**2021 - 2022 Annual Report of Performance**

**Business Functions:** Lifeline Connections (LLC) has expanded our services and are including in the 2021-2022 Annual Report of Performance: School-based SUD, Primary Care, Recovery Resource Center, Mt. Vernon OP, Bellingham/Mt. Vernon Housing and Bellingham PACT. Health Homes Employment, Jail Transition Services and Jail Re-Entry programs were “on hold” this year due to staffing shortages.

**Persons responsible for gathering/collection data**: For **Effectiveness** Measures of Clinical Program, the Clinical Directors and Supervisors are responsible. **Patient Satisfaction** Surveys (Annual, Treatment Interval and Post-Discharge): Program Directors are responsible for the administering of LLC surveys and Quality Assurance is responsible for the collection and compilation. **Service Access** is tracked by Admissions. **Efficiency** measures are found on the Dvaas Dashboard (LLC contracts with XPIO; the VP of Finance and the VP of Quality & Corporate Compliance interface with XPIO).

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| Program | Service Delivery Goals | Outcomes and Extenuating or Influencing Factors | Goal Met  Yes or No | Actions Taken or Changes Made to Improve Performance | Areas Needing Improvement and Related Action Plans |
| Withdrawal Management | Decrease patients leaving ASA by 10%  Annual Patient Satisfaction Survey return results will reach 51%  Implement nursing EMAR  Implement new 2 step intake process and with ability to complete process with rolling card  Implement in-house lab draws | *For all Programs,* the pandemic decreased our services across the agency by approximately 30%. In addition, WA. state has been & currently is facing a significant shortage in healthcare workers. | **No**  **Yes**  No  **Yes**  **Yes** | State-wide hiring challenges did not allow us to implement EMAR as planned.  This is being met thru primary care. | *For all Programs*, there isn’t an program specific action plan. Directors make new goals the following year – at times they may carry over a goal. |
| Men’s Residential | From July 2021 to June 2022 average length of stay 18 days.  Create and implement 2 new types of peer or RA ran groups to increase options available while in treatment.  Decrease ASA rate by 2%  Increase productivity to reach a minimum of 45% monthly average  75% of our patients will have aftercare (IOP/OP, medical or MH) set up upon completion. | Gardening group, talent show group, & a peer lead group were created. | **Yes**  **Yes**  No  **No**  **Yes** | Decreased rate was .4%.  Due to COVID, which required the unit to reduce census, it was not possible to meet this goal. |  |
| Women’s Residential | Maintain and average census of 12 from July 2021 to July 2022.  65% of women will state “yes” when asked “I am satisfied with the information I received from this program in order to help me in my recovery”.  65% of patients will have a successful completion (measured by transfer to another SUD program or treatment completed) from July 2021 to July 2022.  Implement a DBT skills group by May 1st, 2022.  Ensure charts are reviewed and returned to admissions within 48 business hours of receipt on the Women's residential Unit. | Total of 222 discharges. 105 completed + 15 transfers - 120 = 54% | **Yes**  **Yes**  **No**  **Yes**  **Yes** |  |  |
| Pregnant & Parenting Women | Maintain and average census of 12 from July 2021 to July 2022.  65% of women will state “yes” when asked “I am satisfied with the information I received from this program in order to help me in my recovery and be successful as a parent”.  Implement 1x a week skill building lab for pregnant and parenting mothers from July 2021 to July 2022.  Implement DBT skills group in PPW by May 1st, 2022.  Ensure charts are reviewed and returned to admissions within 48 business hours of receipt on the PPW unit. | N=16; 100% stated, “yes”.  Childcare staff implemented twice weekly skill building labs & LPN implemented a skills class. | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| SUD Outpatient – Clark Co. | Staff Productivity will average 50%  All staff will receive Trauma Informed training to improve quality of care.  Patients receiving peer services will report an overall improvement of support for recovery from start to end of Peer services.  Conduct quarterly patient satisfaction survey to target Family Services. Identify and implement one change to increase satisfaction.  Improve percentage of successful transfers from LLC residential programs to OP services by 5%. Baseline established in first quarter and reported by November 2021. | Trauma Specific training completed in Relias  Random review of 10 records all showed improvement | **No**  **Yes**  **Yes**  **No**  **Yes** |  |  |
| Therapeutic Specialty Courts | Increase treatment staff productivity average to 55%  Participate in annual patient satisfaction survey and implement one program change based on the feedback received.  Each case manager will attend 1 NADCP training and share new information with team during staff meeting.  Create and initiate a system for offering  naloxone to all new intakes.  New out custody clients will have assessment and case management intake completed within 7 days of referral/prior to next court appearance. | Court client census has remained low over the last year. Productivity remains approx.. 30%.  Participated and change was to return to in person services for IOP and SS groups on 5/15/22.  2/1/22 a Naloxone screen was built into assessments and intakes. At that time, we ordered a supply of Narcan and included the standing order into case management packets. | **No**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Mental Health Outpatient – VA | Program will generate positive income on average for the period of January 2022 to May 2022.  Using the annual satisfaction survey, at least 92% of clients will report satisfaction with services and staff.  Increase positive outcomes AEB a decrease by 3 points on the GAD or PHQ9.  Screening intervals to be completed at 30, 60, 90 and every 3 mo. after.  Program will implement a quarterly wraparound meeting with other LLC providers to best meet patients’ needs.  Program will reestablish walk-in hours for mental health assessments |  | **No**  **Yes**  **Yes**  **No**  **Yes** | While this Program has implemented quarterly wraparound meetings with the centralized scheduling, they we not able to implement meetings across other service departments. |  |
| COMET  Assertive Community Treatment | The program will reach an average of 40% productivity.  COMET will have a 85% response rate on the Annual Patient Satisfaction Survey.  70% of COMET patients will have a lower PHQ-9 score at the end of the review period.  COMET will implement a DBT skills group.  85% of COMET referrals will be contacted/attempted within 3 business days. |  | **Yes**  **No**  **No**  **Yes**  **No** |  |  |
| Mental Health –  Orchards | Program clinical staff will maintain a productivity average of at least 50% for January 2022 to May 2022. Peers will maintain a productivity average of at least 45%.  Using the annual satisfaction survey, at least 92% of clients will report satisfaction with services and staff.  Increase positive outcomes AEB a decrease by 3 points on the GAD or PHQ9.  Screening intervals to be completed at 30, 60, 90 and every 3 mo. after.  Program will implement a quarterly wraparound meeting with other LLC providers to best meet patients’ needs.  Program will reestablish walk-in hours for mental health assessments | This program had attempted to reestablish walk-in hours in March; however, due to staffing issues (pandemic related), we were unable to re-establish. We have restarted in-person services however and we are actively involved in open-access implementation. | **No**  **Yes**  **Yes**  **No**  **Yes** |  |  |
| Crisis Triage Stabilization | Increase average census to 13. Last eleven month average was 9.5.  50% of patients discharged will complete the satisfaction survey.  Create a report on the Basis-24 standardized tool to evaluate outcome measures.  Increase completion of treatment rates to 55%. It is currently 48%  Implement internal blood draws for labs to increase access to medical information. | Restrictions from pandemic both in census and staffing made this goal unobtainable. | **No**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Aberdeen | Productivity will average 25% for new hires for up to 3 months and 50% after for all direct service employees.  Provide monthly treatment interval satisfaction surveys and make 1 improvement based on feedback by January 2022.  Offer 90% of patients seeking MH services with medication evaluations and patients seeking SUD services MH evaluations.  Attempt to engage 90% of patients who "no show" within 2 business days (using "attempt" or "engagement" services).  Begin an ADIS class and offer monthly starting March 2022 |  | **No**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| ECS | Patient visit numbers will increase by an average of 15%.  Patient response rate to the annual satisfaction survey will increase to 50%.  Increase number of patients who graduate from ECS program to lower level of care by 10%.  Implement PHQ-9 as part of the behavior support plan in the EHR.  Implement hospital admission packets for coordination of care and safe discharge that include: MAR, behavior support plan, safety plan, pharmacy, provider, and ROI for 50 patients |  | **No**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Housing | The supportive housing program will breakeven financially.  Obtain a 75% response rate on the annual Patient Satisfaction Survey.  75% of patients will comply with the Barriers to Housing Stability Assessment and re-assessment.  Start a “Rent Well” class for current patients by January 2021.  Will increase new admissions by 20% totaling 40 (or more) new patients served. |  | **No**  **No**  **No**  **No**  **Yes** |  |  |
| OCRP | 90% of patients will have at least 4 services (or attempts) a week.  The Annual Patient Satisfaction survey will have a 80% response rate for patients served in person during the survey date range.  80% of patients will be referred for re-evaluation.  75% of patients will have a lower C-SSRS score at discharge than at intake. 80% of patients will have remained in the community at time of discharge.  90% of patients will have a first appointment within 1 business day of the OCRP intake. |  | **No**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| UA | Reduce OT by 10%.  Post monthly question for clients to ponder to encourage feedback/comment cards; pick 2-3 answers to post on website.  Update signs involving procedure (both observed and unobserved) to be visual rather than lengthy written words, for clients who are hard of hearing, deaf or have limited English proficiency.  Research ETG IT cups/dipstick tests; create guideline and price sheet showing research and place one order minimum.  Create UA information criteria/info sheet and complete educational meeting with 4 programs to help them understand the drug screening process |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| School Based MH | Clinical staff will maintain a productivity average of 43% during the school year.  Participation in annual Patient Satisfaction survey will increase to 35%.  Demonstrate overall reduction in PHQ-9 Scores over the course of the school year (given at least once every 60 days).  For students receiving treatment for both mental health and substance use, SBS will meet with student and SUD staff quarterly to coordinate care during 2021-22 school year.  SBS MH staff will maintain at least 2 groups which meet at least 2 times per month during the 2021-22 school year |  | **Yes**  **No**  **Yes**  **Yes**  **Yes** |  |  |
| School Based SUD | Program will generate positive income on average for the school year.  Using the annual satisfaction survey, at least 94% of clients will report satisfaction with services and staff.  Demonstrate a reduction in substance use or absence of use over the course of the school year for over half of reporting clients.  Increase total number of youth SUD assessments to 10 for time period of August 2021 to May 2022.  Develop flyer with information on SUD youth services and meet with each high school in the Vancouver School District to inform them of availability of SUD assessments and services for youth. |  | **No**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Camp Mariposa | Work within the operational budget of the year, while acquiring at least $5,000 of in-kind donations within the year.  Submit a satisfaction survey to parents/guardians each quarter to measure efficiency of program, needs of campers we work with, and overall satisfaction. Maintain an overall satisfaction rating of 85%.  85% of campers participating in camp will not have used substances to get high during the year: as measured through the youth questionnaire given during camps twice a year.  Increase efficiency of program by creating an approved set of policies and procedures specific to Camp Mariposa and incorporating policies and procedures within orientation for new staff and mentors.  Increase access to services by providing regular transportation via bus to camps located at the Camp Wa-Ri-Ki location, or locations more than 30 minutes from the Lifeline Connections VA Campus. Bus services will pick up campers from the VA Campus and return campers to that location. Guardians will check their campers in at the VA Campus location and sign campers out at that location. |  | **Yes**  **No**  **Yes**  **No**  **Yes** |  |  |
| MAR – Clark County | Obtain GPRAS for 90% of all new patient.  Obtain 50% follow up GPRAS from 8/1/21-5/15/22.  Reduce bridging of patients to 25%.  Increase provider productivity by 5%.  Increase in person or zoom visits (reduce phone visits) by 25%. |  | **Yes**  **No**  **Yes**  **No**  **Yes** |  |  |
| Sobering | Decrease use of professional services by 10%.  Increase annual Patient Satisfaction survey returns to 51%.  Implement two program changes that improve staff/patient safety on the unit.  90% of staff (outside their probationary period) will have cross-trained in another inpatient program.  Complete a clinical case review and documented plan of care coordination for the 5 patients with the most utilization of services each month and provide to Director by the 15th of the following month. | Labor shortages due to pandemic. | **No**  **Yes**  **Yes**  **Yes**  **No** |  |  |
| Bellingham/Mt. Vernon OP | Increase the number of SUD-OP/MH-OP assessments/intakes by 20%. Baseline is 436, Target is 523.  Survey group members quarterly to monitor Zoom and in-person preferences and change group format accordingly.  Conduct two training sessions on diagnosing and treating Tobacco Use Disorder and see an increase in diagnoses and recommendations on the ISP’s for people identified as current nicotine users.  Implement the Carelogic automatic reminder system for one SUD clinician by 01/01/2022.  Re-establish walk-in Assessment schedule. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Men’s Low Intensity Recovery Program | Open program and maintain an average census for the year (4) for program opening date 5/9/2022 to May 2022.  Create 1 feedback form for areas of growth to be completed by the resident at time of discharge.  Less than 40% of patients admitted from opening the program will be discharge as ASA type.  All assessments will be reviewed for admissions within 48 hours of program receiving them.  90%  patients will be referred to Mystrength from TBD date of opening to July 2022 |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| MAR - Bellingham/Mt Vernon | Increase MAT Clinic hours in Mount Vernon from 14 hours a week to 21 hours week.  Document 1 patient success story each quarter and provided to marketing.  Provide med management for at least 90 days for 50% of patients who enrolled in the program.  Increase MAT provider productivity by 5% from an average of 38% for FY21 to 43%.  Implement the Carelogic automatic reminder system for the provider by 4/30/22. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| QA | Pilot a process to increase Post Discharge Survey participation through use of an electronic consent form in CareLogic.  Work with XPIO to design/develop Dvaas Dashboard to monitor & graph incident reports to be able to analyze incident report trends more efficiently.  Convert the OnBoarding Log to "fillable" cells. Design a recorded training on on-boarding log expectations and routing for Directors/ Supervisors. Develop a systematic process for tracking completion of all new hires' on-boarding logs and audit monthly to provide feedback to Directors/Supervisors.  Create Master DOH Plan of Correction spreadsheet; research all past and current POCs, identify all recurring deficiencies and confirm implementation of noted corrections/monitoring.  Complete a full CARF pre-survey review plan prior to 3/30/22 and create a performance improvement plan (PIP) with required completion dates, outcomes and assigned staff to ensure meeting 100% compliance with all performance standards by 5/15/22. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| EHR | Implement Patient Portal module into Carelogic for MAT & Primary Care only.  Implement eLabs (possibly include Paracelsus - Qualifacts contracts with Complex Healthcare Solutions) - eLab implementation would be implemented LLC wide.  Implement Collective Medical Integration (CM) and Prescription Drug Monitoring Program (PDMP) modules into Carelogic for MAT & Primary Care.  Develop a plan/task lists for reconciling and submitting BHDS state reporting thru Carelogic (Episode reconciliation, Missing data follow-up, and schedule for submitting data).  Create one-stop shop manual for Supervisors/Directors: Steps for getting staff ready (HR for adding, Dr. First, schedule set up); Steps for when staff no longer work at LLC (Schedules, alerts, notifying HR, caseloads, etc.); Staff with new/upgraded credentials; Documentation Review. | The HCA’s Behavioral Health Supplemental Data Project took priority. | **No**  **No**  **Yes**  **Yes**  **No** |  |  |
| Records | Attend SAMHSA training titled, "Cares Act Update" - Changes to Federal Privacy Protections for SUD treatment. Update the current Cares ACT bulleting with any necessary changes.  Create bulletin, "Tips on Confidentiality" and send to All Staff quarterly.  Train Open Access Lobby Coordinator (JK) to process records requests, phone & email requests, how to access records located in off-site storage, etc. (2 hrs. per week).  Create Instruction Sheet, "What to do if the Police Come Knocking" and submit for EXEC team review & finalization.  Read the HHS.gov Health Information Privacy document (61 pgs.) titled, "Individuals' Rights to Access their Health Information" and make recommended policy edits if necessary. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Human Resources | Make the recruiting and onboarding process fully electronic, finalizing the ADP onboarding process.  Design and implement stay interviews to assist with staff feedback and retention.  Work with marketing and design and implement a program to increase positive employee ratings on major online recruitment platforms.  Transition the remaining personnel files into the ADP electronic records system.  Research, recommend and start to implement an electronic employee recognition system. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Marketing | Review 60 website pages, collaterals (brochures 6, flyers 13, comment cards, generic business cards 3, mailers, rack cards 20), and digital campaigns with a lens for gender neutral inclusive language and symbols. At time of collateral reprint, review to determine if it should be printed in multiple languages. Develop and receive buy in and approval for a one symbol image and tag line promoting inclusivity.  In conjunction with a BIPOC sub-group of the DEI Committee, develop an annual diversity calendar and 4 associated education and digital campaigns. The diversity calendar will be incorporated into the annual marketing plan and digital strategy for the agency.  Build content-based back links on the Lifeline Connections website. Increase LLC backlinks by 20 (or 10% on three pages) using LLC infographics, PPW, CWC and MRC webpages.  Develop/create two videos with department/executive team spokesperson from MRC & WRC outlining treatment programs and expectations with the goal of decreasing Against Staff Advice (ASA) from CTS patients transferring to inpatient programs. Videos to be uploaded to a “behind the scenes” webpage to be used by CTS and admissions staff with an evaluation after three months. If the product is meeting the goal it will be moved to a public facing webpage.  Develop/create two virtual tours (PPW & WRC) along with two videos that are uploaded to the website and used in the TV lobbies project. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Kitchen | Increase food donation weight by 10% over FY2021.  Introduce and train on Special Diet/Substitution book by 10/01/2021. Have booklet approved by staff dietician.  Plan and implement recycling plan for all organics (food waste), across all locations.  Schedule regular in person one on one supervisions weekly to improve staff communication and effective supervision. Conduct at least 2 supervisions per month with each staff from 2/1/2022 through the goal evaluation period.  Institute set snack menus to include healthier snacks low in processed sugars and carbs. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Business Ventures | Create & implement quarterly review for BV employees.  Café service hours will be 8am-3pm M-F, excluding holidays, by 5/31/2022.  Increase sales by 10% by 5/31/2022.  Create and implement cook cleaning schedule by 01/01/2022.  Update menu and pricing for café public sales. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Front Desk | Develop Administrative manuals for mod A, mod B, CS and Lobby Coordinator with updated workflows.  Cross train all front desk and CS staff to effectively and efficiently cover both teams.  Attend 3 live trainings per staff: “How to manage Emotions in the workplace”;  “Effective Telephone Communication Skills for Receptionists” and “Managing the Front Desk”.  Implement Vital Interactions Appointment Reminder System.  Assign a time slot two days a week for admin staff to assist clients with Medicaid applications. ALSO: Reduce # of patients missing demographics by 10% |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Payroll | Clean up lists in ADP: Validation Tables(Pay Classes, worker category), Job Titles, Main Search lists.  Determine feasibility of moving pay dates up- present findings to E team.  Work towards implementing Online self- service Onboarding for new employees.  Evaluate accumulators and their delayed time populating for new hires; propose change to make information available more timely.  Set up a process to train new hires during their orientation period to acclimate them to ADP, set expectations, etc. | N/a - determined this was not useful as time from orientation to payroll receiving info from HR to input into system varied too much. Worked on other projects instead including setting up activity configuration alerts, new profile workgroups, plan to change departments**.** | **Yes**  **Yes**  **Yes**  **Yes**  **N/A** |  |  |
| Admissions | Scheduled admits for **men's and women's residential** would be an average of 80% of the daily maximum allowed for the month.  Scheduled admits for **withdrawal management** would be an average of 80% of the daily maximum allowed for the month.  5% or less of residential or withdrawal management claims will deny due to authorization issues  Each member will complete 3 trainings relevant to their position or services we provide.  Have 2 team meeting per quarter - this will help with communication and collaboration within the team. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Facilities | Take 5 online courses in project management or administration.  Create and maintain tracker for Lifeline merchandise. Facilities will maintain and be accessible by staff, including a brief guide.  Coordinate the installment of bike lockers at the VA Campus for staff.  Facilitate the purchase and storage of Emergency water barrels for all in-patient units, rotation every 6 months.  Create a daily/monthly/quarterly/yearly task schedule for the department to include inspections and other tasks Facilities oversees and manages. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| IT | Develop a detailed plan with milestones for migrating from mapped network drives on a file server to a more secure and robust platform for sharing and collaborating on files (such as Microsoft SharePoint).  Assess current wifi infrastructure at all locations and develop a plan for effective centralized management of all wireless access points.  Review our current procurement process and make concrete recommendations for improvement, including an examination of internal workflow as well as assessment of pricing and support for hardware and software vendors.  Replace at least 80% of computers running Windows 7 with Windows 10 computers.  Compare help desk systems and make recommendations for improvement of the security and functionality of the help desk, along with a plan for implementing those recommendations. |  | **Yes**  **Yes**  **Yes**  **Yes**  Yes |  |  |
| Bookkeeper | Update desk manual by 10/31/2021 to reflect current processes, including screenshots from Acumatica.  Train at least 3 additional staff in Acumatica, such as those who submit a large number of check requests (housing staff) or a program director with a need for accessing detailed financial reports.  Ensure that all documentation has a process to be scanned into Acumatica entries so that we can eliminate physical monthly close binders  Improve monthly balance sheet account reconciliations to include at least 3 additional accounts, such as the FSA liability account, LNI liability account, and prepaid account.  Fully implement Expense management tool, making it available to all staff who order can submit a check request. | Not included in month end yet. | **Yes**  **Yes**  **Yes**  **No**  **Yes** |  |  |
| Revenue Cycle MGMT | By June 7, 2022, Maximum of 30% of Carelogic payer AR (excluding self pay/private pay and Third Party Collections) will be over 90 days.  Establish and document processes & procedures for Failed Claims errors to improve Failed Claims statistics and to collect failed claim data for statistics gathering to report the Average days for a failed claim All errors and by error for each month, and then whole fiscal year. Work to decrease the days over time.  Establish a Claim Review to Batching reporting form to track statistics related to the review of batching of claims to ensure all claims are batched and gather statistical data. Reduce the average # of days from DOS to Clearinghouse accepted per the Etactics Vitals report for Professional claim forms from 40.4 days to 30 days.  Establish a Claim Follow up Comment tracking system to report Claim Follow Up Comment statistics.  Get Client Statements going out electronically to a clearinghouse. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Primary Care | Implement procedures for onsite lab.  Create primary care guidelines for new hire training to promote consistency of services.  Test and treat 10 individuals for HCV.  Develop and implement primary care EHR system to enhance visit efficiency.  Expand services to 2 inpatient programs. |  | **Yes**  **Yes**  **Yes**  **No**  **Yes** |  |  |
| RRC | Return to the number RRC Recovery Support Groups offered pre-pandemic.  Offer advocacy classes and put together an advocacy action plan.  Have at least 130 unique participants.  Increase/Introduce/Re-introduce employment services, employment education, legal services, and financial education at the RRC.  Increase connections and hold events/groups with community partners that serve specific cultures and populations. | Pandemic.  Pandemic | **No**  **No**  **Yes**  **Yes**  **Yes** |  |  |
| Mt. Vernon OP - Skagit | Increase Jail Assessments from Baseline of 14 to Target of 50.  Track recovery supports (gift cards, backpacks, coins) given to patients purchased with CJTA funds.  Work with EHR supervisor to develop a Carelogic report for jail assessment/drug court quarterly reporting rather than continuing the manual lookup system.  Implement the Carelogic automatic reminder system for one clinician by 4/30/22.  Re-establish walk-in Assessment schedule. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Bellingham/Mt. Vernon Housing | Track all check requests by month and reconcile to the GL report before submitting Monthly Participant logs to NSBHASO.  Document two HARPS participant stories each quarter to add to the HARPS Quarterly reports.  Complete the "Housing Preference Survey" at time of Intake to document participant preferences.  Develop a caseload of 15 HARPS participants per 1FTE Peer Counselor.  Document attempt(s) to conduct HARPS Intake within 5 business days of receiving a referral. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |
| Bellingham/PACT | Initiate services September 1st and serve a total of 27 new patients for the year starting September 1st, 2021 ending May 31st 2022. (average of 3 patients a month).  The information I received from the program manual met my needs in regard to understanding the PACT program as evidence by 75% of patients reporting yes.  All treatment staff will receive the Illness Management & Recovery (IMR) training within 90 days of hire.  85% of patients will be offered a psychiatric evaluation within 14 days of completing their individual service plan.  90% of all accepted referrals will be contacted or attempted within 2 business days. |  | **Yes**  **Yes**  **Yes**  **Yes**  **Yes** |  |  |