SOUTHWEST ARKANSAS COUNSELING AND MENTAL HEALTH CENTER, INC.

STRATEGIC PLAN AND PERFORMANCE REVIEW

WAITING ROOM COPY
Fiscal Year 2022

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INTRODUCTION

This document represents the consolidation of materials from several sources and is intended to result in a comprehensive document that outlines efforts of the Southwest Arkansas Counseling and Mental Health Center, Inc. (SWACMHC) to address areas related to leadership, management, fiscal responsibility, quality improvement, and annual review of performance. The Center is committed to: 1) maintaining the highest level of service quality and 2) meeting the accreditation standards as set forth by CARF. This requires regular planning, reporting, reviewing and additional planning on an ongoing basis. This document provides an accounting of the Center's efforts to maintain quality in all areas.

Southwest Arkansas Counseling and Mental Health Center, Inc. and CARF recognize accreditation as a dynamic process that requires continual oversight and change. As a result, the Center has revised its reporting practices over the years to provide the most efficient and meaningful information on which to base the strategic planning process. The Center is committed to maintaining both the highest level of accreditation and efficient and effective business practices. To that end, this manual is designed to contain information regarding:

- Leadership
- Input from Persons Served and Other Stakeholders
- Legal Requirements
- Financial Planning and Management
- Risk Management
- Health and Safety
- Human Resources
- Technology
- Rights of the Persons Served
- Accessibility
- Information Management
- Performance Improvement
- Medication Utilization Evaluation
- Outcomes
- Performance Goals for the Next Year

This manual is not intended to be an all-inclusive listing of each and every policy supporting the above listed areas, but rather a summary document to outline the major pieces of each area. For more specific information, please refer to the Center's policies and procedures as approved by the Board of Directors.

LEADERSHIP

- **Mission and Vision**

The mission of the Southwest Arkansas Counseling and Mental Health Center, Inc. (SWACMHC) is to prevent, treat, and cure mental illnesses and related disorders regardless of an individual's ability to pay for such services. This will be done in a manner that is consumer oriented, accessible, affordable, and quality driven.

SWACMHC is dedicated to excellence, accountability and advocacy for those citizens most in need of agency services. Services will be provided when and where needed.

The Center will strive to build partnerships with all segments of the community – businesses, schools, the medical community, and neighborhood groups – in order to enhance public awareness and community problem solving in behavioral healthcare.

- **Legal Authority**

Several legislative mandates provide direction to the activities and functions of SWACMHC. In 1971, the Arkansas General Assembly authorized the distribution of funds appropriated by the Legislature to community mental health centers or clinics within the state. This legislation, Act 433 of 1971, specifies that approval or rejection of a center or clinic is to be based, among other things, on the "adequacy of mental health services provided by such centers or clinics".

Several years later – through Act 787 of 1975 – mental health centers and clinics were required to "meet minimum standards of performance in the delivery of mental health services" as defined by the Department of Human Services, Division of Aging and Adult Mental Health Services (DAABHS).

As a Certified Community Mental Health Center and Behavioral Health Agency, SWACMHC must meet these various administrative and clinical service standards and be in compliance with applicable state and federal laws. Additionally, the policies of SWACMHC are administered in compliance with applicable laws prohibiting discrimination based on race, color, religion, national origin, age, gender, marital status, veteran status, sexual orientation, qualified disabled status or other legally-protected characteristics.

Several outpatient sites and the Center's residential substance abuse program are licensed by the State of Arkansas as substance abuse treatment facilities.

- **Governance**

Incorporated as a private, non-profit entity, SWACMHC is governed by a voluntary Board of Directors, representative of a variety of community interests across the six-county mental health catchment area served by the Center. In accordance with the organization's corporate bylaws, this elected Board has full power and authority to promulgate rules, regulations and guidelines to discharge their responsibilities. These powers include maintaining quality of care, fiscal solvency, adequate physical facilities, qualified professional staff, defining Board policies for the operation of SWACMHC and its services, and the implementation of service-delivery standards.

To further assure that planning for services and programs provided by SWACMHC is based on the needs of its six-county service area population (Hempstead, Howard, Lafayette, Little River, Miller and Sevier), the Board has adopted a policy on “Input from Persons Served”. This policy sets forth several mechanisms for obtaining information and feedback from persons served and the community at large.

The SWACMHC Board of Directors is also responsible for employing an Executive Director. The Executive Director is accountable for the day-to-day operations of the organization and for the development of services and programs that are responsive to the needs of the population within the service area. The Board also delegates primary responsibility to the Executive Director for fiscal and program continuity, as well as other areas of authority as assigned by the Board of Directors.

- **History**

Conceived in 1967 as the Greater Texarkana Regional Mental Health-Mental Retardation Center, this Center was originally designed to serve residents of Bowie County, Texas and Miller County, Arkansas who were diagnosed as having a mental health disorder or were in need of behavioral health services. Since that time, many changes have occurred, including name changes and the restructuring of the Center’s mental health catchment area to serve residents of six counties in Southwest Arkansas and to serve the substance abuse treatment needs in twelve counties. Outreach services were begun in 1974. In September of 1976, substantial amounts were budgeted for additional expansion and upgrading of services. A third major expansion occurred in 1978, providing an opportunity to serve individuals nearer to their homes or communities. In this same year, services to Texas residents were discontinued and began being provided by a Texas agency.

With the passage of Arkansas Act 243 in 1987, Act 944 of 1989 and Act 961 of 1991, even greater responsibilities for the care and treatment of adults with serious and persistent mental illness were assumed by the Center. These legislative requirements include the designations of SWACMHC as one of the “points of entry” into the public mental health system; the generation of a comprehensive array of community-based support services for persons with serious mental illnesses; and the development of comprehensive treatment plans for such individuals, extending care beyond the traditional range of clinical services.

Over the years, SWACMHC has responded to the needs of its service area and to the demands for services so that a wide range of behavioral healthcare services is now available.

- **Services**

Major service components of SWACMHC include: 24-hour emergency/crisis intervention services; prevention, consultation and education services; referral to inpatient services; assessment and diagnostic services; psychosocial rehabilitation services; outpatient group and individual therapy; substance abuse services; specialized programs for children and adolescents, including school-based services and treatment foster care services; medication management and intervention services (formerly referred to as case management). Services are provided by duly licensed and/or certified staff with educational backgrounds and specialized training in nursing, social work, substance abuse, psychology, counseling, and psychiatry. Services are provided at SWACMHC-operated facilities and also at other sites as necessary and appropriate.

- **Cultural Competency and Diversity Plan**

Southwest Arkansas Counseling and Mental Health Center, Inc. is duly incorporated within the State of Arkansas as a private, not-for-profit business entity. The legal and administrative structure authorizes the Board of Directors to fully promulgate and implement all necessary and sufficient policies and procedures to allow the organization to operate efficiently and effectively. Within this authority, the Board does hereby put forth this plan for cultural diversity for Southwest Arkansas Counseling and Mental Health Center, Inc.

The Center has adopted the following Cultural Diversity Plan that identifies its intent regarding leadership, management, direct service, and support service positions.

It is the policy of the Center to establish and adhere to those human resource policies – and implement corresponding practices – that promote the recruitment, retention and professional development of a sufficient number of administrative and clinical staff who are appropriately trained and licensed, and represent the cultural and ethnic diversity of the catchment area in which the Center provides services.

The Center takes the following actions to encourage diversity:

- •Encourage employment applications from persons belonging to minority populations through advertisements in local newspapers, etc.;
- .;•Remain mindful of staff composition and the demographic and cultural composition of the population centers served by the organization in hiring new employees;
- •Actively recruit persons from minority groups to serve on the Board of Directors of the Center;
- •Ensure that all staff personnel are afforded equal opportunities for professional growth and development. The Center provides several opportunities for continuing education in cultural sensitivity through new employee orientation, in-service education, and training opportunities outside the agency and;
- •Maintain oversight of cultural issues that relate to staff and the clients and communities served by the Center through input received from the Cultural Diversity Committee."

In support of this plan, the Board of Directors has promulgated and adopted numerous policies and procedures that endorse and support these goals.

All services offered by the Agency will be provided regardless of the consumers' culture, race, age, gender, sexual orientation, spiritual beliefs, socio economic status, language, disability (physical/intellectual) or other legally defined/protected minority or special class status.

SWACMHC will employ individuals without regard to culture, race, age, gender, sexual orientation, spiritual beliefs, socio economic status, language, disability (physical/intellectual) or other legally defined/protected minority or special class status.

SWACMHC is committed to the non-discriminatory delivery of services and is an affirmative action equal opportunity employer.

The Board of Directors will represent a cross-section of the community.

The staff and Board of Directors of SWACMHC will value differences in background, perspectives, beliefs, and traditions in order to offer exemplary behavioral health services to a diverse population.

They will respond to the diversity of its stakeholders by understanding, appreciating and respecting difference and similarities in beliefs, values and practices within and between cultures.

SWACMHC will develop a modified service delivery plan to meet the needs of clients. This will be reflected in the individualized treatment plan. For example, qualified interpreters may be included on a client's treatment team.

Every effort will be made to hire individuals who are representative of the persons served. This will be accomplished by attending job fairs and advertising for qualified employees.

All employees are required to attend training and education in diversity and cultural competency and topics for such training will include, among others, holidays, dietary regulations or preferences, clothing and attitudes toward impairments.

Cultural competency and diversity training will be documented in personnel files.

One appointed employee will be responsible for presenting cultural competency and diversity issues to the Continuous Quality Improvement/Quality Assurance Committee on a quarterly basis. This employee will then be involved in planning future employee training topics.

The Cultural Competency and Diversity plan will be reviewed at least annually for relevance and updated as needed. The plan shall be included in the Annual Performance Review and Strategic Plan.

- **Corporate Compliance**

Corporate Compliance is a voluntary management program that requires that good faith legal compliance be observed by all parties. The program attempts to minimize potential exposure from non-compliance. This program imposes common sense internal disciplines and self-monitoring on medical billings and ancillary activities. From the standpoint of legal protection, a corporate compliance program is specifically endorsed by the Department of Human Services, one of the primary legal enforcement authorities for medical services.

In an effort to reaffirm the Center's longstanding commitment to comply with all laws, regulations and ethical standards applicable to our practice, the Board formally authorized a Corporate Compliance Program in April 2001. This program offers safeguards and designates a compliance officer to conduct day-to-day oversight of the legal and ethical compliance efforts.

The specifics of this program are available in the Center's Clinical Policy and Procedures Manual.

Any reports, investigations/reviews, or findings of the compliance program are considered confidential and will not be reported here. All information is presented to and reviewed by the Compliance Committee of the Board.

INPUT FROM PERSONS SERVED AND OTHER STAKEHOLDERS

SWACMHC continually focuses on the expectations of the person served, personnel and other stakeholders and actively solicits, collects, analyzes and uses input from them to create and enhance services that meet or exceed the expectations of the persons served, the community at large, and other stakeholders. Information is gathered in a variety of ways and is used for program planning, strategic planning, financial planning, and resource planning.

The Center takes pride in its efforts in recent years to establish pathways for clients to have input into the types of services provided and the methods of delivery, as well as taking note of their needs, suggestions, and satisfaction. The primary avenue for this input is built into the Center's outcomes system and involves randomly sampling twice yearly all clients who attend services during a discrete period of time. These surveys provide a measure of effectiveness, access, efficiency and client satisfaction, as well as asking the client for input regarding needed services, suggestions and offers of personal follow-up phone calls if they wish.

The client government continues to be an active and important source of input for persons served in the Community Integration Program. A client council is located at each Community Integration Program location. These groups meet regularly, with support from Center staff as needed. Information is provided to the Board of Directors, and the CQI/QA Committee for review and action, as appropriate. This information is used in program planning for community-based rehabilitation programs and has resulted in the formation of new group therapies for this population and increased opportunities for social skills rehabilitation. In addition, staffing patterns have changed, in part, due to the input from the client councils. At times, Center staff have advocated for its clients with other agencies or facilities as a result of client council reports.

In response to many clients indicating they are unable to afford services and/or their medications, the Center continues to utilize a sliding scale when establishing financial liability for services. A client's therapist can request a further reduction in fees if clinically indicated.

The Center's clients have continued to benefit from funding supporting the provision of inpatient psychiatric services to indigent clients, commonly referred to as "Local Acute Care." Center management has continued to work closely with the Mental Health Council of Arkansas and state legislators to maintain and enhance funding for these services.

The Center has continuously sought input through multiple avenues, including the Community Needs Assessment Survey and through staff involvement in community activities and community service organizations. The Center's staff maintains a high level of involvement in all communities it serves. Members of the Center's Board of Directors, as representatives from their respective communities, provide input through their interaction with fellow community members and their subsequent activity on the Board. Periodically, the Center hosts events for local elected officials to educate them regarding mental health issues and to advocate for their support for interventions that help those in need. Board members provide what is, perhaps, the best insight into their communities and their needs. Each year, the Center sends out surveys to stakeholders within its catchment area in order to assess satisfaction with services and community mental health needs.

LEGAL REQUIREMENTS

Southwest Arkansas Counseling and Mental Health Center, Inc. has a longstanding commitment to comply with all laws, regulations and ethical standards applicable to our practice. Specifically, the Center complies with all legal and regulatory requirements in the following areas:

- Rights of the persons served
- Confidentiality requirements
- Reporting requirements
- Contractual requirements
- Licensing requirements
- Corporate status
- Employment practices
- Mandatory employee testing
- Privacy of persons served
- Debt covenants
- All other areas, as applicable

SWACMHC is designated by the Division of Aging and Adult Behavioral Health Services (DAABHS) as a Community Mental Health Center and as such, must comply with the State Standards for Community Mental Health Centers as promulgated by the DBHS. SWACMHC is also licensed by the DAABHS as a provider of residential and outpatient substance abuse services and, as such, must comply with the Licensure Standards and Rules of Practice and Procedures as developed by that office. In addition, SWACMHC has selected programs nationally accredited by CARF, and must conform to those national standards as well.

In addition to these specifically prescribed standards, the Center is subject to random reviews/audits by Medicaid, Division of Aging and Adult Behavioral Health Services, Arkansas Highway and Transportation Department, the Division of Children and Family Services, the Child Welfare Licensing Board, AMFC, Division of Provider Services and Quality Assurance, the Internal Revenue Service and the Division of Administrative Services.

In order to maintain all the systems necessary to comply with these laws and regulations, the Board has developed policies and procedures to support the Center's ongoing commitment to meeting legal requirements.

FINANCIAL PLANNING AND MANAGEMENT

Southwest Arkansas Counseling and Mental Health Center, Inc. strives to be financially responsible and solvent, conducting fiscal management in a manner that supports the Center's mission, values, and annual performance objectives. SWACMHC's fiscal practices adhere to established accounting principles and business practices. The financial policies and procedures cover daily operational cost management and plans for long-term solvency.

A budget is prepared on an annual basis and approved by the Board of Directors. A financial report is presented at each Board Meeting to the Board for their ongoing review. The financial report includes a Statement of Financial Position and Income and Expense reports for the Center as a whole and for major treatment programs. This internal review also addresses:

- Current financial status

- Financial trends
- Financial challenges
- Financial opportunities
- Business trends
- Management information

In addition to this ongoing review, SWACMHC has established policies and procedures guiding the financial practices of the organization. The Center conducts ongoing reviews of services to ensure proper billing that coincides with services provided. Also, an annual audit is conducted by an external accounting firm. The formal report from this audit is presented to the Board of Directors and copies are provided to the Arkansas Department of Human Services, Division of Behavioral Health Services, Division of Youth Services and the Arkansas Division of Legislative Audit.

The financial condition of the Center continued a pattern of decline throughout Fiscal Year 2019. The Center continues to operate with little or no financial margin and saw a decrease in the number of services approved by Medicaid.

The Center's plans for addressing the challenges with regard to Financial Planning and Management for FY 2020 include the continuation of the efforts delineated above. In addition, the Center will evaluate: the program staffing needs in all programs on an ongoing basis; continue efforts to enhance fee collections and; increase efforts to obtain grants and/or establish a foundation. These efforts will involve ongoing meetings to analyze the Center's current status and to take further measures if necessary.

In addition, the administration is intent on expanding services and exploring new opportunities to provide a broader treatment array to the clients served. The financial impact of expanding offered services will assist in the financial planning process as additional revenues should be realized.

RISK MANAGEMENT ASSESSMENT

Background: Pursuant to the Center's Risk Management Policy and Procedure, Center management has produced this annual document as a way to (1) identify any loss exposures, (2) analyze and evaluate any loss exposures, (3) identify a strategy (including techniques and/or actions) to be taken to counter any potential losses or identified exposures, (4) implement the most effective strategy/plan to reduce risk for the organization, (5) provide ongoing monitoring of any actions taken to reduce risk, (6) reporting results of actions taken to reduce risks and (7) include the results of risk reduction activities in performance improvement activities.

Current Assessment: This document and the Center's response to the following questions provides documentation of the Center's current Risk Management Assessment conducted in preparation for and as a part of the Fiscal Year 2021-22 budget and strategic plan development.

Assessment Findings:

1. Does the organization anticipate significant changes in the types of patients that the organization currently serves?

The Center will be working on establishing and implementing a Medication Assisted Treatment (MAT) program for person addicted so opioids. This will be a significant change in that prescribers shall maintain special credentials and clinicians will follow special treatment protocols. A mental health professional with prior experienced in a MAT program has been hired.

2. Does it appear that the organization's inventory and accountability system for office equipment, computers and other "high value" items is sufficient to protect against loss, theft, or inappropriate use? If "no", identify a course of corrective action.

   The Center has a policy of completing an inventory of all technology equipment annually. In addition, the Center has a checkout system for high value items such as projectors and laptops. This inventory was not kept current by the past support technician last year, however, has been completed for the current fiscal year and a new support technician has been hired and is back under the supervision of the Chief Information Officer in order to help ensure the Center's compliance to its own policies and procedures.

3. Do the organization's physical plants provide reasonable security for patients and staff members? If "no" identify improvements and/or changes needed to rectify the problem.

   The organization provides reasonable security measures at all Center clinical sites. Those measures have included an installation of intrusion alarms in the Texarkana office and Jefferson House facility, restricting access to side or back door to employees only, ensuring that more than one employee is within sound and/or sight for patients at risk of dangerous behavior, improving staff communication capabilities within more intensive treatment programs. Identification badges are worn by each employee while on duty and are required to attend Violence in the Workplace training on an annual basis.

   The Center continues to explore options concerning the restriction of public access to the main hallways in the Texarkana clinic. It is also considering the purchase of security cameras for use in some of its smaller clinics.

4. Has the organization conducted an accessibility evaluation at all program locations to identify all barriers to accessibility and developed a plan for elimination of all identified barriers? If "no", list the projected date for the completion of the accessibility evaluation.

   The accessibility evaluation and plan to address elimination of all barriers is completed annually and is incorporated into the Strategic Plan and Performance Review.

5. Does the organization's, health and safety program appear effective in identifying possible risks and hazards? If "no", list all problem areas and a plan of corrective action.

   The Center's health and safety program appears to be effective in identifying possible risks and hazards. The Center voluntarily entered into an agreement with the Arkansas State Department of Labor concerning Occupational Safety and Health Administration (OSHA) standards for workplace safety in 2005. The Center continues to promote a safe and healthy environment at all locations for persons served, staff, and visitors. The Accessibility, Health,

Safety & Transportation (AHST) Chairperson and/or one AHST committee member attends an OSHA training semi-annually.

The Accessibility, Health, Safety and Transportation committee monitors incident and injury reports, as well as, near misses, in order to provide feedback and recommendations to staff members for improved work place safety on a regular basis.

The AHST committee has not met regularly over the past year and has had problem identifying an employee at each facility who serves on the committee. As part of corrective action, the AHST chairperson is now to report to the Director of Quality Assurance.

6. Does the organization have an adequate oversight system in place to minimize the risk of misappropriation of funds? If "no", what plans does the organization have to address that situation?

The Center's oversight of funds, internal controls over organizational assets and corporate integrity system appear to be adequate. The independent auditors of the Center's finances annually review and, if necessary, recommend improvements in the cash and internal controls systems.

The Corporate compliance program also includes attestations from all employees concerning all Center assets. The Center's insurance package includes some coverage for misappropriation of funds as well as an addition of cybersecurity insurance coverage.

7. Does the organization's corporate compliance program appear to be effective in preventing fraud, waste and abuse? If "no", what changes need to be made?

The Center's Corporate Compliance program appears to be effective in preventing fraud, waste and abuse. The program is comprehensive and has resulted in a number of reviews of practices and procedures of Center operations. The Corporate Compliance Officer reports directly to the Board of Directors on a monthly basis and has access to the Board as needed. The corporate compliance officer receives ongoing training and presents recommended policy and procedure changes and internal audit reports directly to the Board. In addition, effective for the audits performed for the years ending after July 1, 2008, new internal control and integrity standards, required by the Financial Accounting Standard Board's Statement of Standards 112 have been applied by the external auditor to Center operations.

8. Does it appear that the organization will face increased business competition in the next 18 months? If "yes", provide an estimate as to how that competition could affect the organization's revenue generation efforts and client base.

The Center can expect increased business competition as more independently licensed professionals have become eligible to bill Medicaid. In response, the Center has focused on improving access to services and on providing more supportive services beyond medications and individual therapy in order to maintain revenue generation and a client base.

9. Does it appear that the organization has sufficient insurance coverage to protect the organization's assets and protect the organization's personnel in the event of a lawsuit? If "no", describe any shortfalls in insurance coverage that need to be addressed.

   Based upon the Center's experience, frequent reviews of policy limits and the scope of coverage provided, advice and consultation from multiple insurance brokers, and an analysis of potential risks provided by an independent insurance representative, the coverage appears to be sufficient.

10. Are the organization's emergency plans and procedures adequate to provide for the health and safety of persons served, personnel and visitors to the organization in the event of actual emergencies? If "no", please describe any changes that need to be made.

    The organization has emergency plans and written procedures which are adequate to promote the health and safety of persons served, personnel and visitors to the organization in the event of emergencies, especially those requiring evacuation. Frequent drills are facilitated at each Center site by an AHST member for a wide variety of potential threats or emergencies. Staff, persons served and visitors are included in the drills, as well. Drills are performed on all shifts and are reviewed by the AHST committee. If problems occur, they are addressed at the end of the practice drill. Each location has an emergency procedures book to be used as a reference in case of an emergency. The Center will formally adopt State regulations concerning emergency procedures and continuation of services in case of an emergency.

11. Describe the organization's most significant challenge in the next 18 months; include an assessment of how that challenge will impact the organization and more critically, how the organization will meet that challenge.

    The Center did not experience a deficit in the 2019-2020 fiscal year however, anticipated a large deficit for the next fiscal year unless further cuts in the budget were made. At the beginning of fiscal year 2020-21, the board of directors relieved the Executive Director of his position and promoted the Clinical Director into the position. The Clinical Director was tasked with the responsibility of presenting a balance budget for the fiscal year. This was accomplished and, at the time of this review, it would appear that the Center will end FY20-21 with a small profit.

    The State's Provider Led Arkansas Shared Savings Entities (PASSE's) continue to decrease the number of services available to some of the Center's most vulnerable clients. In addition the PASSE's no longer provide retroactive authorizations. Employees have been advised to not provide services until authorizations are received.

12. Are the organization's policies and procedures regarding business associates, business agreements and confidentiality of client information consistent with federal and state laws and more specifically, the Health Insurance Portability and Accountability Act (HIPAA)? If "no", describe the organization's plans for insuring conformance with HIPAA and the projected date for conformance.

The Center believes that its policies and procedures related to HIPPA are consistent with applicable federal and state statutes, regulations and administrative directives. Policies and procedures are consistently reviewed and updated in accordance with these requirements. Staff training regarding Confidentiality and Security is provided upon hire and on an annual basis.

The Center's policies and procedures are in compliance with the HIPAA/HITECH Omnibus Final Rule of 2013 and have been expanded to meet the requirements of the Office of the National Coordinator for Health Information Technology (ONC). Staff and Business Associates are advised of their responsibilities under these provisions. All employees receive training upon hire and on an annual basis and at more frequent intervals as needed. Employees also receive training material and periodic updates throughout the year. As a requirement of the Final Rule, in 2013 business associate agreements were updated, and business associates were required to enter into new agreements. The Notice of Privacy Practices was updated and patients were informed that their rights may have changed and how information about them may be used or disclosed.

The Center continues internal auditing as part of its HIPAA Compliance Program to assure conformity with applicable laws.

13. Does the organization have sufficient hardware, software, peripherals and other technology to accomplish its mission and provide quality care? If "no", describe any purchases/acquisitions that need to be made and the projected timeline for acquiring the technology necessary to support persons served.

    The Center's Chief Information Officer completed a needs assessment and risk analysis which is contained in the technology plan. It is noted that each employee is polled concerning technological needs. During the past year, in response to the COVID pandemic, the Center invested in telehealth equipment for the provision of services. For the coming fiscal year, the Center will focus on installing functioning signature pads for all appropriate end users. It will also focus on purchasing software to be used to remotely manage personal computers on the network.

14. Do any of the organization's policies and procedures have the potential to put the organization at risk and/or subject the organization to legal liability? If "yes", identify the policies and any changes/revisions that need to be made and the timeline for making the changes.

    The Center's policies and procedures are reviewed annually and revised as necessary. In response to last year's risk assessment, the Center has formally adopted a substance use policy for its employees.

HEALTH AND SAFETY

It is the policy of SWACMHC to provide a safe and healthy environment at all locations for persons served, staff, and visitors. This policy is based on the premise that minimizing health and life-threatening hazards within the agency can lessen the possibility of accidental injuries or illnesses to persons served, staff, and visitors and can produce other benefits such as reduced expenditures,

increased accountability and efficiency, and facilitating compliance with external requirements for organizational health and safety promulgated by federal, state, and local authorities.

To this end, SWACMHC has developed and implemented a set of policies and procedures guiding the health and safety efforts that conform to CARF accreditation standards and OSHA regulations. Specifically, these policies, procedures, and plans delineate the organization's timeframe for conducting internal and external inspections and any resulting reports/corrective action plans. There are also written emergency plans that address the following:

- Fires
- Bomb threats
- Natural disasters – earthquakes and tornados
- Utility failures
- Medical emergencies
- Other violent or threatening situations – robbery or burglary
- Transportation – defensive driving, driving in adverse weather conditions, transporting consumers in private vehicles, and for van drivers – emergency procedures for accidents, violence or disruptive behaviors, mechanical/roadside emergencies, and medical emergencies; and a system to check driving record/history

The written plans for all of the above listed items are located in the Clinical Policy and Procedure Manual and will not be listed here. Emergency procedures are located in all agency-owned vehicles.

The written plans for all of the above listed items are located in the Policy and Procedure Manual and will not be listed here.

Responsibility for health and safety has been assigned to a senior staff member who serves as the chair of the Accessibility, Health, Safety and Transportation Committee. Minutes of team meetings are kept and reports are made to the CQI/QA Committee.

Critical incidents are reported to the Accessibility, Health, Safety & Transportation Committee (AHST Committee) through the use of critical incident reports. Critical incidents are defined as incidents that are undesired, unplanned and result in injury or damage to property or the possibility of such injury or damage. Examples of critical incidents include therapeutic holds, injury to staff/client due to equipment, machinery or vehicles, possible exposure to communicable diseases, possible issues of infection control, violence or aggression, possession/use of weapons, elopement and/or wandering by clients that may lead to hazard/injury, transportation issues such as accidents, the presence of error in handling bio-hazardous materials, the possession/use of drugs or other substances, allegations of abuse, neglect and exploitation, deaths of staff or clients that include child abuse, adult abuse or elder abuse that occur within Center facilities and other sentinel events. "Near miss" events are also considered. Critical incident reporting includes the following elements: date, type & time of the incident, location where incident occurred, persons directly involved (staff, clients, visitors), witnesses to the incident (staff, clients, visitors), injuries and/or damage involved, immediate action taken (e.g. emergency care), a description of the incident (narrative), outcome of the incident, additional comments, date incident report is completed and signature(s) of person(s) completing the incident report and supervisors' signature(s).

Incidents that involve clients who receive substance abuse treatment services are reported by the Center's usual procedure, as determined by the AHST Committee. These incidents are also reported to the Division of Aging Adults and Behavioral Health Services.

The AHST Committee performs an annual review of incidents identifying causes, trends, recommended actions for improvement, results of improvement efforts, personal education and training needs, prevention and a review of internal/external reporting requirements. The Committee looks for patterns in incidents, possible causes and trends, reviews documentation of debriefing following the incidents, and evaluates action plans to determine their effectiveness at reducing risks that are reported. Once this is completed, the information is reported to the CQI/QA Committee, The Executive Director and the Program Director where the incident occurred. By disseminating the information in regard to possible trends in various incidents, the Committee hopes to make staff and clients more aware of potential difficulties, and to avert any incidents that might occur, in addition to improving our ability to handle incidents that transpired.

Discussion

Fall by Client continues to rank as the most frequent critical incident report received (including all sites) at 26.6%. The majority of falls by clients occurred at the Horizons of Hope Residential Care Facility. The previous pattern reported in the AHST annual report found similar results. Additionally, the majority of these incident happen on the weekend shift at Horizons of Hope.

As expected, the incidence of Communicable Disease Exposure (CDE) has spiked. This is a direct result of the ongoing COVID-19 pandemic. All CDE CIR's were COVID exposures. CDE made up only 4.31% of total CIR's at the time the last AHST annual report was submitted (October 12, 2020).

Current Concerns

Current concerns at this time include the following:

- Medication errors and falls by staff at River Ridge
- Theft of catalytic converters from company transport vans
- Ongoing COVID-19 Pandemic and resulting company/community/national response

ACCESSIBILITY ASSESSMENT AND PLAN

SWACMHC commits to promoting accessibility and removing barriers to service for persons served, staff members and other stakeholders. Leadership accomplishes this in several ways: 1) by awareness of and having a working knowledge of what needs to be done to promote an accessible setting; 2) by creating and implementing corrective action plans to address and remove barriers (when appropriate), and; 3) by reasonably accommodating all stakeholders so that services may be provided in a manner of dignity and respect; when accommodation is not possible, by actively advocating for the persons served. To this end, SWACMHC has developed the following written accessibility plan.

Texarkana, Jefferson House, Hope, De Queen & Nashville, Lewisville and Ashdown Outpatient Clinics

- **Architectural/Physical:** Although the Nashville outpatient clinic was located in a building which was wheelchair accessible, it lacked a wheelchair ramp close to the entrance door of the

clinic. The Center worked with the landlord and had a wheelchair ramp installed close to the clinic's entrance in order to enhance accessibility. There are no other architectural/physical barriers or issues identified for the Texarkana, Jefferson House, Hope, De Queen and Nashville Outpatient Clinics.

- **Attitudinal/Psychological:** There are no known barriers to access. Anyone who requests services is seen by a mental health professional, or appropriately referred to another agency or service provider. Walk-in emergency services are offered to anyone who feels that he/she cannot wait until a regular intake appointment is available. Attitudinal barriers, if present, are addressed through public education efforts and collaboration with the state and local National Association for the Mentally Ill (NAMI) groups, local interest groups and the Arkansas Mental Health Awareness Coalition.
- **Employment/Social:** All referrals are accepted, without regard to age, gender, sexual preference, social preferences, cultural orientation, psychological characteristics, physical situation or spiritual beliefs. Asian and Hispanic populations are growing throughout the area served, adding to an already large minority population. As a result, interpreters are used when needed (including interpreters for the hearing impaired). Bilingual individuals are encouraged to apply for staff positions. Staff is encouraged to learn appropriate foreign languages through coursework or video/audio study. Diversity within the staffing pattern is also encouraged, to facilitate a balance of age, gender, sexual preference, social preferences, cultural orientation, psychological characteristics, physical situation and spiritual beliefs, within the composition of Center staff.
- **Environmental**: Consistent with the above section on "attitudinal/psychological" barriers, the Center does not appear to have any environmental barriers that might impede access to services. All buildings at all locations are of a one-story construction. There are various ramps to afford easy accessibility in addition to adequate external lighting.
- **Financial:** Consistent with all Center facilities, access to services is based on ability to pay. Various third party reimbursement services are available. When resources are available, a large number of "non-reimbursable" services are extended to clients. Arrangements for fee adjustments are available as needed.
- **Communication**: As noted in previous paragraphs, the cultural diversity of the area that the Center serves has continually changed over time. Efforts are made to obtain appropriate interpretive services for clients. This includes interpretive arrangements for the hearing impaired in our population. Staff members are encouraged to learn some of the more prevalent languages present in our catchment area population, in addition to encouraging the hiring of bilingual individuals for staff positions available. Information about available services through the Center is accomplished through our Center website, a Center brochure, various client handbooks, public speaking engagements, and informal information disseminated by various staff members through word of mouth. Selected center brochures and forms are translated into other languages when needed. Client outcomes data is posted in the waiting rooms.
- **Transportation**: The Center provides transportation for individuals in its community-based rehabilitation program and attempts to obtain other means of transportation for individuals in various other Center programs, through the local public transportation system, in addition to third party transportation when available. Case managers at the Center provide individual transportation to clients with whom they are working on a regular basis. Access to other agencies' modes of transportation are investigated and obtained when available and appropriate.

- **Other Barriers Identified by Persons Served, Staff and Other Stakeholders:** No other barriers have been identified in the current fiscal year. Barriers identified by persons served, staff or other stakeholders are addressed as they are reported.

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River Ridge Residential Treatment Center

- **Architectural/Physical**: The River Ridge Treatment Center is located in a one-story building. The building is easily accessible. There are adequate exits and outside lighting. There are no known barriers to access at the front or side entrances. There is handicapped access at the side entrance. There is a steep hill leading up to the facility, but it is easily accessible by automobile. The markings for the handicapped accessible parking are clearly painted and visible. There are no handrails at the front entrance. When the facility was purchased, there were wooden decorative timbers in place on either side of the entry. Those have since rotted and were removed. There are no steps; there is one rise of 5 inches. The AHST Committee has not recommended replacement of the rails referenced above.
- **Attitudinal/Psychological**: There are no known barriers to access. Referrals are taken directly from all Center service sites, in addition to other community agencies. Individuals seeking access to services are seen by substance abuse treatment professionals, and are assessed for appropriateness of services. Referrals are made to other agencies when appropriate. There may be a waiting list for admission to the program, due to a limited number of beds in the facility. Clients needing more immediate attention are seen by one of the substance abuse treatment professionals located at Center outpatient facilities. Attitudinal barriers, if present, are addressed through public education efforts, in collaboration with state and local support, as well as interest groups that are involved with substance abuse issues.
- **Employment/Social:** Referrals are accepted without regard to age, gender, sexual preference, social preferences, cultural orientation, psychological characteristics, physical situation or spiritual beliefs. Various ethnic groups are growing in the area. Interpreters are used when needed including interpreters for the hearing impaired. Bilingual individuals are encouraged to apply for staff positions. Staff is encouraged to learn appropriate foreign languages through coursework or audio/visual study. Diversity within the staffing pattern is also encouraged to facilitate a balance of age, gender, sexual preference, social preferences, cultural orientation, psychological characteristics, physical situation and spiritual beliefs, within the composition of the Center staff.
- **Environmental**: River Ridge is a single-story facility located near a residential area. River Ridge does not appear to have any environmental barriers that might impede access to services. There are ramps available to afford easy accessibility, and the facility has adequate external lighting. The only environmental hazard is a state highway that is on the western boundary of the Center. However, there is a significant amount of property between the front entrance of the Center and the state highway that offers an adequate buffer zone. There is a small pond behind the Center, but it does not present a significant environmental problem. No environmental barriers are noted.
- **Financial:** Potential clients are responsible for an initial assessment fee prior to entering services. Various third-party reimbursement services are available.
- **Communication**: As noted in previous paragraphs, the cultural diversity of the area that the Center serves has continually changed over time. Efforts are made to obtain appropriate interpretive services for clients. This includes interpretive arrangements for the hearing impaired in our population. Staff members are encouraged to learn some of the more

prevalent languages present in our catchment area population, in addition to encouraging the hiring of bilingual individuals for staff positions available. Information about available services through the Center is accomplished through our Center website, a Center brochure, various client handbooks, public speaking engagements, and informal information disseminated by various staff members through word of mouth. Selected center brochures and forms are translated into other languages as needed.

- **Transportation:** River Ridge provides transportation for residential clients, and attempts to obtain other means of transportation for individuals in various other Center programs, through the local public transportation system, in addition to third party transportation when available. Access to other agencies' modes of transportation is investigated and obtained when appropriate. A center van is available for client transportation.

- **Other Barriers Identified by Persons Served, Staff and Other Stakeholders:** No other barriers have been identified in the current fiscal year. Barriers identified by persons served, staff or other stakeholders are

Horizons of Hope Outpatient Clinic

- **Architectural/Physical:** Horizons of Hope is located in a former nursing home in a residential area of Hope, Arkansas. The structure is one story in design. The facility is a sixty-bed unit, completely housed under one roof. The campus offers private areas for recreation, away from the community. Physical access presents no difficulty. Exterior lighting is adequate. Handicap-accessible parking spaces are available and clearly marked.
- **Attitudinal/Psychological:** There are no known barriers to access. Referrals are taken directly from other Center facilities and other statewide and local agencies, as well as individuals and families. Anyone who requests services is seen by a mental health professional and/or referred to another agency, if services are not deemed appropriate. There may be a waiting list for the residential services that are offered by the owner of the facility. However, Center services are offered to clients on an ongoing basis, whether or not they are residents of the facility. Attitudinal barriers, if present, are addressed through public education efforts, in collaboration with state and local NAMI groups, local interest groups and the Arkansas Mental Health Awareness Coalition.
- **Employment/Social:** Referrals are accepted without regard to age, gender, sexual preference, social preferences, cultural orientation, psychological characteristics, physical situation or spiritual beliefs. Various ethnic groups are growing in the area. Interpreters are used when needed (including interpreters for the hearing impaired). Bilingual individuals are encouraged to apply for staff positions. Staff is encouraged to learn appropriate foreign languages through coursework or audio/visual study. Diversity within the staffing pattern is also encouraged to facilitate a balance of age, gender, sexual preference, social preferences, cultural orientation, psychological characteristics, physical situation and spiritual beliefs, within the composition of the Center staff.
- **Environmental**: Horizons of Hope is located within a renovated nursing home facility and is bounded on three sides by city streets and on one side by a local homeowner. The structure is one story. Access is readily available to the building. A privacy fence encloses the entire campus, separating residents from a busy traffic area. There is adequate outside lighting, as well as two accessible gates for safety purposes. There are no known environmental hazards.
- **Financial:** Services are funded by third party reimbursement. A client must have an acceptable pay source prior to admission, and/or have a readily accessible pay source soon

after admission. Staff members pursue alternative reimbursement sources for potential clients who do not have an appropriate reimbursement plan in place.

- **Communication**: As noted in previous paragraphs, the cultural diversity of the area that Horizons of Hope serves has continually changed over time. Efforts are made to obtain appropriate interpretive services for clients. This includes interpretive arrangements for the hearing impaired in our population. Staff members are encouraged to learn some of the more prevalent languages present in our catchment area population, in addition to encouraging the hiring of bilingual individuals for staff positions available. Information about available services through the Center is accomplished through our Center website, a Center brochure, various client handbooks, public speaking engagements, and informal information disseminated by various staff members through word of mouth. Selected center brochures and forms are translated into other languages as needed.
- **Transportation:** Horizons staff provides transportation for individuals in its community-based rehabilitation program, and attempt to obtain other means of transportation for individuals in various other Center programs, through the local public transportation system, in addition to third party transportation when available. In addition, various case managers do provide individual transportation to clients with whom they are working on a regular basis. Access to other agencies' modes of transportation are investigated and obtained when appropriate.
- **Other Barriers Identified by Persons Served, Staff and Other Stakeholders:** No other barriers have been identified in the current fiscal year. Barriers identified by persons served, staff or other stakeholders are addressed as they are reported.

Split Rail Outpatient Clinic (The outpatient clinic was closed as of June 30, 2021 due to the fact that the clinic had been collocated with a residential care facility and the owner has now closed the facility.)

HUMAN RESOURCES

SWACMHC recognizes that employing and maintaining a professional, productive staff is vital to the successful implementation of the mission and goals of the organization. The Center has developed policies and procedures to guide this process, and management and administrative staff review staffing patterns in each program on a regular basis to ensure that an adequate number of qualified individuals (reflective of the community) are available to meet the needs of the persons served, provide for the safety of the staff and persons served, and meet the performance expectations of the Center.

All staff members are provided with current and complete job descriptions, and this is reviewed annually as part of the performance review process. SWACMHC verifies credentials by a process of primary source verification. Students and volunteers are provided orientation and enter into appropriate agreements regarding confidentiality and Center policies and procedures.

All policies and procedures guiding this process are located in the Policy & Procedure Manual and which is made available to all staff on the Center's computer network.

It is Center Policy that available jobs are posted at all sites, thereby notifying all Center staff of opportunities for advancement.

Areas of improvement identified for Human Resources during FY 2022 will be as follows:

1.) Update employee handbook to provide a useful source of information to employees about the Center's policies and procedures;
2.) Develop personnel record retention schedule;
3.) Complete a review and revise the job descriptions for all personnel as necessary;
4.) Provide input to Continuous Quality Improvement/Quality Assurance Committee regarding workforce need and development and;
5.) Continue full implementation of payroll software.
6.) Streamline onboarding process

TECHNOLOGY AND SYSTEM PLAN FY 2022

The Southwest Arkansas Counseling & Mental Health Center, Inc. has a sophisticated information infrastructure supported by an in-house Chief Information Officer, Technical Support Specialist and a contractual information management service. The organization feels that it sufficiently meets state and federal technology requirements and those of its accrediting agencies in regards to privacy, security, confidentiality and risk management.

Compliance and Accountability:

The organization continues to enhance compliance efforts with government laws and regulations, such as the Deficit Reduction and False Claims Act, Health Insurance Portability and Accountability Act (HIPAA), the American Recovery and Reinvestment Act, the Health Information Technology for Economic and Clinical Health (HITECH) Act Omnibus Rule, as well as 42 CFR Part 2, the laws governing the Confidentiality of Alcohol and Substance Abuse records. The requirements of managed behavioral healthcare organizations like APS Healthcare, Beacon Health, Outcomes Based Healthcare (OBH) and others continue to be on the forefront of the organization's compliance efforts. NPI numbers continue to be obtained on a routine basis in accordance with the National Provider Identifier Standard and the NPI rule.

The organization's electronic billing system interface is updated at least quarterly by the Credible Behavioral Healthcare software, acquired in 2012 to support the agency's electronic medical records needs, and continues to meet the guidelines for Electronic Transactions and Code Sets and Electronic Data Interchange (EDI). Credible employs a group of software developers, product managers and quality assurance analysts focused on resolving software related and process issues, as well as the continuous development of enhancements and updates. Credible continues to produce and deploy innovative enhancements to their products and services on a quarterly and as needed basis and offer many new premium features on a per contract basis.

The organization continues a best practices approach to educating its workforce and business associates with regards to ethics, privacy and security, HIPAA rules and regulations, CFR 42 Part II and the prevention of health care fraud. These educational opportunities are available by the ongoing development of policies, procedures and other materials, as well as web-based and classroom training. The workforce receives HIPAA privacy, security and confidentiality alerts via email notification on an ongoing basis. Security alerts have been upgraded to include the avoidance of spam, phishing and other cybersecurity attacks.

Internal monitoring and audit controls for HIPAA compliance have proven to be very effective since implementation in 2005 and continue to be upgraded as technology changes. Audit reporting mechanisms are designed to reveal improvements and/or deficits in performance and to assist management in determining when stronger internal controls are needed. Audit results continue to

provide a means to maintain acceptable compliance levels as well as identify areas that may require further education and/or corrective action planning. Staff is encouraged to report any known, suspected, or potential breaches in privacy, security, fraud, waste and abuse by utilizing the organization's HIPAA Incident Reporting mechanism. Whistle-blower policies are in effect and staff is assured of no retaliation, harassment or termination for reporting such concerns.

Risk Management:

The organization has implemented numerous methods to identify potential risks and establish ways to reduce and/or eliminate them. In doing so, a multi-layer security system is in place to manage the risks associated with day-to-day business operations which include an electronic medical records system, complete financial reporting and employee-to-employee communications.

Policies and procedures are in place to govern the access and use of protected health information. Employee identification and validation is required in order for anyone to gain access to information over the agency's network. This process is defined in the HIPAA Policies and Procedures Manual. The degree of access to protected health information (PHI) is electronically managed according to employee work assignments and job responsibilities. User identification codes and passwords on a multi-level platform are also utilized and managed by the Information Technology (IT) department. In the event of voluntary or involuntary termination or suspension, access to the technology infrastructure is restricted and/or terminated. Security logs are reviewed periodically to identify any risk exposure.

Paper records are secured in restricted areas behind locked doors, in locked file cabinets, or both. All paper records are signed in and out of the medical records area. Access to these records is further restricted by the designation of a records custodian with the responsibility for maintaining and securing the records each day. Policies on record retention and destruction are in place that identify procedures for securing records in the event of a legal investigation and that comply with applicable state and federal laws.

The organization continues to adhere to a Facility Security Plan that covers the Security Requirements of the Health Insurance Portability and Accountability Act (HIPAA) expanded to include a security risk assessment meeting the criteria of the Office of the National Coordinator for Health Information Technology (ONC) guidelines. The Security Management Process is described and policies and procedures are in place that address contingency operations, security, access control and validation procedures according to CFR 164.310 (a) (1) 45.

Risk analysis is conducted on an on-going basis and potential threats and vulnerabilities, including but not limited to, loss of business and productivity due to damage to computer systems, and the theft of property are measured. An organizational HIPAA Risk Assessment as well as individual Clinic Site Assessments is performed annually. The organization includes email, Internet and cybersecurity among its risk analysis and management activities. Multiple levels of antivirus, malware and security filters are in effect by the utilization of hardware and software deployments at the infrastructure, server, clinic and workstation levels. An antivirus host server that sends antivirus updates to client workstations is also utilized. Firewall management is maintained by group policies established at the infrastructure level and an email security gateway is also in effect. Windows software updates are managed and deployed through the use of a Windows Update Server on a scheduled and consistent basis.

At a minimum level of protection, policies on Internet and email usage as well as user log in procedures for all computers, workstations and servers are in effect and are monitored on a regular basis. To further protect the security and confidentiality of the clients, the organization does not email or publish client protected health information on the Internet in an unencrypted or identifiable format and a texting policy is also in effect.

The organization has taken proactive steps to further protect its resources and deter cyberattacks by securing cyber risk insurance due to the increase in ransomware and computer viruses worldwide. Property insurance and other coverage is evaluated annually as part of the organization's risk management program.

Disposal and Special Handling of Hazardous Equipment and Products

The organization advocates for proper disposal of hazardous equipment and products. All technology equipment requiring repair or destined for disposal is routed to the Information Technology (IT) Department. Sensitive data is removed from the hard drives of equipment targeted for disposal. If hard drives are no longer accessible, the drives are removed and destroyed. The organization utilizes local vendors for the proper handling, recycling and disposal of hazardous hardware components. Vendors are required to enter into a Business Associate Agreement and to guarantee the removal of any remaining data.

Manufacturer trade in programs are utilized to defray the costs of upgrades to major systems and to responsibly dispose of outdated equipment. The organization may consider donating technology equipment to charitable organizations and schools.

The Information Technology Department ensures that retired equipment is removed from inventory. Any equipment no longer in use is tagged for disposal. Disposal occurs on an as needed basis to prevent discarded equipment from creating a potential safety hazard. Photocopier Toner cartridges are disposed of by placing them in plastic bags that are securely sealed to avoid exposure to loose toner powder that could cause skin irritation, respiratory conditions and other health concerns. Photocopier and printer hard drives are removed and destroyed by the Information Technology Department when these devices are retired from service or the product vendor will remove the drives, which could contain embedded images of PHI, and provide a certificate of destruction to the organization.

Document Retention and Destruction Policy

The organization's document retention policy for financial and employee records is ten years. Records may be retained for longer periods at the discretion of state and federal laws or Senior Management. Active records are maintained primarily in electronic format; however, some paper records do exist.

The organization maintains a "no destruction policy" for client medical records, even though the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Administrative Simplification Rule only requires a covered entity, such as ourselves, to retain required documentation for six years from the date of its creation or the date when it was last in effect, whichever is later 45 CFR 164.316(b)(2).

All records are retained in a secure environment that assures administrative, technical and physical safeguards as required by the HIPAA Privacy Rule to protect the privacy of medical records and other protected health information (PHI).

The organization implements reasonable safeguards to limit incidental exposure and prohibit unauthorized use and disclosure of PHI, including records targeted for disposal. Hard copy or paper records are shredded prior to disposal. The disposal of paper records may be contracted out to a commercial incineration service for the mass destruction and disposal of records no longer meeting the criteria for retention. A certificate of destruction is required from all incineration services. Electronic copies of all incinerated and shredded medical records are continuously maintained.

Technology:

The Chief Information Officer and Senior Management meet as needed to assess the status of Information Technology (IT) projects and plan for new requirements. Upgrades as well as changes and additions to the information technology structure are planned and implemented in phases unless business demands require changes be made without delay.

The organization's wide area network spans more than six counties and a number of offices. The network is protected by a minimum 256-bit encryption standard and follows a client/server approach. Network devices authenticate users, encrypt data and otherwise manage sessions.

The organization deploys a Client Portal that provides clients an opportunity to gain access to their health information, request prescription refills, schedule appointments and communicate with their health care providers electronically from their home computer or cellular phone. Clients are also provided with appointment and preventive care reminders via email and text messaging via a secure connection through the agency's EHR system. Additionally, the organization would like to pursue further technology grant funding to make public access workstations available to clients at various clinic locations.

Telemedicine Services

Southwest Arkansas Counseling & Mental Health Center, Inc. recognizes the value of telemedicine and the way in which it can benefit patients, physicians and other healthcare providers. As a result, telemedicine services are offered as a way to improve access to and increase efficiencies in the delivery of patient care. Patient information regarding the use of telemedicine services is available on the organization's website 24 hours a day, 7 days a week. Each site, its equipment and connectivity is RSPMI now OBH certified via a partnership with Arkansas eLink and the Centers for Distance Health.

The organization prides itself in providing clients with information about its telemedicine services prior to providing the service. The telemedicine environment at the originating and remote sites is private rooms and offices equipped with telemedicine equipment and connectivity to a HIPAA compliant platform for the secure transmission of audio and video PHI. Clients are oriented to what telemedicine is, how it can benefit them, the technology and equipment utilized, the mechanics of a video call, their client rights and responsibilities, and assured of the confidentiality and security of the information shared during a telemedicine session. Providers will only schedule a telemedicine service when the nature of the health concern lends itself to the approach safely. Once the patient agrees to participate in telemedicine services, a written informed consent is obtained. An audio-video test call is placed between the remote and originating sites prior to the onset of telemedicine services each day. The participants at both sites are introduced and given an opportunity to ask questions prior to the onset of each session.

Patient Safety

A trained mental health professional, paraprofessional or member of the medical team is present at all times in telemedicine sessions with the client. A family member or the patient's guardian/legal representative may also attend the sessions depending on the needs of the person served. Standard medical procedures are in place to address any emergency aspects of a session that may occur. These procedures include access to a nurse, physician or other healthcare professional or dialing 911 according to the severity of the emergency. The organization's internal Emergency Code System is accessible during normal business hours. All clinic locations are within the 911 emergency calling area and able to obtain emergency services. The organization deploys a HIPAA compliant telemedicine solution that protects confidentiality and provides for secure communications between locations.

Training

Clients are not required to set up, maintain or troubleshoot telemedicine equipment. Staff providing telemedicine services are required to complete an *Introduction to Telemedicine* course, sponsored by the Arkansas Centers for Distance Health, prior to scheduling a telemedicine service. Staff at the remote and originating sites is trained on preparation of the room, orientation of the client and use of the equipment, including connectivity and troubleshooting. They are also provided written instructions in these areas. Quick reference guides to obtain technical support are attached to each telemedicine station along with emergency medical and law enforcement contact information. Test calls are encouraged to facilitate ease of use and familiarity with equipment prior to a live session.

Infection Control

The organization does not currently offer home based telemedicine services. Staff is provided to manage all equipment and assist the patient during each outpatient telemedicine session. No food or drinks is allowed in a telemedicine area. All equipment is maintained according to manufacturer recommendations. The organization adheres to Standard Precautions in healthcare proposed by the World Health Organization. These precautions are a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. Precautions taken include hand hygiene, use of personal protective equipment (PPE) such as gloves and masks, safe injection practices, safe handling of potentially contaminated equipment or surfaces in the patient environment and respiratory hygiene/cough etiquette. The type of precaution used is based on the method of transmission (direct contact, droplet, or airborne). Transmission based Precautions, in addition to Standard Precautions, are used where the suspected or confirmed presence of infectious agents represents an increased risk of transmission. The following materials and equipment are made readily available in order to minimize risks:

- Antibacterial soap
- Water
- Paper Towels
- Latex and non-allergenic gloves
- Hazardous material bags (red) and labels
- Hazardous material sharps containers (puncture and leak proof)
- Buckets and mops
- Disinfectant solutions

- Sodium hypochlorite solution (household liquid bleach), one (1) part bleach to ten (10) parts water; (1-1/2) cups bleach to one (1) gallon of water, freshly prepared.

Assistive Technology

The organization makes every effort to accommodate staff and clients who may require assistive, adaptive, and rehabilitative devices and has deployed a substantial inventory of tablet pc's and signature pads in order to obtain electronic signatures on documents maintained in the electronic medical records system. These devices, as well as other assistive technology devices, are considered to be any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities. An assistive technology service is considered to be any service that directly assists persons with disabilities. The process used in addressing these needs is as follows:

Clients

Special needs of the client are assessed prior to admission. The need for assistive technology is assessed during the Request for Services process and again upon completion of the Self-Assessment. The client's identified needs are evaluated by the primary therapist and arrangements are made with the appropriate staff or through outside resources. Services are often obtained by partnering with area agencies such as services for the blind and bilingual services.

Staff

Special needs of the staff are evaluated upon employment, annually as evidenced by the Annual Technology Assessment and on an as-needed basis. Assistive devices and services may be obtained by purchasing, leasing or otherwise providing for accommodations as appropriate.

With regards to technology and systems deployment, the organization makes every effort to accommodate persons with disabilities, including but not limited to persons with vision, speech, hearing and ambulatory disabilities. Special seating, worktables and desks, computer monitors, Kensington Mice (larger than a regular-sized mouse) and other peripherals may be provided to insure equal access to technology systems. Speech recognition programs and transcription services have also been utilized to accommodate persons with writing difficulties.

With regards to telecommunications equipment and services, accessibility and usability are essential. The organization does make telecommuting available, on a limited basis, for staff that is able to access system resources remotely from their homes where they may be better physically accommodated.

The organization's Assistive Technology plan is designed to reduce barriers with the intention of making new technologies and services available to all persons regardless of disability.

Accessibility and Accommodations

The organization continues to improve network accessibility to accommodate the growing connectivity and productivity demands of the service area. Internet and data broadband services are provided in all locations to facilitate access to the electronic medical records system and point to point communications. Laptops are utilized, on a limited basis, over a secure network connection; however, no protected health or patient information is maintained on these devices. Tablets are utilized as signature pads as well as traditional signature pads. Tablets are strictly accounted for during inventory cross checks.

Video conferencing has become very popular in many of the locations and is used frequently to participate in information sharing and education.

The organization provides multiple interfaces and platforms in an effort to accommodate clinical and support staff with a user-friendly means of accessing the technology infrastructure. Network systems are available on a 24-hour a day, 7-day per week, 365 day per year basis via VPN and remote gateways.

Technical Support
The technical support team has a working knowledge of local and wide area networks, windows, proprietary system applications and security operations. Technical support is available to the staff on a daily basis. Hardware and software assistance is available as well as support for application development. Most of the technical support requests are managed by telephone and/or email communications; however, field operational support is also provided. Technical support staff participates in specialized training on an annual and as needed basis as available.

Interfacing with Statewide and Other Systems
The organization continues to interface its electronic medical record system with other health care providers to facilitate patient health information exchange. A successful interface with Quest Diagnostic Laboratories was achieved in the fall of 2015 to expedite the ability to send lab orders and receive results from the outpatient mental health clinic locations, including two residential sites in Nevada and Hempstead counties. Current initiatives include the ability to exchange patient information in a secure electronic format with other health care providers and hospitals utilizing secure direct messaging protocols.

The organization continues to maintain its interface with the Arkansas Department of Human Services Division of Youth Services, juvenile tracking and billing system (Rite Track). Historically, the Rite Track system tracks admissions and demographic information, juvenile placement and transfer, psychological assessment, offense, and billing data for services provided to residential and non-residential juveniles. As contract providers, billing is submitted through the tracking system by uploading a batch file for processing. The juvenile tracking system also provides extensive web-based reporting.

The organization is actively utilizing the DLA-20, a mental health outcomes measurement of daily living activities adopted by the State of Arkansas. It is believed that measuring outcomes and monitoring patient progress or the lack thereof, allows providers a better opportunity to partner with their patients towards recovery by examining measurable data. This outcomes measure has been integrated into the EHR system as the YOQ Youth Outcomes Measure in previous years.

Technology Assessments
The organization utilizes the results of an Annual Technology Assessment to evaluate technology availability with staff needs. The goal is to develop and use innovative technologies that will improve the quality and cost effectiveness of the care given to all clients and therefore improve patient outcomes.

The Technology Assessment provides an opportunity to review hardware technologies currently in use, those previously deployed, and how that deployment has changed across fiscal years. This

information, combined with treatment data, is utilized in the decision-making process regarding development, expansion and reduction of specific programs and services and to determine whether the current Information Systems deployment will support the organization's business growth plans.

The Technology Assessment supports the organization's policies on Risk Management and Information Security as well as its overall philosophy on Information Management and Internal Controls.

The organization has one objective in mind when assessing Information Management and Internal Controls and that objective is to provide reasonable assurance that the following conditions are met:

- To determine the effectiveness and efficiency of the organization's operations, including performance and reliability of financial reporting.
- To determine the effectiveness of reporting mechanisms.
- To comply with applicable laws and regulations.

The Assessment is provided as a tool to ensure that programs are given sufficient resources to implement and maintain a long-term commitment to a culture of compliance in a changing environment of information sharing and strategic planning.

Changes in technology equipment over the last fiscal year are presented below.
These assessment results for the 2019-2020 Fiscal Year demonstrate only minimal changes in technology inventory overall. However, the following changes were recorded:

There was a 32% increase in personal computer use in the last calendar year and a 17% increase in laptops versus a 12% decline in thin client technology. These changes were due to the replacement of aging workstations. A 26% change was reported in the acquisition of telephone systems due to those systems being under reported in 2018. An 18% increase in multi-function printers was reported due to the replacement of older single function printers no longer operational. A 300% increase was reported in the Portable Digital Assistant device (PDA) inventory due to these devices being returned to inventory and no longer being utilized at the sites. Gross inventory changes averaged 6% for the fiscal year versus last fiscal year.

Other devices were assessed; however, no significant changes in availability or utilization were noted.

Technology Assessment results from all 27 programs, clinics and/or locations were reported during the assessment period.

<u>System Planning:</u>

Software Management:

The organization implements a formal software review as industry standards change and as the demands of the organization dictate. An inventory of approved software is also maintained as a Meaningful Use requirement. The organization incorporates software review as part of all new project management plans to determine if the current software deployment will meet the requirements of any new implementations. Because software projects can easily be delivered over budget, software deployments are reviewed in a systematic and formalized manner according to the needs of the

department, program, location or entire organization. A complete software assessment is always performed in consideration of large projects where software may not meet the expectations in terms of functionality, cost or availability. When purchasing new systems, a primary consideration is longevity of the software in terms of software assurance subscriptions (support), and the availability of continued software updates and security patches. With any major software deployment, the organization selects an internal test group of users for qualitative testing and verification. Usability is of the upmost importance to gain some reasonable assurance that the software will meet the expectations and demands of the organization before a substantial purchase is made and cost effectiveness is always a consideration.

Business Continuity and Disaster Recovery

The organization continues to follow a best practices approach to Business Continuity and Disaster Recovery planning with specific consideration of short and long-term power outages. A formal Disaster Recovery/Business Continuity Plan is in place that provides a set of procedures for responding to a disaster that involves the organization's main data center and its services as well as business operations at the remote clinics. The plan identifies ways to obtain short term emergency telecommunications access, ways to protect the organization's technology resources, and ways to safeguard vital records stored on its information network. It also addresses detection and reaction efforts, emergency services, physical security, risk management as well as restoration and recovery operations.

Credible Behavioral Health, Inc., the organization's EHR provider, offers additional support during inclement weather and other disasters by providing temporary access to their mobile solution, data access service and continuity of care. During a loss of facility power, the organization is able to download all client data to a mobile application utilizing their mobile solution. As a part of Credible's Data Access Service, they will provide individual client information from the client record via telephone for a period of seven (7) days at no charge. Also, in support of continuity of care, Credible will release client information, on an individual basis, from the organization's domain to other healthcare facilities by request. Credible will provide this service for a period of 14 days at no charge.

The deployment of virtual servers has reduced network downtime because hardware and software resources are shared with other operating systems and across multiple servers. This technology saves floor space, is more cost-effective and eliminates the need to purchase a separate machine for each new server requirement. Virtual servers provide more efficient resource control and faster disaster recovery in a hosted environment.

As part of the organization's current disaster recovery efforts, backup systems are maintained in multiple tiers. (1) The organization utilizes an on-site Network Attached Storage (NAS) system to backup network files processed on windows servers and individual workstations allowing a 30-day backup rotation to a multiple month store. The organization converted to a cloud-based retention system during the fall of 2016 that allows for the infinite storage of data. This conversion was attained free of charge through partnership with a contractual information management company. (2) The organization also utilizes collocation facilities on the East and West coasts for redundant storage allowing monthly backup rotation to an annual store and high availability of files processed on virtualized servers as well as the NAS system. In addition to these backup systems, the organization's contracted managed services company performs 24x7 monitoring on the NAS device

and collocation facilities. If a condition arises, we are immediately notified and able to take corrective action.

Implementation of the NAS has provided a fully-managed disaster recovery service encompassing near real-time data backup combined with server virtualization capabilities at a higher level of data and application security. Onsite data replication occurs every 15 minutes, entire volumes of servers are captured allowing an exact digital duplicate of the production servers and multiple servers are virtualized and backed up to a single NAS device allowing faster recovery in the event of hardware failure.

Emergencies that may impact or damage the organizations information systems including fire, vandalism, theft, acts of terrorism, telecommunications and/or electrical power outages, floods, storms, tornados or other natural disasters and system failures have also been addressed in the organization's Emergency Operations Plans (EOP's). These plans can be found in greater detail in the organization's HIPAA Policies and Procedures Manual.

Telecommunications outages are addressed by implementing procedures to restore primary telecom systems. In the event those efforts fail or are not readily available, other solutions such as the use of secondary systems and local broadband circuits or the use of portable wireless network routers (wireless hot spots) that provide internet access to a physical location may also be utilized.

During an emergency that disrupts electrical power, information systems rely on auxiliary power sources to maintain functionality for a brief period of time and/or to initiate an orderly shutdown to preserve data integrity. Telecommunications and power outages lasting an extended period of time (several hours, days) may be significant enough to disrupt service delivery to clients until essential services can be restored. In these instances, staff is required to maintain paper records of information that would normally be recorded electronically (intake and referral information, progress notes, appointment calendars, etc.). After power and telecommunications systems have been restored, electronic databases are updated from the paper records and duplicate paper records are destroyed.

Communications During Emergency Operations:
In the event that electrical services, including telephone, Internet or data circuits are interrupted, other means of communication must be relied upon to relay information to the staff and those we serve. Other means of communication include radio and local television announcements, as well as the use of cell phones and Wi-Fi devices.

Copies of the Emergency Operations Plans are maintained offsite with the organization's Information Technology Staff so that they can be easily accessed in the event of an emergency. The plans were successfully tested in October 2017. The disaster recovery plan is the roadmap from disaster to recovery and specifically focuses on the ability to continue service delivery to the organization's client population as well as insure the ability to continue financial operations and other critical business processes.

Review of FY 2021 Goals:

- Goal #1: Upgrade the Information Technology Infrastructure in response to the Jan. 14, 2020 Microsoft End of Life Announcement for Windows 2007 and Windows Server 2008 Operating Systems. *This goal has been attained.*

- Goal #2: Upgrade or Implement a new Financial Software System as a result of Microsoft's Jan. 14, 2020 End of Life Announcement for the Dynamics GP 2015 and 2015 R2 software. *This goal has been achieved.*

- Goal #3: Secure continued telecommunications funding through Universal Services Corporation, a division of the Federal Rural Healthcare Program. *The Center has filed the funding expects to secure this funding for this past year.*

- Goal #4: Implement Telemedicine Services to hospitals, law enforcement, and other health care facilities. *The Center has increased the use of telemedicine, however, has not moved into hospitals, law enforcement and other health care facilities since the majority of these facilities have already established telemedicine services with other entities.*

- Goal #5: Work with Meaningful Use Team to Achieve 2019 Medicaid Meaningful Use Stage 3 under the Medicaid EHR Incentive Payment Program and Zero Payment Adjustments under the Medicare MIPS Program. *The management team decided that it was not cost efficient to pursue Stage 3 of Medicaid Meaningful Use.*

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FY 2022 Technology and System Plan Goals

1.) Develop a system for tracking deployment of telehealth equipment, current users and usage of telehealth platforms.
2.) Purchase and deployment of signature pads.
3.) Ensure inventory of information technology hardware maintained by ex-employee is correct.
4.) Secure continued telecommunications funding through Universal Services Corporation, a division of the Federal Rural Healthcare Program or seek out an alternative internet service provider.
5.) Investigate current technology for maintaining security of personal health information (PHI) while sending such information via email or any other means and possibly adopting new strategies while still abiding by regulations set forth in HIPAA.
6.) Hire and train support technician.
7.) Complete implementation of Kronos payroll software.
8.) Assist the Youth Services Program in utilization of Credible software in order to document all services provided.

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Summary:

The overall goal for the fiscal year continues to be sustainability in an ever-changing environment of health informatics and security protocols and to achieve the national goals outlined by government healthcare initiatives and other regulations that focus on quality patient care, patient engagement, and the use of electronic health records.

RIGHTS OF THE PERSONS SERVED

SWACMHC strives to protect and promote the rights of the persons served and to identify and address the unique and specific cultural and diversity issues of the persons served. SWACMHC

shares and communicates these rights in a manner that is meaningful to the persons served to ensure and support their engagement in the individualized planning and service process.

To this end, SWACMHC has developed and implemented policies and procedures (as found in the Clinical Policy & Procedure manual) to state and protect the rights of persons served. These rights are reviewed with the persons served as part of the orientation process and annually, thereafter, and are posted in all facilities. Included in these rights is a process by which a consumer may file a complaint or grievance, or appeal a decision made by the staff. This is also reviewed during the orientation process and the persons served acknowledge this in writing. The CQI/QA Committee conducts an annual review of complaints, looking for trends and areas of needed improvement. This review is reported to the Board of Directors.

SWACMHC prefers that persons served take responsibility for their own funds. However, in cases in which the person served is severely mentally ill and incapable of managing his/her own funds, and has no family member to assume this responsibility, Center staff will fulfill this need. Guidelines for handling funds of persons served are specifically listed in the Clinical Policy and Procedures Manual.

INFORMATION MANAGEMENT

SWACMHC shares and provides the persons served and other stakeholders with ongoing information about the actual performance of the Center as a business and the ability to achieve optimal outcomes, both programmatically and for the persons served. The Center is committed to improving the organization and its service delivery. SWACMHC recognizes accreditation, and particularly information management and performance improvement, as a dynamic process. As such, the Center is constantly collecting, reviewing, and analyzing information as part of the ongoing process to manage and improve services.

Information is gathered from each client (and persons presenting for services, even if not admitted) to determine services needed/requested. More detailed information about this is found in the Clinical Policies & Procedures Manual in the sections regarding program services and individual planning and will not be reiterated in this report.

For reasons of business improvement, SWACMHC continually collects information from a variety of sources such as:

- Financial and budgeting planning and update
    - completed annually and reviewed monthly by the Board
- Accessibility Plan
    - reviewed annually by Administration
- Surveys
    - reviewed quarterly by CQI/QA and Administration
- Risk management findings
    - reviewed annually by the Board
- Technology needs assessments
    - reviewed annually by the Board
- Health & Safety reports
    - reviewed quarterly by Accessibility, Health, Safety and Transportation Committee and CQI/QA

- Outcomes management reports
    - reviewed semi-annually by Administration, during the budget planning process, and reported annually to the Board of Directors
- Utilization Review Committee reports

PERFORMANCE IMPROVEMENT

SWACMHC is committed to maintaining an active and 'user friendly' system of monitoring outcomes that provides timely, meaningful information to the organization in the areas of effectiveness, efficiency, service access, and satisfaction. The Center monitors outcomes in each of its accredited programs. Results of this system are reported to all staff on a semi-annual basis with a formal report presented to the Board annually.

The Center believes that treatment services should be continually evaluated and changed to best meet the needs of persons served. To this end, the Center aggressively pursues input from persons served to obtain the information necessary to effectively assess its performance in light of its goals and the overall needs expressed by the clients.

- The system assesses the following effectiveness measures:
    - Quality of Life
    - Symptomology
    - Functional Status
- The system measures access as defined by client feelings about how quickly they were seen for services.
- The system evaluates service delivery rates as an efficiency measure.
- The system evaluates client satisfaction as a measure of client/guardian responses to surveys regarding their overall satisfaction with Center services.

Outcome management information gathered from client input is collected upon admission, at a program-specific time following admission, immediately after discharge, and ninety days after discharge. Outcome expectations are established for each program area, and the data is analyzed by management staff to identify significant trends and challenges. The data is then compared to the expectations developed by the management team.

Productivity and efficiency information is collected by the Division Aging and Adult Behavioral Health Services subscribes. Utilization of measures of mental health treatment staff productivity have been selected to set a baseline, as a platform for reassessing service delivery sites and staff assignments to those sites, and to set goals for improving client access by becoming increasingly efficient. Data may be collected monthly, quarterly or annually as needed. Statewide data is available to help the Center assess service provision rates compared to other centers.

The Director of Quality Assurance, as Chair of the CQI/QA Committee, has responsibility for the implementation and oversight of the outcomes management system, for assistance in preparing the annual Strategic Plan and Performance Review and for ensuring that the outcomes management system continues to function in conformance with national accreditation standards to provide meaningful feedback from which effective management decisions can be made.

EMPLOYEE SURVEY RESULTS

All Center employees had the opportunity to respond to an employee survey. Fifty-eight percent of the employees who responded stated they were either very satisfied or somewhat satisfied with their job. This represents a significant drop in employee satisfaction from the previous year. The top responses to the question of how SWACMHC could improve were as follows:

More training for employees
More peer support services
Improve staff attendance
Formation of specialized group therapies
Improved I.T. support
Revision of leave policies

Employees identified the following training needs: Microsoft Excel, knowledge of Center programs and operations; available community resources; and trauma response.

It would appear that the majority of the respondents receive the greatest satisfaction from the following three areas:

Client improvement
Giving people back their lives
Team work at SWACMHC
Successful client attainment of treatment goals

OUTCOMES: A REVIEW OF LAST YEAR'S GOALS

As part of its efforts to establish outcomes, SWACMHC's FY 2020-2021 organizational goals and specific program goals regarding effectiveness, access, satisfaction and efficiency are listed below and are followed by a status report of each goal.

REVIEW OF LAST YEAR'S ORGANIZATIONAL GOALS

1.) Establish therapeutic foster care homes within Bowie County, Texas.
    - *This goal was not achieved and will be carried forward for next year*
2.) Adjust staffing patterns so as to provide a dedicated, full-time TFC therapist.
    - *SWACMHC has dedicated a full-time TFC therapist and assisted this person in obtaining advanced training.*
3.) Ensure that all full-time outpatient clinics are able to bill "incident to" a physician.
    - *All full-time outpatient clinics are now able to bill "incident to".*
4.) Establish a medication assisted treatment program.
    - *All prescribers are now certified to administer such and the Center has begun to accept MAT*
5.) Liquidate assets such as unused real estate or vehicles.
    - *The Center reduced its inventory of vans this past year.*
6.) Increase income for all employees and/or institute a bonus system for all.
    - *This goal was not achieved and will be carried forward.*
7.) Increase marketing efforts and the use of social media.
    - *A full-time marketing representative was hired at the beginning of the fiscal year.*
8.) Increase the utilization of volunteers and interns.
    - *All interns are not under the direction of the Clinical Director who has been creative in terms of assigning projects.*

9.) Lessen reliance on Medicaid reimbursement by obtaining additional grant funds, ensuring all outpatient clinics have providers who are eligible for third party reimbursement sources.
   - *Management has applied for several local grants and also sponsored several fundraisers.*

10.) Repair the parking lot at River Ridge Residential Treatment Facility.
   - *This goal was not met and will be carried over to the current fiscal year.*

11.) Inclusion of the Youth Services Program in all future strategic planning, management meetings and preparation for the Center's next CARF survey.
   - *This goal can be deleted since the State of Arkansas no longer requires youth services programs to be accredited.*

12.) Improve monitoring over billing to maximize revenue and stay alert to areas of deficiency.
   - *The Center has contracted with an ex-employee to monitor and maximize accounts receivable.*

REVIEW OF LAST YEAR'S PROGRAM GOALS

A. Outpatient Mental Health
   - Effectiveness- 85% of the clients in the outpatient programs will indicate, when polled, that they feel better about the problems which caused them to seek services
     - *79% of respondents stated they felt better or much better after initiating treatment.*
   - Access- All outpatient locations will have a rating of 85% or higher for timeliness of services.
     - *91% of respondents stated they saw their therapist within acceptable time frames.*
   - Client Satisfaction- 80% of clients will rate their overall satisfaction with the Center as excellent or very good.
     - *77% of respondents rated the quality of their services as very good or excellent.*
   - Efficiency- Outpatient clinics will increase the number of billed units for group therapy by 20% over the preceding year.
     - *The number of billed units for group therapy decreased from the prior year, mainly as a result of the Covid pandemic, however, almost all of the clinicians are now performing group therapy at least twice a month.*

B. Community Integration and Case Management
   - Effectiveness- 85% of the clients receiving community integration and/or case management services will indicate, when polled, that they feel better about the problems which caused them to seek services.
     - *100% indicated that they felt better after having initiated services.*
   - Access- 95% of the clients will indicate they have seen their therapist or case manager with the right frequency.
     - *100% indicated that they had seen their therapist with the right frequency.*
   - Client Satisfaction- 90% of clients will rate their overall satisfaction with the center as excellent or good.
     - *100% rated their overall satisfaction as good to excellent.*
   - Efficiency- Case managers will work to lower travel costs by 15% through better planning and routing.

- *During the past year, the travel costs decreased 20%, however, this was due, in part, to an ongoing pandemic.*

C. Crisis Intervention
   - Effectiveness- 90% of those hospitalized will have placement arranged within four hours.
     - *For this fiscal year, it took clinicians an average of 54 minutes to find placement. 84% had placement arranged within four hours.*
   - Access- 90% of all children/adolescents in the custody of DCFS who are in crisis will be seen within the time frame as specified in the Center's contract with the Division of Behavioral Health Services.
     - *This goal was met.*
   - Client Satisfaction-Clients receiving crisis intervention services will begin getting a satisfaction survey and the goal is to have 85% of the respondents report their overall satisfaction as excellent or good.
     - *This measure was not valid since many clients who were sent to the hospital did not return for aftercare.*
   - Efficiency-The Community Needs Assessment Survey will indicate that the Center responds within appropriate time frames in all six counties of the Center's catchment area, as indicated by the absence of complaints, concerns, or dissatisfaction expressed by respondents
     - *Only 7% of those who responded to the community needs assessment had a negative comment about the Center.*

D. Substance Abuse Treatment
   - Effectiveness- 70% of the persons who complete a treatment program will indicate that they are clean and sober at follow-up.
     - *Out of the clients the Center was able to reach, 53.5% were clean and sober after 18 months.*
   - Access-80% of responding clients will indicate that they have been able to see a therapist as quickly as needed. Double the number of clients receiving medication assisted treatment for a substance abuse disorder.
     - *Although the numbers remain small, the Center has quadrupled its number of clients receiving medication assisted treatment for substance abuse disorders.*
   - Client Satisfaction--90% of responding clients will indicate overall satisfaction with the Center.
     - *90% indicated their satisfaction level was good to excellent.*
   - Efficiency- Investigate and possibly utilize the use of teleconferencing for supervision of counselors in training in order to reduce travel time.
     - *The clinical supervisor for the substance abuse treatment counselors has utilized teleconferencing equipment in order to provide supervision for counselors who work in outlying clinics.*

<u>REVIEW OF FY2021 EFFICIENCY IMPROVEMENTS</u>

1.) Implemented cloud-based human resources software program.
2.) Placed a realistic cap on travel reimbursement to encourage more efficient planning and routing.
3.) Increased utilization of web-based platforms (i.e., Facebook) for recruitment purposes and community outreach.

4.) Hired a full-time employee to market throughout the catchment area and to assist support staff in outlying clinics when someone takes time off from work.
5.) Expanded the roles of interns to include duties for special projects within the Center.
6.) Contracted with a previous full-time employee to work from home in order to research and improve client account receivables.
7.) Increased usage of Survey Monkey website in order to more efficiently poll employees.
8.) Began publishing a monthly newsletter to disseminate information to all employees.
9.) Lessened reliance on independent contractors for clinical supervision.
10.) Ended the productivity incentive program for clinicians, thereby increasing the efficiencies of human resources and negating the need for an independent consultant to manage the program. Low productivity is now addressed by supervisors every two weeks.
11.) Utilized Facebook page in order to seek input for the Center's community needs survey.
12.) Established weekly meetings for senior management to improve communication and to address concerns in a timely, more efficient manner.
13.) Evaluated positions within the business office, reassigned duties as appropriate and decreased the number of employees within the department.

GOALS AND RECOMMENDATIONS FOR FY 2022

FY 2022 ORGANIZATIONAL GOALS

1.) Establish therapeutic foster care homes within Bowie County, Texas
2.) Increase income for all employees and/or institute a bonus system for all.
3.) Continue to seek additional funding through grants and sources other than Medicaid.
4.) Repair the parking lot at River Ridge Residential Treatment Facility.
5.) Increase quality assurance efforts in order to ensure paraprofessionals are focusing more on adult living skills rather than on lessening positive symptoms of a chronic mental health disorder or disease.
6.) Begin the utilization of a standardized suicide risk assessment.
7.) Increase follow-up of clients discharged from psychiatric hospitals.
8.) Increase the use of telehealth services, especially in jails and emergency departments.
9.) Improve relationships with prosecutors and law enforcement by providing more dialogue and educational material to these parties.
10.) Evaluate the feasibility of becoming a Certified Community Behavioral Health Center (CCBHC) and possibly apply for an expansion grant, especially if CCBHC's are endorsed by the Division of Aging and Adult Behavioral Health Services. This would establish primary care within the organization and improve access to services.
11.) Establish a five-year capital improvement plan.
12.) Address and achieve all technology and system plan goals as set forth in the strategic plan.

FY 2022 PROGRAM GOALS

A. Outpatient Mental Health
    - Effectiveness- 85% of the clients in the outpatient programs will indicate, when polled, that they feel better about the problems which caused them to seek services

- Access- All outpatient locations will have a rating of 85% or higher for timeliness of services.
- Client Satisfaction- 80% of clients will rate their overall satisfaction with the Center as excellent or very good.
- Efficiency- Outpatient clinics will increase the number of billed units for group therapy by 20% over the preceding year.

B. Community Integration and Case Management
   - Effectiveness- 85% of the clients receiving community integration and/or case management services will indicate, when polled, that they feel better about the problems which caused them to seek services.
   - Access- 95% of the clients will indicate they have seen their therapist or case manager with the right frequency.
   - Client Satisfaction- 90% of clients will rate their overall satisfaction with the center as excellent or good.
   - Efficiency- Case managers will work to lower travel costs by 15% through better planning and routing.

C. Crisis Intervention
   - Effectiveness- 80% of clients receiving crisis intervention in the next year will not have a repeat crisis within the fiscal year..
   - Access- 90% of the clients needing hospitalization will have a placement identified within 4 hours of the intervention. The form documenting an inpatient admission will be revised in order to better collect this data.
   - Client Satisfaction- 90% of clients receiving crisis intervention services will receive a client satisfaction sheet at the end of any crisis intervention service.
   - Efficiency-The Community Needs Assessment Survey will indicate that the Center responds within appropriate time frames in all six counties of the Center's catchment area, as indicated by the absence of complaints, concerns, or dissatisfaction expressed by respondents

D. Substance Abuse Treatment Programs
   - Effectiveness- 70% of the persons who complete a treatment program will indicate that they are clean and sober at follow-up.
   - Access-80% of responding clients will indicate that they have been able to see a therapist as quickly as needed. Double the number of clients receiving medication assisted treatment for a substance abuse disorder.
   - Client Satisfaction--90% of responding clients will indicate overall satisfaction with the Center.
   - Efficiency- Investigate and possibly utilize the use of teleconferencing for supervision of counselors in training in order to reduce travel time.

SUMMARY

SWACMHC's employees and board of directors will continue to work together with input from persons served and input from various stakeholders in the community to provide quality outpatient mental health and substance abuse treatment services. The Center will strive to position itself to meet the challenges of an ever-changing health care field by ensuring continued accreditation as a behavioral health entity.