monthly and annual reports	
MR Residential and Vocational/Day Placement programs	**Indicator 9.** (satisfaction) Lifestyle Satisfaction: Number and percentage of verbal consumers who are satisfied with their lifestyle as measured on the Consumer Satisfaction Survey (Home) and the Consumer Satisfaction Survey (Work/Day Placement). Compared to previous year results. Benchmark = 85% satisfaction as determined by positive responses to survey questions.	Annually	Twelve month Board report	
All programs	**Indicator 10.** (satisfaction) Follow-up for Discharged Consumers: A survey will be administered continuously throughout the year to a representative sample of consumers discharged from CSB programs. Approximately 10% of consumers will be identified and staff will attempt to contact by phone. The survey consists of 7 questions including general satisfaction and need for follow-up services. Reporting consists of the percentage of consumers responding positively to the general satisfaction questions. Benchmark = 80% positive response to questions regarding satisfaction with services.	Continuously throughout year	Four month Board reports, Annual Division reports	

Alexandria Community Services Board
FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF EXTERNAL REVIEW AND RELATED OUTCOME INDICATORS	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
Consumer Complaints	Consumer Complaint Forms, which explain the complaint process and provide an avenue for complaint, are made readily available in all consumer waiting areas. All (100%) consumer complaints are reviewed by management. Each consumer who complains receives a response to his/her complaint. A file of individual consumer complaints is maintained by each program and reported monthly (for billing complaints) and annually in Division Annual reports. Benchmark = 100% of consumer complaints resolved to consumer's satisfaction within 5 working days.	Continuously throughout year	Monthly and Annual Division reports	Department Directive for all directly operated programs

Alexandria Community Services Board
FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF EXTERNAL REVIEW AND RELATED OUTCOME INDICATORS	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
I. f.	**FORMAL FEEDBACK FROM INDIVIDUALS AND COMMUNITY AT LARGE** as an indication of program quality			
CSB Staff	An annual written survey is distributed to all CSB staff to assess staff satisfaction. The survey's scope covers satisfaction with working conditions, environment & policies as well as allowing staff to address any concerns they may have with consumer care.	Annually	Report to Board	Department Directive
The Board	Committee Focus groups: Each year, individual Board committees conduct focus groups of consumers to solicit input regarding program operations and consumer satisfaction with services.	Annually	Division Annual reports	Department Directive
The Board	Each year the Board holds a Public Hearing to receive public comment about the services it provides and its future service plans. The date, time and location of the Hearing, as well as any special issues under consideration by the Board at that time, are widely distributed well in advance of the Hearing.	Annually	Report to City Council	State Statute
I. g.	**INFORMAL FEEDBACK FROM INDIVIDUALS AND COMMUNITY AT LARGE** as a measure of gauging individual consumers' acceptance and approval, and overall community support of Board programs.			
Consumers and their families or guardians; Board members and staff and personnel from other service agencies (public or private) or citizens	Frequently Board members and staff hear, overhear or sense reactions of persons to services and programs offered by the Board. It is important to share and use such informal information in the most appropriate manner, whether it is to change and improve Board programs or to commend staff for a job well done.	Ongoing	Such informal information is brought to the Board's attention in Service Area Committee reports.	State Statute This applies to both direct and contract programs
I. h.	**OUTSIDE REVIEW OF, AND CONSULTATION ABOUT, CARE MANAGEMENT PRACTICES** samples quality of services by examining the care given to individual consumers and provides: 1) an independent judgement of appropriateness of care, and 2) case-relevant training for staff by a professional expert			
Professional Consultant	Division Directors select at least one sample case from each program for in depth outside examination. <u>The examination must include (at a minimum)</u>: (1) assessment of consumer; (2) relation of assessment to treatment goals; (3) involvement of consumer and his/her family or authorized representative in setting treatment goals; (4) adequacy of file documentation; (5) assessment of incident reporting; and (6) recommendations for improved and/or future services. <u>The examination process must include (at a minimum) the consultant's</u>: (1) review of the client record and, where willing, an interview with the client; (2) discussion with treating staff; (3) report to staff; and (4) discussion with staff in a case management setting.	Annually	Complete report of the care management review and consultation process submitted in triplicate to: (1) Program Director, (2) Division Director and (3) Executive Director	Departmental Directive Applies to directly operated programs only.

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Alexandria Community Services Board
FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN

SECTION II. Internal Reviews of Board Programs

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF INTERNAL REVIEW AND RELATED OUTCOME INDICATORS	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
II.a.	**PROGRAM OUTCOME INDICATORS** established and monitored to assess specific aspects of program performance			
The Board	Each year the Board sets program outcome indicators. While it is not possible to assess all aspects of outcome, it is possible to identify some important aspects of outcome to use as indicators that are reflective of the mission of each program. Meaningful outcome indicators cover the three domains of efficiency, effectiveness and satisfaction. Specific indicators are part of both external and internal reviews of programs and are numbered consecutively throughout this document.	Annually	Four month Board reports, Annual Division reports	Departmental Directive for all programs
Discharge Planning, medical services and other linked service programs	**Indicator 11.** (efficiency) Continuity of Care: 1) Percentage of all adult MH discharges from state and Alexandria hospital care followed up by face to face non-emergency appointment within 7 days of discharge. 2) Percentage of all adult MH discharges from State hospitals only, followed up by scheduled psychiatric appointment within 7 days of discharge. Benchmark = 100%	Annually	Twelve month Board report	
Outpatient (adult and Y&F), Detox, Residential, Homebased, PIE	**Indicator 12.** (efficiency) Length of Stay: Average length of stay for discharged consumers by program area. Comparison made to previous year lengths of stay. Benchmark = N/A	Annually	Twelve month Board report	
All programs	**Indicator 13.** (efficiency) Revenue Enhancement: Increase fee revenue (generated by insurance and consumer billing) by 5% per year for the next three years to total of 40% total revenue. Benchmark = 40% (average Fees revenue for all VA CSBs)	Annually	Administration annual report	
Extended and Acute Care	**Indicator 14.** (efficiency) Accounts Receivable: Reduce third party accounts receivable for open cases that are more than 90 days past due to 5% or less of the total accounts receivable. Benchmark = 5% of total accounts receivable for open cases.	Monthly	Division monthly and annual reports	
All programs	**Indicator 15.** (efficiency) Cost per Consumer: Measure cost per consumer seen by core service area. Compared to expected cost per consumer and costs for previous fiscal year. Benchmark = 100% of expected	every four months	Four month Board reports, Annual Division reports	
Extended and Acute Care programs	**Indicator 16.** (efficiency) Wait List: Number of consumers waiting for admission to services. Measured as the number of consumers who have had an intake and are waiting for services after intake and includes the actual of length of time remaining on the waiting list. Benchmark = N/A	monthly	Division monthly reports	
Emergency Services	**Indicator 17.** (efficiency) Access to Emergency Services Care: 1) Waiting time for crisis intervention services measured by response to question asked to walk-in emergency services consumers regarding consumer perception of length of time they waited for service. Benchmark = 75% of consumers responding positively to wait time question. 2) Emergency services response rate to after hours calls as measured by comparison of computerized log of phone calls by answering service to emergency services log of time of response. Benchmark = 80% of calls answered within 10 minutes.	every four months	Four month Board reports, Annual Division reports	
Medical services	**Indicator 18.** (efficiency) Atypical Drug Use: Percentage of consumers receiving atypical anti-psychotic medications as compared to all consumers receiving anti-psychotic medication. Compared to previous year and other CSBs Statewide. Benchmark = 50%.	semi-annual	State contract report and annual Board report	
Prevention and Early Intervention programs	**Indicator 19.** (efficiency) Access to Prevention services: Percentage of consumers reporting Prevention program locations convenient as part of satisfaction survey conducted throughout the year at presentations, consultations and time limited community education programs and interventions. Benchmark = 85% positive response to questions concerning satisfaction with access to programs.	Ongoing	Prevention annual report	

Alexandria Community Services Board
FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF INTERNAL REVIEW AND RELATED OUTCOME INDICATORS	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
Outpatient Adult	**Indicator 20.** (effectiveness) Change in employment status: Percentage of consumers (who are able to work) whose employment status has changed to a more independent or fully employed status from admission to discharge, as compared to total number of consumers able to work. Benchmark = 25% of consumers able to work will have employment status change to more independent or fully employed status.	Annually	Twelve month Board report and Division annual reports	
Outpatient Adult, Methadone, MH&SA Case Management	**Indicator 21.** (effectiveness) Level of Functioning: Consumers will maintain or improve Global Assessment of Functioning score from admission to discharge (or from previous year to current year for ongoing consumers). Sample of 25% Outpatient and Case Management and phase 2 Methadone consumers served. Benchmark = 75% of consumers will maintain or improve functioning level.	Annually	Twelve month Board report and Division annual reports	
Methadone	**Indicator 22.** (effectiveness) Meaningful daytime activities: Methadone phase II consumers will participate in meaningful daytime activities including work, parenting, school or vocational activities. Benchmark = 75% of Methadone program consumers will participate in meaningful daytime activities.	Annually	Four month Board reports, Annual Division reports	
Methadone	**Indicator 23.** (effectiveness) Successful Transition in Treatment: Number and percentage of Methadone program consumers who successfully move from one phase of treatment to the next level. Measured by number who successfully transition from 'Stabilization' to 'Maintenance' and from 'Maintenance' to 'Recovery' divided by all consumers served in program. Benchmark = 35% of Methadone program consumers will successfully move from one phase of treatment to the next.	Annually	Twelve month Board reports, Annual Division reports	
Discharge Planning	**Indicator 24.** (effectiveness) Community Stabilization: The number and percentage of individuals who are discharged from the Alexandria Hospital and state hospitals successfully maintained within the community for 90 days or more without psychiatric re-hospitalization. Includes prior year quarter to allow for 90 day assessment. Last quarter of previous year reported in first quarter of following year. Benchmark = 80% successfully maintained in the community for 90 days or more without psychiatric re-hospitalization.	Every 4 months	Four month Board reports, Annual Division reports	
Detox	**Indicator 25.** (effectiveness) Linkage to SA Services: The number and percentage of individuals who are discharged from the Detox program and follow with treatment after discharge from Detox. Measured as number of consumers discharged from Detox who follow on with SA services divided by all who are discharged from Detox. Based on a one month sample of consumers discharged prior to each reporting period. Benchmark = 50% of Detox consumers following on with SA services.	Every 4 months	Four month Board reports, Annual Division reports	
Detox	**Indicator 26.** (effectiveness) Maintenance in Community: The number and percentage of individuals who are discharged from the Detox program and successfully maintained within the community for 90 days or more without subsequent Detox services. Measured as number of consumers discharged who were not reassigned to Detox within 90 days divided by total discharged from Detox. Includes prior year quarter to allow for the 90 day assessment. Last quarter of fiscal year evaluated in first quarter of following year. Benchmark = 80% of Detox consumers not reassigned to Detox within 90 days of discharge from Detox.	Every 4 months	Four month Board reports, Annual Division reports	
SA Day Support	**Indicator 27.** (effectiveness) Maintenance in community: Number and percentage of consumers who complete SA Day Support who are NOT admitted to Detox for up to one year following discharge from the SA Day Support program. Benchmark = 65% of consumers discharged from SA Day Support not admitted to Detox within one year of discharge.	Annually	Twelve month Board report and Division annual reports	
SA Day Support	**Indicator 28.** (effectiveness) Improvement in Functioning: Percentage of SA Day Support consumers completing the program who show improved functioning using the Global Assessment of Addiction Recovery Functioning (GAARF). The scale is a one score scale ranging from 1-100 and is based on addiction recovery. Benchmark = 75% of SA Day Support consumers showing improved functioning on the GAARF.	Annually	Twelve month Board report and Division annual reports	

Alexandria Community Services Board
FY 2003 QUALITY AND PERFORMANCE IMPROVEMENT PLAN

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF INTERNAL REVIEW AND RELATED OUTCOME INDICATORS	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
Youth and Family and Homebased	**Indicator 29.** (effectiveness) Improvement in Behavior: Number and percentage of children ages 4 to 18 who show an improvement in their behavior as assessed by their parents or guardians on the CAFAS. Instrument collected at admission, 3 mos, every 6 mos and discharge. Report change in scores from first to most recent assessment for consumers with at least two measurements during the fiscal year. Total number of children who improve divided by total number of children who were assessed at least twice. Benchmark = 75% of children showing an improvement in behavior.	Annually	Twelve month Board report and Division annual reports	
Youth and Family and Homebased	**Indicator 30.** (effectiveness) Improvement in School: Number and percentage of school age children served in the MH Youth & Family unit and Homebased program who continue to attend school regularly and achieve passing grades as measured by the assessment on the CAFAS on the school sub-scale. Benchmark = 85% of children attending school regularly and achieving passing grades as measured on the school sub-scale of the CAFAS.	Annually	Twelve month Board report and Division annual reports	
Prevention and Early Intervention	**Indicator 31.** (effectiveness) Positive Change as a Result of Intervention: Percentage of attendees to Prevention community education events, consultations or early intervention programs who show positive change in attitudes toward risk behaviors as assessed through a pre and post test. Benchmark = 75% of consumers indicating positive change in attitudes toward risk behaviors.	Ongoing	Monthly and annual Prevention reports	
Prevention Services	**Indicator 32.** (effectiveness) Reduction in Smoking Rate Among Adolescents: As part of a nine month effort in smoking reduction aimed at ninth grade students, a survey will be conducted in September and May to assess a change in attitudes toward tobacco use. Benchmark = 10% of students will show a positive change in attitudes toward tobacco use.	Annually	Annual Prevention report	
Psychosocial Rehabilitation	**Indicator 33.** (effectiveness) Maintenance in Community: The number and percentage of Clubhouse consumers who are successfully maintained in the community without hospitalization. Measured by comparing number of consumers enrolled in Clubhouse rehabilitation to number of consumers who are enrolled and who are hospitalized during the year. Benchmark = 80% (will be maintained in community without hospitalization)	Annually	Twelve month Board report and Division annual reports	
MH Supported Living, HUD residential program, and Psychosocial Rehabilitation	**Indicator 34.** (effectiveness) Improvement in Functioning: Percentage of consumers who maintain or show improvement in functioning as assessed by the Multnomah Community Ability Scale. Instrument completed at admission, 6 mos, and every six months thereafter while admitted to program. Benchmark = 60% of consumers maintain or show improvement in functioning.	Annually	Twelve month Board report and Division annual reports	
Residential Services	**Indicator 35.** (effectiveness) Independent Living Transitions: Number and percentage of residential consumers who 'graduate' to same or more independent living situations either within the CSB array of services or from CSB services to fully independent living. Based upon the number of consumers who are 'successfully' discharged from Board residential programs to the same or a less intensive housing situation divided by all who are successfully discharged from residential programs. Benchmark = 60%	Annually	Twelve month Board report and Division annual reports	
Care Bed	**Indicator 36.** (effectiveness) Successful Return to Community: Percent of consumers utilizing the Care Bed as an alternative to psychiatric hospitalization who return to the community following discharge as compared to all consumers utilizing Care Bed. Benchmark = 95% of Care Bed consumers return to the community after discharge.	every 4 months	Four month Board reports, Annual Division reports	
SA Case Management	**Indicator 37.** (effectiveness) Successful Shelter Placement: Percentage of consumers who are successfully placed in a shelter as compared to the total number of consumers who are assessed as needing shelter following Detox or direct community request. Benchmark = 75% of consumers assessed as needing shelter are successfully placed in a shelter.	every 4 months	Four month Board reports, Annual Division reports	
MH Homeless	**Indicator 38.** (effectiveness) Linkage to Mental Health Services: Percentage of homeless consumers with mental illness and served by homeless coordinator who are successfully linked to mental health services. Benchmark = 45% of homeless consumers successfully linked to mental health services.	Annually	Twelve month Board report and Division annual reports	

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SA Residential Treatment	**Indicator 39.** (effectiveness) Linkage to Residential Treatment: Percentage of consumers requesting SA residential treatment services who are successfully placed in a residential treatment program (compared to all who are referred). Benchmark = 75% successfully placed in SA residential treatment.	Annually	Twelve month Board report and Division annual reports	
CROP program (discharge support for individuals released from prison)	**Indicator 40.** (effectiveness) Reincarceration Rate for Consumers Released from Prison. Percentage of consumers in CROP program who are reincarcerated due to a new criminal charge or parole violation for at least a 90-day period following admission to program. Benchmark = no more than 30% reincarcerated.	Annually	Twelve month Board report and Division annual reports	
Adult Outpatient (pilot program by sample of clinicians) and Sober Living Unit (SLU)	**Indicator 41.** (effectiveness) Consumer Report of Progress Toward Meeting Goals: Percentage of progress reported by consumers toward meeting their goals in Outpatient and Sober Living unit programs. Consumer is asked to report on scale of 1-10, where they assess their progress during treatment with a 10 being the goal for discharge. In FY 2003, this indicator will be piloted in adult outpatient and used for all consumers in Sober Living Unit. Consumer will self report each outpatient session. In SLU, consumer will report at admission, at 'life story' and pre-discharge. Benchmark = to be set at end of FY 2003 after reviewing initial results.	Annually	Twelve month Board report and Division annual reports	
Outpatient and Case Management services	**Indicator 42.** (effectiveness) Consumer Report of Involvement in Treatment Plan: Percentage of consumers identified as recently completing their treatment plan who respond positively to a short questionnaire regarding their involvement in the treatment planning process. Consumers will be identified monthly. Short questionnaire will be forwarded to front desk staff to administer to consumer based upon date and time of next appointment. Benchmark = 95% positive responses to consumer questionnaire regarding involvement in the treatment planning process.	every 4 months	Four month Board reports, Annual Division reports	
Dual Diagnosis Outpatient Services	**Indicator 43.** (effectiveness) Reduction in Substance Use: Percentage of consumers who report a reduction or elimination of use of one or more substances. Benchmark = 80%	Annually	Twelve month Board report and Division annual reports	
Dual Diagnosis Outpatient Services	**Indicator 44.** (effectiveness) Improvement in Functioning: Percentage of consumers who show improvement in functioning as assessed by the Multnomah Community Ability Scale. Instrument completed at admission, 6 mos, and every six months thereafter while admitted to program. Benchmark = 25% showing improvement in functioning.	Annually	Twelve month Board report and Division annual reports	
Emergency Services	**Indicator 45.** (effectiveness) Absence of Suicides Among Emergency Services Consumers: Percentage of consumers committing suicide and served by Emergency Services staff within 30 days prior to suicide. Measured by reviewing all suicides annually and reviewing cases for Emergency Services interventions. Benchmark = 0% of consumers with emergency services interventions will commit suicide within 30 days of intervention.	Annually	Twelve month Board report and Division annual reports	
Emergency services and Jail Services (CCU & General population)	**Indicator 46.** (effectiveness) Consumer Report of Improved Mental Status as Result of Service: Percentage of consumers who report a more hopeful outlook as a result of the crisis service (in emergency services) or other intervention (in Jail programs) and measured by consumer noting on a written scale of 1-5, mental state at beginning of session and mental state at end of session. Scales administered to all consumer able to complete questions. Benchmark = 75% of consumers will report more hopeful mental status as result of intervention.	every 4 months	Four month Board reports, Annual Division reports	
Jail Services	**Indicator 47.** (effectiveness) Reduction in Suicidal Ideation Among Jail Consumers: Percentage of Jail consumers who initially report suicidal intent and who report decreased suicidal thoughts after intervention with mental health staff. Uses five point scaled survey ranging from 'Suicidal and not willing to contract for safety' to 'No suicidal thoughts'. Benchmark = 85% of consumers will increase on scale by at least two intervals on five interval scale.	Annually	Twelve month Board report and Division annual reports	
MH Group employment, MR Group and Individual Employment	**Indicator 48.** (effectiveness) Maintain Employment: Percentage of consumers who have been enrolled for at least six months and have maintained employment for six months or more during the period. Benchmark = 90% of consumers maintain employment for six months.	Annually	Twelve month Board report and Division annual reports	

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MH Sheltered Employment	**Indicator 49.** (effectiveness) Hourly wage: Percentage of consumers who improve hourly wage as compared to previous year. Benchmark = 100% of consumers increase hourly wage compared to previous year.	Annually	Twelve month Board report and Division annual reports	
MR Day Support	**Indicator 50.** (effectiveness) Hours of Work: Average number of hours of work per day completed by MR consumers in the day support program. Benchmark = five hours per day	Annually	Twelve month Board report and Division annual reports	
MH Supported Individual Employment	**Indicator 51.** (effectiveness) Consumer Self Report of Progress: Percentage of consumers involved in Job Seekers group or who are employed who report progress in meeting their employment goals as recorded on an employment goals short questionnaire administered twice annually. Benchmark = 75% will report progress made in meeting goals	Annually	Twelve month Board report and Division annual reports	
PIE (Parent Infant Education)	**Indicator 52.** (efficiency) Access to PIE services: Percentage of children eligible for PIE services and progressing toward IFSP (Individual Family Services Plan), who complete IFSP within 45 days of referral. Benchmark = 100% complete ISFP within 45 days of referral.	Annually	Twelve month Board report and Division annual reports	
PIE (Parent Infant Education)	**Indicator 53.** (effectiveness) Child Meeting Therapeutic Goals: Percentage of Children in the PIE program who in their annual review show improvement in at least one area of development or have progressed to age appropriate development after receiving therapeutic services in the PIE program. Program supervisor will review all program discharges and annual reviews to determine if progress has been made and will log results. Compared to total number of children who received therapeutic services. Benchmark = 75% of children will show improvement.	Annually	Twelve month Board report and Division annual reports	
PIE (Parent Infant Education)	**Indicator 54.** (effectiveness) Parental Involvement in Child Habilitation: Percentage of parents who answer positively to involvement in treatment planning process as assessed on the Part C family survey for the questions; 'I helped decide which early intervention services would be listed on our IFSP' and 'The goals/outcomes written in our IFSP are the things that I want for my child and family'.	Annually	Twelve month Board report and Division annual reports	
MR Case Management	**Indicator 55.** (effectiveness) Appropriate Linkage to Supports and Services for MR Consumers: Percentage of consumers (or family members or other representative if consumer cannot answer) who respond that they were linked to appropriate services during the past year. Question will be asked and responses logged by using short survey during the annual consumer service planning meeting. Two other questions regarding satisfaction with those supports and services and suggestions as to how we can improve services will be asked as well. Benchmark = 85% positive responses to questions about linkage to services	Annually	Twelve month Board report and Division annual reports	
MR Case Management	**Indicator 56.** (effectiveness) Meaningful Daytime Activities for MR Consumers: Percentage of active case management consumers with a diagnosis of Mental Retardation who participate in a meaningful daytime activity such as day support, vocational support, work, training, therapeutic recreation. Benchmark = 90% of consumers participate in meaningful daytime activities.	Annually	Twelve month Board report and Division annual reports	
II.b.	**DATA QUALITY ASSURANCE ACTIVITIES** ensure the accuracy and completeness of the data collected about consumers, staff productivity, financial information (such as the unit costing of services provided) and consumer invoicing.			
Director, Program Evaluation	This activity provides prioritization areas for study based on degree of risk and the development of a plan for completing these studies. Area(s) identified as posing the highest risk factor are evaluated first. Methods used include sampling, audits, software controls and so forth. Staff will complete four to six studies annually as approved by the MIS Steering Group. Results of study and recommendations will be reported to MIS Steering Group and appropriate Division Director. Follow-up of studies will occur the following year.	Annually	Division Annual Reports	Departmental Directive Applies to directly operated programs

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II. c.	**ONE-TIME QUALITY IMPROVEMENT STUDIES** are a means of addressing special areas of concern about program process or outcome.			
Administration unit of each Service Area Division	One-time special studies are formulated and conducted to address areas of program quality improvement or consumer outcome which cannot reasonably be studied or evaluated on an ongoing basis. These areas of concern may come to light during the normal course of operations or during other quality improvement activities. This is a separate requirement from item I.C. (Board committee program review) with a focus on quality improvement.	Annually	Board Information Item and Division Annual Report	Departmental Directive Applies to directly operated programs
II. d.	**EVALUATION OF DIRECT CARE** is critical to ensuring that clinicians provide quality services that meet consumers' needs			
Supervisory review of subordinate clinicians	To assess quality of direct care, it is necessary to directly observe clinicians during treatment sessions without interfering in the treatment process. For each subordinate clinician, supervisors arrange (through recording or supervisor presence) to assess at least one unit of direct service involving a willing client annually. This first-hand information is used to plan for improvement of clinician performance, identify training needs and officially recognize quality work.	Annually	Reported in the clinician's evaluation record.	Departmental Directive Applies to directly operated programs

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II. e.	**ADEQUACY OF SUPERVISION** is evaluated to determine if supervisors are responsibly assuring the quality of the services they supervise.			
Individual Supervisors	Management of Board programs is based upon a supervisory model. Each direct service clinician has a supervisor who in turn reports to another supervisor or manager. Supervisor evaluations include three separate components: (1) Progress toward meeting specific performance objectives which are designed to ensure quality service. To assess quality of supervision, it is necessary to directly observe supervisors interacting with their subordinates in a supervisory capacity. Each supervisor's supervisor arranges (through recording or supervisor presence) to assess at least one supervisor/supervisee session annually. This first hand information is used to plan for improvement of supervisory performance, identify training needs and officially recognize quality work. (2) Feedback obtained from subordinate employees. Each supervisee is asked, in a structured questionnaire format, to rate the supervisor on such dimensions as availability, usefulness, knowledge, ability and judgement. (3) Final review by upper level managers of the two foregoing evaluation components and any other relevant information.	Annually	Supervisor evaluations and Service Area Division Annual Reports.	State Statute Applies to direct and contract programs
II. f.	**INTERNAL PEER REVIEW** ensures quality of services through sharing of expertise and case-relevant support among clinicians.			
Service Area Division peer review teams, which consist of a cross section of staff members from various programs	Peer review (review of clinical practice by a group of professional peers) has long been viewed as a means to assure quality. Where judgement is required, it is argued that peers are in a good position to apply professional judgements. Peer review occurs for cases meeting certain predetermined criteria (such as length of time in treatment, use of exceptional procedures, client complaints, etc.) Documentation will include (1) Log of peer review activities, and (2) referral of problems to appropriate supervisors	Each peer review team meets monthly and reviews at least one case of each clinician annually	Reported as annual summary report of peer review activities to: (a) Service Area Division Director and (b) Department Head and (c) the Board	Departmental Directive Applies to directly operated programs
II. g.	**REVIEW OF CONCORDANCE OF RECORDS WITH SERVICES DELIVERED** is important because records are typically used as the basis for assessing quality of care, adequacy of treatment plan and client outcome.			
Supervisor or peer review committee Corporate Compliance Staff (Gwen Sither)	It is necessary to ensure that the record reflects the reality of consumer circumstance, treatment delivered and outcome received. While it is not possible to determine the concordance between record and actual services and outcomes for all consumers, it is possible to do this on a selected basis. Focus of corporate compliance reviews is for a sample of records funded by revenue sources with specific record requirements which may be at risk should record problems exist. Review of these records is extremely detailed and spans records for all clinical staff with caseloads meeting sample target. The reviewer(s) must examine in detail the clinician's handling of the selected case. At a minimum the examination must cover: (1) file documentation; (2) treatment plan development; and (3) consumer status, including an interview with the consumer, if the consumer is willing.	Annually for each clinician	A summary of the results of the case study is reported in the clinician's evaluation record.	Departmental Directive Applies to directly operated programs

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II. h.	**PROVISION OF PRINTED INFORMATION MATERIALS** is (1) an indirect means of assuring quality through communication tools that maximize a consumer's ability to achieve the most benefit from Board programs; and (2) a direct means of increasing community awareness and support for Board programs.			
	(1) Brochures and other printed materials about Board services cover many topics, such as (a) the types of services available; (b) what to expect from Board programs; and (c) how to express concerns about the quality of care or other grievances. Each new consumers is given copies of materials relevant to his/her treatment at admission. Any consumer who may not reasonably be expected to understand the written material also receives an oral explanation of the pertinent elements contained in the written materials. Many of these materials are also made available to the community at large. (2) The Board publishes a quarterly newsletter about its activities (3) The Board publishes an Annual Report each November. In addition, each Service Area Division prepares an Annual Report for Departmental release.	1) Consumer material updated annually and distribution is ongoing. (2) the Board newsletter is published quarterly. (3) Division and Board report published annually.	Evidence of the existence of up-to-date and adequate supplies of printed informational materials for distribution. Timely completion and release of newsletters annual reports.	Departmental Directive Applies to direct and contract programs
II. i.	**ENVIRONMENTAL SURVEYS** ensure that each Board facility or site is safe, is in compliance with licensing requirements, and reflects well on the Board and its programs.			
Staff supervisors, Safety Committee members, State officials, Board members and other invited persons	During site inspections a checklist is used to verify that Board facilities meet requirements in many areas. These inspections look at such things as: safety, security, lighting, compliance with licensing requirements, state of repair, professional appearance, cleanliness and neatness, harmony with neighborhood, suitability for intended purpose, accessibility (parking, use of signs, handicapped access), appropriateness of handling of confidential records in public areas and proximity to consumers.	Quarterly self inspection and Annual formal inspection	Report to the Board of inspection findings and resulting corrective actions, if any. Also included in Division Annual report	State Licensing Departmental Directive Applies to directly operated programs

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II. j.	**REVIEW OF INITIAL CONSUMER CONTACTS** ensures that prospective consumers have positive perceptions regarding suitability and equality of services.			
(1) Response rate measured by number of rings at front desk. (2) Sample or "mock" telephone calls to intake staff in each Service Area Division; and, (3) a role playing "consumer" who actually enters each program through the intake process.	Consumers who are not favorably impressed during intake may fail to obtain needed services, or may fail to receive proper treatment or referrals. Quality of initial consumer contacts is tested as described below for (1) number of telephone rings before answer; (2) telephone contacts; and (3) in-person contacts. (1) Phone calls are made to the front desk every four months to measure how many calls are picked up within three rings. Benchmark = 100% of calls are picked up within 3 rings. (2) Sample telephone calls to intake workers: Telephone responses are sampled by placing mock consumer phone calls at various times of the day for a predetermined time period. The mock phone calls are designed to assess promptness of response, pleasantness, accuracy of information and appropriateness of referral. (3) Sample Intake Appointments: To assess the intake process, a role playing "consumer" actually enters each service program through the intake process. The "consumer" uses a preset protocol to assess the adequacy of staff interaction, including supportive and prompt attention; evidence of provision of appropriate information about services, alternatives for services, information on consumer rights, program requirements, adherence to fee policies; and clinician follow-up.	Every 4 months for number of rings. Annually for (1) A random sampling of incoming calls is made to intake staff, and (2) At least one mock intake is arranged for each program each year.	Service Area Division Annual Reports	Departmental Directive Applies to directly operated programs
II. k.	**REVIEW OF VOLUNTEER PROGRAM** to include a review of the number of volunteers, volunteer hours and type of service volunteers are providing ensures quality provision of critical consumer and/of administrative services.			
Volunteer Coordinator	Summary of number of volunteers and volunteer hours of service to meet goals projected for the year. Benchmark = 18 non-rep payee volunteers providing 2,500 hours of service	Annually	Administration Annual report	Departmental Directive

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SECTION III. Review of Staff Quality

SOURCE OF REVIEW & PROGRAMS	DESCRIPTION OF REVIEW OF STAFF QUALITY	FREQUENCY OF REVIEW	REPORT OF RESULTS	AUTHORITY & APPLICABILITY
III.a.	**GOOD EMPLOYMENT PRACTICES** ensure that qualified staff is hired and retained.			
(1) City Personnel Regulations govern new hires and promotions. (2) Departmental policies govern verification of professional licenses.	(1) Adhering to Personnel Regulations includes following City hiring practices as well as maintaining appropriate and up-to-date job descriptions and class specifications detailing requirements for minimum training and experience, education and professional licenses. (2) Adhering to Departmental policies provides for routine verification of employee credentials to ensure that staff is qualified by training and experience. (3) Preparation of Personnel Status reports indicating new hires, resignations and terminations, recruitment status and positions requiring bi-lingual Spanish/English skills. (4) Maintaining data on vacancy rates. Benchmark for Department vacancy rate is no more than 5%. (5) Preparing reports of direct care staff qualifications in terms of a) education, b) license, and c) training (6) Adhering to hiring process hiring standards to include the following: a. Supervisors will send paperwork initiating the hiring and advertising process within five working days of notification of a staff member's resignation at least 95% of the time. b. Supervisors will complete interviews within 15 working days of receipt of application packages at least 95% of the time. c. A selection report will be forwarded to City Hall within 10 working days of completion of interviews at least 95% of the time.	(1) As required for new-hires and promotions. (2) Annually for verification of professional licenses.	(1) City Personnel maintains a record of the hiring process for each position. (2) Verification of academic credentials and current licensure status is maintained in the employee Departmental record. (3)-(5) Monthly and Annual Admin report (6) Four month Board reports	(1) City Personnel Regulations (2) Departmental Policies and Procedures.
III. b.	**EMPLOYEE TRAINING** ensures that employee skills are maintained or enhanced.			
(1) Required Training for licensure (2) Training Needs Assessment (3) Annual Training Plan support Core Needs and staff requests	Staff training includes many subjects, such as City and Department Orientation and Human Rights Training for new employees; first aid and safety training for residential counselors; in-service training for clinical staff, which is focused on developing and improving skills that enhance the quality of service; and customer service, self defense and computer skills for all staff. The training cycle includes the following steps. (1) Identification of CORE training needs per license, accreditation and other outside review requirements (2) Supervisory review of employee training needs at least annually (3) Training Needs Assessment conducted annually to identify training short falls and upcoming needs. Also includes special training requirements identified in assessments such as the annual MIS Needs Assessment (4) Annual Training Plan developed by Director, Consultation and Training (5) Training scheduled and distributed via monthly training calendar (6) Special training events scheduled and advertised as needed (7) 95% of all staff will have completed their CORE training within 30 days of start of employment.	(1) Annually for supervisor training and supervisory review and program review of staff training needs (2) Training is ongoing for all staff	(1) Employee evaluations (2) Program evaluations (3) Training needs assessments (7) Four month Board reports	(1) City Personnel Regulations (2) Department Policies and Procedures Applies to all employees

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III. c.	**STAFF PERFORMANCE STANDARDS** ensure that each employee's performance contributes positively to the Board's quality assurance standards.			
Supervisors	Individual employee performance standards contain productivity and quality indicators to ensure routine supervisory review of those aspects of staff effort that contribute to the quality of programs. Each year at least 95% of employees will receive satisfactory performance ratings as measured by percent of employees receiving merit increases.	Performance indicators are generally set annually; but may be revised as necessary. Each employee also has a six month interim process review	Employee evaluation records Four month Board reports	(1) City Personnel Regulations (2) Departmental Policies and Procedures Applies to all employees
III. d.	**RETENTION RATE STUDY** is a comparative study of one staff classification			
	One clinical staff classification will be selected for study to include a comparison of length in position, salary and benefits packages between Alexandria, Arlington and Fairfax/Falls Church CSBs.	Annually	Admin Annual report	Department Directive

Adopted, May 2, 1995
Revision: October 1, 1998
Revision: May 28, 2002

Matrix of Outcome Indicators by Program

Program Area	Efficiency Indicators	Effectiveness Indicators	Satisfaction Indicators
Outpatient Adult (MH & SA) & Medical Services	1,2,4,5,11,12,13-16,18	20,21,41,42	6,7,10
Dual Diagnosis Team (new unit starting up in FY 2003)	1,2,4,5,11,12,13-16	43,44	6,7,10
Youth and Family & Homebased	1,2,4,5,12,13-16	29,30	6,7,10
Methadone	1,2,4,5,12,13-16	21,22,23	6,7,10
Parent Infant Education (PIE)	1,2,4,5,12,13-16,52	52,53,54	6,7,10
Emergency Services	1,2,4,5,13-16,17	45,46	6,7,10
MH/SA Case Management (includes Discharge Planning)	1,2,4,5,13-16	21,37,42	6,7,10
MR Case Management	1,2,4,5,13-16	55,56	6,7,9,10
Special Case Management Populations (Homeless, CROP and Discharge Planning)	1,2,4,5,13-16	24,38,40	6,7,10
Psychosocial Rehabilitation	1,3,4,5,13-16	33,34	6,7,10
SA Day Support	1,3,4,5,13-16	27,28	6,7,10
Jail Services (Sober Living, Critical Care & Gen Pop)	1,3,4,5,13-16	41,46,47	6,7,10
Detox	1,3,4,5,12,13-16	25,26	6,7,10
Residential Services (group homes, apts & Supported Living)	1,2,3,4,5,12,13-16	34,35	6,7,10
Mental Health Vocational Services	1,2,3,4,5,13-16	48,49,51	6,7,10
Mental Retardation Vocational Services & MR Day Support	1,2,3,4,5,13-16	48,50	6,7,10
CARE (Crisis) Bed / SA Residential Treatment	1,3,4,5,13-16	36,39	10
Prevention and Early Intervention	1,2,4,5,13-16,19	31,32	8