Link Associates

Program Evaluation

Fiscal Year 2022/2023

1452 29TH ST., WEST DES MOINES, IA 50266

HOW TO READ THE MEASURES OF ACHEIVEMENT REPORTS

You will find listed in this grid goals and outcome measures in the following categories:

1. Efficiency 2. Satisfaction 3. Effectiveness 4. Supplemental Measures

Each category is shaded in Dark Grey

Efficiency																	
Primary Objective	Indicator	Who Applied to	Data Source	Who is responsible	Who Complies	Target	Time of Measure/Results (monthly, Quarterly or annually)										
							7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve …	Number of …	Link Associates	XXX Records	XXX Director	XXX Director	No More than XXX/ quarter	0			0			0			0		

Within each category you will find one or more objectives. The Objectives have a darker border for easier location.

Remaining details of the indication, who and how it is applied, data source and responsible staff are outlined in the boxes to the right of the goal

The data gathered throughout the year is laid out in this section. Some are an annual number; some are quarterly, and others are monthly.

The rest of the grid contains drill down detail-here are the key pieces you can look for.

Did we meet the goal?

What did we recommend last year?

How did last year's recommendations work?

When did that goal end?

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous year goal recommendations (i.e., goal continuation and/or new action steps) Action Steps: NA	Update on action step recommendations from last year (REPEAT FOR EACH ACTION STEP LIST) NA	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (2017-2018):	1st QUARTER –	2ND QUARTER-	3RD QUARTER-	4TH QUARTER –

Comparison of last year's (21-22) results to this year (22-23): Extenuating or influencing factors ☒ YES ☐ NO.

New Recommendations for Next Year (2024-2025): ☐ Continue as written ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes -	Person Responsible XXX Director	Timeframe

What did we do throughout this year – update for actions taken each quarter?

How did this year compare to last year?

What do we recommend doing next year?

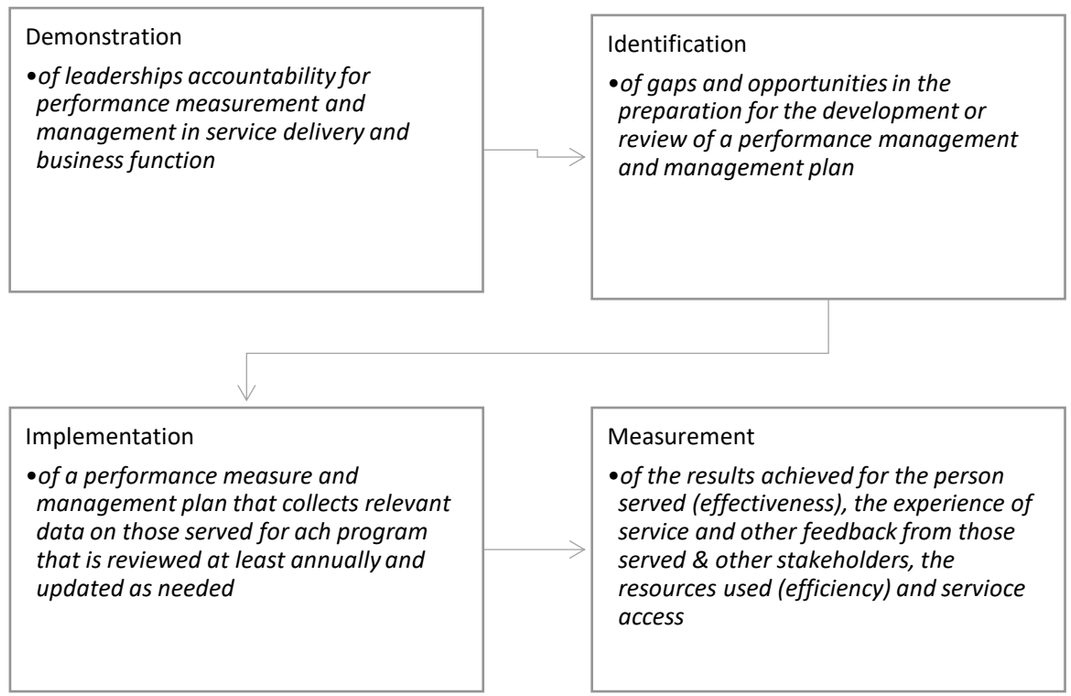
What do we hope will happen?

Who is responsible for the goal?

When is this goal ran and evaluated?

Purpose of Report

This Program Evaluation Report is Link Associates' document that describes how we have monitored and evaluated our programs and services. To survive and thrive in today's environment organization such as Link Associates must produce value and simultaneously ensure service delivery and business practices are ethical, state of the art and durable. Link Associates strives to meet the needs of our stakeholders, support our program/services and support growth and we measure how well we are doing by evaluating the:



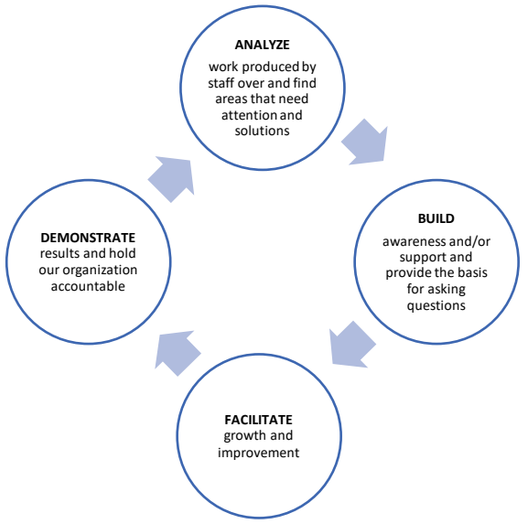
For the Reader

The report is laid out as follows:

1. The Program/Department summary is created by the Department Director or Key Leadership staff of the Program/service. Within this narrative you will find:
    a. The total number of goals along with the number of goals which were successful in meeting the objective.
    b. A director's summary of the past year.
    c. Possible reasons why a goal was not successful.
    d. Recommendations for goal change.
    e. New recommendations.
2. Supplemental Measures or Demographical information
3. Measures of Achievement MOA – detailed lay out of each goal outlining by whom, how and when data is gathered, and recommendations and adjustments made throughout the year.

Executive SummaryLinda Dunshee, Executive Director

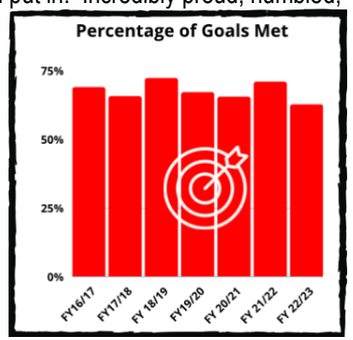
At Link Associates, our determination to fulfill the needs and fuel the potential of the lives we support is leading us to solutions that drive both personal achievement and business sustainability. We use our Program Evaluation information to improve the quality of our programs/services, to make better decisions, to uphold Link's mission, and objectively demonstrate value to those we serve as well as their family/support systems and other stakeholders. Link Associates is committed to continuously establish goals to help improve our overall effectiveness as an organization. This report is intended to relay information gathered from the evaluation of program services and supports to staff, board, stakeholders, and funders.



As the Executive Director of Link Associates, I and our team are focused on ways to build on Link Associates legacy of incredible service despite the extreme challenges. Financial struggles since the implementation of Managed Care in Iowa have been a stranglehold on our ability to pay competitive wages and retain staff further complicated by post COVID hiring shortages. We have developed and are building a daycare for the staff at Link as a mechanism to attract and retain staff and at the end of FY 22/23 made a dramatic increase in the direct support staff wages.

Our mission, vision and values continue to drive Link's commitment to serving our stakeholders and provide the best outcomes for those we serve. There are nearly 5 million individuals in the US with intellectual disabilities (ID). Approximately 60 percent of these individuals rely on Medicaid and 35,000 individuals are in a Medicaid Care system. Roughly 75% of these people live integrated into the community with roommates or on their own with the support of staff like Link provides.

Again, this year you will again see multiple references to the shortage of Direct Support Professionals (DSP), not only in our area, but across the state and nation and the significant related impacts. Because of our amazing leadership staff and the dedication of our employees, Link has continued to provide amazing services. As readers of this report, please spend a few minutes understanding how difficult the situations our staff have been put in. Incredibly proud, humbled, and honored do not summarize how thankful I feel to have all of them on the Link team.



Goals Met

We continue to raise the bar and set higher standards annually which as a company ensures we do not become complacent. In FY 2022/2023 Link Associates had 59 goals to measure the efficiency, effectiveness, satisfaction, and access to programs and services. Of those 59 goals we met 37 or 62.71% which is slightly higher than last year. In FY 2021/2022 Link Associates had 61 goals and we had a 65.50%.

Summary Of Goals Not Met

Despite the multiple challenges we have experienced over the past years goal progress continues as aggressively as ever and we are elated to see even slight progress. For the past two years, meeting many of our goals was complicated by both COVID as well as the nationwide staff shortage. This is not presented as an excuse, just a complication we have worked to address.

Goals that were not met:

Case Management

1. Increase number served in Case Management.

Day Habilitation

1. Maintain cost of service projections to budget.

Fleet & Facilities

1. Improve rider satisfaction.
2. Maintain or improve the number of work-related injuries for employees from previous year.
3. Maintain or improve the number of Link vehicle only accidents from previous year.
4. Maintain or improve the number of vehicle accidents with a 3rd party from the previous year.
5. Maintain, or increase the efficiency of agency routes.

LEEP

1. Increase admissions into job development services.
2. Reach and maintain maximum participation.

3. Expand the businesses available for internships.
4. Maintain cost of services to budget projections.

Residential

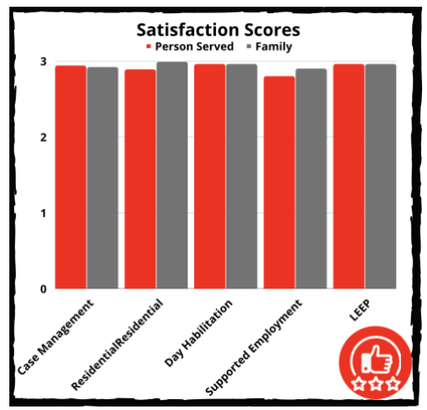
1. Improve the delivery of services to new referrals.
2. Maintain or increase the number of people served.
3. Improve quality of service.

Supported Employment

1. Maintain or increase number of hours worked weekly in job coaching.
2. Decrease amount of time waiting for job placement - (Job Development).
3. Maintain cost of services to budget projections (Job Development & Job Coaching)

Supplemental

1. Improve positive behavior supports to persons served.
2. Improve quality of treatment to those served.
3. Improve staff qualifications.
4. Improve persons served knowledge of grievance and appeal process.



Satisfaction Outcomes

Again, this year our overall satisfaction scores were extremely high. But, if you are ever going to get close to perfect, the satisfaction of those we support is the best place to do it. This measure remains critical, as the satisfaction of the persons we serve, and their families is paramount to our success. Link Associates exists to make a difference in the lives of persons served. Obtaining satisfaction from various perspective gives us a well-rounded picture to determine areas of improvement. Listening and learning to what our stakeholders tell us will help improve our practices, which translates into better service provision and happier stakeholders. It is difficult to compare the scores to previous years as we changed the scoring methodology, yet the outcomes remain extremely high.

a. Overall satisfaction for the agency was 2.95 on a 3-point scale:
    1) Persons served 2.91 on a 3-point scale.
    2) Parents/Guardians/Advocates 2.96 on a 3-point scale.
    3) Business Partners 2.99 on a 3-point scale.

Overall, the positive outcomes of the programs offered, which are described in detail throughout the full report that follows, serve as strong indicators of Link Associates' continued success over the past year.

Respectfully Submitted,

Linda Dunshee

Linda Dunshee, Executive Director

Board of Directors Review

Department Directors walked the committee though each section of the program evaluation report. The following summarizes questions, comments, and suggestions.

Link Associates Program Evaluation

CASE MANAGEMENT
Link Associates Program Evaluation
July 1, 2022 to June 30, 2023
Joan Osborn, Case Management Director

As Case Management Director I have reviewed the data for the past year in which the department established seven goals and met six of them. We will continue to focus on all the seven goals as written, revising targets to also capture quarterly progress with accessing services in less than 60 days. There are no new goals proposed for FY 23-24.

Highlights of achievement areas:
Satisfaction: maintaining high satisfaction from individuals served (CM=2.99/3.0 scale, PM=2.90/3.0 scale) and parent/guardian satisfaction (CM=2.93/3.0 scale, PM=2.92/3.0 scale), both stable results from the previous year.

Personal Goal Achievement: those we serve will meet 97% of their individualized goals, an increase in the target from the previous year of 93%. Both CM and PM programs achieved this goal, with scores of CM=94% and PM=99%.

Maintain or decrease length of time admissions committee approval to services starting. Reducing wait time between being accepted into services and starting services is important in keeping the persons served interested in accessing a Link service. This goal was met all of four quarters with an annual average of wait time of 41 days, an improvement for last FY of 52 days, meeting the goal for the year.

Frequent Contact: regular face to face contact and monitoring services of those served. The target goal for this measure is 3.90 for CM and PM. The average number of contacts on behalf of the person served is CM=5.60, previous year is 3.79, and PM= 4.22, previous year, 4.09. This goal was not met last year I am proud to see the programs once again meet the targets and that the contact data demonstrates high involvement, even during the continued impact of the pandemic the Case Coordination team focused on staying connected to those we serve. These scores reflect only activities that would be considered billable, except for billable Medicaid paperwork, which we opt to exclude so that our scores reflect only contacts on behalf of the person served.

The program also met targets set for goals in the areas of:
Quality Assurance -100% of Case Management records and 20% of Program Management records will be reviewed using the quality assurance process. Goal targets met in CM and PM.

Individuals meeting their person goals - 93% of Individual's goals reviewed via the QA process will show progress toward meeting the individual's goal. Score reflected are CM=5.60 and PM=4.22.

Highlights of areas that goal targets were not met:

Increase number of persons served by 10/year for PM. For CM no growth targets will be set:
The CM program began with 17 persons served and as of June 30th and ended with 18 persons served who are all enrolled in the DHS HIPP Insurance Program which qualifies the person for Fee for Service Case Management. The PM program numbers started with 234 persons served and ending with 232. For FY 22-23, Day Habilitation continued LOA's, and the only programs to see new referrals is the LEEP program and some limited approvals for residential services due to openings, not expansion. It is expected that Day Habilitation will open more LOA slots so persons served can return to their program.

Services:
Both Case Management and Program Management services continue to work with managed care organizations for to understand their needs and how those fits into our framework of quality services. Staff continue to negotiate what they should be doing for persons served and families that are traditional roles of the Medicaid Case Manager.
I am proud of the staff in the Case Management Department for the good work that they do. They are extremely skilled in our communities' services, rules, and the rights of those we serve and are strong advocates.

Case Management Demographics

CM FY 2022-2023	1st Quarter Demographics	%	2nd Quarter Demographics	%	3rd Quarter Demographics	%	4th Quarter Demographics	%
Link	17	100%	16	0%	16	0%	16	0%
Age								
<16	2	12%	2	13%	2	13%	2	13%
16-17	0	0%	0	0%	0	0%	0	0%
18-21	2	12%	2	13%	2	13%	2	13%
22-34	13	76%	12	75%	12	75%	12	75%
35-44	0	0%	0	0%	0	0%	0	0%
45-54	0	0%	0	0%	0	0%	0	0%
55-64	0	0%	0	0%	0	0%	0	0%
65>	0	0%	0	0%	0	0%	0	0%
Gender								
Male	14	82%	13	81%	13	81%	13	81%
Female	3	18%	3	19%	3	19%	3	19%
Ethnicity								
Black or African American	1	6%	1	6%	1	6%	1	6%
American Indian and Alaskan	1	5.9%	1	6.3%	1	6.3%	1	6.3%
Asian		0%	0	0%	0	0%	0	0%
Caucasian	14	82%	13	81%	13	81%	13	81%
Hispanic		0%	0	0%	0	0%	0	0%
Native Hawaiian/other Pacific Islander		0.0%	0	0.0%	0	0.0%	0	0.0%
Other Race	1	6%	0	1%	1	6%	1	6%
Residential Area								
HCBS Daily	7	41%	6	38%	6	38%	6	38%
HCBS Hourly Adults/Children	5	29%	5	31%	5	31%	5	31%
Adult Child No SCL/Res Service	5	29%	5	31%	5	31%	5	31%
Vocational Area								
Day Habilitation	6	35%	5	31%	5	31%	5	31%
Competitive	2	12%	2	13%	2	13%	2	13%
NA, child	2	12%	2	13%	2	13%	2	13%
NA, no placement	4	24%	4	25%	4	25%	4	25%
SE	3	18%	3	19%	3	19%	3	19%
Training Program	0	0%	0	0%	0	0%	0	0%
Population Group								
DD	0	0%	0	0%	0	0%	0	0%
ID	17	100%	16	100%	16	100%	16	100%
Level of Disability								
DD	0	0%	0	0%	0	0%	0	0%
Mild ID	6	35%	6	38%	6	38%	6	38%

Moderate ID	5	29%	4	25%	4	25%	4	25%
Profound ID	1	6%	1	6%	1	6%	1	6%
Severe ID	5	29%	5	31%	5	31%	5	31%

July - September 2022
The program had one discharge due to HIPP eligibility. All other demographics have remained stable and no significant shifts or trends.

October - December 2022
The program had one discharge due to HIPP eligibility. All other demographics have remained stable and no significant shifts or trends.

January - March 2023
Demographics remain unchanged from previous quarter, so shifts or identified trends.

April - June 2023
Demographics remain unchanged from previous quarter, so shifts or identified trends. There are no annual trends or shifts in our demographics. Movement is soley due to persons served losing HIPP eligibility for Fee For Service Case Management. Anyone discharged due to HIPP eligibility is assigned an MCO Community Based Case Manager and Link assists with that transition.

Annual Summary 2022-2023
The Case Management program census remained stable this fiscal year; however, over the last few years it continues to decline due to eligibility. There is no source for new referrals for fee for service case management as the State of Iowa Case Managers are assigned those and there have been no requests for transfer from other Polk County agencies. Continued evaluation of the programs viability will occur. There are no significant trends and the demographics have remained stable with no shifting.

Case Management Measures of Achievement

Case Management Measures of Achievement 2022 - 2023																			
EXPERIENCES OF SERVICES RECEIVED AND OTHER FEEDBACK FROM THE PERSONS SERVED																			
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve individual's satisfaction	Individuals' satisfaction with their Case Manager or Program Manager	Listen to Me Satisfaction survey	Case Managers	Case Managers	Minimum score 2.75 or higher; optimal score 2.9 or higher (3-point scale)	Those served in Case Management (CM) & Program Management (PM)	CM Score= 0 returned N=			CM Score= 0 N=			CM Score= 2.98 N=2			CM Score= 3.00 N=2		
							PM Score= 2.96 N=33			PM Score= 2.76 N=33			PM Score= 2.88 N=41			PM Score= 3.00 N=5		
							Annual Persons Served Satisfaction Results CM Score=2.99 N=4********** PM Score=2.90 N= 112											

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	Continue goal. Action Steps Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER CM = no surveys were returned this quarter. PM = goal met No comments from the persons served.	2ND QUARTER CM = no surveys were returned this quarter. PM = goal met Persons served comments include noting that one person is easily frightened when her roommate is aggressive towards staff, Case Coordinator communicated this to the team to address it. Other comments included two people desiring to move to different homes, all related to roommate issues and working through what to do for coping skills in the interim.	3rd QUARTER CM = goal met PM= goal met No comments from the persons served.	4TH QUARTER CM = goal met PM= goal met One comment submitted for CM/PM services: staff didn't take to farmer's market, my legs hurt. Person served worked with health services and residential supervisor to address health condition.

Comparison of last year's results (21/22) to this year (22/23): For FY 21-22, the programs met the goal target in all four quarters with annual scores stable from the previous years of 2.93 for CM and 2.90 for PM. For FY 22-23, the programs met the targets with blended annual CM score of 2.99 and PM score of 2.90.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Step:	NA	NA	NA

RESOURCES USED TO ACHIEVE RESULTS FOR THE PERSONS SERVED (EFFICIENCY)

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain contact with person served	Monthly contacts per month, averaged per quarter.	Filemaker Database	Case Management Director	Case Management Director	Quarterly average # of contacts made on behalf of the person served = 3.90 or higher per month for CM/PM.	Those served in Case Management (CM) & Program Management (PM)	CM=6.44	CM=3.28	CM=5.00	CM=3.31	CM=5.06	CM=5.81	CM=4.69	CM=4.88	CM=6.98	CM=6.44	CM=8.44	CM=6.81
							PM=3.88	PM=4.34	PM=4.17	PM=4.51	PM=4.07	PM=3.84	PM=3.88	PM=4.13	PM=4.42	PM=4.99	PM=4.31	PM=4.11
							Quarterly Average CM=4.91 PM=4.13			Quarterly Average CM=3.62 PM=4.14			Quarterly Average CM=5.52 PM=4.14			Quarterly Average CM=7.23 PM=4.47		
							Annualized Average Contacts CM=5.60, PM=4.22											

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	Increase PM target to 3.90 or higher per month. Action Steps – Target increased. Did Actions taken accomplish intended results. ☒ Yes ☐ No ☐ NA	Target for PM increased on 7/1/22 at the beginning of this evaluation year.	7/22

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3rd QUARTER	4TH QUARTER
	CM = goal met *high staffing month PM = goal met	CM = goal not met PM = goal met CM did not meet target with a score of 3.62, continue to monitor as this year the target increased to 3.90.	CM = goal met PM = goal met	CM = goal met PM = goal met

Comparison of last year's results (21/22) to this year (22/23): For FY 21-22, the CM program met the goal target 2/4 quarters and did not meet the annual target goal of 3.90 contacts or higher. The PM program met the target 4/4 quarters and met the annual target of 2.83 with an impressive score of 4.09. Persons served in CM through Fee for Service did receive reasonably high contacts from the Link CM with an average of 3.79 contacts per member, per month, which demonstrates the connections between the persons served, their team, and the CM. For FY 22-23, Link CM met the goal with 5.60 average contacts per member, per month and PM met the goal with 4.22 average contacts per member, per month. The high number of contacts per member each month ensures that the case coordinators are engaged with person served and see them frequently as well as make contacts on the persons behalf.

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Step:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Comply with state standards and program policy regarding Quality Assurance	Number of records reviewed annually of those in service as of 07/01/22. CM=17 PM=234	Review of Case File and completion of Quality Assurance Checklist	Quality Assurance Committee	Assistant Case Management Director	100% of Case Management records and 20% of Program Management records will be reviewed using the quality assurance process.	Those served in Case Management (CM) & Program Management (PM))	Case Management N= 6 records Program Management N= 12 records			Case Management N= 6 Program Management N= 12			Case Management N= 4 Program Management N=11			Case Management N= N/A Program Management N=11		

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan). Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER
	Continue to review plans according to set schedule to achieve goal target.	On target for meeting annual goal.	On target for meeting annual goal.	Met targets for CM and PM.

Annual total of case file quality assurance reviews:
CM (goal 100%) = 16, 100%
PM = (goal 20%) = 46, 20%
Trends summarized: Admins have completed all QA's this fiscal year. Trends within individual program managers were identified and training occurred.

Comparison of last year's results (21/22) to this year (22/23): For FY 22-23, both programs again met their targets at 100% and 20%, which has been determined to be a reasonable target for the QA of person served files. For FY 22-23, CM and PM met the goal target of CM, 100% QA completed and the goal of PM, 20% QA completed.

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable
Characteristics of persons served impact performance: ☐ YES ☒ No
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Step:	NA	NA	NA

RESULTS ACHIEVED FOR THE PERSONS SERVED (EFFECTIVENESS)

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Achievement of individual's identified goals.	The number of goals with progress in a 100% sample for CM and 20% sample for PM. Reviewed Annually	Review of Case File and completion of Quality Assurance Checklist	Quality Assurance Committee	Case Management Admin Assistant	93% of Individual's goals reviewed via the QA process will show progress toward meeting the individual's goal.	All Case Management Individuals, Case Management (CM) & Program Management (PM)	CM goals with progress = 17/19 = 89% PM goals with progress = 25/26, 96%			CM goals with progress =22/23, 96% PM goals with progress =25/25, 100%			CM goals with progress = 11/11, 100% PM goals with progress =26/26, 100%			CM goals with progress = N/A PM goals with progress = 23/23, 100%		
							CM ANNUAL SUMMARY Number of goals reviewed for progress = 50/53, 94%						PM ANNUAL SUMMARY Number of goals reviewed for progress =99/100, 99%					
							Case Management Department Blended Scores = Number of goals reviewed for progress =149 /153, 97%											

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	Continue goal as written. Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER
	CM Goal not met, goals will be reviewed with the teams to discuss reasons and make recommendations on the three goals not demonstrating progress. PM = goal met.	CM = Goal met PM = Goal met	CM = goal met PM = goal met	No data reported for CM as 100% of files were reviewed by 3/23 of the fiscal year. PM met goal.

Comparison of last year's results (21/22) to this year (22/23): For FY 21-22, both programs met the annual target with a blended score of 93%. The CM program met the target 2 of 4 quarters and the PM program met the target 3 of 4 quarters. Staff are reviewing DSP documentation in lieu of meeting 1:1 with the supervisor who has completed the review. Concerns with incomplete and missing data has affected goal progress results as a reviewer must default to no progress if there is no data. This is reported to the program Director and Administrator as well as the Corporate Compliance Director when the data appears to be non-billable for their review. For FY 22-23, both CM and PM met the goal targets with scores of 94% and 97%, respectively. Blended scores produced excellent results with 97% of individualized goals reviewed with progress demonstrated.

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain) difficult.

Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe

☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	NA	NA	NA

SERVICE ACCESS																		
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Meet community needs through expansion and maximize time available to coordinators.	Number of people served as of 07/1/22. 17 (CM), 234 (PM)	FileMaker Google dock caseload numbers, monthly billings	Case Management Administrator	Case Management Administrator	Increase number of persons served by 10/year for PM. For CM no growth targets will be set. CC caseload </ or = to 38	Those served in Case Management (CM) & Program Management (PM)	CM=18 PM=232	CM=18 PM=230	CM=17 PM=229	CM=16 PM=226	CM=16 PM=233	CM=16 PM=231	CM=16 PM=229	CM=16 PM=229	CM=16 PM=233	CM=16 PM=235	CM=16 PM=235	CM=16 PM=232

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☐ Goal Met ☒ Goal Not Met	Continue goal as written. Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	CM = two persons served were transferred from HIPP to MCO CBCM due to eligibility. No growth this quarter. PM = Outreach has been made to those served who have been on the wait list for Day Hab. Several teams declined to return which explains the reduced census at the end of the quarter. Caseload averages = 33	CM = one person served was transferred from HIPP to MCO CBCM due to eligibility. No growth this quarter. PM = Link PM continued see increases in discharges as people decline coming back from the Covid wait list. Census at 233 up from the lowest census in October with 226 persons served. Intakes are minimal and are only impacting LEEP referrals from IVRS; however, these referrals are people with developmental disabilities, not intellectual disabilities so they will not continue with job development as IVRS funding expires and the persons served are not waiver eligible. Caseload averages = 28	CM = one discharge due to HIPP pending, 1 new admission (person served used to be served at Link). No growth this quarter. PM = Small growth due to the LEEP program, one person is exploring Link for residential, but this will fill vacancies due to discharges. Waitlist for Day Hab continues	CM = no intakes this quarter. No growth this quarter. PM = Link PM has had a slight decline this quarter from 235 served to 232 persons served, which is stable and typical movement. Intakes and discharges are offsetting each other each month. Approximately 15 persons served remain on the wait list to return to Day Hab. Due to high support needs, these people will be offered to return in the next quarter.

Comparison of last year's results (21/22) to this year (22/23): For FY 21-22, due to the Day Hab continuing LOA, the only program to see new referrals is the LEEP program. It is expected that Day Hab will open more LOA slots so persons served can return to their program. The target was not met with PM program growth of more than 10 person served to reach 280, ending the year with 236, however, it must be noted that the database for part of the year included LOA persons served so the number served was inflated and once adjusted the actual number is 254. For FY 22-23, CM decreased its census by two persons served this FY and PM did not meet target and did not increase its census by 10 and instead dropped by two persons served. The agency had staffing issues for much of the fiscal year; however, an increase in the DSP starting wage in the last quarter has filled many open positions which will position the agency to serve 14 people on the wait list.
Trends: ☒ YES ☐ No Staffing shortages impacted the ability to serve more people.
Causes: ☒ YES ☐ Non-Applicable Lower DSP starting wage did not attract sufficient staff to allow for program expansion and industry wide staff shortages impacted opening areas in Day Hab and new site development in SCL.

Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain) Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)			
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Minimizing time between intake meeting and starting services.	Number of days between admissions and service start date.	Admission referral tracking sheet	Case Management Administrator	Case Management Administrator	Maintain or decrease length of time of admissions committee approval to start services < than two months (60 days).	Those served in Case Management (CM) & Program Management (PM)	Total days CM – NA N = 0 Average = NA Total days PM – N=2 Average = 27 days			Total days CM – NA N = 0 Average = NA Total days PM – N=7 Average = 36.43 days			Total days CM – 30 N = 1 Average = NA Total days PM – N=4 Average = 44 days			Total days CM – NA N = 0 Average = NA Total days PM – N=7 Average = 53.29 days		

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	Continue as written. Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	CM = N/A PM = 2/2 applicants accessed services in < 60 days. Average = 27 days	CM = N/A PM = 6/7 applicants accessed services in < 60 days. Average = 36.43 days	CM = Goal met; 1/1 applicant accessed CM service <60 days PM = 2/4 applicants accessed services <60 days. Average = 35.4 days	CM = N/A PM = 5/7 applicants accessed services <60 days. Average = 53.29 days
	Annual Blended Average = 41 average days between admission date and start of service date. N=21 The programs met annual goal of < 60 days on average to start services in all four quarters. 15/21, 71% persons served required < 60 days to start services. 6/21, 29% persons served required >60 days to start services.			

Comparison of last year's results (21/22) to this year (22/23): For FY 21-22, Link continues with a LOA for many Day Hab participants and cannot take new referrals. This year 10 persons served started services within 60 days, and two individuals required more than 60 days, both due to staff shortages and having to wait to start LEEP until that staff were in place. The overall average was 52 days. For FY 22-23, 15 persons served started services in < 60 days, and 6 persons served started services in > 60 days. With an annual blended average, the programs achieved an overall average of 40.85 days between admission date and start of service date, meeting the annual goal of <60 days.
Causes: ☐ YES ☒ non-Applicable

Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain) Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)			
New Recommendations for Next Year (23/24): ☐ Continue as written ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined below. Action Steps: Target revised to maintain or decrease length of time of admissions committee approval to start services to a quarterly and annual average of < than (60 days).	Expected Outcomes Will include averages per quarter.	Person Responsible CM Director	Timeframe 7/1/23

EXPERIENCES OF SERVICES AND OTHER FEEDBACK FROM OTHER STAKEHOLDERS																		
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve parent/ Guardian satisfaction	Parent/Guardian Satisfaction with their CM/PM Services	Listen to Me Guardian Satisfaction survey	Listen to Me Guardian Satisfaction survey	Case Managers	Case Managers	Maintain or improve satisfaction score of 2.75, optimal 2.9 (3-point scale)	CM = 2.8 N= 2 PM 2.97 N=37			CM = 0 N= 0 PM = 2.76 N=33			CM = 3.0 N= 3 PM = 2.95 N=53			CM = 3.0 N= 2 PM = 3.0 N = 5		
							Annual Parent/Legal Representative Satisfaction Results CM Score= N=2.93 * PM Score= 2.92 N= 128											

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	\Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan) Continue goal as written. Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) NA	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER CM = goal met PM = goal met	2ND QUARTER CM = goal met PM = goal met	3RD QUARTER CM = goal met PM = goal met	4TH QUARTER CM = goal met PM = goal met

Comparison of last year's results (21/22) to this year (22/23): For FY 22-23, scores continue to remain high with annual scores of CM, 3.00 and PM, 2.90. Satisfaction comments were seldom completed this year. Will discuss with team to prompt for comments. For FY 22-23, the programs demonstrated annual scores of CM, 2.93 and PM score of 2.92, both being high scores of satisfaction by persons served. This FY there was a realignment in caseloads so that a case coordinator is assigned all persons served who reside in the same SCL home. While staff expressed concern about the ability to advocate for three-five people living in the same household, this was not an issue in satisfaction surveys and after an adjustment period staff have provided input that this change has prompted positive changes and better relations with the DSP and Supervisory staff.

Trends: ☐ YES ☒ No (if yes provide detail):
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

SUPPLEMENTAL MEASURES																		
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23

Collect and analyze data about Case Management individuals & services	Trends in CM Incident Reports	Incident submitted to or written by CM Staff	Case Managers and Case Management Administrator	Case Managers and Case Management Administrator	Collect, analyze and share information regarding trends identified.	Case Management Individuals	Reviewed as submitted and checked for trends quarterly. Reviewed with management team quarterly. Annually compiled and distributed for consideration.

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☐ Goal Met ☐ Goal Not Met NOT A FORMAL GOAL	Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):

1st QUARTER

Trends observed: During the 1st quarter of FY23, there was only one critical incident reported. No trend was identified. No minor incidents were reported.

Causes of trends observed:
No trends were identified in the major incident reported.

Steps to prevent recurrence:
No trends were identified.

Areas for improvement:
No area of improvement was identified.

Actions to address the improvements needed and implementation of actions:
This is not applicable since no trends or areas for improvement were identified.

Identified areas for education and training of personnel:
No additional education or training was identified as necessary.

Data for persons served in PM is collected and reported via those programs.

Quarterly Summary of Critical Incident Types	July 2022	August 2022	Sept 2022
Physical Injury to or by the individual requiring a physician's	0	0	1

2ND QUARTER

No trends were identified in the incident reports submitted for Case Management in the first quarter of FY23 so there are no implemented action results to report.

Trends observed: During the 2nd quarter of FY23, there were no incidents reported that meet the critical criteria. However, there were two reports made as critical that didn't meet this definition. One report did meet the minor criteria standards.

Causes of trends observed:
No trends were identified.

Steps to prevent recurrence:
No trends were identified.

Areas for improvement:
On-going education on the major and minor incident definitions.

Actions to address the improvements needed and implementation of actions:
No actions were identified other than on-going education with providers on criteria for incidents.

Identified areas for education and training of personnel:
On-going education and discussion with providers on the major and minor criteria for reporting.

Data for persons served in PM is collected and reported via those programs.

Quarterly Summary of Critical Incident Types	October 2022	November 2022	December 2022

3RD QUARTER

Trends observed:
During the third quarter of FY23, five incidents were reported, three involving DHS reports and two requiring medical intervention. Compared to the previous two quarters, there was a significant increase in critical incidents this quarter (1st quarter: 1 & 2nd quarter: 0). Two of the incidents in which DHS was notified involved RB and the two incidents requiring medical treatment involved SC.

Causes of trends observed:
The team for RB had been working on identifying causes for the increase in aggression but it was felt the current living environment wasn't appropriate to meet his needs.

The two incidents involving SC were the results of falling following his paroxysmal spells.

Steps to prevent recurrence:
RV has moved into a host home setting with a former staff.
SC and his family continue to work with his medical professionals to determine the cause of his spells and treatment to reduce frequency. He will be going in May to see a specialist in St. Louis.

Areas for improvement:
No areas for improvement were identified as RB will be transitioning to a new provider and SC and his family will need guidance from medical professionals on addressing his spells.

Actions to address the improvements needed and implementation of actions:
RB's care will be transitioned to the Host Home and information and training related to his care needs provided as needed. The Host Home provider is familiar with RB and has worked with him

4TH QUARTER

Trends observed:
RB discharged from Case Management amid his transition to the host home, so no additional information is available on if this implemented action had the intended results.

SC's family continues to work with medical professionals to see what can be done but no changes have been made at this time.

Trends observed: During the last quarter, there were two critical reports made, with one report meeting duplicative criteria (Police/DHS). SC had another critical incident this quarter similar to last quarter and previous quarters (injury resulting in medical treatment – due to falling after a shaking spell).

Causes of trends observed:
SC and his family believe there is a medical cause for the shaking and falls but no diagnosis has been made.

Steps to prevent recurrence:
SC continues to follow up with medical professionals to determine the cause and find a solution. However, the spells are unpredictable, so it is difficult to prepare and prevent.

Areas for improvement:
No areas for improvement were identified.

Actions to address the improvements needed and implementation of actions:
No areas for improvement identified.

treatment or admission to hospital.			
Results in someone's death	0	0	0
Requires emergency mental health treatment for the individual	0	0	0
Requires the intervention of law enforcement	0	0	0
Results from any prescription medication error	0	0	0
Is reportable to protective services	0	0	0
Person's Served location is unknown	0	0	0

Physical Injury to or by the individual requiring a physician's treatment or admission to hospital.	0	0	0
Results in someone's death	0	0	0
Requires emergency mental health treatment for the individual	0	0	0
Requires the intervention of law enforcement	0	0	0
Results from any prescription medication error	0	0	0
Is reportable to protective services	0	0	0
Person's Served location is unknown	0	0	0

in the past so it is felt this will reduce the incidents of aggression as RB will receive the care and routine he needs.

Identified areas for education and training of personnel:
Education and training for RB's Host Home staff will be provided by the agency and natural supports for RB.

Data for persons served in PM is collected and reported via those programs.

Quarterly Summary of Critical Incident Types	January 2023	February 2023	March 2023
Physical Injury to or by the individual requiring a physician's treatment or admission to hospital.	0	1	1
Results in someone's death	0	0	0
Requires emergency mental health treatment for the individual	0	0	0
Requires the intervention of law enforcement	0	0	0
Results from any prescription medication error	0	0	0
Is reportable to protective services	1	2	0
Person's Served location is unknown	0	0	0

Identified areas for education and training of personnel:

No identified areas for education/training.

Data for persons served in PM is collected and reported via those programs.

Quarterly Summary of Critical Incident Types	April 2023	May 2023	June 2023
Physical Injury to or by the individual requiring a physician's treatment or admission to hospital.	0	0	1
Results in someone's death	0	0	0
Requires emergency mental health treatment for the individual	0	0	0
Requires the intervention of law enforcement	1	0	0
Results from any prescription medication error	0	0	0
Is reportable to protective services	1	0	0
Person's Served location is unknown	0	0	0

Comparison of last year's results (21/22) to this year (22/23): For FY 21/22, there 5 critical incidents reported and no minor incidents. Incidents involved physical injury to or by the individual that required physicians' treatment or admission into the hospital, two requiring the intervention of law enforcement, and two that were reportable to protective services. For FY 22-23, there were 9 critical incidents reported and no minor incidents. Reminders were sent to case coordinators twice this fiscal year to request minor incident reports from providers. The reasons for critical incidents remain stable with interventions of law enforcement, physical injury requiring a physician's treatment, and reports to protective services.
Trends: ☐ YES ☒ No (if yes provide detail):
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	NA	NA	NA

DAY HABILITATION
Link Associates Program Evaluation
July 1, 2022 to June 30, 2023
Claire Sumner, Day Program Administrator & Cassondra Jones, Employment/Day Program Director

As the Day Habilitation leadership team, we have reviewed the data gathered over the past year and all changes made within the department. This year the department established 8 goals and were successful in meeting 5 of them.

During the months of July 2022 – June 2023, the Day Program continued to have several individuals who remained on a leave of absence. The program was unable to bring all individuals services prior to COVID-19 back due to a staffing shortage. All Day Program Supervisors completed their daily responsibilities and covered direct support shifts 4-5 days/week. At the end of May 2023, Link Associates was able to secure funding to increase wages for direct support professionals. The new hiring wage being $18/hour. This greatly increased the number of applicants and new hires we were able to obtain. The Day Program now aims to continue to recruit and retain quality staff to continue our efforts in providing the highest quality services. On average, our program serves approximately 100 FTE's.

This year, the Day Program received many grants (Prairie Meadows $20,000 for flooring; Lincoln State Bank Foundation $1,000 for kitchen renovation in Leisure Department; Plus American Legion of Iowa Foundation $1,400 for mini-cycle and TV monitor). With these purchases we were able to improve the services we deliver.

In the fiscal year, we were not successful in meeting 3 of our established goals. We were unable to meet our 'Maintain or Increase number of persons served' goal as well as our goal to 'Improve the delivery of services to new referrals' due to the staffing crisis. This impacted our ability to bring back persons served who were receiving day program services prior to the pandemic as well as bring back new persons served (referrals). The nationwide staffing shortage caused us to put admissions on hold as we couldn't cover the open day program positions we had, and the program supervisors were covering 4-5 days a week. This also impacted our goal to 'Maintain cost of services budget projections' and we did not meet it. It was budgeted to open 11 areas throughout the 2022-2023 fiscal year and we were only able to open 2 areas due to not being able to recruit new staff (staffing shortage). In June 2023, there was a significant increase in wages for DSPs which has aided in our staff retention as well as getting candidates to fill our open positions. This will lead to the program opening more areas in FY 23-24 and making progress on meeting these goals in the next fiscal year.

In the next fiscal year, we are not recommending any formal changes to goals, but we will continue an action step to "obtain a minimum of 3 satisfaction surveys per quarter" to help ensure we are receiving well-rounded feedback from our VIP sites for FY 23-24.

We are most proud of our supervisory/leadership team and our long-term DSPs for their continued commitment and flexibility over the last year. Amidst all the changes our team continues to work together and provide some of the best supports to those we serve in our Day Program.

Day Habilitation Supplemental Measures

Supplemental Measures	Day Habilitation			
	Quarter			
	1st	2nd	3rd	4th
1. Discharges from program (not due to dissatisfaction) A) Medical supports/safety	1	0	1	2
B) Moved out of service area	0	2	0	1
C) No longer in need/want of services	0	2	0	0
D) Increase in supports (non-medical)	0	0	0	1
E) Transfer to less restrictive setting	0	0	0	0
F) Number of involuntary discharges	0	2	0	1
G) Return to school setting	0	0	0	0
H) To another Link program	0	0	0	0
2. Total number outside of Link Services	2	2	0	0
3. Average number of areas that participated in community outings at least 1 weekday every month (ex: at least 1 Monday, at least 1 Tuesday…Friday)	1	1	1	1

July - September 2022:
There were 3 discharges from the Day Program. One person served discharged due to increased medical needs (CR). Two persons served discharged due to starting a new day program service outside of Link Associates (FF & MJ) when offered an opportunity to return.

There was an average of 14 program areas this quarter. During the months of July – September 2022, 1 area had an outing planned each day of the week for the month: for an average of 0.07 for the 1st quarter.

October – December 2022:
There were 9 discharges from the Day Program. Two persons served moved out of the area (MB, BS). Two were no longer in need/want of services (TS, TC). Two were involuntary discharges due to losing funding eligibility (CA, TD). Two were discharged due to starting a new Day Program outside of Link Associates (BS, JW) when offered an opportunity to return.

There was an average of 16 program areas this quarter. During the months of October-December 2022, 1 area had an outing planned each day of the week for the month: for an average of 0.3 for the 2nd quarter.

January - March 2023:
There was 1 discharge from the Day Program due to needing a higher level of medical needs (DM).

There was an average of 14 program areas this quarter. During the months of January – March 2023, 1 area (108A) had an outing planned each day of the week for the month of March for an average of: 0.3 for the 3rd quarter.

April – June 2023:
There were 3 discharges from the Day Program. One person served was involuntarily discharged due to needing a higher level of care and displaying unsafe behavior (MM). One persons served's family decided to discharge voluntarily due to behavior concerns (BK). One person served moved to a different town and therefore the distance would not be practical to continue attending day program services (WD).

There was an average of 13 program areas this quarter. During the months of April – June, 1 area (108A) had an outing planned each day of the week for an average of: 0.6 for the 4th quarter.

Day Habilitation Demographics

FY 2022-2023	1st Quarter Demographics		2nd Quarter Demographics		3rd Quarter Demographics		4th Quarter Demographics	
Number Served	120	100%	121	100%	122	100%	118	100%
Age								
<16	0	0%	0	0%	0	0%	0	0%
16-17	0	0%	0	0%	0	0%	0	0%
18-21	0	0%	0	0%	0	0%	0	0%
22-34	37	31%	39	32%	39	32%	34	29%
35-44	25	21%	26	21%	27	22%	27	23%
45-54	19	16%	18	15%	17	14%	17	14%
55-64	23	19%	22	18%	22	18%	20	17%
65>	16	13%	16	13%	17	14%	20	17%
Gender								
Male	67	56%	65	54%	66	54%	62	53%
Female	53	44%	56	46%	56	46%	56	47%
Ethnicity								

Black or African American	9	8%	10	8%	10	8%	10	8%
American Indian and Alaskan	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Asian	4	3%	4	3%	4	3%	4	3%
Caucasian	99	83%	100	83%	101	83%	97	82%
Hispanic or Latino	4	3%	4	3%	4	3%	4	3%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Race	4	3%	3	2%	3	2%	3	3%
Level of Disability								
Developmental Disability (DD)	0	0%	0	0%	0	0%	0	0%
Mild MR (50-75)	33	28%	33	27%	31	25%	29	25%
Moderate MR (35-49)	49	41%	49	40%	52	43%	48	41%
Severe MR (20-24)	34	28%	35	29%	35	29%	37	31%
Profound MR (< 20)	4	3%	4	3%	4	3%	4	3%
Secondary Diagnosis								
ADD/ADHD	7	6%	7	6%	7	6%	5	4%
Alzheimer's/Dementia	0	0%	0	0%	0	0%	0	0%
Anxiety Disorder	2	2%	2	2%	2	2%	1	1%
Autism	21	18%	23	19%	23	19%	21	18%
Behavior Disorder	0	0%	0	0%	0	0%	0	0%
Cerebral Palsy	21	18%	22	18%	23	19%	23	19%
Depression	5	4%	5	4%	5	4%	5	4%
Down Syndrome	12	10%	12	10%	12	10%	12	10%
Epilepsy	9	8%	9	7%	9	7%	10	8%
Hearing Impairment	6	5%	6	5%	6	5%	6	5%
Intermittent Explosive Disorder	1	1%	1	1%	1	1%	1	1%
No Secondary Diagnosis Known	12	10%	11	9%	0	0%	10	8%
Other	14	12%	15	12%	15	12%	15	13%
Schizophrenia	2	2%	1	1%	1	1%	1	1%
Seizure Disorder	9	8%	9	7%	9	7%	10	8%
Visual Impairment/ Legally Blind	4	3%	4	3%	4	3%	4	3%

July-September 2022

The data pulled for this quarter reflects there were 120 participants in the program. The average participant was a Caucasian male between the ages of 22-34 years of age, with a primary diagnosis moderate MR and a secondary diagnosis of autism and cerebral palsy. The data pulled for this quarter reflects there were 3 discharges. The average discharge was a Caucasian female between the ages of 55-64 with a primary diagnosis of Mild MR and a secondary diagnosis of Down syndrome and hearing impairment.

October-December 2022

There were 121 participants in Day Program this quarter. The average participant is a Caucasian male between the ages of 22-34, diagnosed with moderate MR (35-49) with a secondary diagnosis of autism. There were 8 participants who discharged from the program. The average person who discharged was a Caucasian male between the ages of 22-34/55-64 (50/50) diagnosed with Moderate MR (35-49) with a secondary diagnosis of cerebral palsy and epilepsy (50/50).

January - March 2023
There were 122 participants in Day Program this quarter. The average participant is a Caucasian male between the ages of 22-34, diagnosed with moderate MR (35-49) with a secondary diagnosis of autism. One participant was discharged due to increased medical needs. This person was a Caucasian male between the ages of 55-64 with a primary diagnosis of moderate intellectual disability and a secondary diagnosis of Down Syndrome and seizure disorder.

April - June 2023
There were 118 participants in Day Program this quarter. The average participant is a Caucasian male between ages of 22-34, diagnosed with moderate MR (35-49) with a secondary diagnosis of autism. There were 3 participants who discharged from the program. Two of the participants who discharged were between the ages of 22-34, both with primary diagnosis of moderate intellectual and secondary diagnosis of autism. The third participant with the primary diagnosis of moderate intellectual disability age 55-64.

The data pulled reflects that there were 14 participants that discharged within this program for the year. The average participant was a Caucasian male between the ages of 22-71 years of age, with a primary diagnosis of severe MR and a secondary diagnosis of autism.

Day Habilitation Measures of Achievement

Day Habilitation Measures of Achievement 2022 - 2023

RESULTS ACHIEVED FOR THE PERSONS SERVED (EFFECTIVENESS)

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Increase community participation.	Number of community activities	DCA-2's	Day Program Supervisors	Day Program Administrator	Minimum of 170 scheduled events per month	Persons Served in the Day Habilitation program	193	237	232	221	229	202	229	237	275	241	277	278

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	It was recommended to continue goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER
	This quarter averaged 220 community integrated activities per month. Participants had the opportunity and chose to participate in outings including Neil Smith Trail, Rose Garden, South Fork Park, Enabling Gardens. There were 0 areas out of 14 that did not meet the expectation to plan and execute 2 outings during the month of July. There were 0 areas out of 14 that did not meet the expectation to plan and execute 2 outings during the month of August.	This quarter averaged 217 community integrated activities per month. Participants had the opportunity had chosen to participate in outings including Spirt Halloween, Howell's Pumpkin Patch, Lotta-POP-Popcorn, Des Moines Art Center, and Christkindlmarket. There was 1 area out of 14 (113B) that did not meet the expectation to plan and execute 2 outings during the month of October. There was 1 area out of 16 (108A) that did not meet the expectation to plan and execute 2 outings during the month of November.	This quarter averaged 247 community integrated activities per month. Participants had the opportunity to choose to participate in outings including Gigi's Playhouse, Robert Ray Asian Garden, St. Patrick's Day Parade in Des Moines, IA, Ankeny Art center. There was 1 area (218A) out of 14 that did not meet the expectation to plan and execute 2 outings during the month of January. There were 2 areas (110A & 210B) out of 14 that did not meet the expectation to plan and execute 2 outings during the month of February.	This quarter averaged X community integrated activities per month. Participants had the opportunity to choose to participate in outings including. There were 4 areas (109A, 110A, 218A, 222B) out of 14 that did not meet the expectation to plan and execute 2 outings during the month of April. There were 0 areas out of 14 that did not meet the expectation to plan and execute 2 outings during the month of May.

	There were 3 areas out of 14 (113B, 113C, 222A) that did not meet the expectation to plan and execute 2 outings during the month of September.	There were 2 areas out of 16 (109A, 113B) that did not meet the expectation to plan and execute 2 outings during the month of December.	There were 0 areas out of 14 that did not meet the expectation to plan and execute 2 outings during the month of March.	There were 0 areas out of 14 that did not meet the expectation to plan and execute 2 outings during the month of June.

Comparison of last year's results (21/22) to this year (22/23): For the 2021-2022 fiscal year, community participation ranged from 162 – 221 for an average of 200. For the 2022-2023 fiscal year, community participation ranged from 193 – 278 events per month with an average of 237 events per month for the 12 months of services.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA	NA	NA	NA

EXPERIENCES OF SERVICES RECEIVED AND OTHER FEEDBACK FROM THE PERSONS SERVED

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Decrease discharges due to dissatisfaction.	Number of discharges due to dissatisfaction	C-35's	Day Program	Day Program Administrator	No more than one discharge annually due to dissatisfaction.	Persons Served in the Day Habilitation Program	0			0			0			0		

Goal Outcome:	**Previous FY goal recommendations** (I.e., goal continuation and/or new action steps/plan)	**Update on action step/plans and recommendations from last year (**REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	**Completion Date**
☒ Goal Met ☐ Goal Not Met	It was recommended to continue this goal as written. **Did Actions taken accomplish intended results.** ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3rd Quarter	4th Quarter
	Day Program had no discharges due to dissatisfaction.	Day Program had no discharges due to dissatisfaction.	Day Program had no discharges due to dissatisfaction.	Day Program had no discharges due to dissatisfaction.

Comparison of last year's results (21/22) to this year (22/23): During the 2021-2022 fiscal year, there were 0 discharges due to dissatisfaction. For the 2022-2023 fiscal year, there were 0 discharges due to dissatisfaction and the goal was met.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA	NA	NA	NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve satisfaction of persons served	Score on satisfaction survey	Satisfaction survey	Case Coordinators	Day Program Administrator	Maintain or improve minimum satisfaction score of 2.75; optimal score of 2.9 (3-point scale)	Persons served in the Day Habilitation program	2.99 N = 12 out of 28			2.92 N = 6 out of 19			2.95 N = 11 out of 32			2.97 N = 9 out of 22		

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	It was recommended to continue this goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3rd Quarter	4th Quarter
	12 satisfaction surveys were completed this quarter. There were no comments noted.	6 satisfaction surveys were completed this quarter. There were no comments noted.	11 satisfaction surveys were completed this quarter. Comments included information that did not necessarily pertain to day program: “After I pay my bills, I decide how to spend my money. I love services. Need transportation; help with appointments (if I move);” “Happy guardian moved back to Iowa;” “Staff on phone.”	9 satisfaction surveys were completed this quarter. Comments included information that did not necessarily pertain to day program: “staff didn’t take to farmer’s market legs hurt.

Comparison of last year’s results (21/22) to this year (22/23): The 2021-2022 persons served satisfaction score averaged 2.94 for the year. The 2022-2023 fiscal year persons served satisfaction score averaged 2.96 for the year, which meets the goal of maintaining or improving a minimum score of 2.75 on a 3-point scale.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA	NA	NA	NA

EXPERIENCES OF SERVICES AND OTHER FEEDBACK FROM OTHER STAKEHOLDERS

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve parent/guardian satisfaction	Score on satisfaction survey	Satisfaction Survey	Case Coordinators	Day Program Administrator	Maintain or improve minimum satisfaction score of 2.75; optimal score of 2.9 (3-point scale)	All parent/ guardians of persons served in the Day Habilitation Program	2.98 N = 23 out of 28			2.96 N = 13 out of 19			2.94 N = 22 out of 32			2.98 N = 17 out of 21		

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	It was recommended to continue this goal as written.	NA	NA

	Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA			
ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER 23 satisfaction surveys were completed this quarter. There was one comment this quarter, "Thank you for all your hard work and commitment!" They also appreciated meeting times that were scheduled to discuss their family member and the services they are receiving.	2ND QUARTER 19 satisfaction surveys were completed this quarter. There was one comment this quarter, "Staff members at house and DH are very easy to talk with and good communication with me."	3rd Quarter 22 satisfaction surveys were completed this quarter. There were no comments.	4th Quarter 17 satisfaction surveys were completed this quarter. One comment was recorded stating: "Always- Link is Excellent!"
Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 parent/guardian satisfaction score averaged 2.92 for the year, which meets the goal of maintaining or improving a minimum score of 2.75 on a 3-point scale. The 2022 – 2023 parent/guardian satisfaction score averaged 2.96 for the year, which meets the goal of maintaining or improving a minimum score of 2.75 on a 3-point scale. **Trends:** ☐ YES ☒ No (if yes provide detail) **Causes:** ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain) **Characteristics of persons served impact performance:** ☐ YES ☒ No (if yes, please explain) **Other extenuating or influencing factors** ☐ YES ☒ No (if yes, please explain)				
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA	Expected Outcomes NA	Person Responsible NA	Timeframe NA	

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve quality service relationships with volunteer businesses	Score on VIP survey to businesses	Performance Survey Form (V-17a)	Day Program Supervisor	Day Program Administrator	Maintain or improve minimum satisfaction score of 2.5; optimal score of 2.9 (3-point scale	Persons served in VIP	3 N = 2 out of 3			3 N = 2 out of 3			2.96 N = 4 out of 3			3 N = 2 out of 2		

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) It was recommended to continue this goal as written with the addition of this action step: obtain a minimum of 3 satisfaction surveys per quarter (1/mo.). Did Actions taken accomplish intended results. ☒ Yes ☐ No ☐ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST): Obtain a minimum of 3 satisfaction surveys per quarter (1/mo). 1st Quarter: 2 satisfaction surveys were completed. 2nd Quarter: 2 satisfaction surveys were completed. 3rd Quarter: 4 satisfaction surveys were completed. 4th Quarter: 2 satisfaction surveys were completed.	Completion Date June 30th, 2023

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER 2 satisfaction surveys were completed this quarter. One comment shared, "It was great to have this group come to Amanda the Panda and support the staff and those we serve. They assisted with a variety of tasks from lawncare to inventory and preparing camp nametags and other camp supplies. We hope to be able to partner with Link Associates in the future when projects present themselves." The other survey's comment said,	2ND QUARTER 2 satisfaction surveys were completed this quarter. The Salvation Army stated "We love having all of them coming here. They have all been very helpful with doing whatever we need done and the supervisors and the link members I wish that they could be here all day with us." Meals from the Heartland stated, "We are always happy to see the Link van pull up	3RD QUARTER 4 satisfaction surveys were completed this quarter. Food Bank of Iowa gave us a 23/24 score and left a comment stating they are very happy with our volunteer groups but would appreciate being notified if we are going to be late or unable to show up to our volunteer shift. Our department has and continues to address this by improving our communication and giving prior notice to any changes in Many Hands Thrift Market gave a 24/24 score stating, "We truly value our Link volunteers. We appreciate the way Link volunteers and staff interact with us and our customers. Link adds so much to our culture here at Many Hands." Bidwell Riverside Center gave a 24/24 score with no comment. DMARC also gave a 24/24 score	4th QUARTER 2 satisfaction surveys were completed this quarter. West Des Moines Public Library gave us a 24/24 score. The Des Moines Children's Museum gave us a 24/24 score. No comments were recorded on either of the surveys.

	"Everything from our end seems to be going well. Thank you for helping to keep the Zoo clean for our guests!"	in our parking lot. The staff and clients are respectful, fun and stay on task."	stating, "We appreciate the volunteers from Link! It's so nice to get to know the participants. They are wonderful!"	

Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 volunteer satisfaction score averaged 2.99 for the year, which meets the goal of maintaining or improving a minimum score of 2.5; on a 3-point scale. The 2022 – 2023 volunteer satisfaction score averaged 2.99 for the year.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☐ Continue as written. ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined below. Action Steps: Obtain a minimum of 3 satisfaction surveys per quarter (1/mo.).	Continued feedback from volunteer sites to improve our volunteer services and anticipated expansion of volunteer duties.	DPS over VIP	July 1, 2023 – June 30, 2024

RESOURCES USED TO ACHIEVE RESULTS FOR THE PERSONS SERVED

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain cost of services budget projections	Monthly Budget Variance	Monthly budget sheets	Day Program Administrator	Day Program Administrator	YTD cost of service will be at or lower than budgeted	Day Habilitation Program	($43,304)	($42,244)	($23,550)	($101,807)	($122,614)	($150,306)	($146,368)	(118,304)	(133,024)	(130,358)	(130,967)	(182,572)

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	Completion Date
☐ Goal Met ☒ Goal Not Met	It was recommended to continue this goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	The program was unable to open new areas and bring persons served back due to staff shortages. The program plans to open a new area 11.1.22.	The program opened a new area 109A and 109B both ratio 1:6 on 11.1.22 brining back persons served who had been on the LOA request to return list due to 2020 COVID-19 shutdowns. Many of these persons served have been at home for the last two years and are happy to be back. We will continue to evaluate opening more areas depending on staff retention and recruitment.	When developing the budget, it was projected to open 9 additional areas by 1.1.23. Due to staffing shortages, the areas were not opened. Supervisors were covering the openings, and often covering DSP hours 4-5 days a week on top of their supervisor duties. This has had an impact on our budget.	EDPD reviewed financials and discussed opening areas with ED. June 1, 2023, there was a significant increase in wages for DSPs which has aided in our staff retention as well as getting candidates to fill our open positions. The program will look at opening more areas in FY 23-24 pending the recruitment of day program DSPs.

Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 fiscal year ended with a rounded variance of $135,279. The 2022-2023 fiscal year ended with a rounded variance of ($182,572).
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☒ YES ☐ non-Applicable (if you feel there were causes for this outcome, please explain) While building the FY 22-23 budget, there were 11 additional areas planned to open throughout the year. Due to continued staffing shortages, those areas were not opened, and we were unable to bring in additional revenue throughout the year as planned.
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☒ YES ☐ No (if yes, please explain) Link Associates continued to experience a staffing shortage during 2022-2023 fiscal year.

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
	NA	NA	NA

☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA			

FLEET & FACILITIES

July 1, 2022, to June 30, 2023

Fleet & Facilities Department

Jim Wilkie, Fleet & Facilities Director

As Fleet & Facilities Director I have reviewed the data gathered over the past year and all changes made within the department. This year the department established 8 goals and were successful on meeting 3 of them or 37.50%. Due to inclement weather the day program was shut down for 2 days this past year as well as the continuation of the Covid-19 pandemic continued to have an adverse effect on the department's goals. On May 11, 2023, the Department of Health and Human Services declared an end to the Covid-19 health emergency. The closing of the day program for inclement weather, person served still not returning to the day program, having to reduce the number of routes from 10 to 9 due to staffing issues in the fourth quarter during the year, impacted the overall ridership and efficiency of the bus routes. With the recent wage increase for DSP staff, it is anticipated that this will attract new staff allowing the day program to open additional rooms increasing the number of persons served attending the day program which in turn will increase the number of passengers for the transportation department.

The goals we were successful in meeting were:

1. Maintain or improve the Injury Incident Rating from the previous year. There were zero (0) accidents that resulted in an injury for both FY 22/23 and FY 21/22. The vehicles were driven a total of 516,789 miles for FY 22/23 in comparison to FY 21/22 where they were driven 496,904 miles. The closure of the Day program for 2 days, the combining of Route 10 with existing bus routes helped in limiting the exposure risk for the vehicles. It can be summarized that the zero accidents that resulted in injury is in part due to Link's staff ability to follow appropriate defensive driving techniques.

2. Maintain or improve fire evacuation drills at the Administration Building. During the 22/23 fiscal year the building was evacuated on average in 5 minutes 02 seconds and roll call was completed in 9 minutes 44 seconds. The evacuation of the building is an improvement from FY 21/22 as the average evacuation time was 5 minutes 32 seconds, and the average overall evacuation time with roll call showed an improvement from FY 21/22 time of 9 minutes 49 seconds.

3. Maintain or improve the average ride time on Link bus routes. During FY 22/23 the average morning bus route ride time was 43 minutes 12 seconds, the average afternoon ride time was 41 minutes 22 seconds and the combined ride time of the am and pm routes averaged 42 minutes 21 seconds. In comparison to FY 21/22 the am route averaged 44 minutes 03 seconds, the pm route averaged 39 minutes 22 seconds and the combined route time averaged 41 minutes 20 seconds. The goal of 1 hour or less on the bus was met for FY 22/23.

The goals that Link were not able to meet this past fiscal year were:

1. To maintain or improve the number of work-related injuries for employees from previous years. For FY 22/23 there were 23 total staff injuries reported which is an increase from FY 21/22 and the 11 staff injuries reported. With the increase in number of persons served in the day programs, it is believed this had a negative effect on the outcome as it increased the direct contact between person served and staff, thus increasing the number of injuries. It is noted that 61% of the staff injuries were related to persons served behaviors which is an increase from the previous year.

2. Maintain or improve the number of Link only vehicle accidents from the previous year. For FY 22/23 there were 4 accidents resulting in a 7.74 rating for the 516,789 total miles driven, as compared to FY 21/22 with 3 total accidents and a 6.04 rating for the 496,904 miles driven.

3. Maintain or improve the number of vehicle accidents with a 3rd party from the previous year. For FY 22/23 there were a total of 12 accidents over the 516,789 miles driven for a 23.22 rating. This is an increase from FY 21/22 where there were 8 total accidents for the 496,904 miles driven and a rating of 16.10. It can be summarized that the higher number of miles driven led to the increased number of accidents with a 3rd party thus, adversely affecting the rating for FY 22/23.

4. Maintain or Improve Satisfactions Scores with a percentage greater than or equal to each category. For FY 22/23 the ridership satisfaction survey was not completed by the Fleet & Facilities Administrator. In comparison for FY 21/22 the department sent out 140 surveys and received 65 completed surveys for a 46% return rate. The satisfaction scores for each category were above the targeted goal. The breakdown of the categories is as follows.

    a. Bus driver polite and nice, goal is 90% the response was 99%.
    b. On time for pick up, goal is 80% and the response was 95%,
    c. Feel safe riding the vehicle, goal is 85% and the response was 95%, and
    d. Overall satisfaction, goal is 80% and the response was 92%.

    For FY 21/22 we provided 50,260 total trips.

5. Maintain or improve the efficiency of the agency's route vehicles. For FY 22/23 the overall average ridership was 70%. The total number of rides provided by the bus routes were 44,003. In comparison, FY 21/22 the ridership was at 96% and the total number of bus route rides provided was 42,002. During the fiscal year the day program was shut down for 2 days due to inclement weather as well as bus route 10 was combined with the other 9 routes effecting the total miles driven for the fiscal year. The fiscal year returned to a maximum capacity of 14 riders on the buses. The goal was not met for FY 21/22.

For FY 23/24 we will continue to focus on the same 8 primary objectives and goals.

Demographics

The Transportation Department's consumer demographics continue to reflect the same variation in age, gender, disability, and race as the specific program sites. Currently the program supports 145 riders with 8 people using a wheelchair. The breakdown of the providers utilizing Link transportation services are as follows:

FY 2022-2023			
FY 2022-2023		**FY 2021-2022**	
Provider	**# of Consumers**	**Provider**	**# of Consumers**
Behavior Technologies	0	Behavior Technologies	0
Candeo	4	Candeo	3
CCO	1	CCO	2
CDAC	0	CDAC	0
Child Serve	0	Child Serve	0
COC	4	COC	7
Comp Community Support	0	Comp Community Support	0
Crest	1	Crest	1
Easter Seals	2	Easter Seals	1
Homestead	0	Homestead	1
Hope	0	Hope	0
Host Home	0	Host Home	1
Link Associates	69	Link Associates	73
Lutheran Services	2	Lutheran Services	2

Mainstream	1	Mainstream	2
Mosaic	1	Mosaic	1
Parent/Family	60	Parent/Family	57
Progress Industries	0	Progress Industries	0
REM	0	REM	0
Respite Connection	0	Respite Connection	1
Tandem Services	0	Tandem Services	1
Vodec	0	Vodec	0
Woodward Resource	0	Woodward Resource	0

For the FY 22/23 the program saw a gain of 1 individual start utilizing Link's transportation services as compared to FY 21/22 where there were 4 individuals that started utilizing Link's transportation services. The breakdown is below.

New/Left Transportation Services FY 2022-2023

	July		August		September		October		November		December		January		February		March		April		May		June		YTD Totals	
	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left	New	Left
	2	1	2	2	5	2	1	1	5	1	1	5	1	0	0	1	0	4	0	4	2	2	5	0	24	23
Net Totals	1		0		3		0		4		-4		1		-1		-4		-4		0		5		1	

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter	
	New	Left	New	Left	New	Left	New	Left
Quarter Totals	9	5	7	7	1	5	7	6
Net Quarter Totals	4		0		-4		1	

Fleet and Facility Measures of Achievement

FLEET & FACILITIES MEASURES OF ACHIEVEMENT 2022-2023

EXPERIENCES OF SERVICES RECEIVED AND OTHER FEEDBACK FROM THE PERSONS SERVED

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain or improve the average ride time on Link bus routes	Average trip ride time for persons served on Link bus routes	All persons served on bus routes	Drivers Route Sheets in Edoc Trans	Fleet & Facilities Director	1 Hour or less	Route Drivers	43:52 minutes AM 40:25 minutes PM 42:14 minutes for AM & PM trips combined			44:08 minutes AM 40:40 minutes PM 42:29 minutes for AM & PM trips combined			42:19 minutes AM 40:45 minutes PM 41:35 Minutes for AM & PM trips combined			42:34 minutes AM 43:38 minutes PM 43:04 Minutes for AM & PM trips combined		

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan) Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) • 1st QUARTER • 2ND QUARTER • 3RD QUARTER • 4TH QUARTER	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter •	2nd Quarter •	3rd Quarter •	4th Quarter •

Comparison of last year's results (21/22) to this year (22/23):

	FY 22/23 Average Ride Times	FY 21/22 Average Ride Time
	43:12 Minutes AM Routes	44:03 Minutes AM Routes
	41:22 Minutes PM Routes	39:22 Minutes PM Routes
	42:21 Minutes AM & PM Routes Combined	41:20 Minutes AM & PM Routes Combined

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes	Person Responsible	Timeframe

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve Ridership Satisfaction.	Score on Satisfaction Survey	Survey Results	Fleet & Facilities Administrator	Fleet & Facilities Administrator	Maintain or Improve Satisfaction Scores with a percentage greater than or equal to each category listed. a. Bus Driver Polite and Nice - 90% b. Timely – 80% c. Feel Safe – 85% d. Overall satisfaction – 80%	All persons served who utilize Link Transportation												

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) NA • 1st QUARTER • 2ND QUARTER • 3RD QUARTER • 4TH QUARTER	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER •	2ND QUARTER •	3rd Quarter •	4th Quarter •

Comparison of last year's results (21/22) to this year (22/23): The survey was not completed by the Fleet & Facilities Administrator for FY 22/23.

FY 22/23	FY 21/22
a. 0% Responded yes	99% Responded yes.
b. 0% Responded yes	95% Responded yes.

c. 0% Responded yes d. 0% Responded Very Happy 0% Responded Sometimes Happy 0% Responded Not Happy	95% Responded yes. 92% Responded Very Happy 8% Responded Sometimes Happy 0% Responded Not Happy
Total Surveys returned 0 out of 0 0% Return Rate	Total Surveys Returned 65 out of 140. 46% Return Rate

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☒ YES ☐ non-Applicable (if you feel there were causes for this outcome, please explain) The survey was not completed for FY 22/23
Characteristics of persons served impact performance: ☐ YES ☒ NO (if yes please explain)
Other extenuating or influencing factors ☒ YES ☐ NO (if yes please explain) The survey was not completed by the Fleet & Facilities Administrator for FY 22/23

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: have survey sent out in October of 2024	Survey sent out to riders and compile responses	Fleet & Facilities Administrator	October 2024

RESULTS ACHIEVED FOR THE PERSONS SERVED (EFFECTIVENESS)

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain or improve emergency fie evacuation drills at the administration building.	Evacuation Drill forms FY 21/22 N = 9:49 Roll N= 5:32 Evac	Evacuation Drill forms	Fleet & Facilities Director	Fleet & Facilities Director	Maintain or improve the Fire evacuation drills at the administrative building	All Staff and Persons served	Average Evacuation time of 3:43 minutes Average Roll Call time of 8:56 minutes FY 21/22 Evac = 5:40 Minutes FY 21/22 Roll Call = 9:02 Minutes			Average Evacuation time of 6:10 minutes Average Roll Call time of 11:14 minutes FY 21/22 Evac = 7:21 Minutes FY 21/22 Roll Call = 12:30 Minutes			Average Evacuation time of 5:51 minutes Average Roll Call time of 10:48 minutes FY 21/22 Evac = 4:20 Minutes FY 21/22 Roll Call = 9:25 Minutes			Average Evacuation time of 4:25 minutes Average Roll Call time of 7:59 minutes FY 21/22 Evac = 4:49 Minutes FY 21/22 Roll Call = 8:19 Minutes		

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)
☒ Goal Met ☐ Goal Not Met	Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	• 1st QUARTER • 3RD QUARTER • 4TH QUARTER		Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
			•	

Comparison of last year's results (21/22) to this year (22/23):	FY 22/23	FY 21/22
	9:44 Minutes average evac time with Roll Call 5:02 Minutes Average to exit the building	9:49 Minutes average evac time with Roll Call 5:32 Minutes Average to exit the building.

Trends: ☐ YES ☒ NO (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)

Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain) Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)			
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes	Person Responsible	Timeframe

RESOURCES USED TO ACHIEVE RESULTS FOR THE PERSONS SERVED (EFFICIENCY)																		
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
To Maintain or improve the # of work-related injuries for employees from previous years	Number of Workman Comp. Claims For FY 2021-2022 total Workman Comp. Claims = 11	Work Comp, First report of injury reports	Outreach Director	Outreach Director	To maintain or reduce the number of work-related injuries from the previous year	Agency Staff	7 FY 2021-2022 = 2			3 FY 2021-2022 = 0			7 FY 2021-2022 = 5			6 FY 2021-2022 = 4		

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Did Actions taken accomplish intended results. ☐ Yes ☐ No☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter •	4th Quarter

Comparison of last year's results (21/22) to this year (22/23):

FY 22/23	FY 21/22
23 Total Staff Injuries	11 Staff Injuries
5 Injuries by Persons Served Behavior	2 Injuries by Persons Served Behavior
9 Injuries Resulting in Treatment from Behaviors	2 Injuries Resulting in Treatment from Behaviors
7 Staff Injuries Treated at Occ Med Clinic	5 Staff treated at Occ Med Clinic

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☒ YES ☐ NO (if yes, please explain) Persons served behavior has a direct impact on staff.
Other extenuating or influencing factors ☐ YES ☒ NO (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps/Plan: NA	Expected Outcomes	Person Responsible	Timeframe

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23

Maintain or improve the Injury Incident Rating from the previous year.	Number of Injury reports from vehicle accidents FY 21/22 Accidents =0 Rating = 0	Accident reports	Fleet & Facilities Administrator	Fleet & Facilities Administrator	To have an injury incident rating that is equal to or better than the previous year.	Agency Staff	Injuries = 0 Rating = 0 FY 2021-2022 = 0 Rating = 0	Injuries = 0 Rating = 0 FY 2021-2022 = 0 Rating = 0	Injuries = 0 Rating = 0 FY 2021-2022 = 0 Rating = 0	Injuries = 0 Rating = 0 FY 2021-20202= 0 Rating = 0

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) • 1st QUARTER • 2ND QUARTER • 3RD QUARTER • 4TH QUARTER	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2nd QUARTER	3rd QUARTER •	4TH QUARTER

Comparison of last year's results (21/22) to this year (22/23):

FY 22/23
516,789 Total Miles
0 Accidents with injuries
Rating = 0

FY 21/22
496,9094 Total Miles
0 Accidents with injuries
Rating = 0

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ NO (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ NO (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps:	Expected Outcomes	Person Responsible	Timeframe

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain or improve the number of Link only vehicle accidents from the previous year	Number of Accident Reports that indicate vehicle damage & rating using Mileage. FY 21/22 Accidents = 3 Rating = 6.04	Monthly total of vehicle accident reports	Fleet & Facilities Administrator	Fleet & Facilities Administrator	Maintain or improve the number of vehicle accidents resulting in damage to only Link owned vehicles from the previous year.	Agency Staff	Accidents = 0 Rating = 0 FY 2021-2022 = 2 Rating = 16.09			Accidents = 2 Rating = 16.15 FY 2021-2022 = 1 Rating = 8.02			Accidents = 0 Rating = 0 FY 2021-2022 = 0 Rating = 0			Accidents = 2 Rating = 14.34 FY 2021-2022 = 0 Rating = 0		

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) • 1st QUARTER. • 2ND QUARTER • 3RD QUARTER • 4TH QUARTER	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter

Comparison of last year's results (21/22) to this year (22/23): Trends: ☐ YES ☒ No (if yes provide detail) Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain) Characteristics of persons served impact performance: ☐ YES ☒ NO (if yes, please explain) Other extenuating or influencing factors ☐ YES ☒ NO (if yes, please explain)				FY 22/23 516,789 Total miles 4 Total Accidents Rating = 7.74		FY 21/22 496,904 Total Miles 3 Total Accident Rating = 6.04																	
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:				Expected Outcomes												Person Responsible						Timeframe	
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23					
Maintain or improve the number of vehicle accidents with a 3rd party from the previous year	Number of Accident Reports that indicate damage to vehicles other than our own & rating using mileage. FY 21/22 Accidents = 8 Rating =16.10	Monthly total of vehicle accident reports	Fleet & Facilities Administrator	Fleet & Facilities Administrator	Maintain or improve the number of vehicle accidents resulting in damage to a third-party vehicle from the previous year.	Agency Staff	Accidents = 2 Rating = 15.98 FY 2021-2022 = 2 Rating = 16.09			Accidents = 4 Rating = 32.30 FY 2021-2022 = 1 Rating = 8.02			Accidents = 4 Rating = 30.24 FY 2021-2022 = 1 Rating = 8.38			Accidents = 2 Rating = 14.34 FY 2021-2022 = 4 Rating = 31.11					
Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA						Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) • 1st QUARTER • 2ND QUARTER • 3RD QUARTER • 4TH QUARTER												Completion Date				
ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter			2nd Quarter			3rd Quarter •			4th Quarter													
Comparison of last year's results (21/22) to this year (22/23): Trends: ☐ YES ☒ No (if yes provide detail) Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain) Characteristics of persons served impact performance: ☐ YES ☒ NO (if yes, please explain) Other extenuating or influencing factors ☐ YES ☒ NO (if yes, please explain)				FY 22/23 516,789 Total miles 12 Total Accidents Rating = 23.22		FY 21/22 496,904 Total Miles 8 Total Accident Rating =16.10																	
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:				Expected Outcomes												Person Responsible						Timeframe	
Primary	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23					

Objective					(Goal)													
Maintain or improve the efficiency of the Agency's route vehicles	Monthly Average Occupancy of the route vehicles FY 21/22 N=96%	Monthly Attendance Sheets	Transportation Administrator	Fleet & Facilities Director	Maintain or improve the efficiency of the agencies route vehicles from the previous year	All people served on bus routes.	76% FY 2021-2022= 114%			71% FY 2021-2022 = 138%			71% FY 2021-2022 = 57%			62% FY 2021-2022 = 75%		

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan) Did Actions taken accomplish intended results. ☐ Yes ☒ No ☐ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) NA • 1st QUARTER • 2ND QUARTER • 3RD QUARTER • 4TH QUARTER	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter • Back to full capacity for riders	2nd Quarter • Due to inclement weather Link was closed on 12/22/22 & 12/23/22.	3rd Quarter	4th Quarter • Reduced the number of routes from 10 to 9 due to a driver leaving employment and not able to hire a replacement driver in a timely manner. The passengers were moved to existing routes for a short period of time,

Comparison of last year's results (21/22) to this year (22/23):

FY 22/23	FY 21/22
70% Average Ridership	96% Average Ridership
44,003 Yearly Route Bus Trips	42,002 Yearly Route Bus Trips
50,820 Total Waiver Trips	50,260 Total Waiver Trips

Causes: ☒ YES ☐ non-Applicable (if you feel there were causes for this outcome, please explain) With the Covid 19 pandemic ending during this fiscal year and increasing the route buses to normal capacity, as well as the day program being closed for 2 days and the elimination of one route and spreading the riders across the other routes negatively affected the efficiency of the bus routes.
Characteristics of persons served impact performance: ☐ YES ☒ NO (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ NO (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes	Person Responsible	Timeframe

LINK EMPLOYMENT EXPLORATION PROGRAM (LEEP)

Link Associates Program Evaluation

July 1, 2022 to June 30, 2023

Alina Chapman, Employment Administrator and Cassondra Jones, Employment/Day Program Director

As the LEEP leadership team, we have reviewed the data gathered over the past year and all changes made within the department. This past year the department struggled with staffing shortages and there were delays in the admissions process for LEEP due to not being able to obtain the required paperwork from teams in a timely manner. This caused the number of participants in LEEP to be fewer than we would have liked and contributed to not meeting 4 of the 7 goals. The Employment Supervisor also struggled to find a new business to partner with in the fourth quarter and was only able to contract with 3 businesses this fiscal year and did not meet the goal of contracting with 4.

In the fiscal year our most significant achievements included receiving amazing satisfaction surveys from the persons served, parent/guardian/concerned others, and businesses throughout the year. We were also able to successfully help 4 LEEP participants obtain community employment. The Employment Administrator and Employment Supervisors continued to participate in monthly Zoom calls and webinars with IVRS and each of the MCO's regarding programming and continued to market LEEP. The monthly Zoom calls with all the IVRS Counselors has continued to strengthen our relationship with them and has allowed us to effectively communicate across all Employment programs we offer.

In the next fiscal year, we are recommending to continue an action step for one of the goals to ensure we continue to bring in new referrals. We have continued to experience external CBCM's (through the MCO's) not actively referring those they support, so we tend to rely on reverse referrals as well as referrals from IVRS. We'd like to continue our action step to 'provide additional education to MCO's and IVRS.' We are not recommending for any goals to be discontinued or added for FY 23-24.

We continue to be extremely proud of the Employment Training Specialists for providing quality services in each of the businesses we are partnered with despite being short staffed for a majority of the fiscal year. We continue to receive nothing but positive feedback from each business we are partnered with, as well as from persons served and their guardians. All their hard work is reflected in the CY 2022 Community Employment Outcomes Evaluation (an evaluation completed by the Law, Healthy Policy and Disability Center at the University of Iowa). Link Associates led the way in the Polk County network and our great scores and comments from persons served are showcased in this report. The dedication that each of the Employment Training Specialists show in supporting those we serve is nothing short of amazing. They continue to embody our mission, vision, and values. As the leadership of the program, there is nothing more we could ask for, and we continue to be beyond proud of the entire department!

LEEP Demographics

FY 2022 - 2023	1st Quarter Demographics		2nd Quarter Demographics		3rd Quarter Demographics		4th Quarter Demographics	
Number Served	5	100%	8	100%	5	100%	5	100%
Age								
<16	0	0%	0	0%	0	0%	0	0%
16-17	0	0%	0	0%	0	0%	0	0%
18-21	3	60%	4	50%	2	40%	1	20%
22-34	2	40%	4	50%	2	40%	3	60%
35-44	0	0%	0	0%	1	20%	0	0%
45-54	0	0%	0	0%	0	0%	0	0%
55-64	0	0%	0	0%	0	0%	1	20%
65>	0	0%	0	0%	0	0%	0	0%
Gender								

Male	3	60%	5	63%	4	80%	4	80%
Female	2	40%	3	38%	1	20%	1	20%
Ethnicity								
Black or African American	0	0%	0	0%	0	0%	0	0%
American Indian and Alaskan	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Asian	0	0%	1	13%	0	0%	0	0%
Caucasian	3	60%	4	50%	2	40%	3	60%
Hispanic	0	0%	2	25%	2	40%	2	40%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Race	2	40%	1	13%	0	0%	0	0%
Level of Disability								
Developmental Disability (DD)	1	20%	1	13%	1	20%	0	0%
Mild MR (50-75)	4	80%	6	75%	3	60%	3	60%
Moderate MR (35-49)	0	0%	0	0%	0	0%	2	40%
Severe MR (20-24)	0	0%	0	0%	0	0%	0	0%
Profound MR (< 20)	0	0%	0	0%	0	0%	0	0%
NA	0	0%	0	0%	0	0%	0	
Secondary Diagnosis								
ADD/ADHD	2	40%	3	38%	2	40%	2	40%
Alzheimer's/Dementia	0	0%	0	0%	0	0%	0	0%
Anxiety Disorder	0	0%	0	0%	0	0%	0	0%
Autism	0	0%	2	25%	2	40%	1	20%
Behavior Disorder	0	0%	0	0%	0	0%	0	0%
Cerebral Palsy	0	0%	0	0%	0	0%	1	20%
Depression	0	0%	0	0%	0	0%	0	0%
Down Syndrome	0	0%	0	0%	0	0%	0	0%
Epilepsy	0	0%	0	0%	0	0%	0	0%
Hearing Impairment	0	0%	0	0%	0	0%	0	0%
Intermittent Explosive Disorder	0	0%	0	0%	0	0%	0	0%
No Secondary Diagnosis Known	0	0%	1	13%	0	0%	0	0%
Other	0	0%	0	0%	0	0%	0	0%
Schizophrenia	0	0%	0	0%	0	0%	0	0%
Seizure Disorder	0	0%	0	0%	0	0%	0	0%
Visual Impairment/ Legally Blind	0	0%	0	0%	0	0%	0	0%

July-September 2022:
The data pulled from this quarter reflects there were 5 participants within the LEEP program. The average participant was a Caucasian male between the ages of 18-21, with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of ADD/ADHD. There were no participants who exited the program.

October 2022-December 2022
The data pulled from this quarter reflects there were 8 participants within the LEEP program. The average participant was Caucasian male between the ages of 18-21/22-34 (50/50), with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of ADD/ADHD. There were no participants who exited the program.

January-March 2023:
The data pulled from this quarter reflects there were 5 participants within the LEEP program. The average participant was Caucasian/Hispanic (50/50) male between the ages of 18-21/22-34 (50/50), with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of ADD/ADHD/Autism (50/50). There were no participants who exited the program.

April-June 2023:
The data pulled from this quarter reflects there were 5 participants within the LEEP program. The average participant was Caucasian male between the ages of 22-34 with a primary diagnosis of mild MR (50-75) and a secondary diagnosis of ADD/ADHD. The average participant who discharged the program was Caucasian female between the ages of 35-44 with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of Anxiety/Depression (50/50).

The average participant who exited the program this fiscal year was a Caucasian female between the ages of 35-44 with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of Anxiety/Depression (50/50).

LEEP Supplemental Measures

Supplemental Measures				
	Quarter			
	1st	2nd	3rd	4th
1. Number of persons served who obtain community employment	0	1	3	0
2. Number of days between date of acceptance and date of the intake meeting	25	29	32	25
3. Maintain 8 or less spoiled product per day (Link General Store)	2.2	2.6	1.7	N/A

July-September 2022:
There were 0 participants who were able to obtain community employment in the first quarter. There was an average of 25 days between the date of acceptance and the date of the intake meeting. The Link General Store averaged 2.2 spoiled products per day in the first quarter.

October-December 2022:
There was 1 participant who was able to obtain community employment in the second quarter. There was an average of 29 days between the date of acceptance and the date of the intake meeting. The Link General Store averaged 2.6 spoiled products per day in the second quarter.

January-March 2023:
There were 3 participants who were able to obtain community employment in the third quarter. There was an average of 32 days between the date of acceptance and the date of the intake meeting. In the months of January and February the Link General Store averaged 1.7 spoiled products per day in the third quarter. The Link General Store permanently closed at the end of February so there were no spoiled products in the month of March.

April-June 2023:
There were 0 participants who were able to obtain community employment in the fourth quarter. There was an average of 25 days between the date of acceptance and the date of the intake meeting. The Link General Store permanently closed at the end of February so there were no spoiled products to record in the fourth quarter.

LEEP Measures of Achievement

EXPERIENCES OF SERVICES RECEIVED AND OTHER FEEDBACK FROM THE PERSONS SERVED																		
Primary Objective	**Indicators (Measures)**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**Who Applied to**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**
Improve satisfaction of persons served	Score on satisfaction survey (TP-1)	Satisfaction survey	Employment Supervisor	Employment Administrator	Maintain or improve minimum satisfaction score of 2.75; optimal score 2.9 (3-point scale)	All participants in LEEP	3 N = 1 out of 1			3 N = 3 out of 3			3 N = 4 out of 4			2.83 N = 1 out of 2		
Goal Outcome: ☒ Goal Met ☐ Goal Not Met	**Previous FY goal recommendations** (I.e. goal continuation and/or new action steps/plan) It was recommended to continue this goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA						**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST) NA						**Completion Date** NA					
ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER** Surveys are completed once the participant completes their internship. There was 1 person who completed their internship during the first quarter, but no comments were noted.			**2ND QUARTER** Surveys are completed once the participant completes their internship. There were 3 people who completed their internship during the second quarter. GC stated "Troubles with transportation in the beginning when using public transportation. Once it switched to SCL staff transportation became more reliable." HR stated, "Wants to learn more about coffee after internship."			**3RD QUARTER** Surveys are completed once the participant completes their internship. There were 4 people who completed their internship during the third quarter. DH stated, "Everything went good."			**4TH QUARTER** Surveys are completed once the participant completes their internship. There were 2 people who completed their internship during the fourth quarter. MU chose not to complete the survey. MC did not make any comments.					
Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 fiscal year concluded with an average satisfaction score of 2.98 (3-point scale). The 2022-2023 fiscal year concluded with an average satisfaction score of 2.96 (3-point scale). **Trends:** ☐ YES ☒ No *(if yes provide detail)* **Causes:** ☐ YES ☒ non-Applicable *(if you feel there were causes for this outcome, please explain)* **Characteristics of persons served impact performance:** ☐ YES ☒ No *(if yes, please explain)* **Other extenuating or influencing factors** ☐ YES ☒ No *(if yes, please explain)*																		
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA	**Expected Outcomes** NA			**Person Responsible** NA			**Timeframe** NA											

RESULTS ACHIEVED FOR THE PERSONS SERVED (EFFECTIVENESS)																		
Primary Objective	**Indicators (Measures)**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**Who Applied to**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**
Increase admission into Job	# Of accepted admissions	LEEP Skill Training	Case Coordinators	Employment Administrator	Maintain 85% of admission approval or better	All persons who graduate from LEEP	100% N = 1 out of 1			100% N = 3 out of 3			75% N = 3 out of 4			0% N = 0 out of 2		

Development services		tracking google doc								

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	**Previous FY goal recommendations** (I.e., goal continuation and/or new action steps/plan) It was recommended to continue as written. **Did Actions taken accomplish intended results.** ☐ Yes ☐ No ☒ NA	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST) NA
		Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER** • There was 1 participant who completed the program during the first quarter (JL). The person was referred to job development.	**2ND QUARTER** • There were 3 participants who completed the program during the second quarter (HR, JG, GC). All three were referred to job development.	**3RD QUARTER** • There were 4 participants who completed the program during the third quarter (DH, SB, PD, CC). 3 were referred to job development (DH, PD, CC) and 1 was referred to VIP (SB) to continue working on soft skills needed for employment.	**4TH QUARTER** • The program had 2 persons served complete their internship during the fourth quarter (MU, MC). Due to both MC & MU's team decisions, they decided not to move forward with Job Development services. MC would continue to build on her skills in VIP and MU will be volunteering with SCL staff to work on soft skills.

Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 fiscal year concluded with 100% admissions approval once LEEP was completed. The 2022-2023 fiscal year concluded with an average of 70% admissions approval once LEEP was completed. This goal was not met.
Trends: ☐ YES ☒ No *(if yes provide detail)*
Causes: ☒ YES ☐ Non-Applicable *(if you feel there were causes for this outcome, please explain)* During the 3rd & 4th quarter there were persons served referred to the program who finished their internship, but still needed to address other barriers prior to obtaining community employment, so they did not move on to Job Development services.
Characteristics of persons served impact performance: ☐ YES ☒ No *(if yes, please explain)*
Other extenuating or influencing factors ☐ YES ☒ No *(if yes, please explain)*

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps: NA	**Expected Outcomes** NA	**Person Responsible** NA	**Timeframe** NA

SERVICE ACCESS

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Reach and maintain maximum participation.	# of intakes per month	LEEP Skills Training Tracking Document	Employment Administrator	Employment Administrator	Maintain 4 intakes or more per quarter	All persons served in LEEP	2	0	2	2	0	1	0	1	1	2	0	1

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	**Previous FY goal recommendations** (I.e., goal continuation and/or new action steps/plan) It was recommended continue the goal as written and modify the action step to provide additional education to MCO's and IVRS.	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST) Action Step #1: Provide additional education to MCO's and IVRS • 1st quarter update: EA met with IVRS on several occasions to provide education and updates to IVRS counselors. EA participated in the quarterly ICIE meeting and was able to obtain contact information for Employment Specialists from both MCO's. Will continue to network and provide education to both MCO's and IVRS.	**Completion Date** June 30th, 2023

	Did Actions taken accomplish intended results. ☒ Yes ☐ No ☐ NA	• 2nd quarter update: EA met with IVRS on several occasions to provide education and updates to IVRS counselors. EA participated in quarterly ICIE meeting and also made contact with the Supported Employment Program Manager at Amerigroup and will meet with him in the third quarter. • 3rd quarter update: EA continued to meet with IVRS regularly this quarter and met with the Amerigroup SE Program Manager in January and discussed Link's Employment services. EA also participated in the quarterly ICIE meeting. • 4th quarter update: EA continued to meet with IVRS regularly this quarter and participated in the quarterly ICIE meeting.	

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER** • The program had 1 person served complete their internship during the first quarter (JL). There were 4 intakes (JG, GC, DH, SB). All went through the admissions process and were approved.	**2ND QUARTER** • The program had 3 persons served complete their internship during the second quarter (HR, JG, GC). There were 3 intakes (PD, CC, MU). All went through the admissions process and were approved.	**3RD QUARTER** • The program had 4 persons served complete their internship during the third quarter (DH, SB, PD, CC). There were 2 intakes (MC, GC), 1 internal referral (MC) and 1 went through the admissions process (GC) and both were approved.	**4TH QUARTER** • The program had 2 persons served complete their internship during the fourth quarter (MU, MC). There were 3 intakes (AL, LP, DH). All went through the admissions process and were approved.

Comparison if last year's results (21/22): to this year (22/23): The 2021-2022 fiscal year concluded with an average of 2 intakes per quarter, this goal was not met. The 2022-2023 fiscal year concluded with an average of 3 intakes per quarter, this goal was not met.
Trends: ☐ YES ☒ No *(if yes provide detail)*
Causes: ☒ YES ☐ Non-Applicable *(if you feel there were causes for this outcome, please explain)* Admissions struggled to obtain necessary paperwork from teams of persons served wanting to participate in LEEP which delayed the process to be able to proceed with admitting new participants and getting intake meetings scheduled.
Characteristics of persons served impact performance: ☐ YES ☒ No *(if yes, please explain)*
Other extenuating or influencing factors ☒ YES ☐ No *(if yes, please explain)* EA worked with admissions each quarter to try to admit 2 persons served per month into LEEP but there were delays in getting necessary admissions paperwork from teams which often delayed being able to get participants admitted and schedule intake meetings. The Assistant Outreach Director would work with up to 5 teams at a time to try to maintain the 2 admissions per month but continued to struggle with receiving necessary paperwork in a timely manner. This resulted in not meeting the expected 4 intake meetings per quarter.

New Recommendations for Next Year (23/24):	**Expected Outcomes**	**Person Responsible**	**Timeframe**
☐ Continue as written. ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined below. Action Steps: Provide additional education to MCO's and IVRS.	Increase referrals	E/DPA & ES	October 1, 2023- June 30, 2024

EXPERIENCES OF SERVICES AND OTHER FEEDBACK FROM OTHER STAKEHOLDERS

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve parent/guardian/ concerned other satisfaction.	Score on satisfaction survey (TP-2)	Satisfaction survey	Employment Supervisor	Employment Administrator	Maintain or improve minimum satisfaction score of 2.75; optimal score of 2.9 (3-point scale)	All parents/guardians/concerned others of participants in LEEP	2.86 N = 1 out of 1			3 N = 1 out of 3			2.61 N = 3 out of 4			3 N = 1 out of 2		

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	It was recommended to continue this goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE	1st QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER

THROUGHOUT THE YEAR (22/23):	• Surveys are completed when a person served completes their internship. There was 1 participant who completed their internship, and we did receive a parent/guardian/concerned other satisfaction survey back. JL's guardian stated "Awesome feedback and give great advice on what needs to be worked on. Wonderful company, thank you."	• Surveys are completed when a person completes their internship. There were 3 persons served who completed their internship and only one with a parent/guardian (JG). The parent/guardian of JG did not make any comments.	• Surveys are completed when a person completes their internship. There were 4 persons served who completed their internship and only 3 parent/guardians who completed a survey. The Parent/guardian of CC stated "Really enjoyed the shadow part of the program. Happy CC had an opportunity to see other jobs."	• Surveys are completed when a person completes their internship. There were 2 persons served who completed their internship and only 1 parent/guardian completed a survey. MC's parent/guardian did not make any comments.

Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 fiscal year concluded with an average satisfaction score of 2.96 (3-point scale). The 2022-2023 fiscal year concluded with an average satisfaction score of 2.87 (3-point scale).
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps: NA	NA	NA	NA

RESOURCES USED TO ACHIEVE RESULTS FOR THE PERSONS SERVED (EFFICIENCY)

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Expand the businesses available for internships.	# of new business contracts signed	LEEP contacted business tracking document	Employment Supervisor	Employment Administrator	Obtain a minimum of 4 business contracts throughout the year (target 1 new business contact/quarter)	LEEP	0	0	1	1	0	0	0	0	1	0	0	0

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	Completion Date
☐ Goal Met ☒ Goal Not Met	It was recommended continue the goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER
	• During the first quarter the Employment Supervisor was able to partner with 1 business. A contract was signed with Heart of Iowa.	• During the second quarter the Employment Supervisor was able to partner with 1 business. A contract was signed with Fareway (Ankeny Blvd).	• During the third quarter the Employment Supervisor was able to partner with 1 business. A contract was signed with DMARC.	• During the fourth quarter the Employment Supervisor was unable to partner with any additional businesses.

Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 fiscal year concluded with a total of 4 new internship options obtained, which meets the goal of a minimum of 4 business contracts throughout the year. The 2022-2023 fiscal year concluded with a total of 3 new internship options obtained, which did not meet our goal of 4.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)

Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)			
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA	Expected Outcomes NA	Person Responsible NA	Timeframe NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain cost of services to budget projections	YTD budget variance	Monthly budget sheet	Employment Administrator	Employment Administrator	YTD cost of service will be at or lower than budgeted	LEEP	($10,474)	($9,994)	($17,716)	($23,101)	($23,154)	($25,002)	($11,621)	(9,219)	(12,093)	(14,080)	(15,380)	(23,842)

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	**Previous FY goal recommendations** (I.e., goal continuation and/or new action steps/plan) It was recommended to continue goal as written. **Did Actions taken accomplish intended results**. ☐ Yes ☐ No ☒ NA	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST) NA	**Completion Date** NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER** • Employment/Day Program Director reviewed monthly financials to ensure they were accurate. • During the first quarter the E/DPD reviewed the financials with EA and provided training on what to look for.	**2ND QUARTER** EA reviewed monthly financials to ensure they were accurate.	**3RD QUARTER** • EDPD reviewed monthly financials to ensure they were accurate. EA worked with AOD to get referrals through the process and started in LEEP.	**4TH QUARTER** • EA reviewed monthly financials to ensure they were accurate.

Comparison of last year's results (21/22) to this year (22/23): The 2021-2022 fiscal year concluded with a YTD variance of $9,124. The 2022-2023 fiscal year concluded with a YTD variance of ($23,842).
Trends: ☐ YES ☒ No *(if yes provide detail)*
Causes: ☒ YES ☐ Non-Applicable *(if you feel there were causes for this outcome, please explain)* Admissions struggled to obtain necessary paperwork from teams of persons served wanting to participate in LEEP which delayed the process to be able to proceed with admitting new participants and getting intake meetings scheduled, which then impacted financials.
Characteristics of persons served impact performance: ☐ YES ☒ No *(if yes, please explain)*
Other extenuating or influencing factors ☐ YES ☒ No *(if yes, please explain)*

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps: NA	**Expected Outcomes** NA	**Person Responsible** NA	**Timeframe** NA

COMMUNITY HOUSING AND SUPPORTED LIVING

Link Associates Program Evaluation
July 1, 2022 – June 30, 2023
Allison Warren, Residential Director

As the Residential department, we have reviewed the data gathered over the past year and all changes made within the department. This year the department established 8 goals, and was successful in meeting 4 of the targets:

- Decrease discharged due to dissatisfaction.
- Improve consumer satisfaction.
- Improve parent/guardian satisfaction.
- Improve consumer's satisfaction with where they live.

Last year we were not successful in meeting the target for 4 objectives:

- Improve the delivery of services to new referrals.
- Improve quality of service.
- Improve quality of life.
- Maintain or increase the number of consumers served.

One of our main focuses was for persons served who receive daily service to reside in settings that made them feel happy and with people who they could positively interact with. Unfortunately, there has been some struggles to keep the roommates happy, in addition to, finding matching roommates together or adjusting placements as needed. It has been observed that those who have a primary diagnosis of mental health are having physical altercations with roommates and DSPs and are making verbal threats of harm towards their roommates and staff. Due to this, peers become unhappy with their living conditions. We have observed significant slowdown in the referral of individuals seeking services that were an appropriate fit for Link's residential program. This combined with continued challenges of recruitment/retention of direct support professionals significantly impacted the ability of the department to open new residential locations and/or create new living opportunities for current or future persons served. However, we did purchase 2 handicap accessible homes, which allowed for the department to me move roommates around to provide better roommate opportunities for those who were consistently unhappy.

The Residential Department focused a significant amount of time on identifying and implementing strategies to address service delivery needs due to the number of staff openings, and to sustain practices that demonstrate fulfillment with regulatory entities. The advocation and passion by the supervisory personnel and DSP's was apparent as services continued to be provided regularly with little to no disruptions, nor were persons served discharged due to a lack of ability to provide services. The department has a few persons serve either transitioned on to higher levels of care and/or pass away. As these openings transpired, decisions often were made to consolidate current open locations. This allowed some normal reduction in the people we served. Yet at the time the availability of DSPs continued to be in the forefront of the Residential Department's endeavors as we worked towards better housing current persons served and looking toward ways of future expansion and providing services to new referrals in both daily and hourly services.

The failure in achieving these goals is not due to the lack of effort to meet the targets, this does not dismiss that alternative action steps are needed this coming year with the intent to meet identified targets.

In the next fiscal year, we are recommending continuing the same key objectives with action steps identified to increase those objectives that were not successfully met this year. Our plan is to continue holding the supervisory staff and DSPs accountable for the failure to complete significant responsibilities within the job descriptions and daily responsibilities. In addition, now that the residential department is hiring staff consistently, we will work to regularly create actions plans for those who require more attention when tasks are not getting completed timely and again holding both supervisor personnel and staff accountable for the lack of job commitment.

We were exceptionally proud of the Residential Program personnel for their willingness and commitment to ensuring service delivery is being completed at a high level with little to know disruptions.

Community Housing and Supported Living Demographics

**CH=Community Housing, SL Daily=Supported Living with 8+ hours support each day and SL Hourly=Supported Lining with less than 8 hours support/day

FY 2022-2023	1st Quarter CH Demographics		1st Quarter SL -Hourly Demographics		1st Quarter SL-Daily Demographics		2nd Quarter CH Demographics		2nd Quarter SL-Hourly Demographics		2nd Quarter SL-Daily Demographics		3rd Quarter CH Demographics		3rd Quarter SL-Hourly Demographics		3rd Quarter SL- Daily Demographics		4th Quarter CH Demographics		4th Quarter SL- Hourly Demographics		4th Quarter SL- Daily Demographics	
Number Served	51	40%	18	17%	43	43%	54	41%	15	17%	43	42%	56	43%%	17	17%	39	40%%	58	44%%	17	17%	35	39%
Age																								
<17	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
18-21	0	0%	0	0%	1	2%	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
22-34	6	12%	6	33%	17	40%	6	11%	6	40%	16	37%	6	11%	6	35%	15	38%	6	10%	6	35%	13	37%
35-44	10	20%	3	17%	5	12%	6	11%	3	20%	5	12%	6	11%	3	18%	4	10%	7	12%	3	18%	4	11%
45-54	10	20%	4	22%	10	23%	8	15%	4	27%	9	21%	9	16%	4	24%	8	21%	13	22%	4	24%	8	23%
55-64	18	35%	4	22%	10	23%	18	33%	4	27%	10	23%	18	32%	4	24%	11	28%	16	28%	4	24%	10	29%
65>	10	20%	3	17%	9	21%	11	20%	3	20%	9	21%	11	20%	3	18%	9	23%	16	28%	3	18%	7	20%
Gender																								
Male	34	67%	10	56%	27	63%	32	59%	8	53%	26	60%	33	59%	9	53%	32	82%	40	69%	9	53%	21	60%
Female	17	33%	8	44%	25	58%	17	31%	7	47%	24	56%	17	30%	8	47%	17	44%	18	31%	8	47%	23	66%
Ethnicity																								
Black or African-American	4	8%	4	22%	2	5%	4	7%	4	27%	2	5%	4	7%	4	24%	4	10%	4	7%	4	24%	4	11%
Asian	0	0%	0	0%	1	2%	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Caucasion	45	88%	13	72%	38	88%	43	80%	15	100%	38	88%	44	79%	15	88%	33	85%	52	90%	15	88%	29	83%
Hispanic	1	2%	1	6%	2	5%	1	2%	1	7%	2	5%	1	2%	1	6%	1	3%	1	2%	1	6%	1	3%
Other Race	1	2%	0	0%	0	0%	1	2%	0	0%	0	0%	1	2%	0	0%	1	3%	1	2%	0	0%	1	3%
Employment / Day Program																								
Competitive Employment	1	2%	5	28%	0	0%	1	2%	5	33%	2	5%	1	2%	5	29%	1	3%	1	2%	5	29%	0	0%
Supported Employment (Link)	6	12%	8	44%	7	16%	6	11%	8	53%	6	14%	6	11%	8	47%	6	15%	8	14%	8	47%	7	20%
Supported Employment (Other)	0	0%	0	0%	1	2%	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Work Activity/Prevoc	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Day Hab (Link)	33	65%	2	11%	26	60%	31	57%	2	13%	26	60%	32	57%	2	12%	31	79%	33	57%	2	12%	20	57%
Day Hab (Other)	1	2%	0	0%	4	9%	1	2%	0	0%	1	2%	1	2%	0	0%	1	3%	3	5%	0	0%	4	11%
No Placement	10	20%	5	28%	14	33%	10	19%	5	33%	14	33%	10	18%	5	29%	10	26%	10	17%	5	29%	13	37%
Training/Certificate Program (Link)	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Training /Certificate Program (Other)	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Level of Disability																								

Developmental Disability (DD)	0	0%	2	11%	0	0%	0	0%	2	13%	0	0%	0	0%	2	12%	0	0%	0	0%	2	12%	0	0%
Intellectual Unspecified	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Mild ID (50-75)	16	31%	15	83%	25	58%	17	31%	10	67%	24	56%	17	30%	15	88%	17	44%	18	31%	15	88%	15	43%
Moderate ID (35-49)	24	47%	2	11%	16	37%	21	39%	2	13%	15	35%	22	39%	2	12%	21	54%	22	38%	2	12%	19	54%
Severe ID (20-24)	11	22%	1	6%	11	26%	11	20%	1	7%	11	26%	11	20%	1	6%	11	28%	11	19%	1	6%	10	29%
Profound ID (< 20)	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Secondary Diagnosis																								
ADD/ADHD	3	6%	0	0%	2	5%	3	6%	0	0%	2	5%	3	5%	0	0%	3	8%	4	7%	0	0%	2	6%
Alzheimer's/Dementia	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Anxiety Disorder	0	0%	0	0%	0	0%	1	2%	0	0%	0	0%	1	2%	0	0%	1	3%	0	0%	0	0%	1	3%
Autism	6	12%	2	11%	6	14%	6	11%	2	13%	6	14%	6	11%	2	12%	6	15%	6	10%	2	12%	5	14%
Bipolar Disorder	0	0%	0	0%	2	5%	0	0%	0	0%	2	5%	0	0%	0	0%	0	0%	0	0%	0	0%	1	3%
Borderline Personality Disorder	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	2%	0	0%	0	0%
Cerebral Palsy	9	18%	0	0%	6	14%	9	17%	0	0%	6	14%	9	16%	0	0%	9	23%	9	16%	0	0%	11	31%
Depression	2	4%	0	0%	2	5%	2	4%	0	0%	2	5%	2	4%	0	0%	2	5%	2	3%	0	0%	2	6%
Diabetic	2	4%	1	6%	1	2%	2	4%	1	7%	1	2%	2	4%	1	6%	2	5%	2	3%	1	6%	2	6%
Down Syndrome	6	12%	0	0%	8	19%	5	9%	0	0%	6	14%	6	11%	0	0%	5	13%	6	10%	0	0%	5	14%
Hearing Impairment/Deaf	3	6%	4	22%	1	2%	3	6%	4	27%	1	2%	3	5%	4	24%	3	8%	3	5%	4	24%	1	3%
Intermittent Explosive Disorder	0	0%	0	0%	1	2%	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%	0	0%	0	0%	2	6%
No Secondary Diagnosis Known	5	10%	5	28%	8	19%	5	9%	5	33%	8	19%	5	9%	5	29%	5	13%	5	9%	5	29%	5	14%
Other	9	18%	7	39%	7	16%	9	17%	7	47%	7	16%	9	16%	7	41%	9	23%	9	16%	7	41%	9	26%
Schizophrenia	2	4%	0	0%	0	0%	2	4%	0	0%	0	0%	2	4%	0	0%	2	5%	2	3%	0	0%	2	6%
Seizure Disorder/Epilepsy	2	4%	1	6%	5	12%	2	4%	1	7%	5	12%	2	4%	1	6%	2	5%	2	3%	1	6%	5	14%
Visual Impairment/ Legally Blind	0	0%	0	0%	3	7%	0	0%	0	0%	3	7%	0	0%	0	0%	0	0%	0	0%	0	0%	1	3%

July - September 2022

The average person served within the Community Housing Program is a male (67%) Caucasian (88%) between the ages of 55-64 (35%) with moderate (47%) ID primary disability and Cerebral Palsy/Other (18% each) secondary diagnosis and is in a Link Day Habilitation Program (65%).

The average person served within the Supported Community Living (SCL)--Hourly Program is a male (56%) Caucasian (72%) between the ages of 22-34 (40%) with Mild (83%) ID primary disability and a secondary diagnosis of other (39%) and has placement in a Link employment program (44%).

The average person served within the SCL-Daily Program is a male (52%) Caucasian (90%) between the ages of 22-34 (33%) with mild ID (48%) and a secondary diagnosis of Down Syndrome (15%) and is in a Link Day Habilitation Program (52%).

October - December 2022
The average person served within the Community Housing Program is a male (65%) Caucasian (88%) between the ages of 55-64 (37%) with moderate (43%). ID primary disability and cerebral palsey (18%) secondary diagnosis and is in a Link Day Habilitation Program (63%).

The average person served within the Supported Community Living (SCL)--Hourly Program is a female (60%) Caucasian (75%) between the ages of 22-34 (30%) with Mild (75%) ID primary disability and no secondary diagnosis or other(35%) and is in the Link Supported Employment program(40%) or not employed/attending a day program (also 25%).

The average person served within the SCL-Daily Program is a male (52%) Caucasian (90%) between the ages of 22-34 (32%) with mild ID (48%) and no secondary diagnosis (16%) and is in a Link Day Habilitation Program (52%).

January - March 2023
The average person served within the Community Housing Program is a male (66%) Caucasian (88%) between the ages of 55-64 (36%) with Moderate (44%) ID primary disability and no secondary diagnosis (16%) or other secondary diagnosis (18%) and is in a Link Day Habilitation Program (64%).

The average person served within the Supported Community Living (SCL)--Hourly Program is a female (60%) Caucasian (75%) between the ages of 22-34 (30%) with Mild (75%) ID primary disability and autism as a secondary diagnosis (18%) and is in a Link Supported Employment program (47%).

The average person served within the SCL-Daily Program is a male (68%) Caucasian (91%) between the ages of 22-34 (32%) with Moderate ID (45%) and other secondary diagnosis (19%) and is in a Link Day Habilitation Program (66%).

April - June 2023
The average person served within the Community Housing Program is a male (67%) Caucasian (88%) between the ages of 55-64 (35%) with moderate (43%) ID primary disability and other secondary diagnosis (18%) and is in a Link Day Habilitation Program (66%).

The average person served within the Supported Community Living (SCL)--Hourly Program is a male (53%) Caucasian (65%) between the ages of 22-34 (35%) with Mild (76%) ID primary disability and autism as a secondary diagnosis (18%) and is in a Link Supported Employment program (47%).

The average person served within the SCL-Daily Program is a female (65%) Caucasian (89%) between the ages of 55-64 (27%) with mild ID (43%) and autism or cerebral palsy as secondary diagnosis (each 18%)and is in a Link Day Habilitation Program (59%).

Community Housing and Supported Living Measures of Achievement

`Community Housing & Supported Living Measures of Achievement 2022 - 2023

EXPERIENCES OF SERVICES RECEIVED AND OTHER FEEDBACK FROM THE PERSONS SERVED																		
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
			Case Managers			SL - Hourly	3			2.98			2.72			2.94		

Improve consumer satisfaction	Score on Satisfaction survey	Satisfaction survey		Program Administrative Assistant	Minimum score 2.75 or higher; optimal score 2.9 or higher (3-point scale)	SL - Sites	2.89	2.83	2.90	2.98
						Community Housing	2.99	2.50	2.98	2.99
						Average	2.96	2.77	2.87	2.97

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Action Steps Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) NA	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER • SL – Hourly: All were satisfied. • SL – Sites: All were generally satisfied, some expressed wanting to move to new homes. • Community Housing: All were generally satisfied, one individual expressed wanting to buy their own home and wanting access to community with preferred staff.	2ND QUARTER • SL – Hourly: All were highly satisfied. • SL – Sites: All were highly satisfied, one individual noted they don't get along well with a peer. • Community Housing: All were generally satisfied, one individual expressed wanting to move and no longer have a guardian or payee	3rd QUARTER • SL – Hourly: All were highly satisfied. • SL – Sites: All were highly satisfied. • Community Housing: All were highly satisfied. One individual reported significantly lower scores following their experience moving from SL hourly to SCL daily services, their team has since implemented changes to address concerns.	4TH QUARTER • SL – Hourly: All were highly satisfied. • SL – Sites: All were highly satisfied. • Community Housing: All were highly satisfied.

Comparison of last year's results (21/22) to this year (22/23): In FY 21/22 the persons served satisfaction averaged 2.89 (2.85 for SL and 2.96 for CH). That was a slight decrease (0.7 points) in overall satisfaction from the previous fiscal year appearing to be attributed to delays in the ability to identify alternative housing, access to payees/funds, and issues related to being able to access services to find jobs. The minimum target of 2.75 was met for all areas and quarters except for the 4th quarter with respondents from SL-Sites, or daily SCL locations. This is due to frustrations from persons served about space in their homes, and limited options to make changes in placement/roommates. The department met the optimal score on average for 2 of 4 quarters. For FY 22/23 the person served satisfaction averaged 2.89 (2.90 for SL and 2.87 for CH). On average, the overall satisfaction met the same level as the previous FY and met the target minimum for all areas in all quarters except for CH during the second quarter, wherein it was identified the small number of respondents providing negative responses/reporting dissatisfaction with current housing arrangements or peers. Throughout FY 22/23, lower scores across all areas can be attributed to challenges involving peer conflicts, immutable aspects of the physical plant of homes and persons' desires to move, and limited opportunities for changes to housing in general.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Decrease discharges due to dissatisfaction	Number of discharges due to dissatisfaction	Census Log	Residential Administrator	Residential Administrator	No more than one discharge annually due to dissatisfaction	SL - Hourly		0			1			0			0	
						SL - Sites		0			0			0			0	
						Community Housing		0			0			0			0	

						Total	0	1	0	0

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan). Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) N/A	Completion Date NA	
ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER SL – Hourly: No discharges due to dissatisfaction. SL – Sites: No discharges due to dissatisfaction Community Housing: No discharges due to dissatisfaction	2ND QUARTER SL – Hourly: J.B. discharged on 10.31.22 due to services not falling in alignment with services being provided. SL – Sites: No discharges due to dissatisfaction Community Housing: No discharges due to dissatisfaction	3RD QUARTER SL – Hourly: No Discharge due to dissatisfaction SL – Sites: No discharge due to dissatisfaction Community Housing: No discharge due to dissatisfaction.	4TH QUARTER SL – Hourly: No Discharge due to dissatisfaction. SL – Sites: No Discharge due to dissatisfaction Community Housing: No discharge due to dissatisfaction.
Comparison of last year's results (21/22) to this year (22/23): In 2021/2022 there was 1 discharge for Supported Living -daily and in FY 2022/2023 there was 1 discharge for Community Housing. Trends: ☐ YES ☒ No (if yes provide detail) Causes: ☐ YES ☒ non-Applicable – Characteristics of persons served impact performance: ☒ YES ☒ No Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)				
New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps:		Expected Outcomes N/A	Person Responsible N/A	Timeframe N/A

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve consumer's satisfaction with where they live.	Score on the Outcome Indicator	Outcome Indicator	Residential Supervisors	Residential Administrator	Minimal average score of 90%; and optimal average score of 97%.	SL - Hourly	100%	92%	96%	100%	100%	100%	100%	100%	100%	75%	100%	100%
						SL – Sites	100%	97%	98%	94%	90%	98%	100%	96%	100%	93%	96%	91%
						Community Housing	91%	100%	95%	90%	96%	100%	92%	90%	89%	90%	76%	91%
						Average	97%	93%	96%	95%	95%	99%	97%	95%	96%	86%	91%	94%

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan) Action Steps Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) NA	Completion Date NA	
ACTIONS TAKEN / CHANGES MADE	1st QUARTER • SL – Hourly: All were highly satisfied.	2ND QUARTER • SL – Hourly: All were highly satisfied for the whole quarter.	3RD QUARTER • SL – Hourly: Responses reported lower due to a small number of responses. Two persons	4TH QUARTER

THROUGHOUT THE YEAR (22/23):	• SL – Sites: All were highly satisfied. • Community Housing: Highly satisfied, some persons wanted new/different settings or were unhappy with other persons served in their settings.	• SL – Sites: Highly satisfied, some cited roommate conflicts or wanting a change. • Community Housing: Highly satisfied, those expressing dissatisfaction continue to explore options via their teams.	expressed dissatisfaction due to landlord/community issues. • SL – Sites: Persons reported high level of satisfaction, occasional conflict with peer behaviors reported. • Community Housing: One individual reported they wanted to return to living independently and was not satisfied by living with peers.	• SL – Hourly: Responses reported lower due to a small number of responses. Two persons expressed dissatisfaction due to landlord/community issues. • SL – Sites: Persons reported high level of satisfaction, occasional conflict with peer behaviors reported. • Community Housing: Lower scores appear to reflect pending transitions to different services/settings and also conflicts between peers regarding disruptive behaviors.

Comparison of last year's results (21/22) to this year (22/23): In 21/22 the persons served satisfaction with where they lived averaged 97% (with SL Scoring 98% and CH scoring 95%). Individuals expressing dissatisfaction cited wanting to live in settings with larger bedrooms, more space or different roommates. Some individuals wanting to move had specific physical accommodation needs and personal care needs that made it difficult to identify suitable alternatives. Teams continue to address potential placements with persons served and continue to evaluate the placements and needs of all persons served by the Residential Program. In 22/23 the persons served satisfaction with where they lived averaged 95% (with SL Scoring 97% and CH scoring 92%), exceeding the target of the minimal average score of 90% yet not achieving the optimal average score of 97%. Individuals expressing dissatisfaction with different roommates, specifically citing dissatisfaction with the behaviors of roommates (predominantly) and some citing dissatisfaction with the physical location. Some respondents in the Hourly SCL program experienced issues with neighbors/landlords prompting their reports of dissatisfaction and desire to move.

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	NA	NA	NA

SERVICE ACCESS																		
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve the delivery of services to new referrals	Average number of days	Admissions Referral Tracking google sheet	Residential Administrator	Residential Administrator	Maintain or decrease # of days from 1st "meet/greet" to decision to pursue/discontinue referral process SL < 17 days CH < 13 days	SL- Hourly	Total days for all candidates = 0 Num. of potential candidates = 0 Average = 0			Total days for all candidates =0 Num. of potential candidates = 0 Average =0			Total days for all candidates = 0 Num. of potential candidates = Average = 0			Total days for all candidates = 0 Num. of potential candidates = 0 Average = 0		
						SL – Sites	Total days for all candidates = 0 Num. of potential candidates = 0 Average = 0			Total days for all candidates = 0 Num. of potential candidates = 0 Average = 0			Total days for all candidates = 0 Num. of potential candidates = Average = 0			Total days for all candidates = 28 Num. of potential candidates = 1 Average = 28		
						Community Housing	Total days for all candidates = 0 Num. of potential candidates = 0 Average = 0			Total days for all candidates = 33 Num. of potential candidates =1 Average = 33			Total days for all candidates = 0 Num. of potential candidates = Average = 0			Total days for all candidates = 65 Num. of potential candidates =1 Average = 65		
						TOTAL AVERAGED	0			33			0			47		

						PER QUARTER				

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter **SL – Hourly**: No meet/greets scheduled for this quarter. **SL – Sites**: No meet/greets scheduled for this quarter. **Community Housing**: No meet/greets scheduled for this quarter.	2nd Quarter **SL – Hourly**: No meet and greets scheduled for the quarter. **SL – Sites**: No meet and greets scheduled for the quarter. **Community Housing:** CC toured hull Ave on 10.4.22. On 11.7.22, Link made the decision to move forward with a candidate that needed a higher level of care.	3rd Quarter **SL – Hourly**: No meet and greets scheduled for this quarter. **SL – Sites**: No meet and greets scheduled for this quarter. **Community Housing:** No meet and greets scheduled for this quarter.	4th Quarter **SL – Hourly**: **SL – Sites**: K.R's family toured Grandview on 4.11.23-Link made the decision to move forward with admission. Admissions approved KR on 5.9.23. C.C family toured Grandview on 6.7.23 and 6.21.23. Link made the decision to move forward with admission. Admission approved CC on 7.14.23 **Community Housing**

Comparison of last year's results (21/22) to this year (22/23): In 2021/2022 on average this period it took 18 days (29.75 days for SL-daily, 16 days for Community Housing, and 6 days for SL-Hourly). There was a total of 9 referrals with 4 admissions: all 4 admissions for SL-Daily. In 2022/2023 on average this period took 42 days (49 days for Community Housing and 28 days for SL-Sites, there were 0 referrals for SL-hourly). There was a total of 1 referral with 1 admission. The one admission is for SCL-Daily
Trends: ☒ YES ☐ No
Causes: ☒ YES ☐ non-Applicable
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☒ YES ☐ No (if yes, please explain) Difficulty with guardians responding and scheduling additional tours/move in.

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

EXPERIENCES OF SERVICES AND OTHER FEEDBACK FROM OTHER STAKEHOLDERS

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve parent/guardian satisfaction	Score on Satisfaction Survey	Satisfaction Survey	Case Managers	Program Administrative Assistant	Minimum score of 2.75 or higher; optimal score of 2.9 or higher (3-point scale)	SL - Hourly	3			3			3			3		
						SL - Sites	3			3			2.95			2.96		
						Community Housing	2.99			2.96			2.94			3		
						Average	3			2.99			2.96			2.99		

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Action Steps: Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) NA	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2ND QUARTER	3RD QUARTER	4th QUARTER
	• SL- Hourly: All respondents reported being highly satisfied. • SL -Sites: All respondents reported being highly satisfied. • Community Housing: All respondents reported being highly satisfied	• SL- Hourly: All respondents reported being highly satisfied. • SL -Sites: All respondents reported being highly satisfied. • Community Housing: All respondents reported being highly satisfied	• SL- Hourly: Respondents reported being highly satisfied. • SL -Sites: One respondent commented they'd like more frequent/prompt communication from the site supervisor. All others reported being highly satisfied. • Community Housing: Respondents reported being highly satisfied.	• SL- Hourly: I responses reported lower due to a small number of responses. Two persons expressed dissatisfaction, due to landlord/community issues. • SL -Sites: persons reported high level of satisfaction, occasional conflicts with pier behaviors reported. • Community Housing: lower scores appear to reflect pending transitions to different services/settings, and also conflicts between Piers regarding disruptive behaviors.

Comparison of last year's results (21/22) to this year (22/23): In FY 21/22 the parent/guardian satisfaction averaged 2.93 (with SL scoring 2.93 and CH scoring 2.95). Parents and guardians continued to report high levels of satisfaction with the Residential Programs. In FY 22/23 the parent/guardian satisfaction averaged 2.99 (with SL scoring 2.99 and CH scoring 2.97), meeting the optimal score of 2.9 or higher on average. Parents/guardians continue to report high levels of satisfaction with Residential Programs.
Trends: ☐ YES ☒ No (if yes provide detail):
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

RESOURCES USED TO ACHIEVE RESULTS FOR THE PERSONS SERVED (EFFICIENCY))																	
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain or increase the number of persons served	Number of persons served. SL – Hourly (20) SL – Sites (44) Community Housing (51)	Billing & Census Logs	Assistant Outreach Director	Program Administrative Assistant	Maintain or increase the number of consumers served	SL - Hourly	18	18	18	17	16	15	17	17	17	17	17	17
					Maintain or increase the number of consumers served	SL - Sites	44	45	43	40	44	43	43	43	39	39	38	40
					Maintain or increase the number of consumers served	Community Housing	51	51	51	53	53	54	53	53	56	56	57	55

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan) Action Steps:	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date NA

	Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	• SL – Hourly: ○ KR and CB chose to discharge at the end of June 2022. ○ JL chose to discontinue services Sept 2023. • SL – Sites: ○ AM was discharged July 2023. AS moved into a SL site July 2023. ○ CB moved into SL site in Aug 2023. ○ JW and SZ discharged Aug 2023, SZ move to higher level of care and JW discharged Aug 2023. ○ CB moved in in Sept 2023. • Community Housing: ○ New CH site opened at the end of September 2023; 3 persons moved from SL Site to CH. CR moved to higher level of care Sept 2023	• SL –Hourly: ○ JB chose to discharge in Oct 2023. ○ SM went from hourly to CH Nov 2023. • SL – Sites: ○ PM moved from SL to CH Nov 2023. ○ SM transitioned to SL-site from Hourly in Nov 2023. • Community Housing: ○ PM moved from SL-site to CH in Nov 2023. MW passed away Dec 2023	• SL – Hourly: Two new hourly persons started services in January 2023 • SL – Sites: ○ ES moved from SL to CH Feb 2023; ○ HD, DD, and JP moved from SL to CH Feb 2023 ○ CB discharged April 2023 ○ CC discharged April 2023 ○ MM discharged April 2023. ○ DP moved from CH to SL May 2023. SM moved to SL from CH May 2023. • Community Housing: Three persons moved from SL sites to CH Feb 2023 DP moved to SL May 2023; SM moved from CH to SL May 2023	• SL – Hourly: No change. • SL – Sites: MM, CB, and CC discharged from services April 2023. SM and DP moved to SL in May 2023 Community Housing: SM and DP moved out of CH to SL sites May 2023.

Comparison of last year's results (21/22) to this year (22/23) In 21/22 the program ended the year supporting 115 persons served – SL hourly 20, SL Sites 44, and CH 51. The program saw movement towards more CH opportunities over the previous year and movement towards rental single-family homes and away from apartment style living. The program also saw the exit or loss of some of its elder program participants and/or those that were seeking different service methods. The program did not meet its goal to maintain or increase the number of persons served yet was successful in aiding persons to move into other appropriate living arrangements. In FY 22/23 the program ended the year supporting 112 persons served – While this is 3 less than the prior year (115 in 21/22), there have been a significant number of shifts in individuals moving to more supportive and longer-term environments through moves to more single-family style homes and away from apartment settings. The Residential Department continues to work closely with the MCOs and colleagues internally and externally to identify the best possible placements for persons currently served as well as efforts to identify persons to fill current vacancies. The department continues to see elderly program participants exit services at the end of life and due to increased medical support needs associated with aging, while also challenging itself to create new opportunities to allow persons served to continue to "age in place" and receive care in the least restrictive settings possible.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps/Plan:	NA	NA	NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve quality of service	Score on outcome indicator	Outcome Indicator	Residential Administrator	Program Administrative Assistant	Minimum average score of 90% or higher; optimal score of 97% or higher	SL - Hourly	6%			29%			57%			21%		
						SL - Sites	52%			67%			60%			56%		
						Community Housing	49%			64%			60%			68%		
						Average	35%			53%			59%			49%		

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan):	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☐ Goal Met ☒ Goal Not Met			Action Step 1:

	Ensure Supervisors are held accountable for the responsibilities; ensuring documentation reviews are at 80% weekly and communicating with staff in timely manner to get any EDOC corrections completed. Action Step 1: Residential Administrators will ensure Residential Supervisor are completing documentation reviews as directed. IF supervisors are not completing reviews as expected, a plan of action will be put in place or disciplinary action will occur. Action Step 2: Residential Supervisor will communicate with their staff immediately with documentation errors occur. If staff do not get errors corrected within in 48 hours, disciplinary action will occur. Did Actions taken accomplish intended results. ☐ Yes ☒ No ☐ NA		Action Step 1: The Director and Administrators send log audit reports to Supervisors weekly to make them aware of the EDOC corrections that are missing. Action Step 2: As staff are not coming completing their EDOC corrections in a timely manner or with in the 48-hour corrections are being sent to them, Administrators are either drafting the warning or ensuring supervisors are drafting and issuing the warnings in efforts to get EDOC completed.	6.30.23 Action Step 2: 6.30.23
ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER SL – Hourly; SL – Site; Community Housing: Checkbox documentation has been approved. With checkbox documentation, this will lessen the amount of time supervisors are reading daily documentation. In addition, this will allow staff to focus on provide quality services versus spending a significant amount of complete daily documentation, which should reduce the number of documentation corrections supervisors have to seek from staff.	2ND QUARTER SL – Hourly; SL – Sites, Community Housing: • Checkbox documentation began on October 12, 2022. With the implementation of checkbox documentation, supervisors will resume reading all daily documentation for all their locations. Supervisors are still learning check box documentation and the log audit process and what is still needed to accurately capture quality services being provided. • The Agency learned that EDOC has been bought and new system SETWorks would be introduced.	3RD QUARTER SL – Hourly; SL – Sites, Community Housing: - Checkbox documentation has been a new change for the supervisory group. Supervisors are getting use the minimal documentation and new process to ensure the data is provided. This is causing some delays in making sure the documentation is read and audited timely. Administrators continue to review strategies in 1:1 meeting with supervisors.	4TH QUARTER SL – Hourly; SL – Sites: Community Housing: • This quarter, supervisors averaged 90% in regard to getting all of their documentation read and corrections completed by staff. Administrators will continue to monitor the timelessness of Supervisors ensuring log auditing percentages are at 100% during each billing period and ensure corrections are sent out to staff before lockdown. • There has been a trend of supervisors waiting until the last minute to contact about documentation corrections. This has been identified when the department director is unlocking EDOC. Administrators will continue to have these conversations during 1:1s.
Comparison of last year's results (21/22) to this year (22/23): In fiscal year 2021 – 2022 the program had an overall average of 22%. SL-Hourly averaged 12%, SL-Sites averaged 26%, and Community Housing averaged 33%. In fiscal year 2022 – 2023 the program- had an overall average of 21% SL-Hourly averaged 28%, SL-Sites 56% average, Community Housing 68% average. Trends: ☐ YES ☒ No (if yes, please explain) Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain) Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain) Other extenuating or influencing factors ☒ YES ☐ No (if yes, please explain) There will be a new documentation system implemented. The Director, Administrators and Supervisors are learning new ways to track auditing and sending out corrections in a timely manner.				
New Recommendations for Next Year (23/24): ☐ Continue as written ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined below. Action Steps: 1. The Director and Residential Administrators will ensure supervisors are completing documentation reviews as directed. If Supervisors are not completing reviews as expected, a plan of action will be put in place or disciplinary action will occur. 2. Residential supervisors will communicate with their staff immediately when documentation errors occur. If staff do not get errors completed within 48 hours, disciplinary action will occur.		Expected Outcomes 1. Learn the new set works system and develop ways to ensure auditing documentation is completed timely. 2. To reduce the number times for unlocking and entering late documentation.	Person Responsible Residential Director, Administrators, and Supervisors.	Timeframe Actions Steps 1: 6.30.24 Action Steps 2: 6.30.24

SUPPORTED EMPLOYMENT PROGRAM

Link Associates Program Evaluation
July 1, 2022 to June 30, 2023
Alina Chapman, Employment Administrator
& Cassondra Jones, Employment/Day Program Director

As the Supported Employment leadership team, we have reviewed the data gathered over the past year and all changes made within the department. A global supply chain crisis and inflation, as a result of the pandemic, had an impact on the program as a whole. Businesses had to temporarily close or cut hours of employees due to not being able to get needed supplies to operate or having to cut labor costs due to rising prices, resulting in fewer working hours available for persons served. Admissions also had to be put on hold during part of the fiscal year due to staffing shortages within the Supported Employment department. We were still able to meet 5 of our 8 goals during the fiscal year.

In the fiscal year our most significant achievement was graduating 4 persons served from our Supported Employment program by helping them build natural supports at their place of employment leading to their success of no longer needing support from a Job Coach. The Community Placement Manager was able to place 22 persons served in jobs throughout the year. We continue to contract with IVRS, and to hold a monthly meeting with all IVRS counselors to strengthen our relationship and be able to communicate effectively.

As a program we exceeded our goal for all three satisfaction measures. There was a total of nine employers who shared a comment, and the following are some of the comments they left. “SM is doing a great job. Good fit for employer & SM. Ron (ETS) is easy to talk to & work with,” “Employees provided have been consistent,” “Everything has been going very well and we enjoy having HA here” “Many Hands is thankful for the relationship we’ve developed with Link Associates! We enjoy working alongside both the staff and their clients.” “I can go to Link if I need assistance with my employee.” “Everyone knows what we expect and helps EG achieve her goals.” The Employment Supervisors (ES), Employment Training Specialists (ETS), and Community Placement Manager (CPM) did a very nice job of building and maintaining great relationships with new & current employers; so much so that they have had several businesses reach out to them in order to hire more persons served we support when they have an opening. The Employment Administrator (EA) continues the task of completing and submitting the Employment Evaluation (Scorecard) information bi-annually. For CY 2022, Link received approximately $19,547 in incentive monies for outstanding outcomes within our Employment program; the money was used as an incentive payment for employees within the program. FY 22-23 we exceeded our goal by admitting 53 persons served into Supported Employment despite having to put admissions on hold as a result of the staffing shortage for part of the year. The leadership team will continue to closely monitor any budget deficits for the Supported Employment program (Job Coaching and Job Development). The pandemic continued to have an impact on the businesses person served worked at. While some had hours cut due to supply chain issues, slow business, others were being offered position quickly due to staffing shortages in all industries. This past year we had to put Job Development and Job Coaching referrals on hold due to our own staff shortages for part of the fiscal year.

We were unsuccessful in meeting our goal to maintain or increase the number of hours worked per week. The ES was able to meet with several ETS’ to discuss increasing hours, meeting directly with business, and was also able to discuss plans to help increase person served hours during annual team meetings but was unable to successfully increase hours enough to make an impact in the average number of hours worked each week. We are still recommending continuing an action step for the ES to ‘meet with the ETS’s and discuss persons served on their caseloads and how to work with employers to potentially give more hours to persons served.’ We are recommending discontinuing the second action step for the ES’s to discuss increasing person served hours at annual team meetings in attempt to get additional support from service team members in supporting the person served to obtain more hours per week at work due to the barriers being more with the employers and then with the person served or the teams. The ES’s and ETS’s will continue to meet with current employers to discuss increasing hours worked, decreasing hours of support (we provide) and moving to follow-along services. The last goal we were unsuccessful in meeting was our goal to decrease the amount of time waiting for job placement for those who were not actively employed. We are still recommending continuing an action step ‘CPM will provide at least 20 billable hours per week (EA will review if hours were met monthly and share with E/DPD).’

We were exceptionally proud of the CPM and ETS’s as they did an amazing job assisting persons served with finding employment they enjoy as opposed to ‘just a job.’ The Employment leadership team continues to track tier assignment to ensure the support we provided fell in line with their authorization. Throughout the year the ETS’s consistently met the persons served tier and they received all of the support that was deemed necessary by the team. Our group of employees continue to embody Link’s mission, vision, and values. This is reflected in 2022’s Community Employment Outcomes Evaluation (an evaluation completed by the Law, Healthy Policy and Disability Center at the University of Iowa), with our great scores and comments from persons served. Even with staff shortages, the ETS’s continue to provide the absolute best support to our persons served. Each one of them have stepped up and taken on extra hours weekly throughout this past year to ensure those we serve are supported. As leadership of the program, there is nothing more we could ask for, and we are proud of the hard work and dedication they continuously display.

Supported Employment Demographics

FY 2022 - 2023	1st Quarter Demographics		2nd Quarter Demographics		3rd Quarter Demographics		4th Quarter Demographics	
Number Served	75	100%	70	100%	73	100%	77	100%
Age								
<16	0	0%	0	0%	0	0%	0	0%
16-17	0	0%	0	0%	0	0%	0	0%
18-21	0	0%	1	1%	3	4%	1	1%
22-34	40	53%	34	49%	36	49%	39	51%
35-44	18	24%	17	24%	16	22%	17	22%
45-54	7	9%	9	13%	9	12%	10	13%
55-64	10	13%	9	13%	9	12%	10	13%
65>	0	0%	0	0%	0	0%	0	0%
Gender								
Male	54	72%	52	74%	55	75%	58	75%
Female	21	28%	18	26%	18	25%	19	25%
Ethnicity								
Black or African American	11	15%	9	13%	9	12%	9	12%
American Indian and Alaskan	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Asian	3	4%	3	4%	2	3%	2	3%
Caucasian	55	73%	52	74%	54	74%	58	75%
Hispanic	4	5%	3	4%	3	4%	3	4%
Native Hawaiian/other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Race	2	3%	3	4%	4	5%	4	5%
Level of Disability								
Developmental Disability (DD)	6	8%	7	10%	8	11%	8	10%
Mild MR (50-75)	58	77%	53	76%	54	74%	57	74%
Moderate MR (35-49)	11	15%	10	14%	10	14%	11	14%
Severe MR (20-24)	0	0%	0	0%	0	0%	0	0%
Profound MR (< 20)	0	0%	0	0%	0	0%	0	0%
other	0	0%	0	0%	0	0.0%	0	0.0%
Secondary Diagnosis								
ADD/ADHD	12	16%	9	13%	9	12%	9	12%
Alzheimer's/Dementia	0	0%	0	0%	0	0%	0	0%
Anxiety Disorder	0	0%	0	0%	2	3%	2	3%
Autism	13	17%	10	14%	11	15%	12	16%
Bipolar Disorder	3	4%	2	3%	2	3%	3	4%
Cerebral Palsy	1	1%	2	3%	3	4%	3	4%
Depression	2	3%	2	3%	2	3%	2	3%
Down Syndrome	5	7%	4	6%	4	5%	4	5%
Epilepsy	4	5%	4	6%	5	7%	5	6%
Hearing Impairment/Deaf	3	4%	3	4%	3	4%	3	4%
Intermittent Explosive Disorder	0	0%	0	0%	0	0%	0	0%

No Secondary Diagnosis Known	11	15%	10	14%	10	14%	10	13%
Other	17	23%	17	24%	15	21%	16	21%
Schizophrenia	3	4%	3	4%	2	3%	2	3%
Seizure Disorder	4	5%	4	6%	5	7%	5	6%
Visual Impairment/ Legally Blind	0	0%	0	0%	0	0%	0	0%

July-September 2022
The data pulled from this quarter reflects there were 75 participants within the Supported Employment program. The average participant was a Caucasian male between the ages of 22-34 years, with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of 'other'. The average participant that exited the program was a Caucasian male between the ages of 22-58 years with a secondary diagnosis of 'other'.

October 2022-December 2022
The data pulled from this quarter reflects there were 70 participants within the Supported Employment Program. The average participant was a Caucasian male between the ages of 22-34 years, with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of 'other.' The average participant who exited the program was a Caucasian/African American (50/50) male between the ages of 22-34 years, with a primary diagnosis of Mild MR (5-75) and a secondary diagnosis of Autism/Behavior Disorder (50/50).

January 2023-March 2023
The data pulled from this quarter reflects there were 73 participants within the Supported Employment Program. The average participant was a Caucasian male between the ages of 22-34 years, with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of 'other.' The average participant who exited the program was a Caucasian female between the ages of 22-34 years, with a primary diagnosis of Mild MR (5-75) and a secondary diagnosis of Autism/Anxiety (50/50).

April 2023-June 2023
The date pulled from this quarter reflects there were 77 participants within the Supported Employment Program. The average participant was a Caucasian male between the ages of 22-34 years, with a primary diagnosis of Milk MR (50-75) and a secondary diagnosis of 'other.' The average participant who exited the program was an African American/Asian (50/50) male between the ages of 22-34 years, with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of ADHD.

The average participant who exited the program for the fiscal year was a Caucasian male between the ages of 22-34 years with a primary diagnosis of Mild MR (50-75) and a secondary diagnosis of Autism.

Supplemental Measures

Supported Employment Supplemental Measures	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
1. Number of persons served earning benefits.	5	5	4	11
2. Number of persons served with job changes A) Job advancement	0	0	0	0
B) Job title change/change of responsibilities	0	0	6	3
C) Resignation	4	2	4	4
D) Lay-off	0	0	0	0
E) Termination	1	1	0	0
3. Average number of hours of staff intervention/month.	11.7	11	11.1	10.1
4. Report persons served average weekly earnings.	$12.47	$12.46	12.48	12.91
5. Discharges from program (not due to dissatisfaction) A) Medical supports/safety	1	0	1	1

B) Moved out of service area	0	0	0	0
C) No longer in need/want of services	2	6	2	2
D) Increase in supports (non-medical, training program)	0	0	0	0
E) Number of involuntary discharges	0	0	0	0
F) No Funding available	0	0	0	0
6.Total number outside of Link Services	0	1	0	0

July – September 2022:
There were 5 persons served earning benefits this quarter (GB, AF, SH, MO, & TT). There were 5 persons served with a job change: 4 resignations (DK, KC, JM, & CM) and 1 termination (TP). The average number of hours of staff intervention/month was 11.7 hours. There were 4 discharges from the program: 1 for medical supports/safety (SM) and 3 due to no longer in need/want of services (SB, SK, & DK).

October – December 2022:
There were 5 persons served earning benefits this quarter (GB, AF, SH, MO, & TT). There were 2 persons served with a job change: 2 resignations (AK, SW) and 1 termination (MF). The average number of hours of staff intervention/month was 11 hours. There were 7 discharges from the program: 6 due to no longer in need/want of services (DE, LC, KC, MF, AK, JM) and 1 who chose to receive services through another agency (MO).

January – March 2023:
There were 4 persons served earning benefits this quarter (GB, AF, SH, & TT). There were 10 persons served with a job change: 6 with a job title change/change of responsibilities (JO, JL, PS, JA, VZ, DR) and 4 resignations (ND, DD, PS, MJ). The average number of staff intervention/month was 11.1 hours. There were 3 discharges from the program: 1 Medical supports/safety (MJ), and 2 due to no longer in need/want of services (ND, PS)

April – June 2023:
There were 11 persons served earning benefits this quarter (JA, GB, AB, MB, BB, TB, MC, AF, EG, SH, TT). There were 7 persons served with a job change: 3 with a title change/change in responsibilities (MB, AB, AP) and 4 resignations (SS, LN, BR, JL). The average number of hours of staff intervention/month was 10.1 hours. There were 4 discharges from the program: 2 Medical supports/safety (LN, JL) and 2 due to no longer in need/want of services (JM, BR).

Supported Employment Measures of Achievement

Supported Employment (Job Development & Job Coaching) Measures of Achievement 2022-2023

EXPERIENCES OF SERVICES RECEIVED AND OTHER FEEDBACK FROM THE PERSONS SERVED																		
Primary Objective	**Indicators (Measures)**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**Who Applied to**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**
Improve satisfaction of persons served (Job Development & Job Coaching)	Score on satisfaction survey	Satisfaction survey	Case Managers/ Case Coordinators	Employment Administrator/ Supervisor	Maintain or improve minimum satisfaction score of 2.75; optimal score of 2.9 (3-point scale)	Persons served in Supported Employment	JC = 2.99 N = 7 out of 10 JD = 2.97 N = 2 out of 4			JC = 2.99 N = 5 out of 11 JD = N/A N = 0 out of 0			JC = 2.73 N = 11 out of 18 JD = 2.97 N = 4 out of 6			JC = 2.98 N = 9 out of 12 JD = 2.33 N = 2 out of 5		

Goal Outcome:	**Previous FY goal recommendations** (I.e. goal continuation and/or new action steps/plan):	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	**Completion Date**
☒ Goal Met ☐ Goal Not Met	It was recommended to continue this goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER • There were no comments directly related to employment services this quarter. • Persons served KJ, PS, and DE chose not to complete the survey for job coaching services. Persons served BR and DZ chose not to complete the survey for job development services.	2nd QUARTER • There were no comments directly related to employment services this quarter. • Persons served MH, AP, TP, AM, DS, & KK chose not to complete the survey for job coaching services. Person served CG did not complete all of the questions on the survey. There were no persons served in job development services to complete a survey this quarter.	3rd QUARTER • There were no comments directly related to employment services this quarter. Persons served CM, BW, SH, JV, and DR chose not to complete the survey for job coaching. Persons served CM & CB chose not to complete the survey for job development.	4th QUARTER • There were no comments directly related to employment services this quarter. Persons served KJ, DZ, and HA chose not to complete the survey for job coaching. Persons served GC, JW, and RM chose not to complete the survey for job development.

Comparison of last year's results (21/22) to this year (22/23): The average person served satisfaction from fiscal year 2021-2022 was 2.9 for job development and 2.9 for job coaching for an overall average of 2.9. The average person served satisfaction from fiscal year 2022-2023 was 2.76 for job development and 2.92 for job coaching for an overall average of 2.8.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps: NA	NA	NA	NA

RESULTS ACHIEVED FOR THE PERSONS SERVED (EFFECTIVENESS)

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22 – 9/22	10/22-12/22	1/23-3/23	4/23-6/23
Maintain or increase number of hours worked weekly. (Job Coaching)	# of average hours worked weekly	'CY 2022 Employment Scorecard Info' Google Sheet	Employment Supervisor/ Employment Training Specialist	Employment Administrator	To maintain or increase # of hours worked weekly to 14 or more	All persons served in Supported Employment who are employed	12.1	12.6	11.8	10.4

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	Completion Date
☐ Goal Met ☒ Goal Not Met	It was recommended to continue goal as written with Action Step #1: Meet with the ETS' and discuss persons served on their caseloads and how to work with employers to potentially give more hours to persons served (at least once a quarter). Add Action Step #2 ES will discuss increasing work hours with service teams at annual team meetings to a	Action step #1: Meet with the ETS' and discuss persons served on their caseloads and how to work with employers to potentially give more hours to persons served (at least once a quarter). • 1st quarter: ES met with 6 ETS' about 10 different persons served gaining more hours. It was discussed to have them cross train and/or advocating for themselves to ask for more hours. 1 person served (AF) was able to obtain more hours at work. • 2nd quarter: ES met with 3 ETS' about 3 persons served gaining more hours. Each person served was able to talk to their manager to ask to be scheduled for more hours. No persons served were able to gain additional hours this quarter. ETS' will continue to help advocate for each person served. • 3rd quarter: ES met with 3 ETS about 3 persons served gaining more hours. Two of the three persons served were able to gain additional hours at work as a result. • 4th quarter: ES met with 3 ETS' to talk about 4 persons served gaining more hours. None were able to obtain more hours at work. Action Step #2 ES will discuss increasing work hours with service teams at annual team meetings to a create a plan on how to help each person served obtain more hours per week at work.	June 30th, 2023

	create a plan on how to help each person served obtain more hours per week at work. Did Actions taken accomplish intended results. ☐ Yes ☒ No ☐ NA	• 1st quarter: ES discussed ways to increase work hours with 4 different teams of persons served at annual meetings. Teams discussed possibly opening hours available to work and cross training opportunities to help each person served obtain more hours per week. Goals were added into plans of 2 persons served to help them increase their working hours. • 2nd quarter: ES discussed ways to increase work hours with 3 different teams of persons served. Teams discussed availability of persons served and were able to agree that each person served was able to work more and to ask employers for additional hours. No persons served were able to gain additional hours this quarter. • 3rd quarter: ES discussed ways to increase work hours with 3 different teams of persons served and two of those persons served were able to gain additional hours at work. • 4th quarter: ES discussed with 1 team of a person served and this person was not able to gain additional hours at work.	

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER** • During the first quarter persons served averaged working 12.1 hours each week.	**2nd QUARTER** • During the second quarter persons served averaged working 12.6 hours each week.	**3rd QUARTER** • During the third quarter persons served averaged working 11.8 hours each week.	**4th QUARTER** • During the fourth quarter persons served averaged working 10.4 hours each week.

Comparison of last year's results (21/22) to this year (22/23): During the 2021-2022 fiscal year the persons served average number of hours worked was 13.4 hours (the goal was 14 or more at this time). During the 2022-2023 fiscal year the persons served average number of hours worked was 11.7 hours.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	**Expected Outcomes**	**Person Responsible**	**Timeframe**
☐ Continue as written ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined above. Action Steps: Continue action step #1: Meet with the ETS' and discuss persons served on their caseloads and how to work with employers to potentially give more hours to persons served (at least once a quarter). Discontinue action Step #2: ES will discuss increasing work hours with service teams at annual team meetings to a create a plan on how to help each person served obtain more hours per week at work.	To increase number of hours worked weekly (Job Coaching)	ES & ETS	October 1, 2023- June 30, 2024

Primary Objective	**Indicators (Measures)**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**Who Applied to**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**
Decrease amount of time waiting for job placement. (Job Development)	Mean amount of time between referral and placement	JD/JC Program Info Google Document	Community Placement Manager	Employment Administrator	16 weeks or less for those who are not actively employed	Persons served in Supported Employment	Not Employed 26.6 wks. N = 5 Employed 4 wks. N = 1			Not Employed 15.25 wks. N = 4 Employed 23.3 wks. N = 3			Not Employed 20.5 wks. N = 2 Employed 19.8 N = 6			Not Employed NA N = 0 Employed 38 N = 1		

Goal Outcome:	**Previous FY goal recommendations** (I.e., goal continuation and/or new action steps/plan):	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	**Completion Date**
☐ Goal Met ☒ Goal Not Met	It was recommended to continue goal as written with a	Action Step: CPM will provide at least 20 billable hours per week (EA will review if hours were met monthly and share with E/DPD). • 1st quarter: EA reviewed CPM's hours and calculated he averaged 9.75 billable hours per week. CPM's caseload number is currently low and reported to EA this quarter that several persons served canceled scheduled sessions with him. EA provided training to CPM on what he can bill for when working on behalf of someone to help reach 20 billable hours per week and help find jobs faster for persons served.	June 30, 2023

	recommendation to add Action Step: CPM will provide at least 20 billable hours per week (EA will review if hours were met monthly and share with E/DPD). **Did Actions taken accomplish intended results.** ☒ Yes ☐ No ☐ NA	• 2nd quarter: EA reviewed CPM's hours and calculated he averaged 11.59 hours per week. CPM's caseload increased this quarter due to being able to open up admissions for JD services and CPM has been billing more for work he does on behalf of persons served, which has helped increase billable hours. Job Development admissions will remain open and EA is hoping to admit more person served in the third quarter to increase CPM's caseload. • 3rd quarter: EA reviewed CPM's hours and calculated he averaged 13.6 hours per week. CPM's caseload has remained steady due to him finding placements for persons served he is currently supporting faster than Link is able to admit additional persons. served into job development services. EA is working with admissions to try to admit more persons served at one time to help increase his caseload and increase weekly hours. • 4th quarter: EA reviewed CPM's hours and calculated he averaged 13.6 hours per week. CPM's caseload has increased to maximum capacity this quarter after being able to accept more admissions. CPM utilized more PTO this quarter than in other quarters which resulted in a lower average. EA expects CPM will be able to meet the 20 billable hours per week this next fiscal year.	

	1st QUARTER	2nd QUARTER	3rd QUARTER	4th QUARTER
ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	• 6 persons served found employment during the first quarter taking an average of 26.6 weeks: EM (4 wks.), SH (18 wks.), MN (16 wks.), MC (57 wks.), BG (24 wks.), SS (18 wks.) • 1 person served took over 1 year (MC) due to significant barriers limiting where he can work in the community. • 5 persons served were not employed prior to placement (SH, MN, MC, BG, and SS) and it took an average of 26.6 weeks to place them. • 1 person served was already employed prior to placement (EM) and it took 4 weeks to find placement.	• 7 persons served found employment during the second quarter taking an average of 18.7 weeks: CR (19wks), HA (11 wks.), MB (12 wks.), KP (34 wks.), ND (24 wks.), MF (22 wks.), AK (9 wks.), • 4 persons served were not employed prior to placement (CR, HA, MF, AK) and it took an average of 15.25 weeks to find placement. • 3 persons served were already employed prior to placement (MB, KP, ND) and it took an average of 23.3 weeks to find placement.	• 8 persons served found employment during the third quarter taking an average of 20 weeks: AM (8 wks.) GB (33wks), DZ (28wks), JL (9 wks.), JG (4 wks.), BR (45 wks.), MR (13 wks.), HR (20 wks.). • 6 persons served were not already employed (DZ, JL, JG, BR, MR, & HR) and took an average of 20.5 weeks to find placement. • 2 persons served were already employed prior to placement (AM, GB) and took an average of 19.8 weeks to find placement.	• 1 person served (DC) found employment during the fourth quarter. DC was already employed, and it took 38 weeks to find placement.

Comparison of last year's results (21/22) to this year (22/23): The fiscal year 2021-2022 ended with an average of 25 weeks to find job placement for 24 placements. The fiscal year 2022-2023 ended with 22 total placements and an average of 20.8 (due to no placements for those "not employed" in 4th quarter) weeks to find job placement for 15 persons served who were not already actively working and for 7 persons served who were actively working it took an average of 21.3 weeks to find placement.

Trends: ☐ YES ☒ No (if yes provide detail)

Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)

Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)

Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	**Expected Outcomes**	**Person Responsible**	**Timeframe**
☐ Continue as written ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined above. Action Steps: Continue CPM will provide at least 20 billable hours per week (EDPA will review if hours were met monthly and share with E/DPD).	Increase billable hours (Face to face/on behalf) on each person served to potentially help them find employment in a timely manner.	CPM & E/DPA	October 1, 2023-June 30, 2024

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Increase number of persons served transferring to competitive employment.	Number of consumers gaining competitive employment	C-35's	Employment Supervisor	Employment Administrator	Four or more discharges annually due to competitive employment	Persons served in Supported Employment	2			1			1			0		

(Job Coaching)										

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	**Previous FY goal recommendations** (I.e., goal continuation and/or new action steps/plan): It was recommended to continue goal as written. **Did Actions taken accomplish intended results.** ☐ Yes ☐ No ☒ NA	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST) NA	**Completion Date** NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER** • 2 persons served discharged from services to competitive employment during the first quarter (SK & SB)	**2nd QUARTER** • 1 person served discharged from services to competitive employment during the second quarter (DE).	**3rd QUARTER** • 1 person served discharged from services to competitive employment during the third quarter (BS).	**4th QUARTER** • No persons served discharged from services to competitive employment during the fourth quarter.

Comparison of last year's results (21/22) to this year (22/23): During the 2021-2022 fiscal year there were 2 discharges into competitive employment. During the 2022-2023 fiscal year there were 4 discharges into competitive employment.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above Action Steps: NA	**Expected Outcomes** NA	**Person Responsible** NA	**Timeframe** NA

SERVICE ACCESS

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Increase number of persons served (Job Development & Job Coaching)	Number of approved new admissions for Job Development (20 persons served) and Job Coaching (20 persons served)	JD/JC Program Info Google Document	Employment Administrator	Employment Administrator	Approve admissions for a total of 40 persons (20 JD & 20 JC)	Supported Employment Program	JC= 3 JD= 2	JC= 1 JD= 5	JC= 2 JD= 1	JC= 1 JD= 1	JC= 0 JD= 3	JC= 2 JD= 4	JC= 4 JD= 3	JC= 0 JD= 4	JC= 4 JD= 4	JC= 1 JD= 5	JC= 0 JD= 2	JC= 0 JD= 1

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	**Previous FY goal recommendations** (I.e., goal continuation and/or new action steps/plan) It was recommended to continue goal as written. **Did Actions taken accomplish intended results.** ☐ Yes ☐ No ☒ NA	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST) NA	**Completion Date** NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2nd QUARTER	3rd QUARTER	4th QUARTER
	• There were 9 persons served who were approved and started job development services during the first quarter, all internal referrals (KC, MF, JM, MB, DC, HA, GB, & JM). There were 6 persons served who were approved and started job coaching services during the first quarter, all internal referrals (SH, EM, MN, MC, BG, & SS).	• There were 8 persons served who were approved and started job development services during the second quarter, 6 were internal referrals (AK, JL, MR, CM, HR, JG) and 2 went through admissions (CK, CB). There were 3 persons served who started job coaching services during the second quarter, 2 were internal referrals (CR, MF) and 1 went through admissions (AM).	• There were 8 persons served who were approved and started job development services during the third quarter, 7 were internal referrals (SS, SW, DS, DH, AF, PD, BC) and 1 went through admissions (AC) There were 8 persons served who were approved and started job coaching services during the third quarter, all were internal referrals (JG, JL, CM, DZ, GB, HR, AM, MR)	• There were 8 persons served who were approved to start job development services during the fourth quarter, 6 were internal referrals (PD, CC, DD, SS, LC, JL) and 2 went through admissions (PB, BH). There was 1 persons served who was approved to start job coaching services during the fourth quarter (DC) and was an internal referral.

Comparison of last year's results (21/22) to this year (22/23): During the 2021-2022 fiscal year there were 47 persons served admitted into the supported employment program, with 23 persons in job development and 23 people in job coaching. During the 2022-2023 fiscal year there were 53 persons served admitted into the supported employment program, with 35 persons in job development and 18 persons in job coaching. This goal was met by admitting over 40 persons served total for Supported Employment but did not get exactly 20 for Job Coaching specifically.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps: NA	NA	NA	NA

Experiences of Services and Other Feedback from Other Stakeholders

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Maintain or increase quality service relationships with employers (Job Coaching)	Score on Supported Employment survey to employers (target 6 per quarter)	Performance Survey Form- V-17	Employment Supervisor	Employment Administrator	Maintain or improve minimum satisfaction score of 2.75; optimal score of 2.9 (3-point scale).	Supported Employment persons served with jobs	2.82 N = 5 out of 6			2.91 N = 5 out of 6			3.0 N = 7 out of 7			3.0 N = 5 out of 6		

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan):	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	It was recommended to continue the goal as written. **Did Actions taken accomplish intended results.** ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2nd QUARTER	3rd QUARTER	4th QUARTER
	• There were 5 surveys completed during the first quarter. Jimmy John's stated "SM is doing a great job. Good fit for employer & SM. Ron (ETS) is easy to talk to & work with." The Wittern Group stated, "Employees provided have been consistent. "Heritage Building Maintenance stated, "We would like to see KP learn more tasks to become a more beneficial asset to the building he is working in. We would love to see him pick up more days if he is ready and able to do so and doing more than just dusting and vacuuming." ES followed up and noted how it was discussed with	• There were 5 surveys completed during the second quarter. Heart of Iowa stated, "Everything has been going very well and we enjoy having HA here." Paws and Pints stated "We have talked about MC waiting in the break room not in the lobby but it continues to be a problem. He also interrupts staff on the phone." The ES noted she has continued to have conversations with MC and his managers and job coaches continue to work with MC on these	• There were 7 surveys completed during the third quarter. HyVee in Pleasant Hill stated, "I can go to Link if I need assistance with my employee." Raygun stated "Everyone knows what we	• There were 5 surveys completed during the fourth quarter. Animal Lifeline stated, "HR is a pleasure to

	HR manager at Heritage that KP has limited mobility and strength and only able to do a select few tasks and is unable to take on more tasks/hours as a result.	concerns. Many Hands stated "Many Hands is thankful for the relationship we've developed with Link Associates! We enjoy working alongside both the staff and their clients."	expect and helps EG achieve her goals."	work with during her shift."

Comparison of last year's results (21/22) to this year (22/23): The average satisfaction score for fiscal year 2021-2022 was 2.98. During the 2022-2023 fiscal year the average satisfaction score was 2.93.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	**Expected Outcomes**	**Person Responsible**	**Timeframe**
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps: NA	NA	NA	NA

Primary Objective	**Indicators (Measures)**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**Who Applied to**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**
Improve parent/guardian satisfaction (Job Development & Job Coaching)	Score on satisfaction survey	Satisfaction survey	Case Managers/ Case Coordinators	Employment Administrator/ Supervisor	Maintain or improve minimum satisfaction score of 2.75; optimal score of 2.9 (3-point scale)	Parent/guardians of consumers in Supported Employment	JC = 3 N = 4 out of 10 JD = NA N = 0 out of 4			JC = 3 N = 4 out of 11 JD = NA N = 0 out of 0			JC = 2.92 N = 12 out of 16 JD = 2.95 N = 3 out of 6			JC = 2.86 N = 7 out of 12 JD = NA N = 0 out of 6		

Goal Outcome:	**Previous FY goal recommendations** (I.e. goal continuation and/or new action steps/plan):	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	**Completion Date**
☒ Goal Met ☐ Goal Not Met	It was recommended to continue this goal as written. **Did Actions taken accomplish intended results.** ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER**	**2nd QUARTER**	**3rd QUARTER**	**4th QUARTER**
	• There were no comments made related to employment services in the first quarter. No parents/guardians of persons served receiving job development chose to complete the survey this quarter.	• For Job Coaching MC's guardian stated, "Extremely happy with services." No parents/guardians of persons served receiving job development filled out a survey.	• There were no comments made to employment services in the third quarter.	• There were no comments made to employment services in the fourth quarter.

Comparison of last year's results (21/22) to this year (22/23): During the 2021-2022 fiscal year, the average parent/guardian satisfaction score was 2.94 (2.9 for job coaching and 3 for job development) During the 2022-2023 fiscal year the average parent/guardian satisfaction score was 2.95 for job development and 2.95 for job coaching for an overall average of 2.95. This goal was met.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	**Expected Outcomes**	**Person Responsible**	**Timeframe**
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below Action Steps: NA	NA	NA	NA

RESOURCES USED TO ACHIEVE RESULTS FOR THE PERSONS SERVED (EFFICIENCY)

Primary Objective	**Indicators (Measures)**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**Who Applied to**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**

Maintain cost of services to budget projections (Job Development & Job Coaching)	Monthly Budget Variance	Monthly financials	Employment Administrator	Employment Administrator	YTD cost of service will be at or lower than budgeted	Supported Employment Program	JC= 10,894 JD= (3,745)	JC= 3,357 JD= (6,050)	JC= (5,461) JD= (9,038)	JC= (14,495) JD= (9,894)	JC= (26,122) JD= (13,241)	JC= ($35,371) JD= ($16,141)	JC= ($44,203) JD= ($18,334)	JC= (44,501) JD= (19,105)	JC= (53,760) JD= (20,944)	JC= (52,321) JD= (22,118)	JC= (50,253) JD= (24,431)	JC= (67,851) JD= (26,568)

Goal Outcome:	**Previous FY goal recommendations** (I.e. goal continuation and/or new action steps/plan):	**Update on action step/plans and recommendations from last year** (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION LIST)	**Completion Date**
☐ Goal Met ☒ Goal Not Met	It was recommended to continue this goal as written. **Did Actions taken accomplish intended results.** ☐ Yes ☐ No ☐ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER**	**2nd QUARTER**	**3rd QUARTER**	**4th QUARTER**
	• Employment/Day Program Director reviewed monthly financials to ensure they were accurate. • During the first quarter the E/DPD reviewed the financials with EA and provided training on what to look for.	• EA reviewed monthly financials to ensure they were accurate.	• EA reviewed monthly financials & followed up on concerns.	• EA reviewed monthly financials to ensure they were accurate.

Comparison of last year's results (21/22) to this year (22/23): During the 2021-2022 fiscal year Job Coaching ended with a variance of (64,070) and Job Development with a variance of (26,306). During the 2022-2023 fiscal year Job Coaching ended with a variance of (67,851) and Job Development with a variance of (26,568).
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☒ YES ☐ No (if yes, please explain) They pandemic/economy continued to have an impact on the businesses person served worked at. There were some persons served who had hours cut due to supply chain issues, and others were being offered position quickly due to staffing shortages in all industries. Job Development and Job Coaching referrals were put on hold until January due to our own staff shortages, and while that happened, we continued to pay overtime costs to those who are willing to work additional hours with persons served we support in Supported Employment.

New Recommendations for Next Year (23/24):	**Expected Outcomes**	**Person Responsible**	**Timeframe**
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps: NA	NA	NA	NA

THERAPEUTIC RECREATION

Link Associates Program Evaluation
July 1, 2022 – June 30, 2023
Cristy Jennings, Outreach Director

As Outreach Director, I have reviewed the data gathered over the past year and all changes made within the Leisure Services program; now identified as Therapeutic Recreation Program (TR Program). This year the program maintained four goals; one measuring service access, two measuring experiences of services received and other feedback from persons served, and one measuring results achieved for persons served (effectiveness); and was successful in meeting four out of four goals.

In FY 22-23, we continued providing innovative programming options, in-person and virtual (limited once a week and facilitated by a Link VIP group), for both the Day Habilitation and Community programs. We also worked to develop new community partnerships and secure donations/grants. Some of the new partnerships established for the community program included Sundown Mountain, Banana Leaf Restaurant, Tormented Souls Haunt Park, Pots & Shots, Molly's Cupcakes, and Monsterama Arcade, Buff City Soap, Instructor Hailey Cole, Ruan (providing volunteers for programs), Sheffler Rock & Geode Mine, Black Cat Ice Cream, Blank Golf Course, and The Great Wolf Lodge in KC.

The TR Program provided a 5 week Water Walking Class at Cascade Falls Aquatic Center for a low impact exercise activity, they offered Celebrating You: A Guide to Self-Worth Group, a Halloween Outdoor Movie Night & Haunted Carnival, an Overnight Holiday Lock-in, a Glow Dance Party, a Music & Mindfulness 3 session series, a TikTok Dance Series, a S.T.O.P. Safety 2-part class, Horsin' Around 3 session series, a Music Trivia Night, a 14-week Healthy Living Program "Live Excellently", a Boot Camp challenge, Improvisational Movement class, Boxing 3-part series, Adventure Hiking Series and a Virtual Biking 2-part program funded by the American Legion of Iowa Foundation to purchase mini exercise bikes, and TV monitor system.

The extended club travel programs continue to be a hit with great participation and high demand. The group was able to take a great 4-day trip to Lake Geneva, WI; a 3-day weekend trip to Old Market in Omaha, NE; a memorable 8-day trip to San Antonio. TX; an exciting 3-day trip to Great Wolf Lodge in Kansas City, MO; and a thrilling 4-day trip to Wisconsin Dells. The new Adventures Day Camp program that was piloted in the June of 2021 to offset the decrease in UW funding continues to thrive and is offered 4 times per year. The overall number of participants in the TR Programs continues to climb and has increased from 661 last fiscal year to 921 this fiscal year.

The Therapeutic Recreation Supervisor engaged two Universities; offering opportunities for Therapeutic Recreation students to be involved. This continues to foster Link's Therapeutic Recreation Intern program and the relationship with the Universities.

The TR Program has been fully staffed with the budgeted Therapeutic Recreation Supervisor and 2 full time Therapeutic Recreation Specialists. The program was able to hire a part time TR Specialist with funding from a private donation and revenue from raising registration fees. TR interns and an On-Call TR Specialist continue to be utilized to fill any voids and maintain programming. This fiscal year there has been a total of 5 interns. The TR Program continues to be in high demand and there is a growing need to add more programming so more individuals can participate. The TR Program is seeking funding to add another Therapeutic Recreation Specialists to grow the program and meet more of the demand. The attempt was made with the UW funding and unfortunately was not successful. The Executive Director along with the Outreach Director, Assistant Outreach Director and TR Supervisor are reaching out to all three MCO's as another alternative for funding. This is currently in the works and right now the MCO's are listening.

The Volunteer program will continue to utilize as many volunteers as possible. Continued contact with current, past, and interested volunteers is maintained via email and monthly newsletter. The number of volunteers has been increasing since the pandemic, last year we had 250 and this year we have 342 volunteers.

The TR Program participated in the United Way investment process and has been notified of funding for the upcoming year, FY 23/24. The application was for the Health & Well-being element, which most aligns with TR's programming. UW continues to state donations are unpredictable and difficult to predict due to the post-pandemic and economy. Link's TR Program was awarded funding $43,000.00, a 20% decrease.

Donations and grants during the 2022-23 FY included $2,000 from Sam's Club for Track & Field and Swimming athletics, $1,400 from the American Legion for mini exercise bike program, more than $3,845 from Annual Appeal letter put towards programming/activities, registration fees, and expense for additional TR Specialist.

In the next fiscal year, the TR Program will continue to seek alternative options and new partnerships for new and existing programs, as well as look for additional avenues of funding. We will have a change in staff and will be looking for a new TR Specialist to fill a new vacancy. We have a strong and resourceful team! I have no doubt a great new staff will be found, and no programming will be jeopardized in the interim. I continue to be amazed and exceptionally proud of the TR staff, especially the Therapeutic Recreation Supervisor and the Assistant Outreach Director who oversees the TR Supervisor and supports the program. They lead with positivity, calmness, and support to the entire agency. They are committed to providing an exceptional program for those we support, despite any challenges that are thrown at them. This group continues to be a shining example of great teamwork!

Therapeutic Recreation Demographics

FY 2022-2023

FY 22-23	**1st Quarter Demographics**		**2nd Quarter Demographics**		**3rd Quarter Demographics**		**4th Quarter Demographics**	
Client Descriptors	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
GENDER								
Male	197	53%	202	54%	200	55%	211	55%
Female	169	46%	171	46%	164	45%	176	45%
AGE								
0-5 years old	0	0%	0	0%	0	0%	0	0%
6-13 years old	0	0%	0	0%	0	0%	0	0%
14-18 years old	2	<1%	2	<1%	0	0%	2	<1%
19-24 years old	73	20%	72	19%	67	18%	76	20%
25-34 years old	98	27%	99	26%	89	24%	99	26%
35-64 years old	183	50%	186	50%	191	52%	191	49%
65-74 years old	12	3%	13	3%	17	5%	18	5%
75 + years old	1	<1%	1	<1%	0	0	1	<1%
ETHNICITY								
Caucasian	295	80%	297	80%	290	80%	324	84%
African American	53	14%	54	14%	56	15%	63	16%
Asian	6	2%	6	2%	4	1%	6	2%
Hispanic	13	4%	13	3%	12	3%	14	4%
Native Indian/Alaskan	0	0%	0	0%	0	0%	0	0%
Native Hawaiian	1	<1%	1	<1%	1	<1%	1	<1%
Unknown	0	0%	0	0%	0	0%	3	<1%
Other	2	<1%	2	<1%	1	<1%	3	<1%
RESIDENCE								
Parents/Relative/Independent	195	53%	197	53%	191	54%	212	55%
Link Residential	32	9%	34	9%	33	9%	37	10%
Other HCBS	142	38%	142	38%	140	38%	138	36%
COUNTY OF LEGAL SETTLEMENT								
Polk	335	91%	337	90%	329	90%	342	88%
Warren	8	2%	9	2%	8	2%	10	3%
Dallas	24	7%	26	7%	24	7%	33	9%
Madison	0	0%	0	0%	0	0%	0	0%

Jasper	0	0%	0	0	1	<1%	1	<1%
Union	0	0%	0	0%	0	0%	0	0%
Story	2	<1%	1	<1%	2	<1%	1	<1%
PRIMARY DISABILITY								
Borderline (71-84)	19	5%	21	6%	22	6%	24	6%
ID/Mild (50-70)	162	44%	164	44%	153	42%	167	43%
ID/Moderate (35-49)	95	26%	97	26%	100	27%	102	26%
ID Severe (20-34)	31	8%	29	8%	29	8%	31	8%
ID/Profound (below 20)	2	<1%	2	<1%	1	0%	4	1%
Developmental Disability	39	8%	39	10%	32	9%	41	11%
Other	21	6%	21	6%	27	7%	33	9%
SECONDARY DISABILITY								
Autism	35	9%	37	10%	35	10%	41	11%
Cerebral Palsy	16	4%	16	4%	16	4%	19	5%
Visual Impairment	5	1%	6	2%	6	2%	8	2%
Hearing Impairment	2	<1%	2	<1%	2	1%	3	1
Seizure disorder	40	11%	40	11%	43	12%	45	12%
Physical Disability	28	8%	29	8%	25	7%	27	7%
Emotional/Behavioral	26	7%	27	7%	26	7%	28	7%
Wheelchair Assistance	16	4%	15	4%	14	4%	16	4%
Diagnosed MI	24	7%	26	7%	23	6%	25	6%
None Reported	126	34%	123	33%	131	36%	130	34%
Other	51	14%	52	14%	43	12%	45	12%

Therapeutic Recreation Measures of Achievement

Leisure Measures of Achievement 2022- 2023

EXPERIENCES OF SERVICES RECEIVED AND OTHER FEEDBACK FROM THE PERSONS SERVED																		
Primary Objective	Indicators (Measures)	Who Applied to	Data Source	Who Is responsible	Who Compiles	Target (Goal)	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve persons served life satisfaction	Score on Post-Program Survey	Leisure participants	Post-Program Survey	Leisure Specialists	Leisure Services Manager	To achieve 90% or greater on satisfaction survey	99%			98%			99%			98%		
Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Recommended to continue goal. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA			Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)													Completion Date NA	
ACTIONS TAKEN / CHANGES	**1st QUARTER**			**2ND QUARTER**			**3RD QUARTER**						**4TH QUARTER**					

MADE THROUGHOUT THE YEAR (22/23):	Leisure staff facilitate completion of survey with consumers after activities with exception to large events. Along with the survey, the Leisure staff complete weekly athlete spotlights with a survey and a feature on the social media accounts for Link Leisure Services. This is done weekly for a total of 12 done per quarter. This is exciting not only for the participants of leisure but also brings awareness to our Leisure page of family and friends of leisure participants.	Leisure staff facilitate completion of survey with consumers after activities with exception to large events. Along with the survey, the Leisure staff complete weekly athlete spotlights with a survey and a feature on the social media accounts for Link Leisure Services. This is done weekly for a total of 12 done per quarter. This is exciting not only for the participants of leisure but also brings awareness to our Leisure page of family and friends of leisure participants.	Leisure staff facilitate completion of survey with consumers after activities with exception to large events. Along with the survey, the Leisure staff complete weekly athlete spotlights with a survey and a feature on the social media accounts for Link Leisure Services. This is done weekly for a total of 12 done per quarter. This is exciting not only for the participants of leisure but also brings awareness to our Leisure page of family and friends of leisure participants.	Leisure staff facilitate completion of survey with consumers after activities with exception to large events. Along with the survey, the Leisure staff complete weekly athlete spotlights with a survey and a feature on the social media accounts for Link Leisure Services. This is done weekly for a total of 12 done per quarter. This is exciting not only for the participants of leisure but also brings awareness to our Leisure page of family and friends of leisure participants.

Comparison of last year's results (21/22) to this year (22/23): Results ranged between 98% - 99% in 21/22 and remained the same during 22/23. Exceeding goal expectancy for another year.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes	Person Responsible	Timeframe

Primary Objective	**Indicators (Measures)**	**Who Applied to**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**
Improve persons served life satisfaction	Number of completed Leisure Services Participant Surveys	Leisure participants & families	Leisure Services Participant Survey	Leisure Services Manager and Leisure Specialists	Leisure Services Manager	Obtain testimonials from 4 persons served over one year		1			1			1			1	

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	Recommended to continue goal. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA		NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER**	**2ND QUARTER**	**3rd QUARTER**	**4th QUARTER**
	Leisure Manager conducted participant survey to obtain testimonial.	Leisure Manager conducted participant survey to obtain testimonial.	Leisure Manager conducted participant survey to obtain testimonial.	Leisure Manager conducted participant survey to obtain testimonial.

Comparison of last year's results (21/22) to this year (22/23): Four (4) testimonials were provided in 21/22 and this year as well.
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes	Person Responsible	Timeframe
	NA	NA	NA

RESULTS ACHIEVED FOR THE PERSONS SERVED (EFFECTIVENESS)																		
Primary Objective	**Indicators (Measures)**	**Data Source**	**Who Is responsible**	**Who Compiles**	**Target (Goal)**	**Who Applied to**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**
Persons Served accessing social alternatives	Social isolation of Leisure participants	Leisure participants on the Leisure Times mailing list with 0-30 hours per week of support	Leisure Times mailing list and Leisure Registration	Leisure Services Manager and Leisure Specialists	Leisure Services Manager	An annual average of 43% of persons served (0-30 hrs./wk. of support) accessing Leisure Services	56%			57%			58%			59%		

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) It was recommended to continue goal. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	**1st QUARTER** Process 0-30 hrs. of support registrations first to ensure access to services.	**2ND QUARTER** Process 0-30 hrs. of support registrations first to ensure access to services.	**3RD QUARTER** Process 0-30 hrs. of support registrations first to ensure access to services.	**4TH QUARTER** Process 0-30 hrs. of support registrations first to ensure access to services.

Comparison of last year's results (21/22) to this year (22/23): In 21/22 the range was 56% to 58%, and in 22/23 the range was 56% to 59% of persons served with 0-30 hours per week of support are accessing TR services (not much of a change).
Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined below. Action Steps:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

SERVICE ACCESS																		
Primary Objective	Indicators (Measures)	Who Applied to	Data Source	Who Is responsible	Who Compiles	Target (Goal)	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Increase number of persons served	Number of new people served	All persons	LEISURE TIMES registration	Leisure Services Manager	Leisure Services Manager	Provide service for 20 new persons served. Over one year	16			6			10			9		

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) It was recommended to continue goal. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER Link's Leisure staff has maintained existing partnerships and continued to seek out new partnerships. This quarter Leisure has made new connections with Buff City Soap, Hailey Cole for CAC's including seed bombs and watercolors, and Ruan Volunteer Group. Existing partnerships include the following: Cascade Falls Swimming Pool, Warrior Run Golf Course, Clive Aquatic Center, Valley Community Center, MVP Sports, and Bowlerama.	2ND QUARTER Link's Leisure staff has maintained existing partnerships and continued to seek out new partnerships. This quarter Leisure has made new connections with Banana Leaf Restaurant, Tormented Souls Haunt Park, Pots & Shots, Molly's Cupcakes, and Monsterama Arcade. Existing Partnerships include Bowlerama, Valley Community Center, Glazed Expressions, Windstar Lines, MVP Sports, and Five Monkeys.	3RD QUARTER Link's Leisure staff has maintained existing partnerships and continued to seek out new partnerships. This quarter leisure has made new connections with Sun down Mountain skiing, Great Wolf Lodge. Existing partnerships include Special Olympics, B-Fit, Dowling, Krave Gym, MVP Sports, Civic Center, Title Boxing, Signature Nails, AR Workshop.	4TH QUARTER Link's Leisure staff has maintained existing partnerships and continued to seek out new partnerships. This quarter leisure has made new connections with Sheffler Rock & Geode Mine, Black Cat Ice Cream, Blank Golf Course, and Coopers Hawk Restaurant. Existing partnerships include Special Olympics, Urbandale Soccer Complex, Dowling High School, and Smash Park.

Comparison of last year's results (21/22) to this year (22/23): In 21/22 there were 35 new participants, and in 22/23 there has been an increase to 41 new participants. An increase of six people experiencing the true value of Therapeutic Recreation. Leisure Services changed its name to Therapeutic Recreation Programs (TR) in the 4th quarter to encompass the importance of recreation improving the quality of life for each participant.
Trends: ☒ YES ☐ No (if yes provide detail) Each quarter shows a steady increase in TR participation showing the importance of this program.
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps/Plan:	NA	NA	NA

SUPPLEMENTAL MEASURES OF ACHIEVEMENT
Link Associates Program Evaluation
July 1, 2022 – June 30, 2023

Measures of Achievement Supplemental Measures

SUPPLEMENTAL MEASURES OF ACHIEVEMENT 2022-2023																		
PERSONS SERVED SERVICES																		
Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve service documentation to meet IAC standards	Percent of records reviewed by Internal Review Committee whose documentation supports billing for services	Service Documentation	Chairs of Internal Review Committee	Chairs of Internal Review Committee	At least 95% of the required detail information is present in the service records (to bill)	Random samples generated by Internal Review Committee (up to 10% quarterly)		95.5%			100%			99.9%			99%	

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan) NA Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) 1st QUARTER. 2ND QUARTER 3RD QUARTER 4TH QUARTER	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter 37 – 15-minute units paid back in SCL when reviews showed persons served napping at time-of-service delivery. Training and follow up provided to supervisor and DSP involved	2nd Quarter Addressed departmental reviews and responses needed with leadership	3rd Quarter 2 units paid back out of 1334 due to no documentation in residential and VIP services that were not identified by supervisory staff prior to billing	4th Quarter 6 units paid back out of 569 due to no documentation in residential services that were not identified by supervisory staff prior to billing.

Comparison of last year's results (21/22) to this year (22/23): Last fiscal year the billing compliance average was 100% and for this fiscal year the average was 99% mostly attributed to residential services and incomplete and/or poor reviews by supervisory staff in that department.
Trends: ☒ YES ☐ No (if yes provide detail): See meeting minutes for additional details
Causes: ☐ YES ☒ non-Applicable (if you feel there were causes for this outcome, please explain)
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps: NA	Expected Outcomes NA	Person Responsible NA	Timeframe NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve medication administration.	Percent of doc omission errors and number of	PCC reports and Medication error records	Agency Nurse	Agency Nurse & Outreach Director	1. Reduce percent of documentation omission errors to 2.5% average annually.	All persons served medication errors recorded. Target 1: Target 2:	2.1% N=26	1.8% N=15	2.0% N=23	1.4% N=14	2.5% N=16	1.7% N=10	1.2% N=7	1.5% N=4	1.4% N=17	0.9% N=11	1.1% N=12	0.7 %

	medication errors	and tracking form			2. Reduce number of med errors reported in one year. New data counting individual meds effected, baseline year.													N= 32

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	Modify targets based on previous year performance and begin new baseline for target #2 Did Actions taken accomplish intended results. ☒ Yes ☐ No ☐ NA		8/1/22

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):

1st Quarter

Agency Nurse continues to run reports monthly for doc omissions and providing recognition & awards for sites with minimal doc omission errors.
Using PCC community messaging to educate / remind staff of proper procedures.

Med errors recorded were as follows:

	July '21	Aug '21	Sept '21
Total Med Errors	26	15	23
Wrong Person	0	11	0
Wrong Dose (wrong amount)	0	0	0
Wrong Med	0	0	0
Wrong Time	1	0	0
Missed Med	25	4	22
Other	0	0	1

2nd Quarter

Agency Nurse runs bi-monthly reports for doc omissions and informs Res. Supervisors for corrections to be made and provides recognition & awards for sites with minimal doc omission errors.
Using PCC community messaging to educate / remind staff of proper procedures.
Identified need for annual med manager review to be accessed via Relias, will work on updating training and transition to Relias.
Med errors recorded were as follows:

	Oct '21	Nov. '21	Dec '21
Total Med Errors	14	16	10
Wrong Person	0	0	0
Wrong Dose (wrong amount)	1	0	0
Wrong Med	0	1	0
Wrong Time	0	0	1
Missed Med	13	15	9
Other	0	0	0

3rd Quarter

Agency Nurse runs bi-monthly reports for doc omissions and informs Res. Supervisors for corrections to be made and provides recognition & awards for sites with minimal doc omission errors.
Using PCC community messaging to educate / remind staff of proper procedures.
Annual med manager review for Relias is complete and will be available in May through Relias.
As the agency transitions electronic documentation to SetWorks eMAR will also change and be run through SetWorks MedSupport. Outreach Director setting up meeting and trainings to learn the new system.

Med errors recorded were as follows:

	Jan '22	Feb '22	March '22
Total Med Errors	7	4	17
Wrong Person	0	0	0
Wrong Dose (wrong amount)	0	0	1
Wrong Med	0	0	3
Wrong Time	0	0	1
Missed Med	7	3	12
Other	0	1	0

4th Quarter

Agency Nurse runs bi-monthly reports for doc omissions and informs Res. Supervisors for corrections to be made and provides recognition & awards for sites with minimal doc omission errors.
Using PCC community messaging to educate / remind staff of proper procedures.
Transitioned annual med manager review to Relias. Continue to prepare for change in eMAR systems; scheduled trainings for supervisors and staff, set pilot homes to start July 12 & all others Aug. 1. Trainings will occur in June and July.

Med errors recorded were as follows:

	April '23	May '23	June '23
Total Med Errors	11	12	32
Wrong Person	0	0	0
Wrong Dose (wrong amount)	0	1	0
Wrong Med	0	0	0
Wrong Time	1	1	0
Missed Med	10	10	32
Other	0	0	0

Comparison of last year's results (21/22) to this year (22/23): In fiscal year 21/22 the target goal #1 averaged 3.3% annually. In the Target goal #2; Last year was a baseline year for collecting data from the MD-7 med incident reports as it excludes the doc omission errors. The total number of med errors reported at 117 (a monthly average of 9.8). For fiscal year 22/23 Target #1 averaged 1.5% annually of doc omission errors, well below the previous year and intended goal. Target #2 reports 187 med errors recorded (a monthly average of 15.6).

Trends: ☐ YES ☒ No (if yes provide detail)
Causes: ☒ YES ☐ non-Applicable (if you feel there were causes for this outcome, please explain) The agency nurse took great efforts and consistently gave updates on progress to supervisors. Also, motivated staff by monthly emails to all posting the homes that showed great documentation and no doc omissions.
Characteristics of persons served impact performance: ☐ YES ☒ No (if yes, please explain)
Other extenuating or influencing factors ☐ YES ☒ No (if yes, please explain)

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above Action Steps:	NA	NA	NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23

Improve Positive Behavioral Supports to Persons served	Number of incident reports N=7 fy 21-22	Incident Report from EDOC	PBS Committee Chair	PBS Committee Chair	Maintain or reduce the number of trend reviews per year	All persons served	3	4	3	2

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan): NA Action step: Did Actions taken accomplish intended results: ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) NA	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter Total Incident Reports: 176 Behavioral: 92 Medical: 62 Present during Police intervention: 1 Left Unsupervised: 0 Other: 21 Trends: There were 3 trend reviews involving 2 persons served. Causes of Trends Observed: 2 trend reviews were behavioral, and 1 trend review was medical this quarter. PBS Trend Review Summary: M.M. had 2 trend reviews this quarter. M.M. behavioral incidents were due to unexpected changes occurring during day program, at home, and with health services staff. M.M. was unable to make contact with staff immediately to answer his questions and concerns regarding the changes. E.S. had one trend review this quarter. E.S. medical trend was due to an increase in falls that occurred around the same time as a medication error. Areas for Improvement: Recommendation for M.M. was to seek out additional resources to help him cope with unexpected changes that may occur day to day and to evaluate his participation in day program. Recommendation for E.S. was to continue to monitor falls and ensure correct medication/dose is given.	2nd Quarter Total Incident Reports: 205 Behavioral: 130 Medical: 55 Present during Police intervention: 0 Left Unsupervised: 1 Other: 19 Trends: There were 4 trend reviews involving 3 persons served. Causes of Trends Observed: All trend reviews this quarter were behavioral. PBS Trend Review Summary: C.C. had 2 trend reviews this quarter. All incidents occurred in the community and were an attempt to or actual stealing of pop from individuals or locations within the community. M.C. had 1 trend review this quarter. Incidents occurred at day program as well as at home and in the community. M.C. behavioral incidents seem to occur when changes in the environment occur (loud noises, lots of talking by peers/staff, peers being redirected) or when staff are providing attention to other person served. M.R. had 1 trend review this quarter. M.R. behavioral incidents all occurred in his home. M.R. incidents occurred surrounding a variety of different things including start date for VIP being delayed, staff asking about soiled laundry in the bathroom, and feeling that he was being treated unfairly by staff. Areas for Improvement: Multiple interventions have been tried with C.C. to decrease the behavior of stealing pop when in the community. Recommendation for M.C. was for PBS Committee to conduct observations in day program, create a backpack for her to take with coping mechanisms (sensory items, stress balls, etc.), and allow occasional breaks from Day Program by having 1:1 staff at home. Recommendations for M.R. was to meet with ITABS, begin	3rd Quarter Total Incident Reports: 222 Behavioral: 108 Medical: 78 Present during Police intervention: 3 Left Unsupervised: 5 Other: 28 Trends: There were 3 trend reviews involving 3 persons served. Causes of Trends Observed: 2 trend reviews were behavioral, and 1 trend review was medical this quarter. PBS Trend Review Summary: M.R. had 1 trend review this quarter due to medical incidents related to falls, bruises after falls, vomiting, and complaint of body weakness. M.M had 1 trend review this quarter due to behavior at home and day program. D.T. had 1 trend review this quarter due to behavior that occurred at home. Areas for Improvement: Recommendation for M.R. was to see her doctor to address the frequent falls and complaint of body weakness. It was also recommended that staff monitor M.R. when walking and provide verbal prompts and reminders to watch where she is going and to watch for potential tripping hazards. Recommendation for M.M. was to add a 30-minute time limit for him to use coping skills and calm down when engaging in behavior at day program. It was also recommended that a follow up appointment/discussion occur with his psychiatrist due to the PRN medication seeming to be ineffective for escalations in behavior. It is recommended that M.M. continue with his weekly counseling sessions to continue to work on utilizing his coping skills, expressing how he feels, and continuing to work on	4th Quarter Total Incident Reports: 266 Behavioral: 129 Medical: 96 Present during Police intervention: 1 Left Unsupervised: 9 Other: 31 Trends: There were 2 trend reviews involving 2 persons served. Causes of Trends Observed: 1 trend review was behavioral, and 1 trend review was medical this quarter. PBS Trend Review Summary: C.C. had 1 trend review this quarter due to behavioral incidents that were related to refusing to take scheduled medications, verbal aggression, and non-compliance. T.E. had 1 trend review this quarter related to falls, complaint of pain, and refusal to follow staff directions or allow staff to provide assistance. Areas for Improvement: Recommendation for C.C. was for the team to complete the C60 and C61 due to a roommate moving out and a new roommate moving in. Once completed team/PBS committee will review and provide recommendations on further action. Recommendation for T.E. was to install longer bed rails on the bed and grab bars near the toilet in the bathroom. It was also recommended that the shower schedule be adjusted to help with behavioral concerns. The team plans to meet for annual meeting and with staff to review changes and ways to support T.E. Actions for Improvement: C.C. team is completing the C60 and C61s and will return when finished. Home dynamic changed with one roommate moving out and another moving in. Team would like to complete C60 and C61 after new roommate has had some time to settle in to get the most accurate assessment of the environment and behavior occurring. The team would also like to monitor

	Actions for Improvement: M.M. was suspended from his day program for 30 days. During this time, additional supports/resources were utilized to assist M.M. with behavioral challenges. Additional training will be provided to day program staff working with M.M. E.S. will be monitored for falls and report any falls or concerns to immediate supervisor. Supervisor will ensure correct medication is received from the pharmacy. Implementation of Actions Taken: M.M- Medication was prescribed by psychiatrist. M.M. is being referred to a new counselor. Training was provided to day program staff and support staff on how to work with M.M. and assist with behavioral needs. E.S.- Medication error was resolved (there was an issue with the pharmacy), and no additional medication issues have occurred since. Staff have continued to monitor E.S for falls and assist him when walking. E.S. has attended physical therapy to gain strength and be able to get up on his own after a fall. E.S. also got new shoes and staff assist with making sure they are tied correctly to prevent slipping when walking. Prevention of Recurrence/Training Needed: Training was provided to Day Program staff prior to M.M. returning to Day Program on how to best support him when behavioral challenges arise. Day Program staff/supervisor continued to take ABC data to look at strategies that are most effective when M.M is escalated. Follow up on actions taken previous quarter. (Did actions accomplish intended result): Yes, staff continue to monitor and document in notes of concern for incontinence for T.H. and actions taken	attending VIP (M/W/F), and add a second staff in the home when possible. Actions for Improvement: C.C. was given his 3-strike notice on 10/13/22. His team is looking for other residential placement options at this time. The team continues to support C.C. and handle stealing incidents when they occur. M.R. has been given a 30-day notice and is looking for other living arrangements at this time. M.R. began attending VIP 3 days a week to get him out of the house and active in the community. A second staff will be at the home to provide more opportunities for M.R. to get out into the community and alleviate some of the frustrations that occur due to being bored at home. M.R. also had a med change (discontinued PRN for behavior). PBS Committee will conduct observations in the day program for M.C. for further insight into her behavior. Implementation of Actions Taken: C.C. team continue to look for other placement options at this time. The search for another placement is ongoing at this time. M.R. Case Coordinator has begun looking for other living arrangements. This has helped since M.R. has been unhappy in his current home since he moved in. Case Coordinator has created social stories for M.C., implemented ABC data collection, emotion cards, and regularly scheduled breaks during the day when attending Day Program. Observations in day program will occur between 1.18.23-2.1.23. Prevention of Recurrence/Training Needed: Training has been provided to all staff working with M.C. at home and day program to ensure procedures are implemented correctly across all environments. ABC data collection continues to occur to assist with further intervention if needed. Additional staff are scheduled to work at the home to provide additional support to M.C. on certain days. M.R. team continues to look for placement options. M.R. continues to attend VIP to decrease being bored at home during the day. Staff have been trained on de-escalation techniques and preventative strategies. C.C. team continues to look for other placement options. Observations were conducted with C.C. and his staff and training/feedback was provided on ways to best support him in the community and how to intervene if/when stealing occurs. Follow up on actions taken previous quarter (did actions accomplish intended result) Yes, E.S. has not had any	emotional regulation. Recommendations for D.T. were that her team will complete the C60 & C61 forms and then discuss outcomes and additional resources or actions needed to best support D.T. It was also recommended that D.T. increase the number of days she attends Day Program. Actions for Improvement: M.R. was taken to see her doctor and was diagnosed with a UTI. Staff need to ensure M.R. is wearing her brace daily and help with getting it on and making sure it is worn correctly. M.M. is trialing the 30-minute time limit at day program when engaging in behavior His team will meet on 4/26/23 and discuss the effectiveness of the time limit and add to his BIP if successful. M.M's appointment with psychiatrist was moved up from 5/16/23 to 4/20/2023 discuss the medication effectiveness and recent increase in behavior. M.M. Will continue with weekly counseling appointments. D.T.'s team will complete C60 & C61 forms by 5/19/23. Case Coordinator reached out to Day Program provider for additional days of attendance for D.T. Implementation of Actions Taken: M.R. was prescribed medication for her UTI and the medical issue has resolved. Staff continue to monitor falls and provide support to M.R. with her brace as well as verbal prompts and reminders to watch for tripping hazards and be aware of where she is walking. M.M. refused to attend his appointment on 4/20/23 and was hospitalized at that time. Prevention of Recurrence/Training Needed: Continue to monitor and document falls for M.R. Staff know how to assist M.R. with her brace and ensure she wears it daily. M.M. was discharged from services effective 4/20/2023 and continued to be hospitalized until alternative placement can be found. Follow up on actions taken previous quarter. (Did actions accomplish intended result): C.C. continues to engage in stealing pop when in the community. C.C.'s stealing behavior has not resulted in any further trend reviews at this time. C.C. team continues to look for alternate placement/living arrangements. M.C. has not had any further trend reviews and the team continues to monitor behavior and look for preventative and intervention strategies. Providing additional staff and breaks throughout the	number of absences from day program and the use of the PRN medication and effects on behavior. Longer bed rails were installed for T.E. to allow him to be able to get out of bed on his own but prevent his legs from hanging over/sliding out of bed onto the floor. Grab bars were installed near the toilet for T.E. to grab onto when using the restroom. Shower schedule was adjusted at the home to decrease behavioral challenges surrounding showers/hygiene. Implementation of Actions Taken: C.C. began seeing counselor every 2 weeks instead of monthly to address the increase in agitation and refusal of scheduled medications. Meeting with SCL staff occurred to review the BIP that is currently in place, administration of the PRN medication, de-escalation strategies, and coping skills. T.E. team met to discuss recent concerns and addressed concerns at the annual staffing. Team then met with SCL staff to go over changes in shower schedule and ways to best support T.E. to reduce the number of incidents. T.E. was also seen earlier in the month and was treated for a UTI that was contributing the complaint of pain. Prevention of Recurrence/Training Needed: Continue to monitor and document medication refusals by C.C. Training/review of BIP provided to staff on 6.15.2023 in the home. Reviewed BIP, CCSP (indicators, triggers, coping skills), administration of PRN medication, and de-escalation strategies. Team will follow up with the PBS committee once C60 and C61s are completed for further recommendations. Continue to monitor and document falls and complaint of pain for T.E. Review of information/changes was completed at annual staffing 6.28.23 and with staff at house meeting end of June. Follow up on actions taken previous quarter. (Did actions accomplish intended result): M.M. was discharged from services effective 4/20/23 – No additional information to report. M.R. medical issues were resolved. Staff continue to monitor for falls and assist M.R. with correctly wearing her brace. M.R. requires support from staff to watch for tripping hazards and be aware of her surroundings. D.T's team met with the PBS Committee to discuss ways to best support D.T. when engaging in behavior. D.T. increased the number of days she attends day program, and it is reported that this is going well at this time. The team continues to meet as needed to best

	for B.S. have improved behavior surrounding medications.	reported falls since the past trend review. M.M. has had an improvement in his behavior, reflected by a decrease in incidents. The team also reported that how staff are responding when M.M. does get upset is working and he is able to deescalate quickly.	day have helped to decrease instances of behavior. M.R. has not had any behavioral incidents since his team has been looking for other living arrangements and he has been attending VIP.	support D.T. and has developed a behavior intervention plan. Psychiatrist also added a PRN medication for agitation to assist with challenging behaviors and instances of increased agitation and aggression. PBS committee members have been assigned to provide observation and recommendations for further behavioral support for D.T.

Comparison of last year's results (21/22) to this year (22/23): In fiscal year 2021 – 2022 fiscal year, there were a total of 7 trend reviews completed. For fiscal year 2022-2023, there were a total of 12 trend reviews completed. See Agency Program Policy #17 – Persons served Incident Reports for the written description of internal and external reporting requirements.

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☐ Continue as written ☐ Discontinue Goal ☒ Continue Goal with modifications as outlined above Action Steps: The PBS committee members will bring information to monthly PBS meetings if a team is experiencing any struggles in supporting a person served. The committee will discuss and provide some suggestions/ideas to better support the am and person served, also evaluate DSPs at PS site attending C3 De-escalation training.	Decrease the number of trend reviews	PBS Chair & Co-Chair	June 2024

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
To improve agency services	Number of appeals and grievances	Appeals and Grievance Records	Program Director(s)	Corporate Operations Director	No more than two appeals and/or grievances per year	All persons served and family	0			0			0			0		

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☒ Goal Met ☐ Goal Not Met	NA Action step: NA Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	1st QUARTER. 2ND QUARTER 3RD QUARTER 4TH QUARTER	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	No concerns reported	No concerns reported	No concerns reported	No concerns reported

Comparison of last year's results (21/22) to this year (22/23): In 2021/2022 there were no appeals or grievances initiated by persons served and/or stakeholders and in 2022/2023 we did not experience any appeals or grievances from any stakeholders.

Trends identified: None

Areas needing performance improvement: None

Actions to be taken: None – Continue current practices which include - Upon admission to Link services and annually thereafter, persons served, and family members are provided with the current Handbook for Persons Served, Legal Representatives, Advocates, and Family Members. This handbook contains specific information on appeals and grievances and reinforces that our goal is to help persons served benefit from the services we provide and that we strive to work together to eliminate all causes of complaints. Further assurance is provided that complaints will not result in barriers to services or that any retaliatory actions will occur.

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps: NA	NA	NA	NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/

																		23
To improve treatment of persons served	1.Number and reasons for mandatory abuse reports made 2. Abuse reports and critical incident reports reported timely as defined by IAC	Data from completed M-18's	Program Director(s)	Corporate Operations Director	1.No more than one founded abuse report on Link Associates employees per year 2. All reports completed timely	All persons served and family	1 3 of 3			0 3 of 3			1 6 of 6			1 7 of 7		

Goal Outcome:	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☐ Goal Met ☒ Goal Not Met	NA Action step: NA Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	1st QUARTER. 2ND QUARTER 3RD QUARTER 4TH QUARTER	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	3 reports were submitted this quarter, and all were reported timely to DHS with critical incident reports completed. 1 founded report involved staff member determined to have committed personal degradation in SCL services who had been immediately suspended and terminated upon conclusion of the investigation. 1 report was made regarding a person served family member (unfounded) and 1 report made for an employee not reporting to work site and person served left unsupervised in SCL that was not accepted by DHS but none the less was addressed by Link.	3 reports were submitted this quarter, and all were timely reported. All reports were unfounded; 1 was submitted for a serious fall of a person served and 1 was for a person served not having staff in violation of their alone time which were unfounded. 1 report was made regarding concerns expressed about a person's served family that was also unfounded.	5 of 6 reports made by Link Associates were unfounded. 4 of which were not accepted for evaluation by DHS that related to various instances of violations of agency established alone time periods while one was investigated for by DHS for alleged staff conduct that was unfounded by DHS as well as Link Associates investigation. 1 founded report related to willful failure to provide adequate supervision as determined by Link Associates and resulted in timely discharge from employment.	6 of 7 reports made by Link Associates were unfounded. 1 was not accepted for evaluation by DHS (alone time), 1 was a report made on a family member, 2 were due to Link transportation dropping off persons served without verifying staff presence (alone time). 2 were deemed inaccurate reports by persons served by DHS. 1 founded report related to failure to provide adequate supervision by Link Associates and resulted in immediate discharge of the employee prior to DHS beginning their investigation.

Comparison of last year's results (21/22) to this year (22/23): These records have been kept electronically for review and target goals were added in 2022/2023. In 2022/2023 all 19 reports made by Link Associates were processed timely in accordance with IAC and 2 of the 3 founded reports by DHS directly related to failure to provide assigned supervision as directed by Link which resulted in immediate termination of the employees involved. Trending of the year reveals that 10 of the 19 reports were associated with persons served alone time violations while 3 were reported on persons served family members.

New Recommendations for Next Year (23/24):	Expected Outcomes	Person Responsible	Timeframe
☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps: Department Directors will systematically ensure they are reminding their employees of their responsibilities related to persons served alone time.	Decreasing the number of reports/investigations and improving services provided	Fleet/Facility, Residential, and Day/Employment Directors	On-going

PERSONNEL

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/

																		23
To improve employee satisfaction	Scores on Employee Satisfaction Survey	Employee Satisfaction Survey	Executive Director	Executive Director	To obtain an average score of 75% or higher agreement with survey statements.	All employees	80.33%											

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) NA Action step: NA Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST) 1st QUARTER. 2ND QUARTER 3RD QUARTER 4TH QUARTER	Completion Date NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter

Comparison of last year's results (21/22) to this year (22/23): In 2021/2022 the overall rate of employee satisfaction was 73.37% and in year 2022/2023 this raised to 80.33%. In this fiscal year, Link received the highest scores in the past seven years on: In the last month I have received recognition or praise for doing good work, my fellow employees are committed to doing quality work, I have a good friend at work, in the last six months, someone at work has talk to me about my progress, in the last year, I have had opportunities at work to learn and grow and overall I am satisfied with my employment experiences at Link Associates.

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps:	Expected Outcomes Staff satisfaction will be equal to or higher than 80.33%	Person Responsible Linda Dunshee, Executive Director	Timeframe Fiscal year 2023/2024

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve Staff qualifications	Personnel File Audit Report results	Personnel Files 1. Goal # 1 will include all new hires 2. Goal #2 will be all employees upon annual anniversary dates	HR Administrator (Targets 1&2.a) QA Administrator (Target 2.b.)	HR Administrator (Targets 1&2.a) QA Administrator (Target 2.b.)	1. All new hires will contain 100% of required components (Background checks) 2.Current employment files will have 95% compliance for a) annual review timelines b) required trainings	All Employees Target 1:	100%			100%			83%			83%		
						Target 2a:	63%			75%			81%			80%		
						Target 2b:	98%			91%			88%			93%		

<table>
<tr><td>Goal Outcome:
☐ Goal Met
☒ Goal Not Met</td><td colspan="2">Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)
NA
Action step: NA

Did Actions taken accomplish intended results.
☐ Yes ☐ No ☒ NA</td><td colspan="2">Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)
1st QUARTER.
2ND QUARTER
3RD QUARTER
4TH QUARTER</td><td>Completion Date

NA</td></tr>
<tr><td>ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):</td><td>1st QUARTER
• Target 2.a - 29 of 46 annual evaluations due were done timely. Several were done 2 – 10 days late while two were found to be over a year past due even after monthly notifications are provided. This concern shared again to the department director for corrective action. Residential was only @ 56% or 11 of 25 annual evaluations due were done timely. All other Department except Transportation were at 100% including other bigger departments like Employment – Day Program and Case Management. HR Administrator attended the Residential Department meeting on 10/4/22 to encourage the supervisor to make evals a priority and ensure they are timely. At that time, they were at 46%. HR Administrator shared with Employment / Day Program Director that Employment and Day Programs were 100% for the quarter on both 90 Day and Annual Evals. Employment / Day Program Director is sharing the results with her team during a supervisor / administrator meeting on 11/15/22.
• Target 2.b. - 1 employee did not complete 2 of her annual trainings on time but did complete within 11 days of the due date.</td><td>2nd Quarter
• Target 2.a – 33 of 44 annual evaluations were completed timely and 11 were not completed timely. Three were completed one – two days late, two were completed one- two months late, four are not completed and currently more than one month past due, one is more than three months past due and Executive Directors is done and the end / beginning of the fiscal year. All departments except Residential and Supported Employment / Day Program were in compliance. Residential accounted for 90% (9) of the late annual evals and Supported Employment / Day Program accounted for 10% (1). The HR Administrator will be providing specific details including the employee, supervisor and due date of all late and past due annual evals with the Residential Director and the Employment Day Program Director. All departments were at 100% for 90-day evals. Residential had 32% of their annual evals that were either late or still past due.
• Target 2.b – 5 employees did not have all their annual trainings due on time. 2 employees have yet to complete mandatory reporter (M.A. due date of 10.23.22, A.K. due date of 12.16.22 (met with training manager on 1.12.23 to re-set up mandatory reporter)), 2 employees have yet to complete medication manager review (I.D. due date of 12.26.22 and K.G. due date of 12.16.22), and 1 employee has yet to complete CPR (K.G. due date of 12.17.22). One employee did not complete 2 of his annual trainings on time but did complete within 26 days of the due date for CPR and within 5 days of the due date for medication manager review.</td><td>3rd Quarter
• Target 1 – 5 of 6 files complete, HR Administrator is following up with one employee to have him resign a new Med Administration Policy form that is not in his file.
• Target 2.a – 35 of 43 annual evaluations were completed timely and 8 were not completed timely. Residential accounted for 62.5% (5) of the late annual evals, Supported Employment / Day Program accounted for 25% (2) of the late annual evals and Fleet and Facilities accounted for 12.5% (1) of the late annual evals. Two were completed less than one week late, one was completed two weeks late, three were more than 43 days late, two are still incomplete one the two is over 55 days late and the other one the employee is on a PLA. There is on 90 Day eval past due in Residential and it is over 45 days past due.
• Target 2.b – 5 employees did not have all their annual trainings due on time. 2 employees have yet to complete Mandatory Reporter (A.N. due 3.17.23 and J.D. due 3.20.23), 2 employees have yet to complete Rights of Individuals with IDD (D.G. due 3.30.23 and J.A. due 3.8.23), 2 employees have yet to complete Infection Control (D.G. due 3.30.23 and J.A. due 3.10.23), 2 employees have yet to complete Guidelines for Documentation in IDD (D.G. due 3.30.23 and J.A. due 3.9.23), 2 employees have yet to complete Fire Safety (D.G. due 3.30.23 and J.A. due 3.11.23), 2 employees have yet to complete Hazardous Chemicals (D.G. due 3.30.23 and J.A. due 3.11.23). One employee did not complete 1 of their trainings on time but did complete within 5 days of the due date for CPR (A.T. due 1.7.23 completed 1.12.23). Another employee did not complete 5 of their trainings on time, but did complete within 5 days of the due date for CPR (due 2.18.23 completed 2.23.23), within 39 days of the due date for Rights of Individuals with IDD (due 1.20.23 completed 2.28.23), within 34 days of the due date for Guidelines of Documentation with IDD (due 1.20.23 completed 2.23.23), within 35 days of the due date for Hazardous Chemicals (due 1.20.23 completed 2.24.23), and within 34 days of the due date for Infection Control (due 1.20.23 completed 2.23.23).</td><td>4th Quarter
• Target 1 - 10 of 12 files were complete, HR Administrator is following up with two employees that do not have the proper education records in their file.
• Target 2a 43 of 54 were completed timely. 11 of the annual evals were not done timely. 1 past due from CM, 4 from EDP and 6 from Residential. There are still 3 annual evals that have not been issued yet and the evals that were not completed timely range from 43 days past sue to 129 days past due
• Target 2.b – 4 employees did not have all their annual trainings due on time. 2 employees have yet to complete Mandatory Reporter (L.N. due 6.1.23 and S.F. due 7.3.23), 2 employees have yet to complete Hazardous Chemicals (G.D. due 7.1.23 and N.A. due 7.20.23), 2 employees have yet to complete Rights of Individuals with IDD (G.D. due 7.1.23 and NA. due 7.16.23), 2 employees have yet to complete Infection Control (G.D. due 7.20.23 and N.A. due 7.16.23), 1 employee has yet to complete Fire Safety (G.D. due 7.1.23) and 1 employee has yet to complete Guidelines for Documentation in IDD (N.A. due 7.20.23).</td></tr>
<tr><td colspan="5">Comparison of last year's results (21/22) to this year (22/23): Target 1: In 21/22 this average was 80% and in 22/23 the average was 91.5%. Target 2a: In 21/22 this average was 49% and in 22/23 the average was 75%. 2b: In 21/22 this average was 79% and in 22/23 this average was 92.5%.</td></tr>
<tr><td colspan="3">New Recommendations for Next Year (23/24):</td><td>Expected Outcomes</td><td>Person Responsible | Timeframe</td></tr>
</table>

☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps: 2a: HR Administrator will run weekly reports and email Program Department Administrators and Directors with a list of annual performance evaluations that are rapidly due and/or past due and still within the 30-day grace period. HR Administrator will also recommend to upper management that Link continues to use the condensed evaluation form for DSPs performance evaluation and also recommend that a section is added to the evaluation forms for all supervisors to capture whether or not all evaluations for their staff were completed in a timely manner. 2b: The training Managers will include the Department Director and Administrators on the Monday training report email. This will help give them an awareness of who has upcoming trainings and who is past due in a timelier manner.	2a: Evaluations to be completed within 30 days of staff's anniversary date. 2b: All annual trainings to be completed by due date	2a: HR Administrator 2b: Training Managers	2a: June 2024 2b: June 2024

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve knowledge of grievance and appeal process	Files demonstrate that the agency appeals, and grievance process was provided annually	Review of Case File and completion of Quality Assurance Checklist 100% sample for CM and 25% sample for PM, scores on CM-01. Reviewed Annually	CM Director	CM Director	100% of files demonstrated that the agency appeals, and grievance process was provided to persons served at least annually	Those served in Case Management (CM) & Program Management (PM))	CM records in compliance = 6/6, 100% PM records in compliance =11/12, 92%			CM records in compliance = 6/6, 100% PM records in compliance = 12/12, 100%			CM records in compliance = 4/4, 100% PM records in compliance =11/11, 100%			CM records in compliance =N/A PM records in compliance =11/11, 100%		

Goal Outcome:	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan)	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date
☐ Goal Met ☒ Goal Not Met	Continue goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	NA	NA

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER	2nd Quarter	3rd Quarter	4th Quarter
	Met goal	Met goal	Met goal	No data reported for CM as 100% of files were reviewed by 3/23 of the fiscal year. Met goal for PM.

Comparison of last year's results (21/22) to this year (22/23): In FY 21/22, the program did not meet the goal, with CM having 95% compliance (one of six files missing, one file missing acknowledgement, now corrected, and PM meeting 100%, with a combined total of 75/76 files compliant, or 99% compliancy. In 2022/2023 the program did not meet the goal with CM having 100% compliance and PM averaging 98%.

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps:	Expected Outcomes	Person Responsible	Timeframe
	NA	NA	NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve advocacy of persons served rights	Rights restrictions have due process	Review of Case File and completion of Quality Assurance Checklist 100% sample for CM and 20% sample for PM, scores on CM-01.	Quality Assurance Committee	Case Management Director	95% or higher compliancy (blended score) by ensuring that all components of rights that are restricted are in place before the implementation of a restriction and ensuring quarterly reviews are	All Case Management Individuals, Case Management (CM) & Program	CM = 27/27, 100% PM = 35/40, 88%			CM = 28/28, 100% PM = 33/44, 75%			CM = 5/5, 100% PM =37/38, 97%			CM = N/A PM = 42/42, 100%		

					conducted for all restrictions identified	Management (PM)					

Goal Outcome: ☐ Goal Met ☒ Goal Not Met	Previous FY goal recommendations (I.e., goal continuation and/or new action steps/plan) Continue goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER Goal met for CM. Goal not met for PM. Discussed goal with QA lead, Laurie Harris, and this was discussed with the Case Coordinator.	2nd Quarter Goal met for CM. Goal not met for PM. Discussed goal with QA lead, Laurie Harris, and this was discussed with the Case Coordinator. Three files had a total of five rights restrictions that were missing components from three files. Missing components included a missing statement that the restriction would cause undue harm, one missing the statement that the restriction would be reviewed annually in the CCSP, and one file was missing the quarterly review of all rights restrictions noted on the log. Will be discussed at our next team meeting, 2/18/23.	3rd Quarter Goal met for CM. Goal met for PM.	4th Quarter No data reported for CM as 100% of files were reviewed by 3/23 of the fiscal year. Met goal for PM.

Comparison of last year's results (21/22) to this year (22/23): In FY 21-22 both programs met the annual target with the blended score of 96%. Rights restrictions are all reviewed quarterly for continued need by the CM/PM, which was a new component resulting from an HCBS review. Staff are prompted quarterly to do the review, and it is working well. In FY 22-23 the blended score was 92%.

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above. Action Steps:	Expected Outcomes NA	Person Responsible NA	Timeframe NA

Primary Objective	Indicators (Measures)	Data Source	Who Is responsible	Who Compiles	Target (Goal)	Who Applied to	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23
Improve quality of persons served service plans	Persons served individual plans identify health and safety needs.	Review of Case File and completion of Quality Assurance Checklist 100% sample for CM and 20% sample for PM, scores on CM-01. Reviewed Annually	Quality Assurance Committee	Case Management Director	Persons served individual plans identify health and safety needs. 100% of the plans will comprehensively identify health and safety needs of the individual served.	All Case Management Individuals, Case Management (CM) & Program Management (PM)	CM = 6/6, 100% PM = 12/12, 100%			CM = 6/6, 100% PM = 12/12, 100%			CM = 4/4, 100% PM = 11/11, 100%			CM = N/A PM = 11/11, 100%		

Goal Outcome: ☒ Goal Met ☐ Goal Not Met	Previous FY goal recommendations (I.e. goal continuation and/or new action steps/plan) Continue goal as written. Did Actions taken accomplish intended results. ☐ Yes ☐ No ☒ NA	Update on action step/plans and recommendations from last year (REPEAT FOR EACH ACTION STEP/PLAN or RECOMMMENDATION. LIST)	Completion Date

ACTIONS TAKEN / CHANGES MADE THROUGHOUT THE YEAR (22/23):	1st QUARTER Goal met	2nd Quarter Goal met	3rd Quarter Goal met	4th Quarter No data reported for CM as 100% of files were reviewed by 3/23 of the fiscal year. Met goal for PM.

Comparison of last year's results (21/22) to this year (22/23): In FY 21-22, both programs met the target goal of 100% and this was also achieved for FY 22-23 at 100%.

New Recommendations for Next Year (23/24): ☒ Continue as written ☐ Discontinue Goal ☐ Continue Goal with modifications as outlined above.	Expected Outcomes NA	Person Responsible NA	Timeframe NA

Action Steps:			