Center for Human Services

*Building a stronger community...one family at a time.*

# Executive Summary 2023

# TABLE OF CONTENTS

# CENTER FOR HUMAN SERVICES
# ANNUAL EXECUTIVE SUMMARY
# 2023

## INTRODUCTION

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

## AGENCY OVERVIEW

### Mission

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

### Our Vision

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

- Thriving children, vital individuals and stable loving families are strengthened and supported.
- Children and their families are able to increase emotional strength and resolve personal and interpersonal issues.
- Community members have a sense of belonging and have access to resources that promote a healthy life free from harmful use of alcohol and other drugs.

## Our Values

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

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

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

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

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

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

## Our Philosophy

CHS believes that the most critical element for strengthening a community is to strengthen its members and their families through preventive and responsive programs. This is accomplished by taking an approach that is strengths-based, family-focused, client-centered, trauma-informed, integrated with other services, and culturally responsive.
It is our philosophy that all people have gifts and strengths and our role as a human service provider is to create opportunities for them to use these talents and skills to strengthen themselves and their community. Our premise is that change will occur only when we firmly believe in our clients/participants and when we collaborate with them to positively use their aspirations, perceptions, and strengths. We believe that anyone who seeks our services at CHS deserves the best quality services possible. Our approach is holistic in that we try to understand the whole person or whole family rather than a dissection of parts. Not one therapeutic approach works for all people or in all situations, so various techniques are applied. However, general themes of emotional/physical safety, respect, and cultural sensitivity are consistent. Intra-agency referrals are made when we see that a combination of our program services will best serve the client's/participant's needs; when services are needed which CHS cannot provide, referrals outside the agency are made. Staff have a commitment to provide effective services, thus they engage in an on-going process of evaluation, education, and self-care. CHS is striving to be a leader in the human services

community by providing preventive and responsive services and using our identified strategic approaches.

## Strategic Approaches

### Strengths-Based

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

### Client-Centered

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

### Family-Focused

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

### Trauma-Informed

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

### Integrated with Other Services

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

**Culturally Responsive**

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

## Strengths

**CHS:**

- is CARF accredited for our mental health and substance use disorders programs.
- has a solid set of core values and we model these values.
- values diversity, equity, inclusion, and belonging and has made significant investments toward our commitment to DEIB efforts.
- has a strong and active board.
- is financially stable.
- has an experienced and respected leadership team (with significant longevity) that values the organization's employees and clients and exhibits collective mental flexibility.
- has employees, with vast knowledge and skills, who exhibit compassion and enthusiasm for the mission of the organization and the services provided.
- has a strong investment in professional development, which enhances the commitment and confidence of its staff members to provide quality services and keeps best practices at the heart of the organization.
- treats clients with dignity and respect.
- is committed to Continuous Quality Improvement (using a CQI Leadership Team, a CQI Systems Team, and a CQI Manager Team that all meet at least once a month).
- is using an industry-leading electronic health record.
- has an excellent benefit package for employees.
- has a forward-thinking vision and is ahead of the curve on most regional efforts.
- provides services in primary care clinics, schools (6 school districts), clients' homes, and other community locations as well as in six agency locations.
- is dedicated to developing and maintaining partnerships with other community agencies.
- uses data to make wise (management and service) decisions.
- strategically plans and prioritizes program and service expansion as needed (includes reflection for sustainability).
- integrates our services and programs, serving as a one-stop-shop for many.
- has a respected reputation with local and regional contractors/funders and other community organizations.

## Challenges and Opportunities

**CHS is challenged to:**

- maintain up-to-date credentialing with the five Managed Care Organizations (MCOs).
- manage multiple contracts and grants, with complex reporting requirements, and deal with subsequent increased administrative burdens.
- ingrain diversity, equity, inclusion, and belonging into all we do with a focus on anti-racism and social justice.
- find health insurance for employees that is affordable.
- have adequate space for offices and services.
- earn incentives from King County Integrated Care Network (KCICN) for identified milestones.
- recruit and retain qualified staff during a behavioral health workforce crisis in an increasingly competitive market.
- sustain operations during a time with a significant workforce shortage of SUDPs and Mental Health therapists.
- recruit and retain board members who represent the people we serve.
- face the increased cost of doing business.
- respond to the opioid crisis by providing preventive services as well as treatment.
- compete with other organizations for resources and funding (Local, State, Federal).
- effectively use technology to help us meet our goals.
- respond to our steady growth as an agency.
- prevent staff burn-out.

## Highlights of Agency-Wide Accomplishments

(in addition to department highlights noted later in this report)

**CHS:**

- actively participated in Affordable Communities of Health efforts in Snohomish and King Counties.
- received substantial ARPA funding from various sources.
- continued to develop pathways and workflows to standardize clinical and administrative processes.
- held a successful in-person auction as a board fundraiser.
- held all-staff meetings, a staff picnic, and a Winterfest celebration.
- received extensive DEIB & leadership consultation and coaching.
- was nominated for a North Urban Human Services Alliance (NUHSA) award as Outstanding Human Services Program and our Family Support Director was nominated as a Human Services Champion.

## CHS Locations

CHS owns three buildings where we provided services in 2023:

- **CHS – 170th**
  17018 15th Ave NE Shoreline, WA 98155
  (King County Substance Use Treatment Services, Infant & Early Childhood Mental Health, Integrated Behavioral Health, and Family Support)

- **CHS – 148th**
  14803 15th Ave. NE Shoreline, WA 98155
  (King County Mental Health Counseling & Administration)

- **CHS – Silverlake**
  10315 19th Ave. SE, STE 112 Everett, WA 98208
  (Snohomish County Substance Use Treatment Services, plus limited Infant & Early Childhood Mental Health services)

We lease office space at the following locations:

- **CHS - Edmonds**
  21727 76th Ave. W, STE J Edmonds, WA 98026
  (Snohomish County Mental Health counseling)

- **CHS – Lynnwood**
  3924 204th St SW Lynnwood, WA 98036
  (Community-Based Intensive Services Department)

- **CHS – Bothell**
  12900 NE 180th St, Suite 140 Bothell, WA 98011
  (Mental Health & Family Support)

CHS also provides services on a regular basis at schools in the Edmonds, Mukilteo, Shoreline, Northshore, Everett, and Seattle School Districts; Shoreline Recreation Center; and Ballinger Homes King County Housing Authority community. We also have therapists placed on-site at the Virginia Mason Medical Clinic in Edmonds (formerly Edmonds Family Medicine); at the Community Health Center of Snohomish County in Lynnwood, Edmonds, and two in Everett; and at the Providence Pediatric Clinic in Mill Creek. Additionally, we provide SUD assessments at Carnegie Resource Center and Snohomish County Jail. Additionally, clients often receive services at other community locations of their choosing including their homes. All of our locations had in-person services and virtual services available in 2023.

# BOARD OF DIRECTORS

## Overview

At the end of 2023, CHS had 11 board members (21 is the maximum size of board). Board Officers in 2023 were Wesley Madsen, President; Laurie Chapman, Vice-President; Shawn Karmil, Secretary; Ed Sterner, Treasurer. Our Board of Directors, at the end of 2023, represented a diverse representation of age range, males and females, and sexual minorities. We are actively recruiting more people to join the board, particularly people of color.

Attendance was very good at board meetings, whether they were held remotely or in person. The board held a successful virtual auction in the fall of 2023, raising unrestricted funds for CHS.

## Board Members

2023 Board Members (and their affiliations) were:

We added 2 new board members, Diana Cadena- Sanner and Heidi Ihde, in 2023.

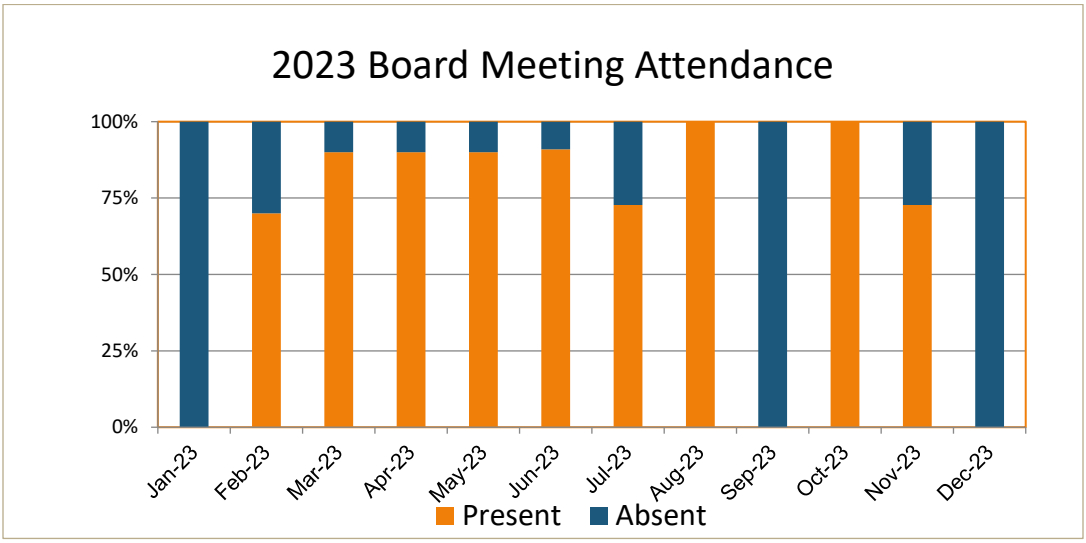
- Diana Cadena- Sanner, Mountain Pacific Bank
- Dave Calhoun, Northshore School District
- Laurie Chapman, Copiers Northwest
- Heidi Ihde, Coldwell Banker
- Shawn Karmil, Premera Blue Cross
- Ryan Madsen, Business Owner
- Wesley Madsen, Alliant Insurance Services
- Adam Ormonde, Virginia Mason Medical Center
- Marisa Pierce, Skagit Valley College
- Katerina Plushko, Kaiser Permanente
- Ed Sterner, Ed Sterner Law Office

## Board Committees

The active board committees in 2023 were the Executive Committee, Finance Committee, Audit Committee, Auction Fundraising Committee, and the Board Development Committee.

## Board Attendance

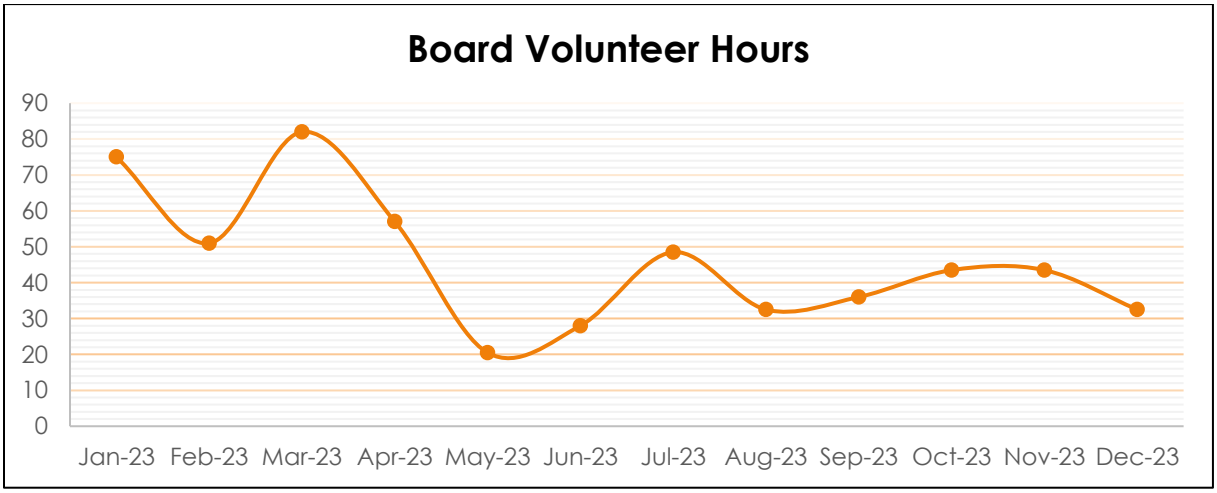
Board attendance in 2023 was excellent. See graph below.




Note that the board did not meet in January, September, and December.

## Board Volunteerism

Board members reported the following number of volunteer hours at CHS in 2023.



# STRATEGIC PLANNING

## Overview

2023 is the final year of the 2020 – 2023 Strategic Plan, which was developed by a Strategic Planning Committee, consisting of five staff and two board members, and approved by the board. To inform the development of the plan, the committee conducted an environmental scan. The scan included both an external component (identifying and assessing opportunities and possible problems in the external environment), and an internal component (assessing organizational strengths and weaknesses), and a needs assessment (reviewing existing relevant literature and other community assessments). The committee solicited and reviewed input by administering surveys to community interested parties, conducting SWOT exercises with staff, administering client surveys, and conducting focus groups. Additionally, they reviewed data collected throughout the previous three years obtained from client surveys, employee satisfaction surveys, fiscal audits, employee and client grievances, and other community input.

CHS successfully fulfilled the goals/objectives of our 2020 – 2023 Strategic Plan. In the fall of 2023, another Strategic Planning Committee was developed consisting of 8 staff, and Board Members: Ryan Madsen (Chair), Ed Sterner, and Shawn Karmil. A strategic plan for 2024 – 2026 was adopted at the November 2023 board meeting.

## Strategic Plan Review

The 2020 – 2023 Strategic Plan and progress toward the goals in 2023 (as well as the previous 2 years) are below:

### 2020-2023 Strategies and Goals
### 2023 Review

### Strategy 1

**Support a Thriving Community by Providing Exceptional Services to Clients and Participants**

**GOAL 1:** Maintain practice as a Trauma-Informed Organization.

**Objectives:**

1. Continually assess our agency regarding trauma-informed approaches (TIA) using a nationally recognized tool to identify areas for improvement.
   **2020 – TIA Committee met several times in 2020 and continued to assess our TIA approaches and suggest improvements.**
   **2021 – TIA assessment was tied to our DEIB work. Our status as a Trauma-Informed Organization was renewed.**
   **2022 – We maintained our status as a TIA organization. HR was responsible for assessment.**
   **2023 – We maintained our status as a TIA organization. HR was responsible for assessment.**

2. Assure that all staff are trained in TIA and maintain staff who are trained as trainers.
   **2020 – All staff participated in at least one training regarding TIA in 2020. Four staff members were trainers.**
   **2021 – Three staff members were trained as trainers.**
   **2022 – HR Manager had active trainer status. Two other staff had been trained as trainers but are not active.**
   **2023 – We continued to train all staff and have TIA trainers on staff.**

3. Support an active TIA staff committee.
   **2020 – TIA Committee had six active members and met regularly.**
   **2021 – The TIA Committee did not meet actively in 2021 due to COVID-19 hardships. We rolled much of our TIA activity in with our DEIB work.**
   **2022 – TIA committee was dissolved, and the work was absorbed by our HR team & DEIB team. This objective was closed.**

4. Assure that CHS is a safe and supportive environment for staff and clients.
   **2020 – CHS took several steps to provide a safe and supportive environment in 2020. The TIA Committee continued to assure that our physical spaces were comfortable and welcoming to everyone. The committee trained our staff in trauma-informed approaches so our environment felt safe for all.**
   **2021 – CHS worked on having a safe and supportive environment through a DEIB lens.**
   **2022 – Our HR team and our DEIB Manager worked to offer a safe and supportive environment. Numerous activities were completed.**
   **2023 – Several steps were made to improve safety, such as cleaning out the brush at 170th; installing cameras and a security system at 170th; improving the lighting at the Lynnwood site and the 170th site; etc.**

**GOAL 2:** Use cultural humility and responsiveness in every aspect of our work.

**Objectives:**

1. Hire & retain staff who represent the diversity of our communities.
   **2020 – Nine people of color were hired; Six 1st or 2nd generation immigrants were hired.**
   **2021 – 40% of our staff identified as non-white.**
   **2022 – 41% of our employees identified as non-white; 22% identified as 1st or 2nd generation immigrants.**
   **2023 – 42% of our employees identified as non-white; 29% identified as 1st or 2nd generation immigrants.**

2. Evolve staff's cultural competency to work with special populations (including people of color, immigrants/refugees, LGBTQIA+, etc.)
   **2020 – Staff attended a variety of workshops around race & equity (Family Support Director attended an Equity and Social Justice Training provided by Verdant; several staff across departments attended The Ripple Effect training hosted by Best Starts for Kids; SUD staff attended the Saying it Out Loud Conference; etc.); created an Equity Lending Library; modeled responsiveness to social justice issues by posting "Black Lives Matter" on our Reader Board (even after it was vandalized) and advocating for equity by publishing articles in the Shoreline News, talking with legislators, etc.; and purchased a training curriculum for staff specific to equity.**
   **2021 – Massive amount of work done toward DEIB. Used outside DEIB consultants, provided trainings, leadership received individual coaching, etc.**
   **2022 – Emphasis remained on our DEIB work. Worked diligently with DEIB consultants as a leadership team. Please refer to our DEIB report later in this document for additional information.**
   **2023 – Completed our work with DEIB consultants at the end of 2023. Numerous staff participated in relevant trainings.**

## Strategy 2

**Strive to Be the First Choice as a Resource for Interested Parties Driving Change in Human Services**

**GOAL 1:** Participate in Behavioral Health System Transformation.

**Objectives:**

1. Integrate our services with primary care settings and objectives.
   **2020 – BHI staff worked in five medical clinics.**
   **2021 – We had a staff vacancy at one clinic that lasted most of the year.**

**Other BHI staff filled in to provide minimal services.**

**2022 – BHI staff worked in five medical clinics. Keeping the clinical positions staffed with master's level therapists proved difficult.**

**2023 – BHI added another site in Everett where we placed a therapist at a medical clinic. CHS worked in a total of six clinics.**

2. Develop & implement procedures to address acute care transitions (from emergency departments, jail, etc.) for our clients.

**2020 – Worked with Snohomish County Drug Court to improve procedures for referral, treatment, and reporting regarding Drug Court clients; implemented the use of administering Social Determinants of Health (SDOH) surveys to specific inmates while in jail and assisted them to address these issues; obtained video capabilities to provide remote assessments and transitional work to inmates; all mental health staff attended an on-boarding academy at King County regarding Care Transitions prompting numerous improvements in service delivery by individual clinicians.**

**2021 – Implemented procedures to use Collective Medical alerts to track when our clients were seen in an emergency department or admitted to a hospital. Staff made direct contact with said clients on the same or next day after notified of their medical circumstances.**

**2022 – Consistently used Collective Medical effectively.**

**2023 – Used Collective Medical effectively.**

3. Work toward prevention, intervention & treatment of opioid use and misuse.

**2020 – Narcan kits at each location and trained new staff on how to use them; dispensed Narcan kits to clients and employees who wanted them; provided trainings at Ballinger Homes Public Housing and one for King County Housing Authority employees on how to use Narcan; provided treatment and relapse prevention to opioid users; posted related messages on our Facebook page.**

**2021 – Continued with our efforts from 2020. Increased the number of Narcan kits that we received and dispensed. Provided training on how to recognize overdose and how to administer Narcan.**

**2022 – Our SUD Director worked as lead on the Practice Transformation Cohort for North Sound ACH. We distributed approximately 150 Narcan kits.**

**2023 – CHS continued to dispense Narcan at all of our sites. SUD Director provided training to community on using Narcan.**

4. Promote child health (including well-child visits, immunizations, etc.)
   **2020 – Resource/information sharing occurred in our Kaleidoscope Play & Learn groups prior to and during COVID; all clinical assessments with children and parents included questions about last well-child visit and immunizations, along with prompts to provide resources if needed.**
   **2021 – Continued with 2020 efforts. Process became institutionalized and built into our clinical assessments in the electronic health record.**
   **2022 – Routinely promoted child health. Practices are now institutionalized. This objective is closed.**

5. Develop & use methods to access, track, measure, and evaluate data that shows progress toward regional goals.
   **2020 – Continued to develop reports in Credible that allowed us to track, measure and show progress toward goals. Provided training to leadership about how to access and evaluate these reports.**
   **2021 – Tracked relevant data and measured to evaluate our progress toward regional goals.**
   **2022 – Tracked relevant data and measured to evaluate our progress toward regional goals. Our work is supporting regional goals.**
   **2023 – Invested in a new Data Collection tool (Janet); began developing build-out with consultants.**

**GOAL 2:** Provide quality services that result in positive outcomes for our clients.

**Objectives:**

1. Apply evidence-based and promising practices throughout our programming to achieve desired outcomes.
   **2020 – All staff trained in EBPs; workflows implemented on treating depression and anxiety using EBPs.**
   **2021 – Using evidence-based practices throughout our programs. Began tracking which EBP was used during encounters in the electronic health record.**
   **2022 – Continued to record EBPs during encounters, but the information was not consistently tracking correctly, and the information was not being transmitted to MCOs by billing team.**
   **2023 – Traced EBPs during encounters. Billing team fixed the problem noted earlier and began transmitting the EBPs with encounters to the MCOs. Began re-training staff on how to record EBPs used.**

2. Continually improve performance for client and community benefit.
   **2020 – Even through the pandemic our performance outcomes remained very good.**

**2021 – Performance outcomes remained good.**
**2022 – Performance outcomes continued to be good.**
**2023 – Very pleased with our performance and outcomes.**

3. Maintain CARF International accreditation for substance use disorder services and mental health services.
   **2020 – Maintained CARF accreditation; next CARF accreditation review will be in 2021.**
   **2021 – CARF accreditation was extended to 2022 due to CARF's backlog as a result of COVID-19.**
   **2022 – CARF surveyors spent three days working with us, resulting in a very complementary report and a 3-year accreditation.**
   **2023 – Continued performing according to CARF standards. Maintained our accreditation.**

4. Provide whole-person care that addresses social determinants of health.
   **2020 – Implemented process to screen all new clients for SDOH issues and develop case management goals to address these needs.**
   **2021 – Clinical programs used SDOH questionnaires routinely, particularly with new clients.**
   **2022 – Clinical programs and case managers routinely used SDOH questionnaires and worked with clients to improve situations when possible.**
   **2023 – Clinicians and case managers were routinely using SDOH questionnaires and working with clients to improve situations when possible. Family Support Department also used SDOH questionnaires to help determine case management needs and allocation of emergency funds using Bothell ARPA grant allotment.**

## Strategy 3

### Promote Community Engagement Through Collaborative Partnerships

**GOAL 1:** Strengthen marketing and outreach efforts to increase community awareness and investment in CHS.

**Objectives:**

1. Maintain up-to-date web page, brochures, and other marketing material.
   **2020 – Web page was redesigned and updated; began creating new brochures.**
   **2021 – Web page working well; agency brochures were created and printed.**
   **2022 – New brochures were created and printed for the agency and several programs. Numerous printed materials were made**

**available. Web page remained active although we were sometimes slow in making changes to it.**

**2023 – Continued updating brochures & printed materials as needed. Updated web page as needed.**

2. Utilize social media to promote our services.

   **2020 – Actively posted on our Facebook page.**

   **2021 – Increased frequency of posting on our Facebook page.**

   **2022 – Increased posting frequency from previous year and gave posting authority to additional staff.**

   **2023 – Maintained steady posting to our social media outlets.**

**GOAL 2:** Build and maximize community partnerships with entities such as schools, medical clinics, governments, community-based organizations, managed care organizations, etc.

**Objectives:**

1. Identify existing and potential partnerships and create an integrated approach to strengthening relationships.

   **2020 – We adapted our work with partners to continue our work through the pandemic.**

   **2021 – Continued to work with partners in ways that worked best during the pandemic.**

   **2022 – As organizations began working with less pandemic restraints, partnerships were revived and new connections were made.**

   **2023 – Partnerships with existing partners grew. New partnerships, such as with Housing Hope and additional medical clinics began.**

2. Keep local, regional, and state governments informed regarding human services needs and gaps.

   **2020 – Participated in several local and regional coalitions that advocate for human services; met personally on two occasions with our King County Council Member to discuss specific needs of CHS; worked with NUHSA to educate city governments on human services needs/gaps; provided testimony twice to Bothell City Council and participated in group conversations with Bothell council members and the City Manager individually; worked with the Cities of Shoreline, Kenmore, and Lake Forest Park about human services needs, specific to COVID-19.**

**2021 – Shoreline, Lake Forest Park, and Bothell were all very supportive of us during another year of the pandemic. Had conversations with political leaders through Zoom.**

**2022 – Worked closely with government entities regarding behavioral health needs in the community we served. Worked extensively with the City of Bothell; their City Council approved our request to use some of the city's COVID-19 ARPA federal funds to establish a CHS presence in Bothell. Opened new offices for mental health services and family support. Began providing services in local schools. Family Support staff distributed ARPA funds directly to Bothell residents and Shoreline residents in need of financial assistance as a result of the pandemic – ARPA funds provided by the respective cities. City of Shoreline also provided additional ARPA funding to help with family support capacity. The City of Kenmore used some of their ARPA funding to contract with us to provide mental health services in a local school. The pandemic definitely magnified all of the government entities' awareness of behavioral health service needs and gaps.**

**2023 – Continued to work with NUHSA to educate local and regional governments about human services needs. Worked independently with County Councilmember, Rod Demboski, regarding increasing King County funding. Attended and participated in stakeholder meetings and focus groups by government officials. Hosted City of Shoreline focus groups regarding their strategic plan. Executive Director or another Director testified at City Council meetings (Shoreline, Bothell, Kenmore, Lynnwood, Lake Forest Park) to keep them informed. Executive Director made a presentation to Shoreline City Council regarding CHS.**

**GOAL 3:** Focus advocacy efforts on issues that impact the mission of CHS.

**Objectives:**

1. Develop an Advocacy Plan that is specific, measurable, and relevant.

**2020 – Most advocacy work in 2020 was devoted to finding financial support for COVID-19 relief. Our Executive Director worked with our County Council Member Rod Dembowski to successfully get CHS written into the King County budget as a special line item for $50,000 for 2021.**

**2021 – Advocacy work focused on COVID-19 relief, improving Medicaid rates, and the workforce shortage.**

**2022 – Advocacy work continued to focus on COVID-19 recovery and workforce shortage.**

**2023 – Advocacy work had a primary focus on workforce enhancements and rate increases.**

2. Dedicate time and energy to implement the Advocacy Plan.

**2020 – Most significant activity and advocacy came when the City of Bothell decided to discontinue funding human services. Partnering with North Urban Human Services Alliance (NUHSA), our Executive Director and one board member participated in numerous conversations with the City Manager and City Council members and testified at a council meeting urging them to reconsider. We were successful in getting funding extended for 2021. Also had meetings with our King County Council Member and one of our State Senators.**

**2021 – Executive Director participated in advocacy efforts individually and as a part of several community groups.**

**2022 – Several leadership team members, including the Executive Director, participated in various advocacy efforts. Various staff made presentations to North Urban Human Services Alliance (NUHSA). Executive Director made a presentation to the North Sound ACH advocating for our work. Staff presented information to three different city councils.**

**2023 – Executive Director and other Directors participated in advocacy efforts individually and as a part of several community groups. We attended (and testified at) several city council meetings including Shoreline, Bothell, Kenmore, and Lynnwood.**

## Strategy 4

### Build a CHS Workforce that is Second to None

**GOAL 1:** Recruit, develop, and retain staff and volunteers that deliver exemplary services.

**Objectives:**

1. Offer competitive salaries to employees

**2020 – The 2020 staff satisfaction survey showed that 17% of the staff felt like their salaries were not competitive. We were able to give an agency-wide raise in 2020.**

**2021 – Revised salary scale for clinical staff to make it more competitive.**
**2022 – Gave everyone a $4.00 an hour raise, making our wages very competitive.**
**2023 – At the beginning of 2023, we gave all staff a 6% raise. The board voted to give staff a 5% raise effective January 1, 2024, and change our current salary scale at the same time to include an increase of 4%. In 2023, the board approved a $1500 bonus to be paid to staff.**

2. Offer exceptional benefits to employees.
**2020 – Continued to offer health insurance at no cost for employees with no deductible, no co-pay, & no co-insurance; match for retirement investment; more than typical amount of paid time off, plus an additional 3 days the week of Christmas due to COVID fatigue.**
**2021 – Continued to offer health insurance at no cost for employees with no deductible, no co-pay, & no co-insurance; match for retirement investment; gave 35 days of paid time off (vacation, sick, and agency observed holidays), plus an additional 3 days the week of Christmas due to COVID fatigue.**
**2022 – Continued to offer health insurance at no cost for employees with no deductible, no co-pay, & no co-insurance; provided a match for employees' retirement investments; gave 35 days of paid time off (vacation, sick, and agency observed holidays), plus an additional day the week of Christmas.**
**2023 – Continued to offer exceptional benefits including health insurance at no cost for the employee with no deductible, no co-pay, & no co-insurance; provided a match for employees' retirement investments; gave 35 days of paid time off (vacation, sick, and agency observed holidays), plus an additional day the week of Christmas.**

3. Maximize internship opportunities.
**2020 – Even through COVID-19, we had six clinical interns from four different school programs as therapists.**
**2021 – Although COVID-19 still impacted our ability to recruit interns, we had eight interns in 2021.**
**2022 – We had eight interns.**
**2023 – We had ten interns in 2023.**

4. Provide exceptional supervision and training to employees/volunteers.
**2020 – Full time staff received 1 hour of supervision weekly (may have been prorated for some part-time employees); offered group supervision for one hour twice a month for MSW staff needing supervised hours for licensure (using a contracted MSW supervisor); provided additional supervision (by adding another part-time clinical supervisor) by LMHC for clinicians needing LMHC supervision hours for licenses; standardized annual**

**employee training was conducted and each program implemented a training plan specific for their staff.**

**2021 – We continued to provide the level of supervision as noted in 2020. At one point, we lacked enough approved supervisors to provide "approved supervision" for licensure, so we paid staff a stipend to receive outside supervision. All departments implemented training plans.**

**2022 – We now have numerous approved supervisors on staff. Full time staff received 1 hour of supervision weekly (may have been prorated for some part-time employees); offered group supervision for one hour twice a month for MSW staff needing supervised hours for licensure.**

**2023 – We continued to have several approved supervisors on staff. Full time staff received 1 hour of supervision weekly (may have been prorated for some part-time employees); offered group supervision for one hour twice a month for MSW staff needing supervised hours for licensure.**

5. Provide employees/volunteers the tools they need to do their jobs.

**2020 – Because of the pandemic, we replaced numerous laptops so they were faster and had a camera for telehealth as well as webcams, microphones, earphones, and headsets. We provided extensive onboarding experiences for new staff and on-going trainings to all staff to give them the skills they need to do their job.**

**2021 – Since we worked both remotely and at offices, most of our trainings were offered virtually. We were able to continue with our training schedule without interruption.**

**2022 – All staff had the electronics (desktops, laptops, phones) they needed to do their jobs; they are kept in working order and replaced when outdated. Various staff attended trainings on how to provide evidence-based practices. While we could always use additional therapeutic curricula, toys, games, etc., we believed all staff had the tools needed to do their jobs without compromise.**

**2023 – As substantiated by the Employee Satisfaction Survey, staff, for the most part, believed they had the tools they needed to do their jobs. We replaced computers and phones according to our replacement schedule. Some new curricula and items for child play were purchased.**

# TREND ANALYSES

# &

# ASSESSMENTS

# CONTINUOUS QUALITY IMPROVEMENT (CQI)

In 2023, CHS (with the help of outside consultants) restructured our CQI Program into three distinct groups: Leadership CQI (All Directors, Associate Directors, and Managers), Systems CQI (relevant staff working on systems' improvements), and CQI Management (Associate Directors, Managers, and Executive Director). These three teams meet at least once a month to discuss and act upon CQI issues.

CHS uses our Leadership Continuous Quality Improvement (CQI) Team to develop, review, and update our Accessibility Plan; Risk Management Plan; Diversity, Equity, Inclusion & Belonging (DEIB) Plan; and our Quality Improvement Plan. The CQI Team usually met twice a month and addressed other quality improvement issues or initiatives.

## Accessibility Planning

### Overview

A 2023 Accessibility Plan was an extension of our 2020 – 2022 Plan with a few additions. The plan was developed by the CQI team and reviewed regularly in 2023. The Accessibility Plan and our analysis of the review of the plan are shared through minutes, all staff meetings, this report, etc. A new Accessibility Plan will be adopted by Leadership CQI early 2024.

The following is a review of the barriers and action items and their status at the end of 2023.

### 2023 Accessibility Plan Review & Analysis

## Accessibility Plan - 2023 Review

**Attitudinal**

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Stigma toward individuals with behavioral health issues and ability to recover | • Educate staff<br>• Educate public<br>• Promote a culture of recovery & resiliency | Attitude and stigma remain barriers for some people who are seeking and receiving services. This category needs to be continually addressed. The following steps were taken in 2023 to improve |

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| Stigma toward minority cultures & different socio-economic groups. | • Educate staff<br>• Educate public<br>• Promote a welcoming and inclusive environment. | accessibility that could be inhibited by attitude.<br>• CHS continued certification as a Trauma-Informed Agency by CARE.<br>• CHS allowed traditionally under-represented groups to hold support meetings or other activities at our locations. These included battered women, AA, NA, kinship caregivers, and Arabic Language School.<br>• We held equity trainings for our staff and each department |

## Physical & Architectural

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Need for more trauma-informed spaces to see clients. | Continual assessment by the TI Work Group. Improve spaces as opportunities allow. | Workspaces improved where possible. |
| Vandalism & buildings need to be more secure. | Assess security of buildings and implement solutions. Improve lighting where needed. | Improved lighting at Lynnwood & 170th sites; installed new security system & monitoring at 170th. |

## Policies, Practice & Procedures

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Development, revisions, updates, and combinations of existing or non-existing clinical policies & procedures need to be made. | Integrate new policies & procedures in relation to WACs/RCWs, BHO requirements, county requirements, & CARF. | Additional revisions were made, and some new policies were established to comply to clarify intent. |
| Language barriers. | Hire more staff; educate staff on use of interpreters and translators. | 30% of our staff are bilingual. In 2023 we used both telephone interpreters and in person interpreters. Staff were provided details on how to request an interpreter. |
| Too much time between assessment and first on-going appointment. | Improve response time for assessment first on-going appointment | Time between assessment and first appointment has improved overall. |

## Communication

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Some agency cell phones need replacement. | Purchase new cell phones on a regular basis. | At the end of 2023 all staff who needed cell phones had them and many were upgraded. |
| Not all program brochures are up to date. | Update and print marketing material. | All program brochures were updated and printed. |
| Difficulty communicating by text with clients in WISe program. | Upgrade staff phones. | All CBIS phones were upgraded and dispensed. |

## Technology

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Some computers need replacing. | Replace computers according to replacement rotation schedule | Everyone has a computer that is reliable. We followed our replacement rotation schedule. Accurately tracking computer assignments |
| Cost of computer replacement for staff. | Implement a Replacement Plan to replace all computers on a rotating basis. | All costs were budgeted. |
| Not utilizing Credible as effectively as we could. | Build reports & explore use of unused tabs. | We have hired a company that's line of business is Credible Data Management to create a new data retrieval system (Janet) for us. In process of having reports built |

## Financial

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Need to increase billing. | Increase number of clients & service encounters. Assure that all encounters are billed, and payments received. Recoup state Medicaid direct billing. | Service encounters in 2023 were very good. Having success with Qualia doing our IMC/MCO Medicaid billing. Successfully recouped some State Direct Medicaid missed billing and are currently billing State Direct correctly and being paid correctly. |
| Rates do not cover all costs for services. | Negotiate rates with MCOs and other contractors. | Received a 7% increase in 2023. Will receive a 15% in 2024. |
| Some clients are not insured or have insurance deductibles so high that they discourage use of coverage. | Obtain more unrestricted funds to subsidize services. | We obtained significant funding from Snohomish County for behavioral health services for low-income individuals without adequate insurance. Received additional |

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| | | funding from Snohomish County so now there is funding for low-income non-Medicaid clients for School & office-based mental health clients, IEC clients, BHI clients, and SUD clients if they live in Snohomish County. |

## Transportation

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Some clients have trouble accessing services due to lack of transportation. | Work with clients in accessing various transportation options including the new light rail system. | Assisted clients by providing ARPA funds for transportation needs, utilizing HopeLink services, utilizing public transportation options including buses and light rail. |

## Employment

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Some clients have a difficult time finding and keeping a job. | Include employment goals in ISPs when appropriate; develop partnerships with employment programs. | We continue to work with employment goals in clients' individual service plans. |
| Workforce shortage for clinicians affects quantity & quality of services. | • Use Workforce Shortage special funds wisely<br>• Educate legislators about improving Medicaid rates so a reasonable wage can be paid | Gave agency-wide raises and extra days off.<br>Ex. Dir. working with 3 coalitions/networks to educate legislators.<br>Medicaid rates were increased in 2023 and budgeted by the State for an increase in 2024. |

## Community Integration

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Lack of knowledge of available community opportunities and resources. | • Educate clients and staff<br>• Use Care Coordinators as source experts<br>• Use Case Managers to explore resources and assist clients assess them<br>• Screen clients for SDOH | Worked on educating clients about available community resources. Used Care Coordinators & Case Managers to develop resource information. We do not have capacity for all clients to have SDOH screens, but most receive this. |
| Clients (particularly youth) are reluctant to become involved in pro-social activities. | Educate clients on what is available to them; include pro-social activities as part of ISP when appropriate. | Pro-social activities are being used in treatment plans as needed. |
| People of color are disproportionately represented in the criminal justice system. | Advocate for and model racial equity. | Conducted trainings and facilitated/directed conversations regarding racial equity. Staff attended equity trainings. We regularly posted messages on our Facebook page related to equity. DEIB Director was active in exploring how we can improve our work around racial equity and educating staff. |
| Lack of affordable housing. | Utilize case managers and other staff to assist clients find housing | Used case managers to assist clients with housing issues. A grave shortage of affordable housing remains a problem. Used ARPA funds in Bothell and Shoreline to help residents with housing issues. |
| Issue of racial justice and equity nationally. | • Model inclusion and equity<br>• Anti-racism work within our agency | Worked with consultants to work with us on anti-racism & leadership. DEIB Director developed a new DEIB Plan. |

## Other Barriers

| IDENTIFIED BARRIER | ACTION PLAN | STATUS - End of 2023 |
|---|---|---|
| Childcare is inaccessible for some clients and very expensive for staff. | Offer as much free childcare as possible when clients are in session and promote its use. Continue to improve wages for staff. | This has been achieved for SUD King County clients through PPW funding. However, it remains an issue for other programs. Took steps to raise employees' wages. |
| High cost of living for both clients & staff were barriers in multiple ways. | Continue to help clients thrive and increase wages for staff. | Utilized all resources available for our clients & raised employees' wages. |

# Risk Management

## Overview

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

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

We continued to monitor and address cyber security in 2023.

Additional risk management activities in 2023 included:

- All staff adhere to the confidentiality rules outlined in 42 CFR, part 2 and 45 CFR (HIPAA).
- Background checks were completed on all employees and volunteers.
- HR routinely checked the LEIE Exclusion List to look for any of our employees who may be on the list. None were found.
- At orientation with new employees, Human Resources verified the employee's credentials and received consent to obtain a driving record on the employee.
- All new employees signed our Substance Use Policy and our Ethical Codes at orientation.
- Accounting policies and procedures were reviewed and updated.
- Board members signed an attestation regarding no conflict of interest by serving on our board.

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

The Risk Management Plan identifies our loss exposure or risks. The Leadership CQI Team reviewed the potential loss categories regularly and analyzed the loss exposure (likelihood of occurrence and seriousness of risk), identified how to rectify identified exposures, implemented actions to reduce risks, and reported results of these actions.

The 2023 results of our risk mediation efforts follow.

# CHS Risk Management Plan for 2018-2025

## 2023 Review

| Loss Exposure/ Risk | Analysis of Loss Exposure | | | | | | Actions to Reduce Risks | Projected Results | Actual Results |
|---|---|---|---|---|---|---|---|---|---|
| | Likelihood of Occurrence | | | Seriousness of Risk | | | | | 2023 |
| | Low | Med | High | Low | Med | High | | | Baseline 2022 |
| **FISCAL** | | | | | | | | | |
| Loss of funding | | | X | | | X | Increase marketing and grant requests. Replace lost funding with new funding.<br><br>Apply for federal Payroll Protection Program (PPP) funding and other local or regional COVID-19 relief funding. | Funding base will be increased by 5%. | Revenue was increased by well over 5% compared to 2022.<br><br>Goal met in prior years. |
| Expenses exceed revenue | | | X | | | X | Maintain internship relationships with schools. Maximize available billing hours. Bill more insurance. Monitor monthly budget to identify trends of excess costs or under-billing. Increase revenue. Find ways to lower costs. | Cost will stay even with or less than revenue | Our expenses were less than budgeted, primarily because of staffing vacancies. Did not focus on private insurance billing and tried to maximize our Medicaid funding instead. |

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| Delay in payment | | | X | | X | | Participate in conversations with decision makers regarding impact of new funding structures. Increase communication with funders. Build reserves. | Reserves will be ample to cover all expense for 3 months. | All identified strategies to mitigate this risk occurred. Executive Director participated in Clinical Operations Committee of KCICN and other coalitions to strategize how to deal with the impact of the funding method in King County. We have maintained reserves that will cover a minimum of 3 months of expenses. |
| **HUMAN RESOURCES** | | | | | | | | | |
| Loss of key personnel | | X | | | | X | Open door policy for all supervisory staff members. Transparency in all business dealings. Retreat. Boost employee retention efforts. Maintain exceptional benefits. | Minimize “key staff” turnover | No key positions were vacated in 2023. Implemented all strategies in our mitigation plan. Executive Director announced her retirement will be at the end of 2027. A 5-year succession plan was shared with |

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| | | | | | | | | | Board and management. |
| Increase in training requirements | | X | | | X | | Simplify access to training. Use of Relias web-based training. Review and update training curriculum. Stay up to date with training requirements. Customizing and documenting training (new hires & on-going). | 100% of required staff trainings will be offered. There will be a 95% completion rate for all training requirements. | We continued to offer trainings in 2023 and met our training goals. All identified strategies to mitigate this risk occurred. |
| High staff turnover | | | X | | | X | Utilize staff incentive programs. Utilize satisfaction surveys. Utilize exit interviews. If possible, increase salaries. Maintain excellent employee benefits. Improve training programs. Involve line staff in decision-making when appropriate. Explore new ways to invest in employees. | Reduce staff member turnover by 10%. | Our turnover rate at the end of 2023 was 27% This is a decrease of 17% from the prior year. Rate of staff turnover improved after implementing significant salary increases. However, there is simply a shortage of professional staff and there is an abundance of competition. We utilized all of the identified methods we identified to mitigate this risk. |

| SERVICE DELIVERY | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Improper service documen-tation | | | X | | | X | Increase staff training & improve professionalism. Standard utilization of collaborative documentation. Supervisors monitor case notes. Proactive clinical supervision. Keep training manuals up to date. Maintain professional liability insurance. | Excellent clinical documentation | Documentation was an issue for several clinicians. Primarily the issue is about including all the required data elements in our notes. We streamlined and simplified our forms and processes as much as possible. We hired a 32 hour a week QA Manager (new position) to assist with this issue. |
| Poor outcomes or outputs | | X | | | X | | Proactive clinical supervision. Use evidence-based practices. Staff training. | Excellent outputs and outcomes. | Continued to provide weekly clinical supervision. Use of EBP recorded in clients' records & are reportable. Outcomes and outputs were very good in 2023. All identified strategies to mitigate this risk occurred. |

| HEALTH & SAFETY | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Serious on-site accident | | X | | | X | | Safety trainings for all staff members. Maintain proper insurance. Active Safety Team. Timely repair of hazards. | Avoidance of serious accidents. | One on-site accident occurred when a client fell in our lobby at 148th. No serious injury occurred. All identified strategies to mitigate this risk occurred. |
| Traffic accident | | X | | | X | | Properly orient staff members who are drivers. Staff training. Minimize travel. Ask City for flags at cross walk at 148th. Maintain vehicle insurance or consider de-commissioning the agency van. | Reduce number of annual traffic accidents. | Staff had 2 car accidents while working, using their personal vehicles. Neither accident caused injury Prior years: flags were put out for crossing 15th Ave. in Shoreline at the 148th building, & we dispensed of the agency van. |
| Fire incident | X | | | | | X | Safety trainings for all staff members. Train staff members about safety plan. Maintain adequate property insurance. | No fires. | No fires occurred. All identified strategies to mitigate this risk occurred. |
| Disaster | | | X | | | X | Educate staff regarding our Emergency | As small an impact on our operations | Our Emergency Operations |

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| | | | | | | | Operations Plan. Contingency planning. Maintain adequate insurance. | and continuation as possible. | Plan is up to date. We maintained the same level of insurance. All identified strategies to mitigate this risk occurred. |
| Potential of violence or harmful situations | | X | | | | X | De-escalation & other safety trainings; safety drills; safety inspections; implement safety protocols for new situations. | No violence or threat of violence occurs at CHS, or if it occurs, harm is minimized. | The few cases of behavioral escalation by clients were controlled with de-escalation techniques. No remarkable situations occurred. All identified strategies to mitigate this risk occurred. |
| **LEGAL** | | | | | | | | | |
| Sexual harassment charges | X | | | | | X | Training during orientation and annually thereafter. Maintain proper insurance. | No sexual harassment incidents. | No sexual harassment was reported. Both of the identified strategies to mitigate this risk occurred. |
| HIPAA or 42 CFR violation | | X | | | | X | Training in confidentiality. Maintain insurance (including cyber insurance). Training about HIPAA security. HIPAA security audit. | 0 reportable incidents | Only minor violations were reported, and none had any consequence to the agency. Cyber ins. was maintained. Conducted our standard HIPAA Security |

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| | | | | | | | | | audits with no major concerns found. All identified strategies to mitigate this risk occurred. |
| Malpractice lawsuit | | X | | | | X | Educate staff on documentation techniques. Effective client grievance process. Regular supervision, performance coaching, & training. Maintain insurance. | 0 lawsuits | No lawsuits were filed against us. Insurance was maintained. There was one client grievance reported, and it was handled on the Dept. Director level. All identified strategies to mitigate this risk were implemented. |
| Waste, fraud & abuse | | X | | | | X | Have strong w/f/a policy. Educate staff on what w/f/a is and how to report violations. Implement quality assurance measures to verify proper billing. | 0 waste, fraud, or abuse. | No incidents of waste, fraud, or abuse were reported or suspected. All identified strategies to mitigate this risk were implemented. |
| Employment practice lawsuit | | X | | | X | | Effective employee grievance process. Regular supervision, performance coaching, & training. Mgt training. Maintain insurance. | 0 lawsuits | No lawsuits were filed against us. HR Director participated in various trainings about employment practices. All identified strategies to |

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| | | | | | | | | | mitigate this risk occurred. |
| **TECH-NOLOGY** | | | | | | | | | |
| Data breach or data loss (affecting confiden-tiality, integrity, or availability of EPHI) | | X | | | X | | Maintain strong back-up policies & procedures. Review back-up P&Ps annually. Regular testing by IT vendor. Maintain cyber insurance. | 0 data breaches | No reportable data was breached. Tested per schedule. All identified strategies to mitigate this risk occurred. |

# Diversity, Equity, Inclusion, & Belonging (Cultural Competency and Diversity)

## Overview

CHS's Diversity, Equity, Inclusion, and Belonging (DEIB) Plan is woven into every aspect of our work. The plan is developed in collaboration with CHS leadership. It is the DEIB Director's responsibility to assure that our DEIB Plan is relevant, implemented, tracked, and analyzed on an annual basis. Input was considered from employees, clients, and other interested parties in the development and analysis of this plan. The plan is based on the consideration of culture, age, gender, sexual orientation, gender identity, gender expression, spiritual beliefs, socioeconomic status, and language. The DEIB Plan and our analysis of the review of the plan are shared through minutes, all staff meetings, board reports, other presentations by the DEIB Director, this report, etc.

## 2023 DEIB Plan Review & Analysis

**2023 Diversity, Equity, Inclusion, & Belonging Plan**
**AKA Cultural Competency & Diversity Plan**
**Review**

**GOAL**: CHS seeks to improve the quality of life of all staff members, clients, and other stakeholders by providing a dynamic and well-rounded Diversity, Equity, Inclusion, & Belonging Program. Through the DEIB Program, employees will gain skills and learn processes that will help them navigate through difficult situations and conversations centering around race and social justice. Building upon these skills will help empower staff to build stronger and more collaborative relationships with persons served, colleagues, and other stakeholders. This includes communities they belong to, as well as historically excluded community members, where this exclusion has been based on factors such as race, age, culture, gender / gender expression, sexual orientation, spiritual beliefs, limited English proficiency, ability / disability, and various other factors. CHS will strive to model the importance of effective allyship, self-care, authenticity, and cultural humility by continuing to embody CHS's core values in our interactions and relationships with all stakeholders.

**Guiding Principles of the DEIB Program**

Antiracism is our GUIDING LIGHT
Cultural Humility is the PATH we walk
Decolonizing Behavioral Health is our GOAL

The top priorities for 2023 were # 1, 5, 8, 9, and 10
DEIB Director was responsible for implementation and monitoring of DEIB Plan.

| Action Steps | Strategies | STATUS – End of 2023 |
|---|---|---|
| Identify, recruit, select, and retain employees, board members, and volunteers that are reflective of the diverse population we serve. | • Continue outreach efforts and collaborations with partner organizations and community stakeholders - with intentional focus on organizations that work with BIPOC populations or whose values align with CHS.<br>• Build partnerships with higher education institutions - with specific outreach to BIPOC, immigrant, and other historically excluded community led student clubs / organizations.<br>• Build / launch an internal "self-care / regular maintenance" campaign amongst staff<br>  ○ Encourage staff to build healthy habits in order to mitigate burnout.<br>  ○ Redefine the conversation around the term "self-care" and begin shifting the conversation towards "routine maintenance". | • Timeline: Ongoing<br>• Progress:<br>  ○ 2022 Turnover Rate: 43.7% / 2023 Turnover Rate: 25%<br>  ○ 2022 Growth Rate: 2.3% / 2023 Growth Rate: 13.2%<br>  ○ Partnership / connections created between CHS and higher education institutions.<br>  ○ Partnerships / connections built with external agencies, organizations, and governmental entities.<br>  ○ DEIB Director diversified outreach / recruitment efforts.<br>Continued internal investment in the professional development of existing staff. |
| Review existing policies to ensure that they align with our core values and DEIB guiding principles. | • Continue creating avenues of honest feedback for staff.<br>  ○ Reassure staff that their ideas are heard, discussed, and implemented as needed.<br>• Work collaboratively as a Leadership Team to provide transparency in our decision-making process. | • Timeline: Annually<br>• Progress:<br>  ○ Leadership Team has been working towards solidifying how policy changes can be communicated to staff that incorporates transparency and time to provide feedback.<br>  ○ Employee manuals and policies continue to be revisited to ensure that language and wording are inclusive, up to date, and trauma-informed. |
| Create and maintain marketing and outreach materials that are easily updateable and reflective of our communities. | • Build a cohesive branding and marketing strategy that's reflective of CHS.<br>  ○ Ensure that our information about our programs and services is up to date. | • Timeline: On-going<br>• Progress:<br>  ○ DEIB Director created CHS Canva Account and implemented Canva 101 training. |

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| | ○ Use Canva to create materials.<br>• Place our marketing materials in strategic spaces.<br>○ Partner with small local businesses, especially those that are immigrant / BIPOC owned | ○ Marketing materials have been created that represent CHS' core programs and services.<br>○ Business Card format has been updated to be more inclusive of staff needs and to be more cost effective. |
| Assess and modify the physical facility and tools to reflect the population we serve, to be welcoming, clean and attractive by providing cultural art, magazines, culturally relevant toys, etc. | • Do an audit of all locations through a DEIB / Trauma-Informed lens.<br>• Ensure that all locations are accessible to folks regardless of physical and mental abilities.<br>○ This includes an in-depth assessment of physical, auditory, and other sensory environmental factors and how they affect different populations, such as those who are neurodivergent. | • Timeline: On-going<br>• Progress: (specifically around physical safety of locations)<br>○ Investments made into ensuring CHS locations are physically safe and welcoming for staff and community members.<br>○ Cleaning and organizing of locations to accommodate new staff offices and maximize utilization of existing spaces. |
| Continue to build and maintain psychologically safe spaces for staff and other stakeholders. | • Maintain open avenues of feedback<br>○ Provide various ways of sharing feedback (in-person, formal, informal, etc.…)<br>• Implement a staff satisfaction survey annually.<br>○ Ensure anonymity for honest feedback. | • Timeline: On-going<br>• Progress:<br>○ Anonymous Client / Participant and Stakeholder Satisfaction Surveys sent out.<br>○ Anonymous Employee Satisfaction survey was sent out.<br>○ Survey results trended positively on all avenues and shared with CQI leadership team for evaluation. |
| Assess the linguistic capabilities of our staff and work towards ensuring we're meeting the linguistic needs of our community members. | • Hire and compensate staff who are bi or multi-lingual.<br>○ Ensure that we are taking lived experience into account when we are hiring.<br>• Provide training and support to all staff on how to access and successfully communicate with the use of interpreters. | • Timeline: On-going<br>• Progress:<br>○ Investing in interpreter certification training for multilingual staff (Family Support staff specifically).<br>○ Conversation amongst leadership on policies and procedures on how |

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| | | to access interpreter services, and what are alternative options if services are inaccessible. |
| Ensure that staff from historically excluded communities are provided avenues for their voices to be elevated. | • Continue building capacity amongst staff in order to mitigate burnout.<br>• Encourage the creation of affinity / support groups within individual departments.<br>  ○ Similar to Clinicians of Color Support Group in MH Department<br>• Provide technical and admin support for staff who want to present / implement trainings. | • Timeline: On-going<br><br>• Progress:<br>  ○ Staff satisfaction survey results indicated overall positive relationships dynamics on various levels at CHS.<br>  ○ Community agreements introduced, built, and implemented within different CHS teams, with an emphasis on creating spaces in which all voices can be heard and ideas uplifted. |
| Introduce and begin implementing a new process based DEIB strategy. | • 3 Tier Approach<br>  ○ Antiracism is our guiding light<br>  ○ Cultural Humility is the path we walk<br>  ○ Decolonizing Behavioral Health is our goal<br>• Introduce overview of strategy during All Staff Meetings.<br>• Implement DEIB trainings during Dept Meetings. | • Timeline: On-going<br><br>• Progress:<br>  ○ Successfully introduced 3 DEIB Guiding Principles to CHS staff at all-staff training.<br>  ○ Emphasized how CHS guiding principles, core values, and philosophical approached help create our agency identity.<br>  ○ Shifted CHS DEIB program from “content” learning to “process / behavior based” learning.<br>  ○ Emphasized the importance of building and practicing “self-first” skills (self-reflection, self-awareness, mental flexibility, etc.…)<br>  ○ Introduced a model that helps connect “micro to macro” systems of inequities (how harm and oppression shows up on different levels) |

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| Continue strengthening communication and collaboration amongst staff. | • Introduce the idea of generative conflict in Dept DEIB Meetings.<br>• Get each department on the same training schedule.<br>  ○ Update department leadership monthly on DEIB training efforts. | • Timeline: On-going<br>• Progress:<br>  ○ More instances of inter-departmental collaboration on all levels (programming, client services, and general support).<br>  ○ Brought in CRUX to support CQI team on goal setting, relationship building, and to strengthen interlevel communication skills. |
| Move away from the term / idea of "Cultural Competency". | • Review official CHS documents and remove the term "cultural competency" and replace with "cultural humility".<br>• Explain during all-staff training why we are actively moving away from this term.<br>  ○ Shift from content based to process-based approach.<br>  ○ Gives the wrong idea that culture is static and can be learned instead of experienced. | • Timeline: On-going<br>• Progress:<br>  ○ CHS materials reviewed and updated accordingly.<br>  ○ Introduction of guiding principle "Cultural Humility is the path we Walk" used to explain shift in language. |
| Review and update the DEIB Plan | • Review plan annually | • Timeline: Annually<br>  • Progress: Completed for 2023 |

Additional 2023 efforts related to Cultural Competency and Diversity are listed below:

- DEIB Director position replaced the DEIB Manager position.
- Staff were encouraged to attend trainings on DEIB and given paid time off to do so.
- All job descriptions had elements regarding our expectations regarding cultural humility.
- CHS used certified interpreters during sessions as needed.
- CHS maintained its relationships with agencies that provide cultural-specific services (i.e., Consejo, Asian Counseling & Referral Services, SeaMar, International Community Health Services, etc.) and referred to these agencies when appropriate.
- Play and Learn groups, Out-of-School Time tutoring, parenting classes, and information and referral services were provided in Spanish.
- We hosted a Women and Infant Children (WIC) site where staff speak Spanish, Korean, and Vietnamese at our 170$^{th}$ Shoreline location.
- The CQI Leadership Team worked with consultants intensively to improve our agency from a DEIB perspective.

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

# Technology

## Overview

Technology is an essential part of our business. We use an outside contractor (Real Impact) to help us navigate our technological needs. The Plan is reviewed annually by our IS team and consultants. As is shown in the Plan Review below, we accomplished all of our objectives for the 2021 – 2023 Plan with the exception of two regarding end-of-life servers and the SQL Server migration which will be part of the 2024 – 2026 Plan. We will implement a new Technology Plan in 2024.

# 2021 – 2023 Technology Plan

## 2023 Review

**Information Systems (IS) Team = HR Director; IT Vendor; Finance Director; Executive Director**

## HARDWARE

| ACTION STEPS | PRIORITY | RESOURCES NEEDED | RESPONSIBLE PARTY/PARTIES | TARGET DATE | STATUS End of 2023 |
|---|---|---|---|---|---|
| • Bothell Site infrastructure planning and deployment | High | See Bothell funds | IS Team | 03/01/2023 | Completed 04/2022 |
| • Purchase and set up 50 new laptops | Medium | $100,000 (LFP ARPA funds) | IT Vendor/HR Director | 12/31/2023 | Completed 02/2022 |
| • Purchase and deploy 21 new monitors | Medium | $6300 (LFP ARPA funds) | IT Vendor; HR Director | 06/30/2023 | Completed 02/2022 |
| • Lease and deploy a printer/ copy machine in Bothell location | High | See Bothell funds | IS Team | 03/01/2023 | Completed 06/2022 |
| • Replace printer/copy machines in 3 locations | Medium | TBD | IT Vendor/ HR Director | 07/31/2023 | Completed 03/2022 |

## SOFTWARE

| ACTION STEPS | PRIORITY | RESOURCES NEEDED | RESPONSIBLE PARTY/PARTIES | TARGET DATE | STATUS End of 2023 |
|---|---|---|---|---|---|
| • Maintain current software | High | None | IS Team | On-going | On schedule |
| • Migrate MIP software to Cloud | High | $ TBD | Finance Director/ Vendor | 12/31/2023 | Completed 04/2022 |
| • Purchase new donor database | High | $10k cost annually | Vendor/ ED/ HR Director | 04/15/2023 | Operational 4/13/2023 |
| • Renegotiate the learning software contract | High | $23 k | ED/ HR Director | 04/15/2023 | Completed 5/15/2023 |

## SECURITY & CONFIDENTIALITY

| ACTION STEPS | PRIORITY | RESOURCES NEEDED | RESPONSIBLE PARTY/PARTIES | TARGET DATE | STATUS End of 2023 |
|---|---|---|---|---|---|
| • Media (drives) & software disposal | Critical | $2k cost | IT Vendor | On-going | On schedule |
| • Review back-up policies & revise as necessary (ongoing) | High | Time | IS Team | Annually | Completed 12/2022 |
| • Review Disaster Recovery Plan & revise as necessary (ongoing) | High | Time | IS Team | Annually | Completed 12/2022 |
| • Deploy Multi-factor Authentication to all staff (Includes alternate MFA / physical tokens if needed.) | High | $4000 | IS Team | 10/01/2023 | Completed 01/01/2023 |

| | | | | | |
|---|---|---|---|---|---|
| • Perform quarterly scans for PCI Compliance | High | TBD | IS Team | Ongoing | Completed each quarter |

## FIREWALL

| ACTION STEPS | PRIORITY | RESOURCES NEEDED | RESPONSIBLE PARTY/PARTIES | TARGET DATE | STATUS End of 2023 |
|---|---|---|---|---|---|
| • Continue use of Integra firewall | Critical | Continued funding | IT Vendor; HR Manager | 07/31/2023 | Ended use with Integra 12/2023. |
| • Replace current MPLS firewall with VPNs | High | Continued funding | IT Vendor | 07/31/2023 | Installed 09/29/2023. VPNs - went live 12/31/2023. |
| • Firewall Hardware for 6 sites | High | $9000 | IT Vendor | 07/31/2023 | Completed 08/2023 |
| • Purchase and deploy new VPN for Bothell location | High | Bothell ARPA Funding | IST Team | 03/01/2023 | Completed 06/20/2022 |
| • Test & upgrade virus protection as necessary (ongoing) | Low | Continued funding | IT Vendor | Ongoing | On schedule |

## ENDPOINT DETECTION/SOC/AUDIT LOGGING

| ACTION STEPS | PRIORITY | RESOURCES NEEDED | RESPONSIBLE PARTY/PARTIES | TARGET DATE | STATUS End of 2023 |
|---|---|---|---|---|---|
| • Endpoint Detection and Response | Medium | $2800 / month | IT Vendor; HR Director | **On-going Updated** | On schedule |
| • Managed SOC | Medium | Funding | IT Vendor; HR Director | On-going | On schedule |
| • Microsoft 365 Monitoring | High | Funding | IT Vendor; HR Director | On-going | On schedule |
| • SIEM | Medium | $8000 | IT Vendor; HR Director | **12/2023 Updated** | Completed 01/25/2024 |
| • Security upgrades implementation including new Microsoft 365 features. | Medium | Funding | IT Vendor; HR Director | 06/30/2023 | Completed 01/25/2024 |

## ASSISTIVE TECHNOLOGY

| ACTION STEPS | PRIORITY | RESOURCES NEEDED | RESPONSIBLE PARTY/PARTIES | TARGET DATE | STATUS End of 2023 |
|---|---|---|---|---|---|
| • None needed | | | | | N/A |

## MISCELLANEOUS

| ACTION STEPS | PRIORITY | RESOURCES NEEDED | RESPONSIBLE PARTY/PARTIES | TARGET DATE | STATUS End of 2023 |
|---|---|---|---|---|---|
| • Meet with IT Vendor at least twice a year (ongoing) | Critical | Planning time | HR Director | Annually | Completed |
| • Purchase and deploy access points in new Bothell site | High | Bothell ARPA Funds | IS Team | 03/01/2023 | Completed 04/2022 |

| | | | | | |
|---|---|---|---|---|---|
| • Purchase and replace malfunctioning access points at all locations | Low | $1600 (LFP ARPA funds) | IS Team | 05/31/2023 | Completed 01/2023 |
| • Purchase and deploy laptop bags for 50 new laptops | Low | $1250 (LFP ARPA funds) | HR Director | 06/01/2023 | Completed 09/2022 |
| • Purchase and deploy 26 HDMI Connection Cords | Low | $260 cost (LFP ARPA funds) | HR Director | 06/30/2023 | Completed 09/2022 |
| • Purchase and deploy 50 USB pens | Medium | $2500 (LFP ARPA funds) | HR Director | 06/30/2023 | Goal Deleted |
| • Purchase and deploy 26 DP Connection Cords | Low | $170 (LFP ARPA funds) | HR Director | 12/31/2023 | Completed |
| • Train staff on basic usage of Microsoft Teams | Low | $6000 | IT Vendor/HR Director | 6/30/2023 | Goal Deleted |
| • SQL Cloud Migration | Medium | $12,000 | IT Vendor / Data Team | 12/31/2023 | Pending |
| • End of life server deprovisioning and cloud migration | High | $12,000 | IT Vendor | 06/30/2023 | Move to 2024 – 2028 Technology Plan |
| • End of life servers / cloud hosting | High | $1,000/month | IT Vendor | 6/30/2023 | Move to 2024 – 2028 Technology Plan |

# CORPORATE COMPLIANCE

## Critical Incidents

### 2023 Critical Incidents Review & Analysis

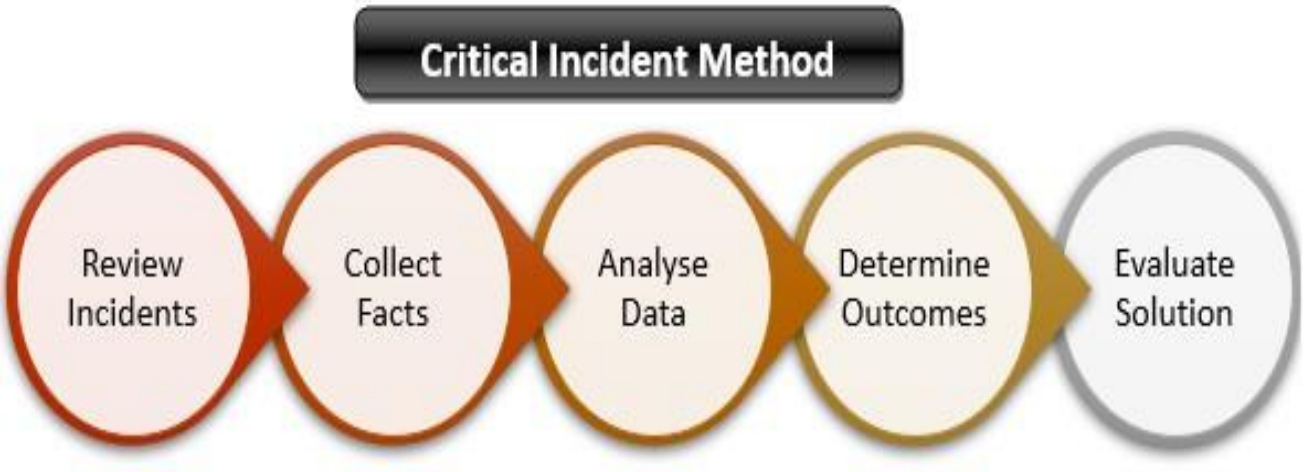
Staff managed **469** Critical Incidents in 2023 which is an increase of 193 from 2022. The incidents fell into the following categories:

| **Type of Incident** | |
|---|---|
| CPS Report | 361 |
| Other | 102 |
| WISe after-hours crisis response | 21 |
| Abuse/neglect and exploitation of a client | 17 |
| Credible threat to client's safety | 10 |
| Suicide/attempted suicide | 9 |
| Major injury or major trauma to client | 4 |
| Media Interest (if known or suspected) | 2 |
| Alleged fraud | 1 |
| Homicide/attempted homicide | 1 |
| Property damaged by a client (on site) | 1 |
| Violent acts allegedly committed by client | 1 |
| Bio-hazardous accident (on site) | 1 |
| Infection control incident (on site) | 1 |
| Use or possession of weapons (on site) | 1 |
| Fall on CHS property | 1 |
| Vehicle accident – staff during work time | 2 |
| **TOTAL** | **472** |
| | |
| **TOTAL** | **472** |

The Corporate Compliance committee reviewed and analyzed the 2023 critical incidents and found the following:

- Cause of each incident – None of the causes of the incidents were out of the ordinary. The incidents were categorized as listed above.
- Trends – The number of incidents increased by over 70%. The only trend noted is that CPS reports were the highest category. The "Other" category is not well-defined and requires more examination.
- Debriefing – Two incidents required debriefing in 2023. One was with the Substance Use Disorders Treatment team when a client overdosed and died. Another was a debrief in the Mental Health Department in regards to the impact of the Israeli/Hamas war.
- Action plans for improvement – Our responses to each incident were appropriate. We plan to continue discussing improving the reporting to clarify what the "Other" category means.
- Results of performance improvement plans – Ongoing training scheduled.

- Education and/or training of personnel needed – Education and/or training was assigned to staff as necessary.
- Prevention of recurrence – None of the incidents were within our control.
- Internal reporting requirements – All internal reporting requirements were met, and incidents were reported in a timely manner.
- External reporting requirements – Occasions when staff were required to report the incident to the MCO were done so properly. CPS and APS reports were made as required.
- Further explanation – The one case of “fraud” was when a hacker was attempting to represent us and was not due to any activity by staff. The situations involving biohazardous materials and infection control were due to the presence of bodily fluid and was minor in nature.



# SERVICE DELIVERY (JAN. 1, 2023 – DEC. 31, 2023)

## Services Provided & Department Highlights

**Mental Health Services**

The Mental Health Department provided the clinical services outlined in its Program Descriptions, including Intake/Assessment, Individual Therapy, Family Therapy, Group Therapy, Conjoint Therapy, Case Management, and Medication Management, when appropriate. These services were provided mainly onsite and face-to-face in our offices, in schools, and in community settings such as the Shoreline Rec Center. We also provided services through telehealth when clients requested. Throughout the year, we worked with both adults and children/youth (age 6 and older).

2023 was another year of transition, growth, and changes in the MH Department. The School Based Team had a growth spurt and provided services onsite throughout many school districts; Office Based Team has been operating onsite at three different locations, and in person assessments and ongoing sessions have continued to increase.

**Highlights of 2023 include:**

- Increased our personnel significantly to add 10 School Based Therapists and a School Based Care Coordinator to expand our School Based Mental Health services. We added therapists to schools from the Everett School District and increased our presence in more schools within Northshore and Edmonds School Districts as well.
- At the end of the year, the Mental Health Department had 68 staff including 8 interns, a Mental Health Director, and an Associate Director. The school-based team has 43 team members that include therapists, interns, a manager, and a care coordinator. One school-based therapist works primarily at the Shoreline Rec Center (through a Shoreline BSK grant). The office-based team has three small teams in Bothell, Edmonds and Shoreline comprised of about 25 staff which includes therapists, a case manager, an administrative support specialist and typically two managers. 2024 will bring more leadership to increase support to the growing teams.
- Worked in 54 schools across 5 districts. In the Edmonds School District, we had therapists at 21 schools (all high schools and middle schools, and 10 out of 21 elementary schools, and E-Learning). In the Mukilteo School District, we had therapists placed at 20 schools, (including Sno-Isle Tech which has students from multiple counties). In the Northshore School District, we had therapists placed at two schools, and added another school with the help of ARPA funds from the city of Kenmore. We also had therapists in 4 Shoreline Schools. We managed 6 grants across these schools. One grant includes the goal of increasing group work within secondary schools within the Edmonds School District with the addition of a .4 FTE Verdant Grant School Based Coordinator to help coordinate this effort.
- We were able to secure more ARPA funding from the City of Kenmore and the City of Lynnwood and were able to retain for one more year funding from foundry10 to support staffing at two alternative schools in ESD and MSD.

- Celebrated the graduation of 8 interns with an outdoor gathering and welcomed 9 new interns for the fall. We changed our internship process back to accepting a cohort for Fall start and added an Intern Coordinator (.2 FTE) to help with the administration and admissions process.
- Expanded our Leadership Team to 5 leaders and began designing new managerial roles for the school-based team by defining and refining tasks and responsibilities from the current SB Manager position (SB Clinical Manager and SB Program Manager) to increase the Mental Health Management Team to 6 leaders by early 2024. We also have a Clinical Supervisors Team (8 supervisors) to support therapists, and the new School Based Clinical Manager role will lead that team to increase cohesion as we support our therapists across districts and sites.
- Mental Health Director actively participated as the Chair in the City of Lynnwood Human Services Commission advocating for MH Services; and at the Council of Trinity Lutheran to collaborate around many items including the Lynnwood Community Center. This community center is planned to be built and running by 2024 and we are hoping that our mental health team will have offices on that site.

## Community-Based Intensive Services

Our Community-Based Intensive Services (CBIS) Department consists of Infant and Early Childhood (IEC) Mental Health and Wraparound/WISe programming. Both of these programs serve families with intensive needs and work primarily in the community (client's home or other convenient location for the client). IEC serves families with a child(ren) under age 6 and people who are pregnant or parenting a child under age 3. Wraparound/WISe provides a team-based intervention with families with children/youth up to 21 who have complex needs and/or are involved in other systems (i.e., Child Welfare, Juvenile Justice, Special Education, etc.).

### 2023 highlights for the CBIS Department included:

- Received and processed over 150 referrals for WISe/Wraparound.
- Refined tools and procedures to improve WISe/Wraparound service delivery.
- Celebrated a CHS WISe employee being recognized as a statewide "WISe Champion".
- Supported two WISe staff in participating as presenters at the annual WISe Symposium.
- Celebrated the completion of the 18-month Child Parent Psychotherapy certification for a cohort of IEC therapists.
- Began a collaboration between CBIS and Housing Hope, providing regular consultation and coordination of services for housing hope staff and the families they serve.
- Continued to expand the WISe team to increase representation of BIPOC and LGBTQIA+ staff.
- Continued to be known regionally as a leader in providing intensive services to LGBTQIA+ youth, particularly trans and gender nonconforming youth.
- Grew the Birth-to-5 WISe model.
- Hosted representatives from Japanese State Department and universities to share information about the WISe model and early childhood mental health.

## Substance Use Disorders Treatment

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

**2023 SUD Department highlights include:**

- Intentional movement towards in person services, specifically for IOP groups. Seeing an improvement in client engagement and retention due to this. Moved Monthly Monitoring groups to in person and continued with Youth Groups in-person.
- Continued with in-person walk-in assessments 4 days per week for Open Access and added a Friday scheduled appointment time for Pregnant and Parenting Women (identifying) clients' assessments.
- Added weekly walk-in in-person assessments conducted at Carnegie Resource Center in Everett.
- Scheduled a dedicated assessment time at our Everett office to conduct assessments for Snohomish County Outreach Team (SCOUT), increased services by conducting in-custody assessments on an as needed basis.
- Increased our census for Adult Recovery Court by increasing availability for in-custody assessments as well as office-based assessments.
- Increased our involvement at Shoreline Community Court by attending pre-court and becoming their premier referral agency. Began conducting on-site screenings and assessments during court time to reduce access to care barriers.
- Increased involvement in Edmonds Community Court to weekly engaging in a combination of Zoom and in-person on alternate weeks in order to reach more participants.
- Returned to in-person services at Ingraham High School, providing assessments and individual sessions on site, increasing to providing education for parents and staff.
- Continued to serve our PPW population with expanded services, childcare, parenting support, case management, and provided funding for emergency needs. Established a Business Uber account in order to provide transportation for PPW clients.
- Reduced barriers to services for Snohomish County clients by using grant funding to provide SUD treatment for low-income residents who were not otherwise eligible.
- Staff participated in Overdose Awareness Event where we distributed over 100 Narcan kits, fentanyl test strips, and information and education on overdose prevention and reversal. A youth graduate also spoke at the event sharing a message of hope and recovery with the crowd.
- Supplied approximately 300 additional Narcan kits and fentanyl test strips for the community, clients, and staff as well as information and education.
- Offered SUD staff ongoing opportunities for professional development with trainings on Trauma-Informed Care, Moral Reconation Therapy Fidelity Calls, Motivational

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

- Staff are beginning to learn about the new ASAM 4th Addition Criteria and how Measurement Based Services will define care.
- Began to use Contingency Management by providing motivational incentives for clients when they completed specific treatment objectives, increased, or decreased targeted behaviors as a way of reinforcing positive behavioral change.
- Planned and created a therapeutic walking labyrinth for staff and clients to use for mindfulness exercises, recovery support, and stress management.
- Substance Use Department Director conducted trainings for the Washington Behavioral Healthcare Conference on Promoting Resiliency with the LGBTQIA+ Population. She also presented at the Co-Occurring Treatment Conference two separate sessions, one on having an intentional treatment approach to the fentanyl crisis and co-presented with our DEIB Director on Decolonizing Behavioral Health: how intersecting identities impact trauma and resiliency.
- Implemented a second outpatient group due to increase in census.
- Added specific individualized curriculum using Change Companies Journals and Moral Reconation Therapy Workbooks.
- Continued to provide trauma focused treatment through Breaking the Chains of Trauma, an MRT program which has gotten positive feedback from all clients who have completed to date. The impact of the 9-session group is significant and lasting and provides coping skills for ongoing recovery.

## Behavioral Health Integration

The Behavioral Health Integration Department consists of three types of programming: Medical Clinic-Based Behavioral Health services, ATOD Education, and Centralized Screening for CHS. Services were provided through telehealth and in-person. Screening services were provided by telephone at the office. We had clinicians placed in five medical clinics: Providence Medical Clinic in Mill Creek, Virginia Mason Edmonds Family Medicine; Community Health Center of Snohomish County in Edmonds, Lynnwood, Everett, and our new CHC location Everett south. Services at three of the medical clinics are funded by Verdant.

### 2023 BHI Department highlights include:

- Began collaborations with Court mandated co-occurring clients for direct referrals.
- Began serving clients in an additional medical clinic - CHC Everett South.
- Provided Alcohol Tobacco and Other Drug (ATOD) Educational Class twice a month.
- Created an outline and planned for providing an ADIS (Alcohol and Drug Information School) class.
- Strengthened our plan for recruiting participants in our ‘Breaking the Chains of Trauma’ groups and began offering this new service.
- Provided SUD assessments to help cover the overflow for our SUD department.
- Served Mental health overflow clients when other departments were full.
- Provided co-occurring counseling to Family Court referrals for the SUD Department.
- Hired two interns and helped them grow into licensed therapists.
- Hired and trained two new therapists.

## Family Support

The programming offered by family support are designed to decrease the isolation of families (particularly immigrants) and increase peer support and strengthen protective factors that build resilience. Specific programs provided in 2023 were:

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

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

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

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

**Kinship Support Program** – case management, support groups and family events for caregivers raising relative's children.

**Out of School Time Program** – afterschool and summer programming for youth K-12$^{th}$ grade that are residents of Ballinger Homes, a King County Housing Authority public housing complex in Shoreline. Also includes ICAN Academy that provides one-on-one career and college planning support for teens and adult residents as needed.

**Community Outreach Program** – case management and resource navigation based on the social determinants of health with potential financial relief for housing, utilities, transportation, and food access. Services primarily focused on residents of Shoreline and Bothell due to funding source of financial assistance.

**Family Support highlights of 2023 include:**

- 2023 included renewals of ARPA funds for the Community Outreach Program, to provide financial relief and case management to address social determinants of health for Shoreline and Bothell residents.
- Created a new "Community Engagement Specialist" position at Ballinger Homes that was filled by an adult resident. Position includes programmatic support and engaging parents in the program and opportunities to connect with the school and community resources.
- Resumed 3 in-person weekly Kaleidoscope Play & Learn groups at our Shoreline site.
- Restructured our Bothell Community Outreach Specialist position to include Administrative Support at the Bothell office. This change resulted in more wraparound care and case management opportunities for Mental Health clients being served through that location.
- Fully transitioned our department data to Credible and are able to track.
- Successfully implemented quarterly offerings of Circle of Security parenting classes after staff were certified in late 2022.
- The ICAN program at Ballinger Homes that initially was designed for teens, naturally evolved into serving more adults and parents of youth residents. Particularly in practicing English or getting support with enrollment and homework from ELL classes at the community college.
- As an agency, we began brainstorming potential solutions with challenges accessing interpreters for clinical program access, specifically in Spanish on site at our Shoreline

office. We decided to pilot supporting a Family Support staff member in attending a Medical Interpreter training and she was certified in November 2023. Our hope is to have her take the DSHS interpreter exam in 2024 and explore opportunities to bill Medicaid when she helps Spanish speaking clients access our clinical services.

- Trained and coached two additional staff in Promoting First Relationships 1:1 parent coaching model (using our internal certified PFR trainer). We now have 5 certified providers of PFR.

# Persons Served (Calendar Year 2023)

**Mental Health Clients**

**2,135** people received Mental Health services:

Adults - 748

Children/Youth – 1,387

Children between six and eighteen - 1,366

Children younger than six – 21

This is an increase of 402 individuals compared to 2022.

**Substance Use Disorders Clients**

**528** people received Substance Use Disorders services:

Adults - 470

Youth - 58

This is an increase of 32 individuals compared to 2022.

**Behavioral Health Integration Clients**

**723** people received BHI services.

This is an increase of 42 individuals compared to 2022.

**Community-Based Intensive Services**

**510** people received CBIS services:

Received Wraparound services – 284 clients

Received IEC services - 226

This is an increase of 142 individuals compared to 2022 .

**Family Support Participants**

**912** unduplicated people participated in family support programs or classes. This is an increase of 419 people compared to 2022. Approximately 26 individuals (3%) received service in more than one Family Support Program.

Parenting Classes (adults) – 259

Promoting First Relationships (adults & children) – 31

Kaleidoscope Play & Learn (adults & children)– 406

Community Outreach/COVID Financial Relief (adults only) – 113

Out of School Time Program (adults & children) - 71

Afterschool & Summer Program (children only) – 61

ICAN (College & Career Support) (adults & children) - 10

Kinship Support Program (adults and children) – 62

**Total Unique Individuals Served in Programs – 5,037**

This is 1,365 more people served in 2023 than in 2022.

**NOTE:** The total number of unduplicated served does not include many of the people who only received screening, information & referral, outreach & engagement, or prevention services. In the Family Support Department, the unduplicated number of people served does not include those who were connected to our social media pages where program content is shared virtually to the wider community. Currently we have two active Facebook pages that are promoting the Parenting Classes and Kaleidoscope Play & Learn program and sharing content with its followers through activity ideas, tips, and strategies for parenting and early learning, etc. We

have 836 followers of our Positive Discipline for Families page (an increase of 137) and 288 members in our Kaleidoscope Play & Learn Facebook group (an increase of 50).

## Characteristics of Persons Served

N= 4,507 (includes only individuals who completed demographic forms).
Of the 4,507 individuals who completed demographic forms, 4% (187) identified as unhoused.

| Residence | |
|---|---|
| **County:** | |
| King | 1,631 |
| Snohomish | 2,594 |
| Other County in Washington State | 65 |
| Outside Washington State | 10 |
| Unknown | 207 |
| **Total** | **4,507** |
| City: | |
| Bellevue | 17 |
| Bothell | 399 |
| Edmonds | 236 |
| Everett | 873 |
| Federal Way | 10 |
| Kenmore | 63 |
| Kirkland | 68 |
| Lake Forest Park | 59 |
| Lake Stevens | 57 |
| Lynnwood | 636 |
| Mountlake Terrace | 150 |
| Redmond | 23 |
| Seattle | 474 |
| Shoreline | 623 |
| Woodinville | 58 |
| Other King County City | 152 |
| Other Snohomish County City | 457 |
| Other Washington City | 62 |
| Outside Washington State City | 10 |
| Unknown | 79 |
| **TOTAL** | **4,507** |

| Race/Ethnicity | |
|---|---|
| American Indian/Alaskan Native | 60 |
| Asian and Pacific Islander | 298 |
| Black/African American/Indigenous African | 358 |
| Hispanic/Latinx | 555 |
| White/Caucasian | 1,616 |
| Middle Eastern | 60 |
| Multi Racial | 316 |
| Not Revealed | 1,244 |
| **Total** | **4,507** |

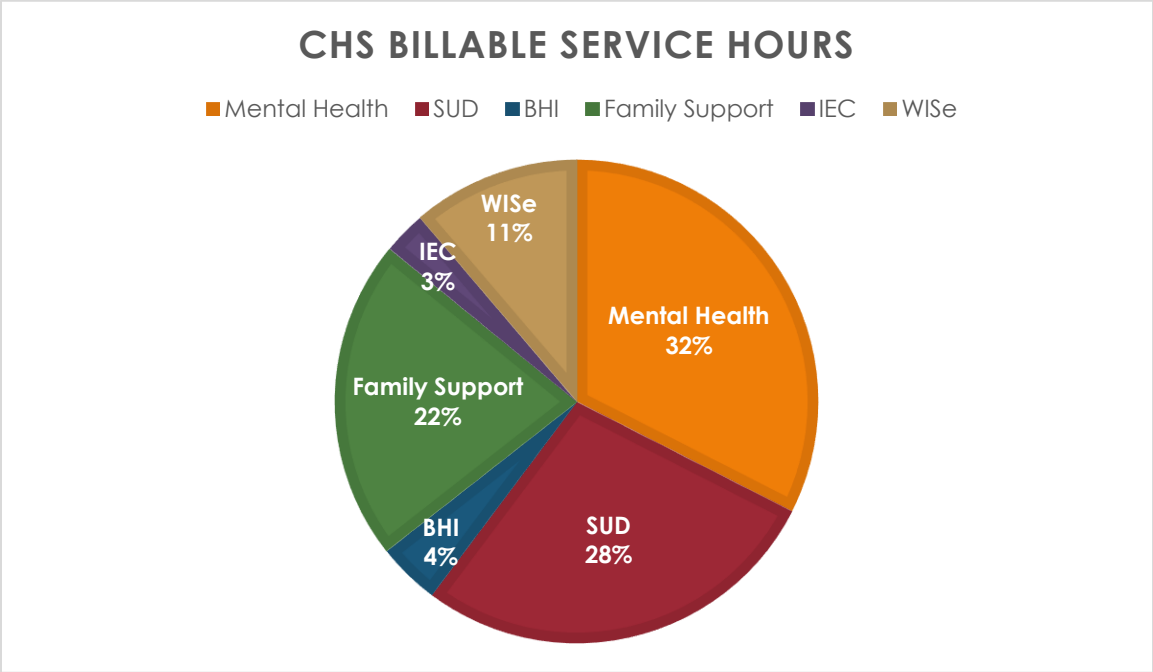
| Gender | |
|---|---|
| A-gender | 5 |
| Female | 2,132 |
| Gender Fluid | 33 |
| Gender Queer | 12 |
| Intersex | 1 |
| Male | 1,426 |
| Non-Binary | 103 |
| Transgender | 36 |
| Two Spirit | 2 |
| **Total** | **4,507** |

| Ages | |
|---|---|
| 0-5 years | 344 |
| 6-12 years | 977 |
| 13-17 years | 1,118 |
| 18-24 years | 466 |
| 25-34 years | 470 |
| 35-54 years | 815 |
| 55-74 years | 215 |
| 75+ | 32 |
| **Total** | **4,507** |

## Service Hours

A total of 72,003 service hours were provided in 2023. This number does not include telephone screening, information/referral services, and most outreach activities. It is an increase of 25,246 compared to 2022.

| Department | Service Hours |
|---|---|
| **Mental Health** | **23,399** |
| **Substance Use Disorders** | **19,973** |
| **Behavioral Health Integration** | **3,002** |
| **Family Support** | **15,483** |
| **Community-Based Intensive Services (WISE & IEC)** | **10,147** |
| IEC 2,064 | |
| WISe 8,083 | |
| **TOTAL** | **72,003** |



# INPUT FROM INTERESTED PARTIES

## Methods and Trends

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

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

Trends included:

- Clients and participants are overall very pleased with and grateful for the services they are provided.
- Frustration was expressed about the continued stressors caused by the pandemic as well as unsettling political situations.

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

## Client/Participant Feedback

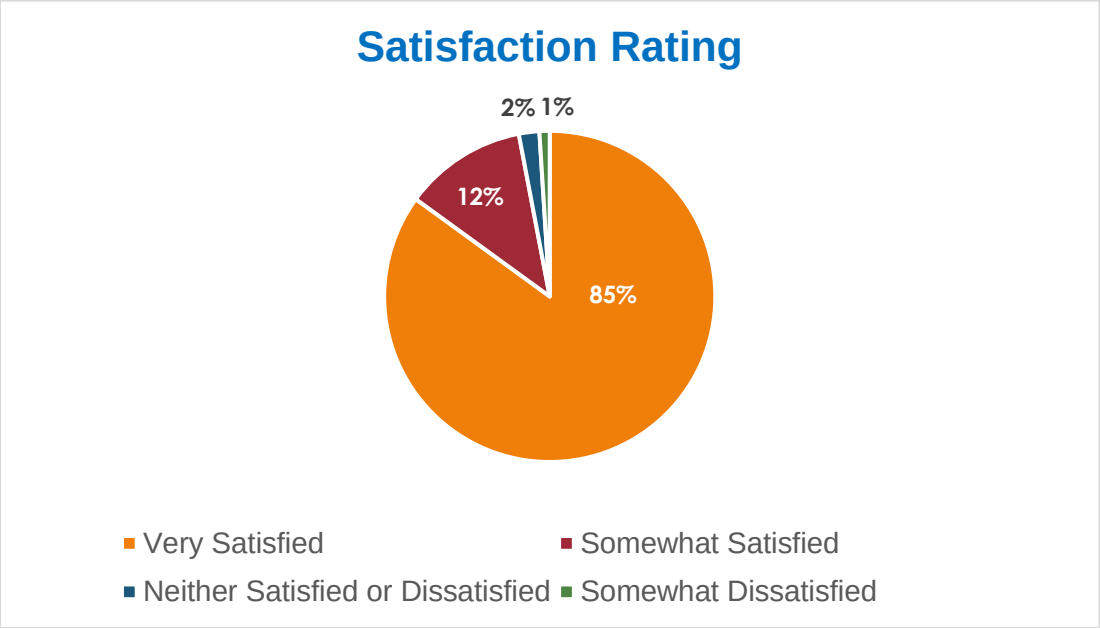
### Client Satisfaction Surveys

### Agency-wide Client Survey:

In the fall of 2023, CHS conducted a client satisfaction survey throughout the agency. 137 people responded to the survey. 80 (58%) were a client/participant; 51 (37%) were a parent/caregiver of a client/participant; 4 (3%) were both a client/participant and a parent/caregiver of a client/participant. The results of the survey per theme are:

**SATISFACTION RATING:** n=137

- 85% Very Satisfied (116)
- 12% Somewhat Satisfied (17)
- 2% Neither satisfied nor dissatisfied (3)
- 1% Somewhat Dissatisfied (1)
- 0% Very Dissatisfied (0)



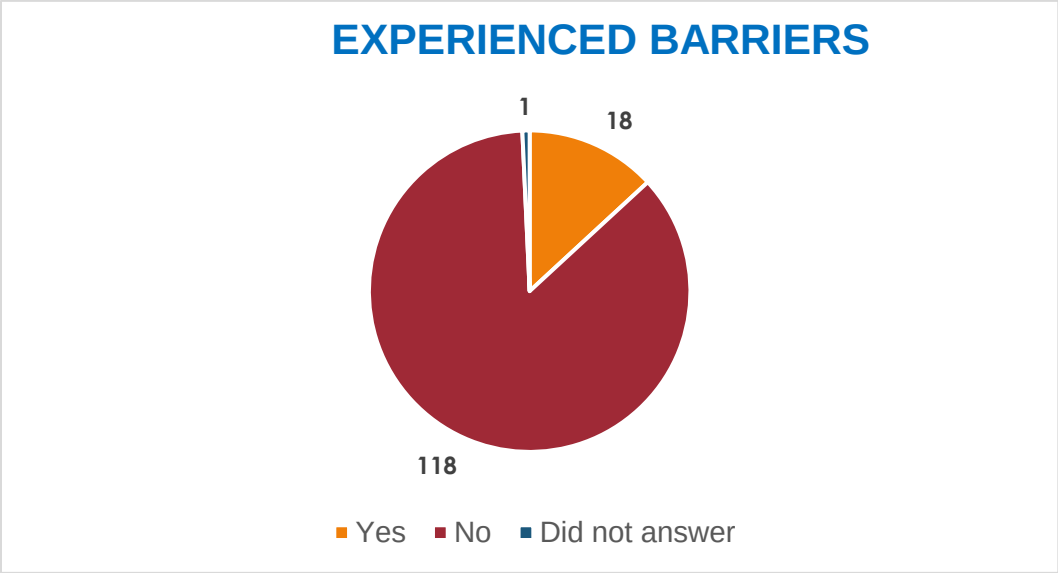

**DIVERSITY, EQUITY, INCLUSION & BELONGING:**

Question: In your opinion, does CHS treat all clients with dignity and respect, no matter their race, ethnicity, gender, gender expression, sexual orientation, age, disability, or religious preference? n=137

- Yes (136)
- No (1)

**ACCESSIBILITY BARRIERS:**
**Question:** Have you experienced any barriers to receiving CHS services? n=137

- Yes (18)
- No (118)
- Did not answer (1)

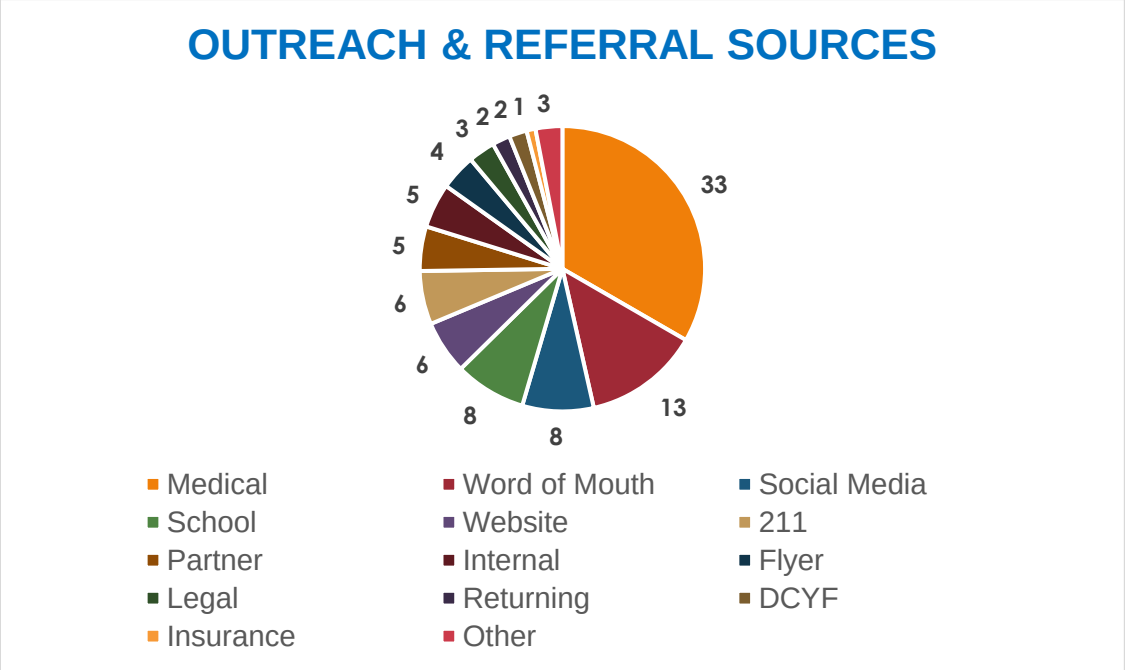



**Of those that answered Yes, the following barriers were noted:**

- Child Care (4)
- Couldn't get appointment in timely manner (4)
- Transportation challenges (2)
- Location not convenient (1)
- Other comments provided by respondents were: unable to get time away from work, grant money ran out, insurance complications, no psychiatric services, anxiety about being on camera (telehealth), therapist neglecting to refer to prescriber and unwillingness to work with certain patients with certain diagnosis.

**OUTREACH/REFERRALS:**
**Question:** How did you hear about CHS and our services? (n=94) Respondents checked all that apply.

- Medical Referral (33)
- Word of Mouth (13)
- Social Media (8)
- School Referral (8)
- Website (6)
- 211 (6)
- Community Partner Referral (5)
- Internal CHS referral (5)
- Flyer (4)
- Legal Referral (3)
- Returning Client (served years prior) (2)
- DCYF/Child Welfare (2)
- Insurance Company (1)
- Other (3): Walk In, Phone Call




**QUALITATIVE ANALYSIS:**

Overall Positive Experience:

- Helpful and supportive staff: Many respondents praised the kindness, compassion, and professionalism of the staff at CHS. They were described as welcoming, patient, and understanding.
- Effective programs and services: Respondents mentioned the positive impact of various programs, including parenting classes, mental health services, financial assistance, and childcare assistance. These programs were credited with improving lives and making a real difference.
- Feeling of hope and support: CHS was described as a place where people can feel safe, listened to, and hopeful about their situation. Respondents appreciated the encouragement and guidance they received.
- Flexible and accommodating services: Respondents appreciated the understanding and willingness to work with individual needs.
- Positive impact on families: Many respondents mentioned CHS's positive impact on families, improving relationships and creating a better environment for children.
- Gratitude for assistance: Respondents expressed sincere gratitude for the financial, emotional, and practical support they received.

Overall, the positive responses paint a picture of the Center for Human Services as a caring and effective organization that makes a real difference in the lives of individuals and families.

There were no changes made to the program based on the above survey.

## ATOD Class Survey Results:

While the BHI Department clients participated in the overall agency client survey, the BHI Department also conducts a monthly ATOD (Alcohol, Tobacco, Other Drug education) class.

A survey is conducted at the end of each class because it is a one-time occurrence. A summation of the surveys is below.

Remarks about the instructor included:

- *She was patient and nice. She explained everything really well and talked about all the drugs. I learned a lot.*
- *Amazing! Knowledgeable, inclusive, practical, friendly, approachable, engaging,*
- *Very good and accommodating. Gave good information and answered our questions.*
- *Knowledgeable and patient.*
- *Very good at explaining and very professional.*
- *She did an excellent job at presenting the information and was clearly knowledgeable.*
- *She presented the information, so it was interesting.*
- *She made me feel comfortable and not judged even though I was there because I got in trouble.*

Some of the comments received about the class included:

- *It was so engaging I wish they would come to the high school.*
- *I liked that there were things we could practice when we are in a dangerous situation.*
- *If I see someone doing drugs, I'm going to advise them to come and learn about drugs.*
- *The videos and explanation of everything was really nice.*
- *I loved learning a bunch of new helpful things.*
- *I really liked the refusal skills activity.*
- *Good videos in a generally friendly environment.*
- *I liked learning about how to avoid using.*

No changes were made regarding the ATOD program based on the results of the above surveys.

## Focus Groups

In addition to participating in the agency-wide client satisfaction survey, the SUD Treatment Department also conducted 3 focus groups with active clients in 2023. A focus group was for IOP clients; another was for Outpatient clients; a third was for clients who participate in a specialty group (Breaking the Chains – women only).

A focus group was conducted on 6/15/22 with an IOP group. The Group was asked two structured questions:

1) What is working?
2) What is not working or could be better?

Feedback received from the participants was:

1) What's working?
    - *"Group has helped me a lot."*
    - *"My counselor is an inspiration to my sobriety."*
    - *"I enjoy being part of a group."*
    - *"I'm comfortable at CHS, in group, and with my IOP counselor.*
    - *"I like it when the counselor asks us personally 'what do you think?'"*
    - *"My counselor actually cares, he has a big heart and a personal approach."*

- *"Support staff has been cool – very helpful."*
- *"Interactions over ZOOM make me feel more comfortable."*
- *"My counselor answers his email in a timely manner and is easy to get ahold of."*

2) What's not working or could be better?
   - *"More clear communication during assessment process, specifically when coordinating with referral sources."*
   - *"Understanding of the process to contact DOL about license."*
   - *"Hybrid/in person groups."*

Based on this focus group we began offering two groups on-site and one group via telehealth per week. We are continuing to improve the assessment process and improving our initial communication with clients, including explaining requirements of DOL thoroughly.

Another focus group was held on 6/28/23 with active clients who attend the Breaking the Chains of Trauma – Women's Group. This focus group was asked the same two questions as the other focus group.

Feedback received from the participants was:

What's working?
- *A group where I can talk and learn*
- *The skills I am learning*
- *Being part of a group of supportive women*
- *The compassion I have been shown*
- *Being able to get the help I need*
- *Doing group on Zoom*

What's not working or could be better?
- *The group being in-person*

No changes had been made at the end of 2023 based on this focus group. However, our plan is to have outpatient groups return to on-site groups as soon as our staffing allows us to do so.

The third SUD focus group was conducted on 10/31/23 and was attended by outpatient clients. When asked about their experiences at CHS, group members only had positive feedback. Group members overwhelmingly talked about enjoying and learning from the groups they attended and felt like it applied to where they are in life and in their recovery. The group had mixed feelings about using telehealth for their sessions, but most agreed that having Zoom as an option was important to them.

Some specific quotes from the clients in the focus groups were:
- *"I can't think of anything that I would change or improve."*
- *"I love the counselors that I have worked with. Both in IOP and OP."*
- *"I like the flexibility. If I'm in a position where I can't make it to my individual session in person, I can do it through Zoom. Even though it's not ideal."*

No changes were implemented based on this focus group.

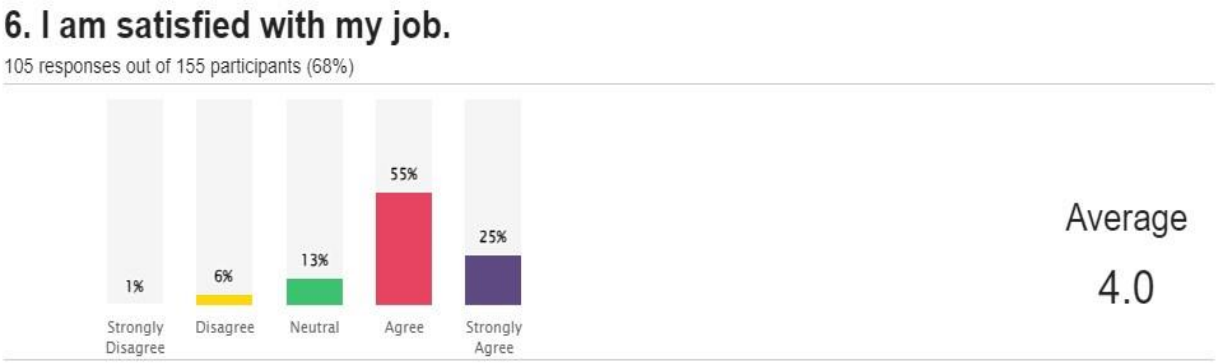
# Employee Input

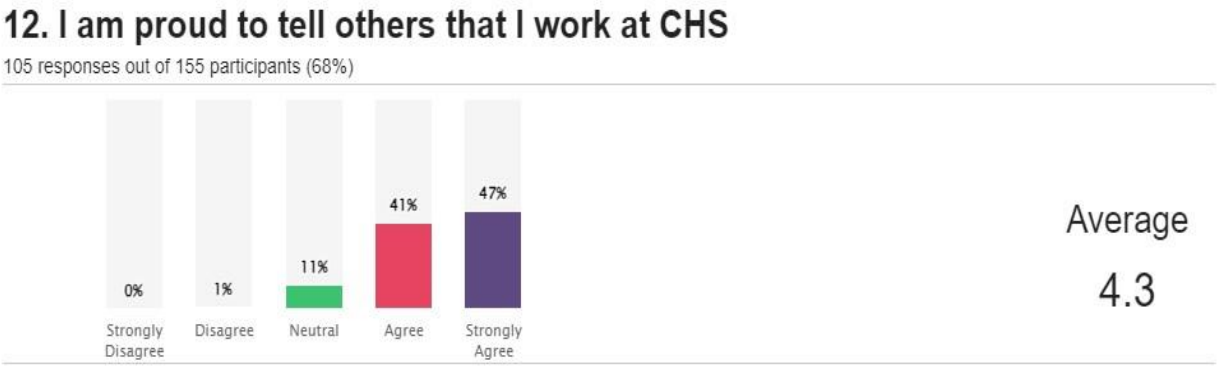
## Employee Satisfaction Survey Results

An Employee Satisfaction Survey was launched on 10/05/23 and closed on 11/04/23. 155 participants were invited to participate in the survey and 105 responded. This is a 68% survey response rate which is considered high. The completion rate in 2022 was 63%, so there was a slight improvement in participation.

The survey contained 37 questions. The questions were on a one to five scale with 1 being ‘strongly disagree’ and 5 being ‘strongly agree’.

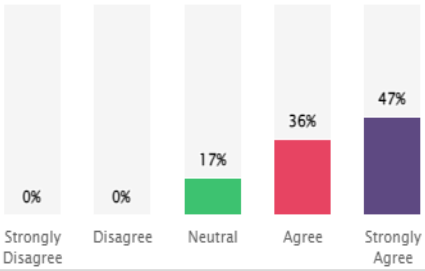
CHS leadership analyzed the results of the survey and was overall very satisfied with the scores. Below is an analysis of a few that are important to highlight.



## 24. CHS is very focused on clients' needs.

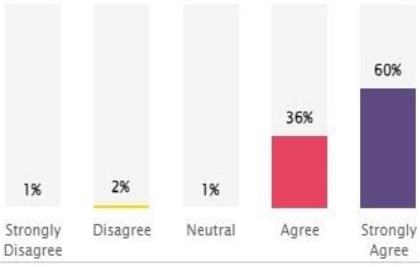
86 responses out of 139 participants (62%)




Average
4.3

## 34. My supervisor treats me with respect.

99 responses out of 155 participants (64%)

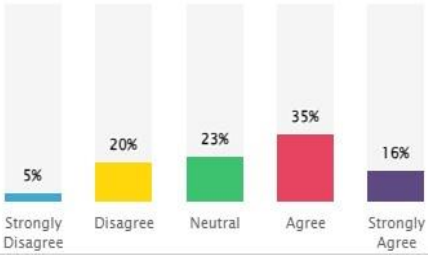



Average
4.5

There were some scores that showed us opportunity for further growth. The two lowest scoring questions are below.

## 32. My job does not cause unreasonable amounts of stress in my life.

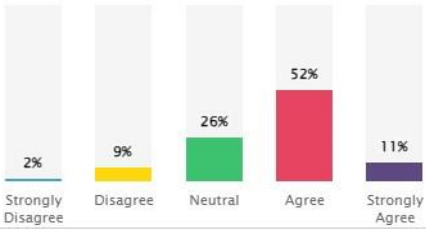
98 responses out of 155 participants (63%)




Average
3.4

## 57. My salary is competitive with similar jobs I might find at similar organizations.

105 responses out of 155 participants (68%)




Average
3.6

Regarding the question above, the survey was conducted before a 5% raise was announced to staff.

## Employee Grievances

There were no employee grievances in 2023.

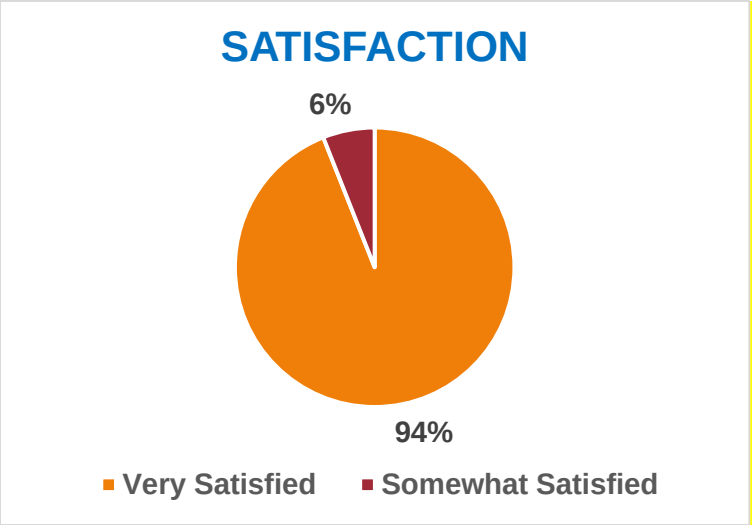
## Input from Other Interested Parties

**Community Survey**

A survey was sent to funders, partner organizations, and community members in September and October 2023. 17 people responded (3 community members, 9 partner organizations, and 5 funders or contractors).

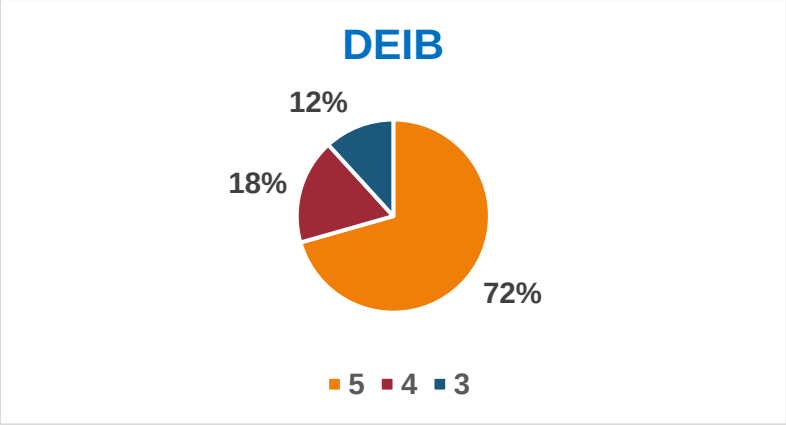
The survey asked: “How satisfied are you with the services that Center for Human Services provides to the community. Their answers were:

- Very satisfied (16)
- Somewhat satisfied (1)
- Neither satisfied nor dissatisfied (0)
- Somewhat dissatisfied (0)
- Very dissatisfied (0)

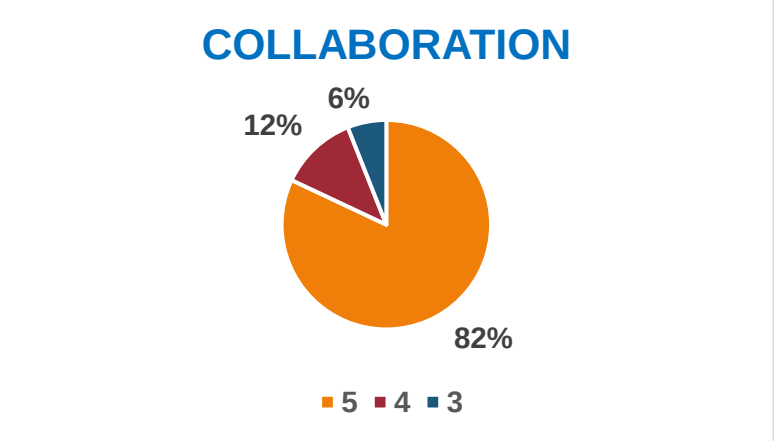



The remainder of the questions were correlated to our agency’s values. The questions asked: “From your perspective, how would you rate CHS’s work toward promoting and instilling these values through our work as an agency? The ratings were on a scale of 1 to 5, with 5 being the highest rating. Per agency value, their answers were as follows:

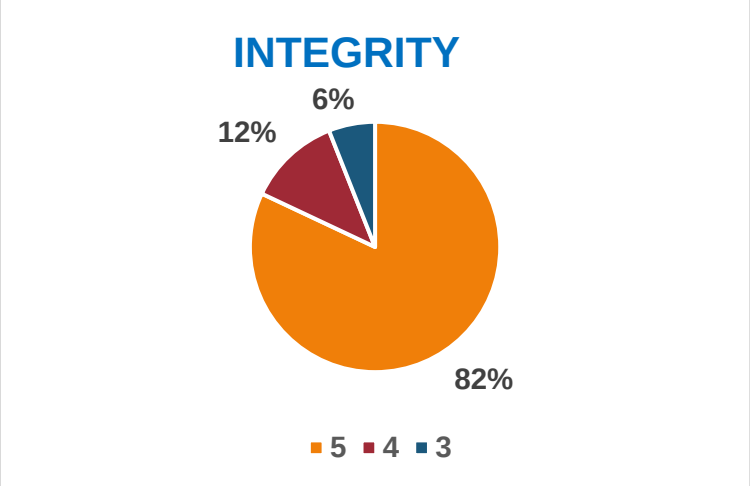
**Value: MODEL DIVERSITY, EQUITY, INCLUSION & BELONGING**
Average Rating = 4.5



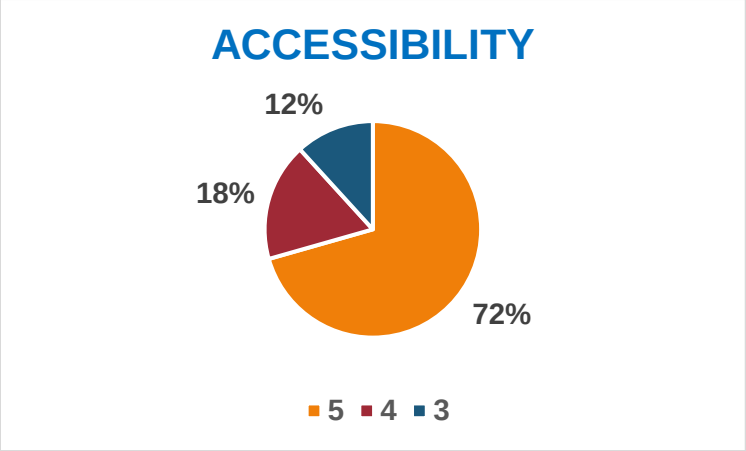

**Value: CHAMPION COLLABORATION:**
Average Rating = 4.7




**Value: PERSONIFY INTEGRITY:**
Average Rating = 4.7

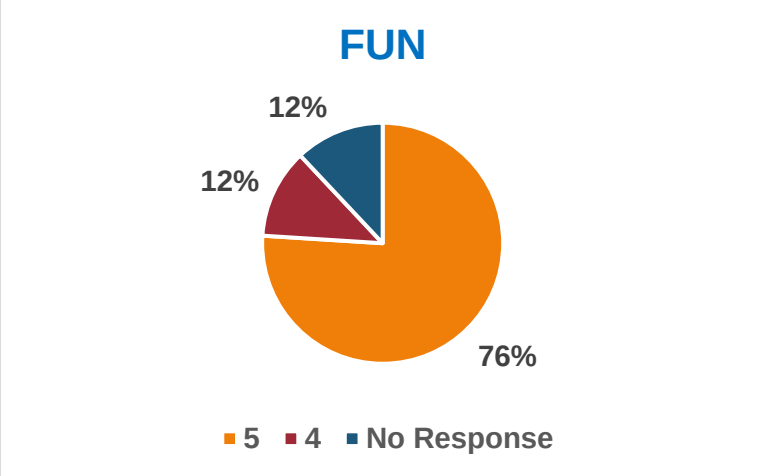


**Value: PROVIDE ACCESSIBILITY**
Average Rating = 4.5




**Value: DEMAND ACCOUNTABILITY**
Average Rating = 4.6


**Value: HAVE FUN**
Average Rating = 4.8



Participants were also provided space to share any other comments they had about their experience with CHS, our staff, and/or our services. A qualitative analysis revealed two themes:

Theme 1: Appreciation for CHS Services

- High-quality services for families
- Staff diversity and representation
- Family-centered approach to program development
- Collaboration and support from in-school MH team
- Timely information and effective collaboration
- Support for residents
- Invaluable service to the community by CHS programs
- Dedication and professionalism of CHS staff in supporting recovery

Theme 2: Positive Working Relationships with CHS

- Effective partnership between CHS and the respondent's organization
- Rewarding collaboration with BHI team
- Positive experience working with the in-school MH team

**Audits**

- ARPA Site Visit:
  The City of Bothell conducted a site visit in June 2023. An introductory visit with new city staff to learn more about programmatic and financial operations of the contract.

- MRT Fidelity Checks:
  On July 12, 2023, a Breaking the Chains of Trauma (BTC) MRT (Men's) group was observed for a fidelity check. The group meets once a week from 4:00-5:00pm, remotely over Zoom. There were 2 male clients present. The summary noted that the therapist conducting the group was prepared did a good job staying on task and following fidelity of BTC MRT. Another comment was made about her having obvious respect and rapport with the clients in the group.

  On July 27, 2023, another MRT group, facilitated by a different counselor than the one noted above, was observed. The group meets once a week from 6:00pm-8:00pm, currently using a Zoom platform. There were 14 clients present, with one new group member. The review summary noted that the counselor was engaged with each one individually in ways that they responded well to. He kept the group members on track and focused on MRT work throughout. It was also noted that the members appeared to enjoy group and were engaged both with each other and the process.

- CBCAP Site Visit:
  Family Support's Promoting First Relationships program had a site visit by Washington State Department of Children, Youth & Families (DCYF). The review was divided into 4 sections: Document Review, Discussion Questions, Program Led, and Programming Feedback. While, as a whole, we were found to be in good standing and in full compliance with contract expectations (best conclusion available), they scored us on each of these 4 sections. Each area was evaluated using a scale of: 3 = Exceed

Expectation; 2 = Meet Expectations; 1 = Approaching Expectations; and 1 = Did Not Meet Expectations. Our results were as follows:

| Document Review | |
|---|---|
| Invoice Review Results | 3 |
| Timesheets demonstrate employee effort toward contracted programs | 2 |
| Other fiscal documentation was explained/demonstrated | 2 |
| Program document review | 2 |
| **Discussion Questions** | |
| Ensuring participants meet primary/secondary prevention definition. Approach with families not qualifying. | 2 |
| Programming addressed need of focus population. | 2 |
| Ensuring adequate time for evaluation. Strengths/Challenges | 3 |
| Consideration of Strengthening Families Protective Factors in the work. | 2 |
| Parent engagement in decision making: strategies to increase parent voice. | 3 |
| Average family experience with agency/program. | 2 |
| Contract with multiple elements - strategies to manage requirements. | 2 |
| Agency guiding principles and contract interactions. | 2 |
| **Program Led** | |
| Program staff provide information to deepen DCYF knowledge of contracted program. | 2 |
| Program staff were prepared for program led activity. | 2 |
| **Programming Feedback** | |
| Parent/Participant feedback | 2 |
| DCYF observed CBCAP-funded programming | 2 |

Federal Way Virtual Contract Monitoring:
In July of 2023, the City of Federal Way conducted a 6 month check in on contract and scope of work. Performance and plans review for remainder of the year. Discussed outreach opportunities and potential partnerships.

## Other Community Feedback

Leadership received positive feedback when participating in community meetings. Overall, feedback was very favorable. We were asked to provide school-based services by other school districts on multiple occasions.

Input from other interested parties (community survey, audits, other) was used to strengthen particular programs and for consideration in the development of a new strategic plan.

# HUMAN RESOURCES

## Overview

On December 31st, 2023, CHS had 151 active employees, a growth rate of 11%. Of the 151 employees, 118 were full-time employees, 28 were part-time employees, and 5 were on-call/temporary employees. We also had 14 vacant positions at the end of 2023. The total number of CHS staff positions, excluding on-call and temporary staff, was 165.

| Department | Number of Employees Per Department | Comparison to 2022 |
|---|---|---|
| Family Support | 16 (plus 5 on-call/ temporary staff) | +3 |
| Mental Health | 56 | +5 |
| Substance Use Disorders | 11 | +1 |
| Community-based Intensive Services | 39 | +3 |
| Behavioral Health Integration. | 8 | +1 |
| Administration | 16 | +2 |
| Total | 151 | +15 |

## Diversity of Staff

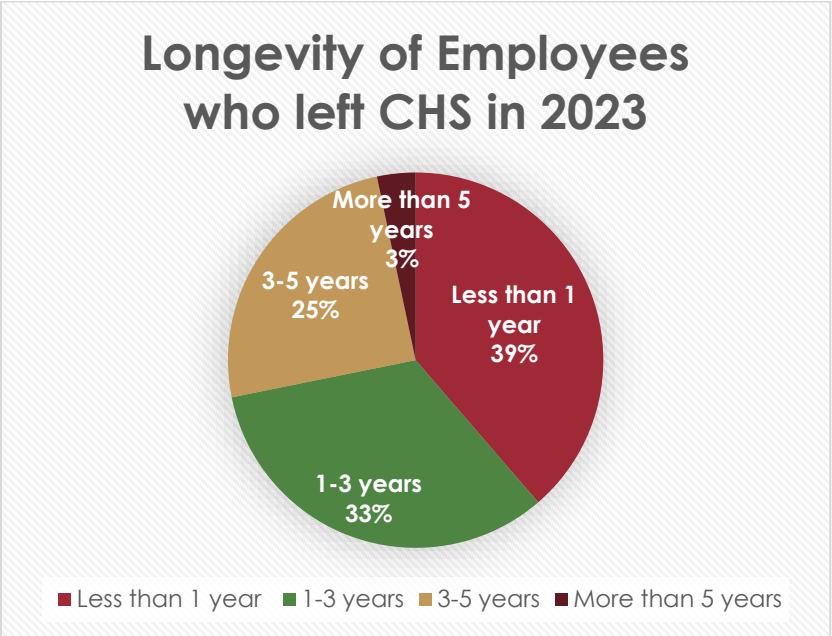
At the end of 2023, the diversity of our staff included:

1. Generations – Baby Boomers- 8; Generation X- 32; Millennials- 66; Generation Z- 45
2. Race – 42% of our staff identify as non-white.
3. Gender – 22 males; 125 females; 4 transgender.
4. Sexual Orientation – 22% of our staff identify as LGBTQIA+.
5. Languages – In addition to English, the following languages are spoken by our staff: Spanish, French, Portuguese, Farsi, Finnish, Arabic, Mandarin, Tagalog, Cantonese, Vietnamese, Korean, Bosnian, Serbian, Croatian, Mandarin, Dari Persian, German. 30% (up 6% from 2022) of our staff are bilingual, speaking English and one of 17 other languages, with some of them speaking up to four languages.
6. Immigrant status- 29% (increase of 7% from 2022) of staff identifies as 1st generation and 2nd generation immigrants.

## 2023 Human Resources Program Highlights

- Were able to offer another year of superb employee medical benefits through Nonstop. No out-of-pocket expenses for employees (nor co-pay, co-insurance, or deductibles) for health insurance.
- On-boarded 54 employees.
- Had 11% agency growth rate in 2023.
- Gave all staff a 6% pay increase.
- Gave all staff a $1,500 holiday bonus (per FTE).
- Gave all staff an additional day off at Christmas.
- Successfully responded to requests for client records on time. Developed a checklist and process for responding to requests.
- Began auditing MH client charts for clinical content.
- Added one new position to HR team: QA Manager.

## Employee Retention




Employee retention improved significantly in 2023. We credit our increases in salaries, our DEIB work, and our management training/coaching as impacting retention. Our turnover rate was 27%, which is a 17% improvement from 2022.
14 employees left before their 1st anniversary,
12 employees left between 1 to 3 years of their employment with CHS,
9 left between 3 to 5 years of their employment and
3 left with 5 or more years of their employment with CHS.

We continue to see our biggest challenge with retention is with employees who have been with the agency for less than 3 years. The current average tenure is 3.5 years.

**2023 Retention Efforts included:**

- Two all-staff meetings were held, one in person and one virtually.
- All staff had training plans that were used for staff growth.
- CHS continued to pay 100% of a full-time employee's health insurance costs with no out-of-pocket expenses for the employee.
- Employee awards were given based on agency values.
- U-Rock was given at each CQI Meeting.
- Provided ongoing supervision (1 hour weekly per FTE).
- Provided specified supervision toward licensure.
- Vacation time for employees was one day per month plus an additional day for each year employed, up to 20 days per year. We allowed employees to carry over 1.5 times their annual allotment at the end of each year up to 20 days.
- Gave employees 11 days of paid leave for holidays. (10 traditional holidays, one discretionary day identified by the Executive Director). Plus, an additional day of holiday was given to the staff by the board for the Christmas holiday.
- Sick time was accrued at the rate of one day per month. Accrual is carried over each year up to a maximum of 60 days per year.

- Employees received one extra day of leave per year as a “personal day.”
- A new training process was implemented.
- Pay adjustments were made.
- Developed a Professional Development fund to assist employees in covering expenses related to training or license renewal to support their continued growth and professional advancement within the company.
- Conducted 27 exit interviews .
- Improved technology.
- Targeted professional development and support for staff regarding Secondary Trauma.
- Used consultants to help build leadership’s skills and capacity.

## Terminations

In 2023, 38 people were either voluntarily or involuntarily terminated from CHS (a slight increase from 2022 due to the elimination of inactive on-call positions). Eight people were involuntarily terminated due to agency policy violations or job abandonment. The reasons for the other 30 employees resigning included:

- Accepted new job or private practice: 11
- Personal reasons not related to the job: 9
- Moved outside of reasonable commute/state: 6
- Went back to school: 2
- Job Ended (inactive on-call staff): 2

One notable difference from 2022 is that departing CHS for another job or private practice went from 19 to 11. We believe that our efforts to improve salaries (making us more competitive) is the reason why.

In total, 27 exit interviews were completed in 2023. The exit interviews conducted in 2023 revealed a common theme among departing staff members. Overall, they consistently expressed that they feel supported by their immediate management and valued the relationships they’ve built with their coworkers. They also appreciated the opportunity to work with a community with significant and urgent needs, feeling that they were making meaningful contributions to the community’s wellbeing. Once again, employees called out our benefit package as a positive for CHS. Notable challenges highlighted by multiple departing staff were the struggle with collaboration among different programs/departments and the difficulties with communication from top leadership to direct staff. We will continue to address these issues in attempt to improve overall staff satisfaction and retention.

## ADA Requests

In 2023, we received a total of 7 ADA (America with Disabilities Act) requests. The requests included one for an employee to utilize a designated parking lot due to their size and visibility concerns while crossing the street. There were 4 requests related to ergonomic office space accommodations, citing health issues such as back pain, wrist pain, and nerve damage. Another request sought a temporary reduction of hours due to difficulties with sleeping, concentrating, focusing, and regulating emotions. Lastly, one request was made to have options

for virtual meetings to accommodate an employee recovering from ear surgery. All of the ADA requests were granted.

## 2023 Employee Award Winners

Our annual awards for employees are based on the agency's values. Staff members nominate individuals for a specific award and explain why they feel the employee deserves this recognition. The Board reviews all nominations and selects the winners. The awards for 2023 were announced at the 2024 Winterfest celebration. The winners were:

- Accountability Award: Rhiannon Jahns
- Accessibility Award: Angelina Roman
- Integrity Award: Kate Dumanian
- Diversity, Equity & Inclusion Award: Asa Baddaluco
- Collaboration Award: Bianca Pacifici
- Fun Award: James Hong

## CHS Leadership

| | |
|---|---|
| Beratta Gomillion | Executive Director |
| Cathy Assata | Substance Use Disorders Department Director |
| Vanessa Villavicencio | Mental Health Department Director |
| Katrina Hanawalt | Community-Based Intensive Services Dept. Dir. |
| Paula Thomas | Behavioral Health Integration Department Director |
| Tanya Laskelle | Family Support Department Director |
| Max Sanchez | Finance Director |
| Arra Rael | Diversity, Equity, Inclusion, & Belonging Director |
| Mirsada Kulovac | Human Resources Director |

We did not lose any of the members of our Leadership Team in 2023. The DEIB Manager and HR Manager positions were both upgraded to Director positions.

## Volunteerism

In 2023 CHS had 129 volunteers who performed 9,881 hours of service. Volunteerism is valued at $314,216 (based on volunteer value of $31.80 per hour).

| 2023 | 1st Q | 2nd Q | 3rd Q | 4th Q | Total | Comparison with 2022 |
|---|---|---|---|---|---|---|
| **Hours** | 3,021 | 2,791 | 1,983 | 2,086 | 9,881 | + 5,114 |
| **Volunteers** | 36 | 30 | 37 | 26 | 129 | + 26 |

# FINANCIAL OPERATIONS

## Summary

The financial oversight and management of Center for Human Services utilizes cross-departmental collaboration for budget planning and has well established internal controls to develop accurate and meaningful financial reporting. Additionally, the control policies and accounting workflows are reviewed annually to mitigate and reduce the risk of fraud and financial reporting misstatements. The agency's financial position is analyzed monthly by management to ensure there are adequate resources and financial stability to achieve the goals outlined in the strategic plan. If any unanticipated events arise that significantly impact the operations of CHS, the risk management plan will be reevaluated to determine the proper course of action. As of 12/31/23, the financial position of CHS remains strong with a favorable outlook for 2024. The metrics below were derived from the agency's balance sheet as of calendar year end.

1. Liquidity
   (ability to meet short-term financial obligations such as monthly agency expenses) - As of 12/31/2023, our quick ratio is 8.36 which is the proportion of liquid assets and receivables to claims tied to them.

2. Debt to Net Assets Ratio
   (debt carried in proportion to net worth demonstrating reliance on borrowed money) – As of 12/31/2023, our debt to net assets ratio is 1%, indicating extremely low reliance on borrowed money. Additionally, the only debt currently recorded is through a forgivable loan set to expire in 2031.

3. Efficiency
   (ability to obtain the maximum output possible from our limited resources) – Our outputs (numbers of people served; number of hours served) compared to our revenue shows efficiency. CHS provided 72,003 hours of service which generated approximately $14.3M in contract revenue between Medicaid and other government sources.

4. Fidelity
   (any appearance of conflict of interest will be identified and reported immediately to the Executive Director). CHS has a clear conflict of interest policy that addresses this. Additionally, all active board members are required to review and sign off on this policy annually.

## Finance Department Highlights for 2023

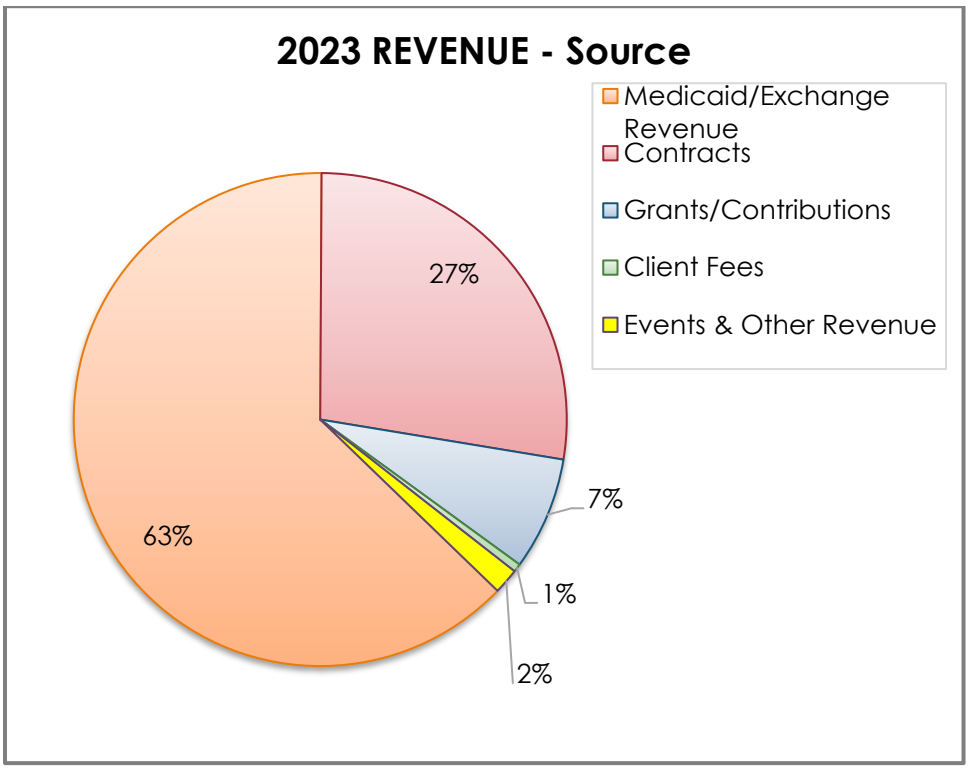
- Received clean audit reports from Jacobson Jarvis & Co, PLLC for both financial and federal funding compliance, with no material misstatements or control deficiencies identified.
- Improved annual budget development process through increased communication and cross-collaboration between program leadership and finance/ED.

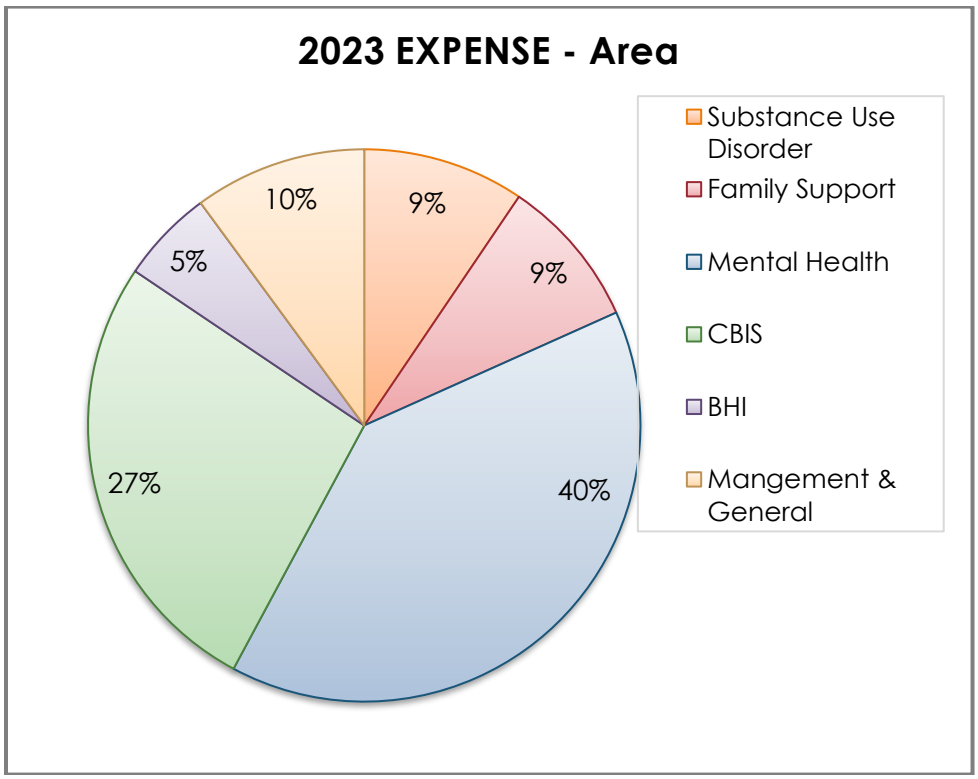
- Implemented lease accounting software to maintain compliance with new accounting standards.
- Implemented and customized EHR data analysis tool utilizing Power BI that provides leadership valuable insights in clinical performance and the associated revenue generated. Additional reporting and other database linking scheduled for 2024.
- In collaboration with HR and finance committee, evaluated existing employee retirement plan and laid groundwork for transition to new provider to offer better services to staff and reduce plan management and advisory fees.
- Successfully converted employee reimbursement process through existing payroll provider to fund through bi-weekly payment schedule which has significantly streamlined the workflow process.
- Worked with banking partners to establish high yield investment options resulting in an increase of approximately $154k of additional annual revenue.
- Annual evaluation on compensation conducted with management to provide competitive wages to staff and as a result made significant investments to keep up with market demand and inflation.
- Received significant funding through the American Rescue Plan Act that allowed continued expansion of services through King and Snohomish counties.
- Reviewed and updated financial policies and procedures to include adaptation and adherence to FASB ASC 842 for lease accounting.

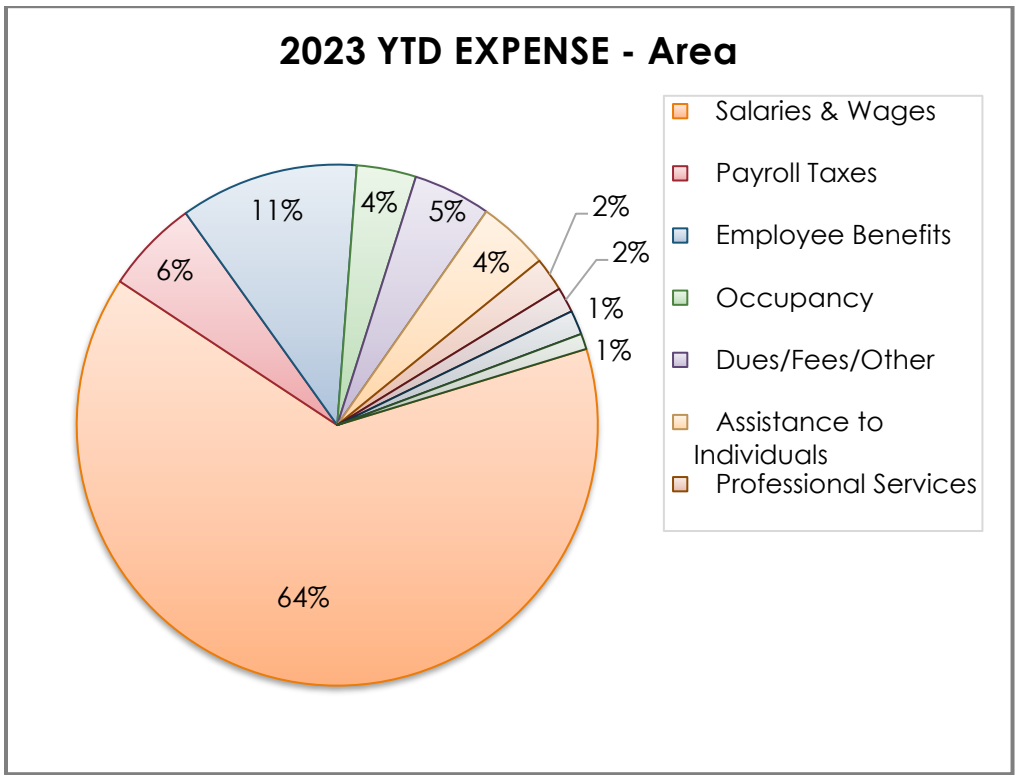
## Financial Statement Ratios

| Indicator | 12/31/2023 | Calculation | Comparison to 2022 |
|---|---|---|---|
| Asset Position | $11,346,654 | Total assets minus total liabilities | + $1,557,274 |
| Working Capital | $8,852,814 | Current assets minus current liabilities | + $1,305,576 |
| Current Ratio | 8.49 | Current assets divided by current liabilities | -3.02 |
| Quick Ratio | 8.36 | Cash + A/R divided by current liabilities | -3.15 |
| Cash on Hand to Current Liabilities Ratio | 6.70 | Cash divided by current liabilities | -2.42 |
| Unrestricted Surplus/(Deficit) | $1,106,200 | Income less expenses | + 355,658 |
| Debt/Net Assets Ratio | 1% | Loans + notes payable divided by net assets | No change |
| Contributions to Total Revenue Ratio | 7% | Contributed income divided by total revenue | + 1% |
| Program Expenses to Total Expense Ratio | 90% | Program expenses divided by total operating expenses | No Change |

## Revenue and Expenses (Actual)




2023 YTD EXPENSE - Area
Salaries & Wages
Payroll Taxes
Employee Benefits
Occupancy
Dues/Fees/Other
Assistance to Individuals
Professional Services
64%
6%
11%
4%
5%
4%
2%
2%
1%
1%


FINANCE
70%

# QUALITY IMPROVEMENT & MANAGEMENT

## Overview

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

## Commitment to Quality

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

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

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

The overarching outcome for all CHS behavioral health programs is for people with behavioral health issues to have access to integrated care and maintain optimum health including recovery. The overall outcome for the Family Support Program is for families to strengthen their protective factors and build resilience.

# QI & Management Plan 2023 Analysis

## Service Delivery Functions

### Effectiveness of Services

**The use of evidence based/informed and promising practices**

- Applied to all programs.
- Data Source – EBP tracking in electronic health record (Credible).
- Person(s) Responsible for Data Collection - Managers and/or Directors.
- Process – Clinicians have a place on each progress note to indicate what EBP was used. Credible Helpdesk will run a report periodically for Managers/Directors that show how many encounters indicate that an EBP was used, as well as which EBP was used for that particular session.
- Achievement Goal – 50% of our services includes evidence-based/informed practices or promising practices, or elements thereof.
- Actual Results – We redesigned our tracking system so we could report EBPs to the MCOs. There is a distinction between using an EBP and completing a recognized training program to obtain certification in an EBP. Some EBPs do not have formalized training programs while others do. For the purposes of our tracking, we are counting EBPs that are used. However, for children/youth services we are reporting to the MCOs only the EBPs used where our staff have been formally trained. Due to the reporting changes, we do not have outcomes for this particular goal for 2023. Evidence-based Practices and Promising Practices were used in the SUD Treatment programs for groups, individual/family sessions, case management, and assessments including GAIN SS, GAIN Assessment, Moral Reconation, MR for trauma survivors, Motivational Interviewing, Cognitive Behavioral Therapy, 7 Challenges, Matrix Model, and ACRA. EBPs and Promising Practices used in mental health programs, including the BHI program & the Community-Based Intensive Services Department, were CBT+, TF-CBT, Dialectic Behavioral Therapy, MI, Play Therapy, Parent-Child Therapy, Promoting First Relationships, Child-Parent Psychotherapy, EMDR, and Rational Emotive Therapy. These were used in individual sessions, family sessions, and/or case management. The EBPs and Promising Practices used in the Family Support Department included Promoting First Relationships, Circle of Security, Positive Discipline Parenting Classes {promising practice}, and Kaleidoscope Play & Learn Groups {promising practice}.

**Case record reviews**

- Applied to mental health programs
- Data Source – Electronic Health Records
- Person(s) Responsible for Data Collection – QA Manager & Compliance Coordinator
- Process – The QA Manager reviews MH clinical records when a client has received services for 90 days. Randomly, the Compliance Coordinator reviews all new admissions 30 days after admission. In both scenarios, individual results are shared with the clinician of record clearly outlining change expectations and a timeline for completion. They monitor the data to assure it is corrected if it is something that can be corrected. The QA Manager addresses any coaching opportunities with the clinicians. The QA Manager utilize trends of aggregate audit results and shares results

with the Systems CQI Team. The intent of the process is to optimize clinical performance through remediation or sharing of best practices.

- Achievement Goal – Every new client record is reviewed at or around 30 days from admission. At least one record from each clinician is reviewed monthly, and every closed record is reviewed as part of the closure process.
- Actual Results – Our process for doing case record reviews changed November 1st when our QA Manager, a newly created position, began working. It is too early to fully evaluate whether or not this new process is working, but initial reports suggest that it will be successful.

**Services and treatment planning maximize child and family access, voice, and ownership**

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

**Client Outcomes**

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

## Family Support Outcomes:

### Parenting Programs

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

- 77% decreased parenting techniques that threaten or criticize their child, 13% positively maintained not using such techniques (n=91)
- 76% improved in warmly and consistently responding to their child's needs, 18% positively maintained (n=91)
- 84% improved in trying to understand the motivation behind their child's behavior, 13% positively maintained (n=91)
- 77% decreased yelling or getting upset in response to their child's behavior, 5% positively maintained not using such techniques (n=91)
- 69% improved in self-awareness and identifying ways to take care of themselves, 27% positively maintained (n=91)
- 79% increased saying positive encouraging statements to their child, 16% positively maintained (n=91)
- 84% increased the use of family meetings to improve communication among their family members, 5% positively maintained (n=91)
- 67% increased talking and sharing ideas about parenting with other adults, 40% positively maintained (n=91)
- 78% improved in helping their child identify and express their feelings, 19% positively maintained (n=92)
- 72% improved in setting clear expectations and being consistent with their child, 18% positively maintained (n=92)
- 75% improved self-awareness and ability to identify when their own emotions interfere with parenting, 18% positively maintained (n=91)
- 72% improved in taking time to listen and ask for the opinions and feelings of their child, 22% positively maintained (n=92)
- 82% were Very Satisfied (5) with their experience in the class, 15% were Satisfied (4), 3% Neutral (3) (n=92)

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

- 81% were Very Satisfied with their experience in the class (n=21)
- 81% reduced their parental stress after taking the class (n=21)
- 81% improved their parent/child relationship, 19% positively maintained (n=21)
- 90% improved in recognizing the behaviors that trigger their negative responses (n=21)
- 90% improved in identifying and responding to their child's need for support (n=21)
- 95% increased their understanding of the importance of repair when they fail to respond to their child's needs (n=21)
- 100% improved in understanding what their child's behavior is telling them about their needs (n=21)
- 81% increased their confidence to meet their child's needs, 14% positively maintained confidence. (n=21)

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

- 100% improved their relationship with their child (n=10)
- 90% increased their understanding of their child's non-verbal cues, 10% positively maintained (n=10)
- 90% improved in responding warmly and consistently to their child's needs, 10% positively maintained (n=10)
- 90% improved in creating an environment in which their child feels safe to express their emotions, 10% positively maintained (n=10)
- 80% increased their understanding of the importance of repair when they fail to respond to the needs of their child, 20% positively maintained (n=10)
- 100% improved in recognizing the behaviors that trigger their negative responses (n=9)
- 80% improved self-awareness and ability to identify when their own emotions interfere with parenting, 10% positively maintained (n=10)
- 80% improved in self-awareness and identifying ways to take care of themselves, 20% positively maintained (n=10)
- 90% improved in trying to understand the motivation behind their child's behavior, 10% positively maintained (n=10)
- 80% increased understanding of their parental role in building a secure attachment with their child, 20% positively maintained (n=10)

**Kaleidoscope Play & Learn**
Methodology: A survey is conducted at minimum once a year with participants in the program. We utilize a survey created by the Kaleidoscope Play & Learn Network. The scale measures if participants increased/improved in areas A lot more, A little more or About the Same. Internally anyone that indicated A lot more or A little more met the outcome, however we have provided the separate scale percentages for extra context.

- 100% increased their understanding that children develop school readiness skills through play (81% A lot more, 19% A little more) (n=32)
- 100% increased their understanding of their role in helping the child in their care prepare for kindergarten (88% A lot more, 12% A little more) (n=32)
- 97% increased their understanding of what to expect from children at different ages and stages of development (81% A lot more, 16% A little more) (n=32)
- 100% increased understanding the importance of having a nurturing relationship with the child in their care (91% A lot more, 9% A little more) (n=32)
- 100% increased the frequency in which they describe things they see and do, talk about numbers shapes, sizes and read or tell stories with their child (84% A lot more, 16% A little more) (n=32)
- 100% increased their use of community activities or services to help the child in their care learn and be healthy (84% A lot more, 16% a little more) (n=31)
- 100% increased talking or sharing ideas about caring for children with other adults (78% A lot more, 22% A little more) (n=32)

## Community Outreach Program

Methodology: During 2023 we implemented a new outcome measurement tool that we invited participants to complete after our primary intervention was complete. Primary interventions were either a referral to additional resources and the completion of financial relief payments and follow up. In 2023 we received 20 surveys.

- 75% improved their financial situation (n=20)
- 80% reduced their stress (n=20)
- 70% increased their knowledge of community resources (n=20)
- 60% decreased their isolation and feel more connected to their community (n=20)

## Kinship Support Groups

Methodology: Short "post" surveys provided at the close of Support Group sessions at minimum once a year to evaluate program's impact on the resilience of caregivers.

- 100 % increased tools to support in reducing stress level (75% A lot more, 25% A little more) (n=8)
- 100% increased gratitude for the good in their lives (75% A lot more, 25% A little more) (n=8)
- 100% increased feeling prepared to handle stressful moments (75% A lot more, 25% A little more) (n=8)
- 100% increased awareness of what causes stress in their lives (75% A lot more, 25% A little more) (n=8)
- 86% Very Satisfied with their experience in the program. (n=7)

## Out of School Time Programming

Methodology: A post survey conducted after the Summer Learning program and in preparation for the school year program to begin. Surveys were conducted in age-appropriate groups with wording that best fit the developmental age of the student. The following data combines the indicators across the age groups.

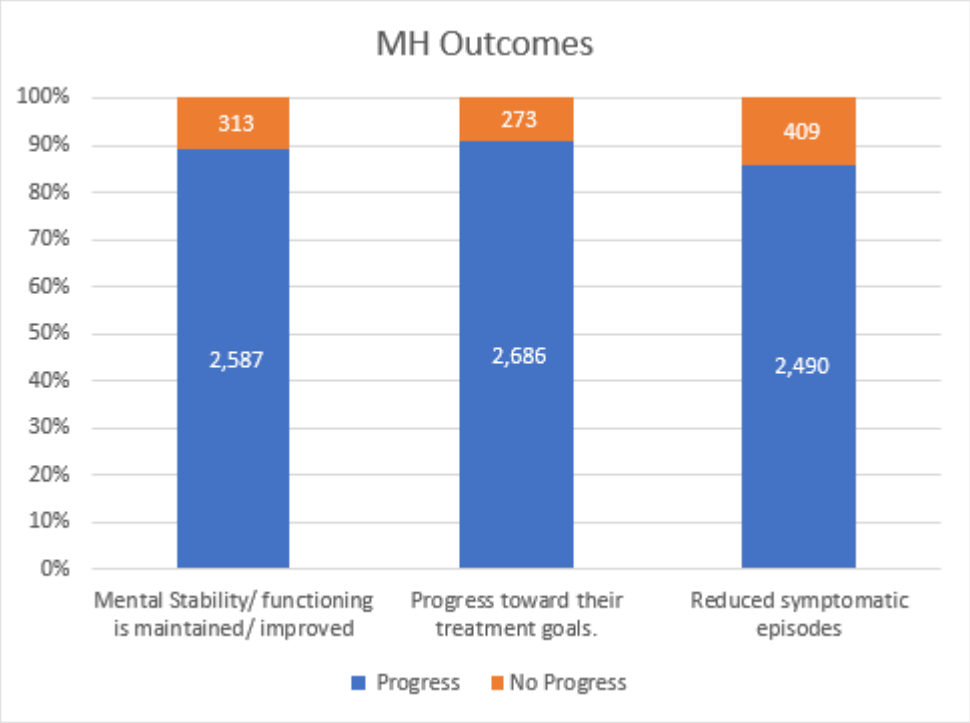
- 100% increased their social connections and sense of belonging (50% Strongly agree, 50% Agree) (n=16)
- 94% learned new skills (44% Strongly agreed, 50% Agreed, 6% Disagreed) (n=16)
- 94% built a trusting relationship with an adult mentor (54% Strongly Agreed, 40% Agreed, 6% Disagreed) (n=15)
- 94% increased their self-esteem and self-confidence (56% Strongly Agreed, 38% Agreed and 6% Disagreed)

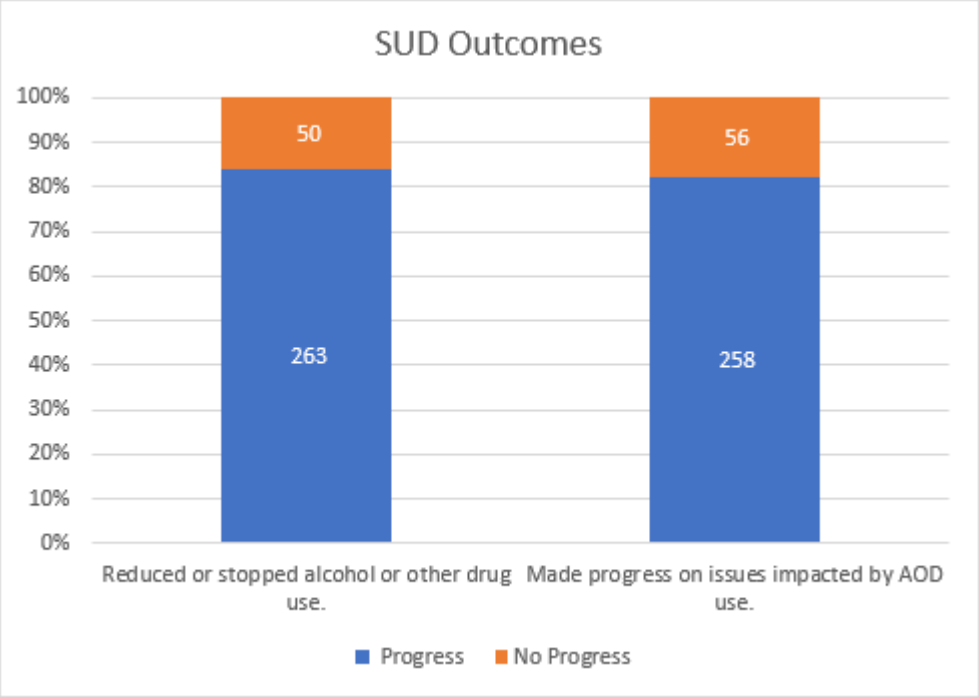
## Clinical Programs Outcomes:

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

- 89% of the clients who received mental health services improved their mental stability/functioning. (increased by 3% compared to 2022)
- 91% of the clients who received mental health services made progress toward their treatment goals. (increased by 6% compared to 2022)
- 86% of the clients who received mental health services reduced symptomatic episodes (increased by 4% compared to 2022)
- 84% of the clients who received SUD treatment decreased or abstained from their alcohol or other drug use. (increased by 10% compared to 2022)

- 82% of the clients who received SUD treatment made progress on issues impacted by their AOD use. (increased by 6% compared to 2022)




**Critical incidents**

- Applied to entire agency
- Data Source – Critical incident reports
- Person(s) Responsible for Data Collection – All staff involved in any incident (as defined in policy)
- Process – When an incident has occurred, staff involved complete an incident report.

Incident reports regarding clients are completed in the electronic health record. Other incident reports are completed using a "Critical Incident Form" and given to the Executive Director within the time frame identified in policy.

- Achievement Goal – 100% of the critical incidents reported are analyzed for quality improvement opportunities.
- Actual Results – The Corporate Compliance Committee reviewed all Critical Incidents from 2023. There were significant more critical incidents reported than in prior years. See Critical Incidents summary and analysis in this report.

**Client complaints and grievances**

- Applied to clinical departments
- Data Source – Grievance reports
- Person(s) Responsible for Data Collection – Executive Director
- Process – Complaints are attempted to be resolved in an informal matter. When a client files a grievance, they complete a grievance form (staff or others may assist clients in completing the form). Each step of the grievance process is conducted per policy and recorded along with any resolution that is agreed upon. The Executive Director keeps all grievances in a secure area.
- Achievement Goal – 80% of the grievances submitted are resolved to the client's satisfaction. 100% of all filed grievances are analyzed for quality improvement opportunities.
- Actual Results – There was one client grievances filed in 2023. It was from a client who was misgendered by the group and, as a result, did not feel safe. Although the Department Director tried to reassure the client, they dropped out of treatment.

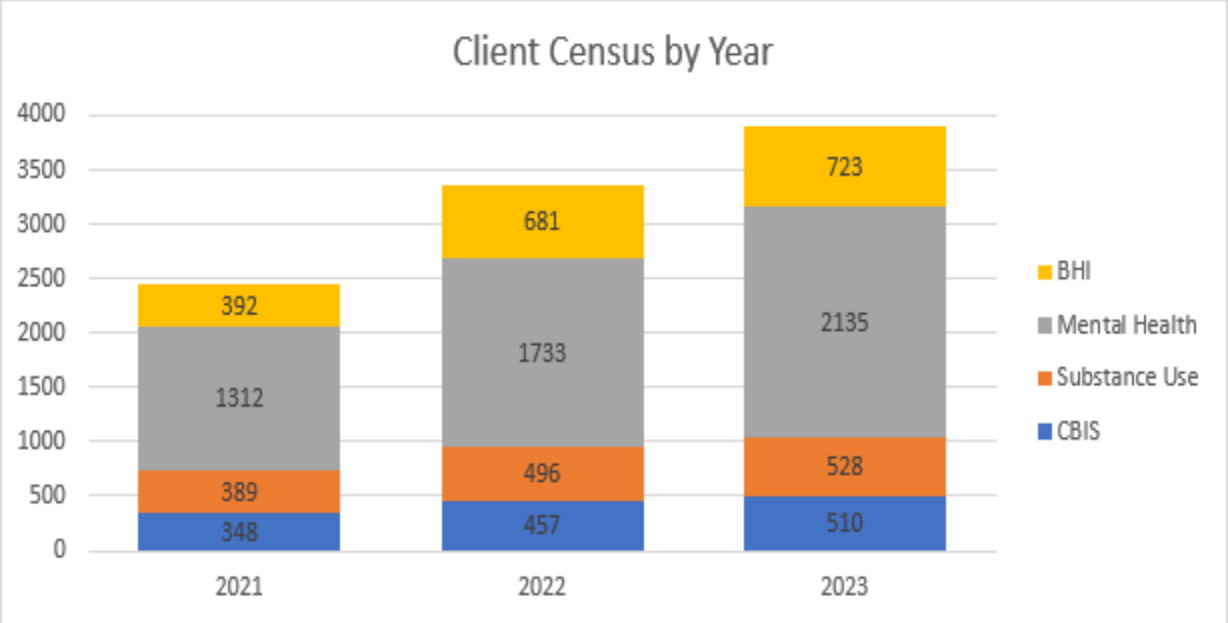
## Efficiency of Services

**Utilization management (appropriateness of admissions and services provided)**

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

**Utilization management (number of clients being served)**

- Applied to clinical programs
- Data Source – Credible Report
- Person(s) Responsible for Data Collection – Clinicians
- Process – Number of clients put in our database for the current year is compared to the number of clients indicated in the previous year.
- Achievement Goal – 15% (or more) increase in admissions over previous year.
- Actual Results – 15.71% more clients were served in 2023 compared to 2022. This is 529 more clients. See a 3-year comparison in graph below.




**Encounter data validation**

- Applied to clinical programs
- Data Source – Electronic Health Record
- Person(s) Responsible for Data Collection –Billing Specialists
- Process – Billing Specialists compare services to coding and billing. The Billing Specialist provides individual results to the clinician of record and their supervisor, clearly outlining change expectations and timeline for completion. The Billing Specialist monitors the data to assure it is corrected. The supervisor addresses any coaching opportunities with the clinicians. The Department Director utilizes trends of aggregate audit results to optimize clinical performance, through remediation or sharing of clinician best practices.
- Achievement Goal – 100% data reviewed & corrected when need be. Encounters submitted for billing should show an accuracy of 95% or higher.
- Actual results – We continue to have problems with data validation. CHS's 2023 EDV review resulted in a 54.3% accuracy (73.2% MH; 11.6% SUD). This is an 28.2% decrease from 2022. Our key issues were not linking the note to ISP goals, missing location of client and state where the provider is; and missing FQ modifier for telephone only services. We continue to work on a performance improvement plan internally.

**Client retention rates**

- Applied to Substance Use Disorders
- Program Data Source – Electronic Health Record
- Person(s) Responsible for Data Collection – Supervisors, Department Director, Program Managers
- Process – Supervisors and staff in management positions run a report in the electronic health record that indicates retention rates (by program and/or by clinician). Trends are analyzed by the supervisors and coaching opportunities are identified.
- Achievement Goal – 60% of clients engaged in SUD treatment (had 3 sessions or more) remain in treatment for at least 90 days.
- Actual Results – For the SUD clients seen in 2023 who received at least 3 sessions of any kind, 88% of them remained in treatment for at least 90 days. We met this goal and improved by 8% from the previous year.

**Billable hours of clinical staff**

- Applied to clinical programs
- Data Source – Electronic Health Record
- Person(s) Responsible for Data Collection – Supervisors, Department Director, Program Managers
- Process – Supervisors and/or staff in management positions run a report in the electronic health record that indicates direct service hours per clinician. If a clinician's direct service hours do not meet expectations one or more of these actions may apply: (1) systems are analyzed and process improvement steps taken (i.e., clinician is given more clients, clinician's hours are reduced, or no-show rates are examined), (2) employee is coached as to how to improve direct service hours, (3) a corrective action plan for the employee may be developed, (4) discipline, up to termination, may occur.
- Achievement Goal – 80% of all clinicians have at least 45% billables each month.
- Actual Results – Data collection was not consistent between Departments, so this outcome was not measured as a whole in 2023. Plan to use new data collection tool to measure this in the future.

**Show & No-Show-rates**

- Applied to clinical programs
- Data Source – Electronic Health Record
- Person(s) Responsible for Data Collection – Supervisors, Department Director, Program Managers
- Process – A Credible report is run after the end of the year, to show how many no-shows we had compared to all appointments scheduled per department. Additionally, supervisors and/or staff in management positions run a report in the electronic health record that indicates show rates per clinician. If a clinician's show rates do not meet expectations one or more of these actions may apply: (1) systems are analyzed and process improvement steps taken (i.e., reminder calls are used, clinician's hours are changed, etc.), (2) employee is coached as to how to retain clients and/or improve attendance of clients, (3) a corrective action plan for the employee may be developed, (4) discipline, up to termination, may occur.
- Achievement Goal – Each program and the agency as a whole will have a no-show rate of less than 30% for the year.
- Actual Results – The only programs with a no-show rate greater than 30% in 2023 was SUD Intake, meaning that the client was receiving interim services until a group space opened for them. Overall, the agency as a whole had a no-show rate of 8%. However, 82 clients were not checked in properly so we do not have data on whether or not they no-showed. Though, not part of this achievement goal, it is an area for continued quality improvement. Additionally, the report shows us that CHS is cancelling a lot of appointments, and we plan to examine that data more closely. See No-Show Report Below.

**2023 No-Show Report**

| Program | # of services not checked in | # of services cancelled by clients | # of services cancelled by clients > 24 hours | # of services cancelled by CHS | # of no-showed services | # of services | %No-show |
|---|---|---|---|---|---|---|---|
| MH KC | 0 | 659 | 329 | 569 | 441 | 6913 | 6% |
| MH SC | 3 | 1636 | 165 | 566 | 1575 | 19509 | 8% |
| SUD Y | 17 | 10 | 0 | 17 | 120 | 400 | 30% |
| SUD A | 62 | 48 | 8 | 46 | 460 | 4488 | 10% |
| SUD Intake | 0 | 1 | 0 | 0 | 7 | 17 | 41% |
| BHI | 0 | 168 | 136 | 225 | 271 | 3079 | 9% |
| IEC | 0 | 376 | 30 | 50 | 87 | 2392 | 4% |
| WISe | 0 | 457 | 54 | 125 | 155 | 3518 | 4% |
| Summary | **82** | **3355** | **722** | **1598** | **3116** | **40316** | **8%** |

## Service Access

**Accessibility and timeliness of access**

- Applied to clinical programs
- Data Source – Electronic Health Record
- Person(s) Responsible for Data Collection – Screeners, Department Directors, Program Managers
- Process – Screeners indicate on the screening form in the EHR the date of the original screening call. They also record the assessment date that is offered to the prospective client. After assessment occurs, the date of the first on-going appointment is noted. The electronic health record is able to track and compare each of these dates. Directors and Managers can pull a report from the electronic health record that shows each of these dates and timeliness of service. Accessibility is analyzed annually.
- Achievement Goal – 90% of assessment appointments and first on-going appointments are within the time frames allowed by state law and/or MCO/ICN contracts (i.e. assessment is conducted within 7 days of request for services). Services are accessible to people needing our services.
- Actual Results – 497 of 1,383 assessments occurred within 7 days of request. This is 35%, so we did not meet our goal. To try to address this performance problem we are implementing Open Access at more of our sites. Because assessments were not conducted within our goal's time frame, on-going first appointments also did not meet our benchmark.

**Penetration of services**

- Applied to clinical programs
- Data Source – Electronic Health Record
- Person(s) Responsible for Data – Supervisors, Department Director, Program Managers
- Process – QA Specialists and or Directors run a report from the electronic health record that shows the number of assessments each year and admissions each year.
- Achievement Goal – 5% increase in assessments each year; 3% increase in admissions each year

- Actual Results – In 2023 we completed 1,383 assessments. This is 149 (12%) more assessments than 2022, exceeding our goal of 5%.

**Agency's accessibility planning**

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

## Service Satisfaction

**Client satisfaction**

- Applied to all programs
- Data Source – Satisfaction summaries from satisfaction surveys, focus groups, suggestion boxes, grievances, incident reports, and outcome data at discharge.
- Person(s) Responsible for Data Collection – Department Director and Program Managers
- Process – Client input is solicited regularly. Clinicians may ask current or closed clients to complete a satisfaction survey; clients may participate in a state-wide satisfaction survey; a focus group may be conducted with clients; suggestion boxes are available at every site with input being collected regularly; client grievances are analyzed annually by the Executive Director; incident reports are analyzed by the Executive Director; and outcome data is collected in the EHR and analyzed by Department Directors and the Executive Director.
- Achievement Goal – Overall client satisfaction is at least 80%.
- Actual Results - This goal was met – 85% of the clients who completed a satisfaction survey stated they were "Very Satisfied" and 12% were "Somewhat Satisfied". Data that was collected through other means did not contradict these findings. See Client Input section of this report.

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

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

## Business Functions

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

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

**Employee satisfaction**

- Applied to entire agency
- Data Source – Satisfaction survey
- Person(s) Responsible for Data Collection – Executive Director
- Process – In the fall of each year Human Resources distributes a confidential web-based satisfaction survey to all staff. The survey is not mandatory, although it is encouraged. The tool we use anonymously compiles the data for management to review. Results are shared with CQI Leadership.
- Achievement Goal – 50% of staff completed a satisfaction survey. submitted are resolved to the employee's satisfaction.
- Actual Results – Goal Met. The response rate for the survey was 68%.

**Employee grievances**

- Applied to entire agency
- Data Source – Grievance reports
- Person(s) Responsible for Data Collection – Executive Director
- Process – Complaints are attempted to be resolved in an informal matter. When an employee files a grievance, they complete a grievance form. Each step of the grievance process is conducted per policy and recorded along with any resolution that is agreed upon. The Executive Director keeps all grievances in a secure area. Annually, the Executive Director compiles a summary report of all grievances received and the results of the grievances.
- Achievement Goal – 80% of the grievances submitted are resolved to the employee's satisfaction.
- Actual Results – N/A. There were no employee grievances filed in 2023.

**Staff credentialing and development**

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

**Staff supervision and training**

- Applied to entire agency
- Data Source – Supervisor logs; training plans; personnel files
- Person(s) Responsible for Data Collection – Supervisors; HR Specialist
- Process – Supervisors provide weekly 1:1 clinical supervision per FTE (prorated for some part time employees) and keep a supervision log on each employee; a training plan is developed by supervisors and clinical staff annually; progress toward completing the training plan is recorded in the employee's personnel file.
- Achievement Goal – 100% of all clinical staff receive weekly supervision for at least 40 weeks per year; 100% of all clinical staff have training plans, with at least 75% of the training plans being achieved.
- Actual Results – Goal met. All clinical staff received supervision as scheduled. All clinical staff have a training plan. Training plans were reviewed regularly and progress was recorded.

**Contract and WAC compliance/deliverables**

- Applied to all programs
- Data Source – Audits and Site Visits; Clinical Reviews
- Person(s) Responsible for Data Collection – Department Directors
- Process – All staff are expected to comply with contracts and WACs as well as negotiated deliverables. Supervisors regularly review the clinical files of each supervisee to assure compliance. If found not in compliance, training is provided and compliance is monitored closely with the particular employee. Managers/Directors monitor deliverables per contract. At the end of the contract, managers/directors see if we met our goals regarding deliverables.
- Achievement Goal – Any compliance issues or problems with deliverables are corrected. All audits and site visits are deemed as satisfactory by the auditing body. Year-end reports show we met all deliverables.
- Actual Results – All audits and site visits had acceptable results.

**CARF Standards compliance/deliverables**

- Applied to clinical programs administration
- Data Source – CARF Survey Report
- Person(s) Responsible for Data Collection – Department Directors, Executive Director Process – All staff are responsible for CARF standards compliance. Supervisors monitor this at every opportunity and initiate change when needed.
- Achievement Goal – 3-year CARF accreditation. CARF standards are institutionalized at CHS.
- Actual Results – Goal met. We continue to follow all relevant CARF standards. Our next review will be in 2025.

**Fiscal controls and efficiency**

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

**HIPAA & confidentiality compliance**

- Applied agency wide
- Data Source – Corporate Compliance Minutes
- Person(s) Responsible for Data Collection – Executive Director
- Process – If a HIPAA or confidentiality violation is suspected or confirmed, the Department Director discusses it during a Corporate Compliance Team meeting. Opportunities for improvement are suggested by the Team as well as any disciplinary action if needed.
- Achievement Goal – Zero HIPAA or confidentiality violations occurred.
- Actual Results – We dealt with approximately 15 incidents that were of concern because of HIPAA or confidentiality laws. They were all a result of sending emails to the wrong individual. However, no PHI was released other than the client's first name. The affected client/caregiver was informed of the mistake in each incident. Fortunately, no damage incurred due to these policy violations. In all situations, the employee was re-educated internally and required to participate in HIPAA training via Relias Learning Platform.

**Employee retention**

- Applied to the entire agency
- Data Source – Retention reports; Employee Satisfaction Summary Report
- Person(s) Responsible for Data Collection – Department Directors, Executive Director, Executive Assistant; HR Specialist
- Process – Retention rates and data from employee satisfaction surveys are used to develop a retention plan each year if needed. Retention rates are calculated by the HR Specialist. We administer an anonymous survey through Paylocity to staff annually. The data is compiled by the HR Director and summarized by the Executive Director. The Executive Director and Department Directors analyze the data to determine opportunities for quality improvement and then implement plans that will help us achieve quality improvement.

- Achievement Goal – Less than a 35% turn-over rate. Retention of staff in community behavioral health is an issue across the state due to a number of factors such as low pay, high caseloads, paperwork requirements, etc. Therefore, we analyze our retention of employees each year by documenting how many employees left CHS and the reasons why. However, our employee satisfaction survey often gives us better data regarding our employee's feelings and thoughts about the agency.
- Actual Results – We met this goal! Our turnover rate at the end of 2023 was 27%. This is a decrease of 17% from the prior year. See the "Employee Input" section of this report including the specific results of the employee satisfaction survey in this report and the "Employee Retention" section to see retention results and strategies. Our prioritized effort toward staff retention is for staff who are with us less than a year. We will approach this by emphasizing making good hires.

| FTE by Dept | Head Count | Open | 12-month Turnover | Prior Year Turnover |
|---|---|---|---|---|
| Substance Use | 11 | 1 | 9.2% | 48.3% |
| Family Support | 21 | +0 | 20.2% | 80.0% |
| CBIS | 39 | 2 | 18.8% | 46.0% |
| Mental Health | 56 | 8 | 44.1% | 29.8% |
| BH Integration | 8 | 2 | 25% | 15.6% |
| Administration | 16 | 1 | 13.3% | 43.6% |
| **Total** | **151** | **14** | **27.1%** | **43.7%** |

## Other Quality Improvement Efforts

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

- Each clinician is to be provided one hour of weekly individual supervision by a qualified supervisor (some part-time staff's supervision time was reduced). This time is to be utilized to coach, train, support, and model quality improvement. Supervisors will maintain supervision logs for each supervisee. Clinical staff are to receive group supervision (typically on a weekly basis) for the purpose of staffing cases and receiving consultation from peers and supervisors. Clinical supervision should support and enhance services and assure adherence to clinical policies and procedures.
- Managers and/or directors are to be responsible for monitoring compliance with WACs, state and federal rules and laws, CARF standards, and contract requirements as applicable.
- CHS will maintain its certification as a Trauma-Informed Agency. We will have staff members who are trained as trainers on trauma-informed approaches, and we intend for these TIA practices and approaches to inform everything we do.
- Our DEIB Program is expected to impact all areas of service delivery.
- Staff members are to receive and participate in a performance evaluation annually, but we expect for supervisors to provide continuous performance feedback throughout the year.
- Each clinician will develop an annual training/enhancement plan in consultation with their supervisor.
- Clinical staff will have access to Relias, a web-based learning system developed for our

field.

- Each staff member is expected to participate in at least one cultural competency/equity/diversity training during the year.
- CHS will offer support to staff in obtaining training based on current trends in treatment and/or to meet training requirements for licenses or certification.
- CHS will maintain our CARF accreditation as a way to assure our commitment to quality and performance improvement by adhering to an international set of standards.
- Evidence-based practices (EBPs) or promising practices are to be implemented in the provision of services. In many circumstances, CHS will continue to have trainers of evidence-based practices on staff when possible, so we have convenient, in-house training available. Documentation of an employee's certification to use EBPs will be kept in personnel files if applicable.
- Supervisors will assure that EBPs are implemented with fidelity as appropriate. This should occur through observation, supervision, and chart review.
- The Corporate Compliance Committee will analyze any critical incidents, extraordinary occurrences, grievances, or HIPAA violations that occur, and make recommendations for quality improvement as applicable.

## Extenuating or influencing factors that affected our work in 2023

The primary extenuating or influencing factors in 2023 were:

- Cost of living – The cost of living in our area is high. It negatively impacted both clients and staff.
- Telehealth vs in-person – There was tension amongst staff who want to continue working remoting and not come into the office regularly. We established a practice of allowing staff (in positions that has flexibility) to work from home up to 25% of their work week, depending upon approval of their Manager/Director.
- Workforce shortage – The workforce shortage continued to impact our work. In some situations, it took months to find an appropriate hire for vacant positions. We are offering competitive salaries and excellent benefits in attempt to improve this situation. While that is working, we cannot compete with private practice, government positions, or private hospitals.
- Private practice internships – Schools are allowing Masters level interns to complete their internships at private practice groups where the work is not as intense and is often mostly remote. This has made accepting interns that are apt to want to be hired at the end of their internship fewer than in the past.
- Global worries – Incidents that had a strong impact on our staff in 2023 included school shootings, mass shootings, racism, xenophobia, transphobia, politics, wars, and other devastating occurrence. Trauma was not only a huge issue with our clients, but also had a strong effect on our staff. In many situations, CHS was unable to relieve staff's stress over these matters, but we continued to focus on self-care and trauma-informed practices.

# ACRONYMS

| | |
|---|---|
| AA | Alcoholics Anonymous |
| ACRA | Adolescent Community Reinforcement Approach |
| ADA | Americans with Disability Act of 1990 |
| ADIS | Alcohol and Drug Information School |
| APS | Adult Protective Services |
| AOD | Alcohol and Other Drug |
| ATOD | Alcohol, Tobacco and Other Drug |
| ARPA | American Rescue Plan Act of 2021 (also called the COVID-19 Stimulus Package) |
| ASAM | American Society of Addiction Medicine |
| BHI | Behavioral Health Integration |
| BHO | Behavioral Health Organization |
| BSK | Best Start for Kids |
| BIPOC | Black, Indigenous and People of Color |
| BI | Business Intelligence |
| CHS | Center for Human Services |
| CPS | Child Protective Services |
| CFR | Code of Federal Regulations |
| CBT | Cognitive Behavioral Therapy |
| CARF | Commission on Accreditation of Rehabilitation Facilities |
| CARE | Community Assisted Response and Engagement |
| CHC | Community Health Center |
| CBCAP | Community-Based Child Abuse Prevention |
| CBIS | Community-Based Intensive Services |
| CPP | Child Parent Psychotherapy |
| CQI | Continuous Quality Improvement |
| DCYF | Department of Children, Youth, and Families |
| DOL | Department of Licensing |
| DSHS | Department of Social and Health Services |
| DP | Display Port |
| DEIB | Diversity, Equity, Inclusion, and Belonging |
| ESD | Edmonds School District |
| EHR | Electronic Health Record |
| EPHI | Electronically stored Protected Health Information |
| ELL | English Language Learning |
| EBPs | Evidence-Based Practices |
| ED | Executive Director |
| EMDR | Eye Movement Desensitization and Reprocessing |
| FASB ASC | Financial Accounting Standards Board Accounting Standards Codification |
| FTE | Full-Time Equivalent |
| GAIN | Global Appraisal of Individual Needs |
| GAIN SS | Global Appraisal of Individual Needs - Short Screener |
| HIPAA | Health Insurance Portability and Accountability Act |
| HDMI | High-Definition Multimedia Interface |
| HR | Human Resources |
| ISP | Immediate Services Program |

| | |
|---|---|
| IEC | Infant and Early Childhood (Mental Health) |
| IS | Information Systems |
| IT | Information Technology |
| IMC | Integrated Managed Care |
| IOP | Intensive Outpatient Program |
| KPL | Kaleidoscope Play and Learn |
| KCICN | King County Integrated Care Network |
| LFP | Lake Forest Park |
| LGBTQIA+ | Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/ Questioning, Asexual, and the "+" holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities. |
| LMHC | Licensed Mental Health Counselor |
| LEIE | List of Excluded Individuals and Entities |
| MCOs | Managed Care Organizations |
| MSW | Master of Social Work |
| MH | Mental Health |
| MIDD | Mental Illness and Drug Dependency |
| MIP | Micro Information Products |
| MRT | Moral Reconation Therapy |
| MI | Motivational Interviewing |
| MSD | Mukilteo School District |
| MFA | Multi-Factor Authentication |
| MPLS | Multiprotocol Label Switching |
| NA | Narcotics Anonymous |
| North Sound ACH | North Sound Accountable Community of Health |
| NUHSA | North Urban Human Services Alliance |
| OST | Out of School Time |
| OP | Outpatient Programs |
| PCI | Payment Card Industry |
| PPP | Payroll Protection Program |
| P&P | Plug and Play |
| PPW | Pregnant and Parenting Women |
| PLLC | Professional Limited Liability Company |
| PFR | Promoting First Relationships |
| QA | Quality Assurance |
| QI | Quality Improvement |
| RCW | Revised Code of Washington |
| SB | School-Based |
| SIEM | Security Information and Event Management |
| SOC | Security Operations Center |
| SCOUT | Snohomish County Outreach Team |
| SDOH | Social Determinants of Health |
| SWOT | Strengths, Weaknesses, Opportunities, and Threats |
| SQL | Structured Query Language |
| SUDP | Substance Use Disorder Professional |
| SUD | Substance Use Disorders |
| FQ | Telehealth service utilizing real-time audio-only communication |
| TI | Trauma Informed |
| TIA | Trauma Informed Approach / Trauma Informed Agency |

| | |
|---|---|
| TF-CBT | Trauma-Focused Cognitive Behavioral Therapy |
| USB | Universal Serial Bus |
| VPN | Virtual Private Network |
| WACs | Washington Administrative Code |
| W/F/A | Waste, Fraud and Abuse |
| WRAP | Wellness Recovery Action Plan |
| WIC | Women and Infant Children |
| WISe | Wraparound with Intensive Services |


Shoreline-170th

Shoreline- 148th


Edmonds- Pacific Commons


Everett-Silver Lake

Lynnwood

Bothell

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- Snohomish County Superior Court
- King County MIDD Initiative
- King County Best Start for Kids Initiative
- North Sound Accountable Communities of Health
- HealthierHere
- foundry10
- Hundreds of individual donors
- And many more.

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

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