2013-2014 Link Associates Program Evaluation

A snapshot of FY 2013/2014

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EXECUTIVE SNAPSHOT

SUMMARY AND RECOMMENDATIONS

This Executive Summary is designed to provide a high-level overview of the data gathered. This summary is short and can "stand alone", however all data and details are in the following sections for reference and deeper review.

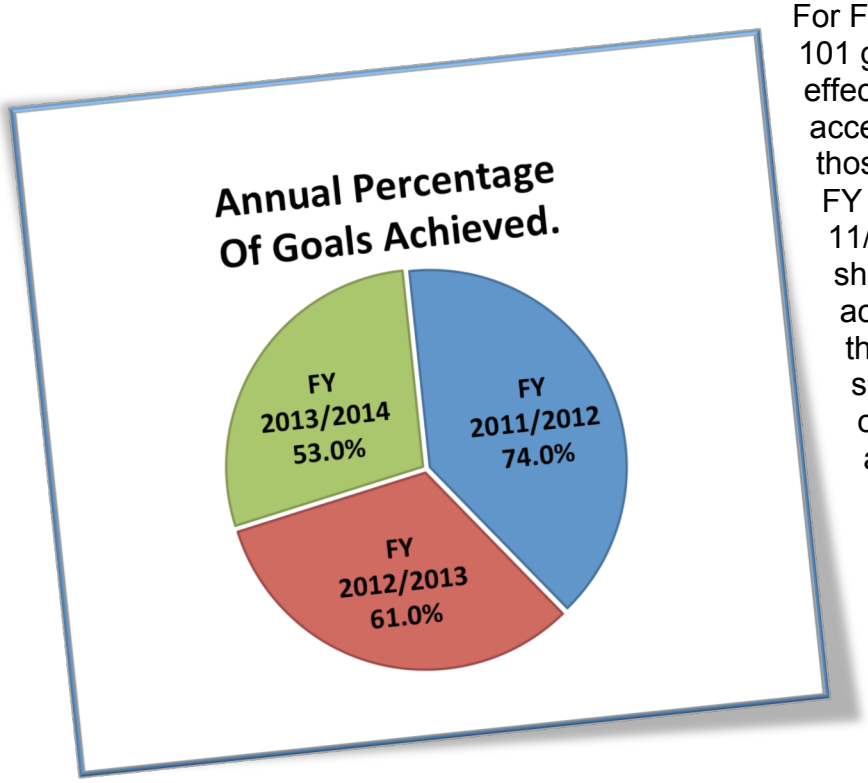
- The purpose of the evaluation:
  Link Associates' Program Evaluation is a systematic methods to assess the design and implementation of all programs, services and supports. Specific purposes include:
  - Evaluation of program effectiveness for all stakeholders
  - Improve the implementation ineffectiveness of programs and service delivery
  - Ensure effective management resources
  - Document program accomplishments
  - Satisfy ethical responsibilities to stakeholders
  - Evaluate successful methods as well as necessary remediations

This summary will offer you:

- The Executive Director's summary of the contents
- Success highlights
- Focus areas for the next Fiscal Year

The goals established were aggressive and demonstrate our desire to challenge ourselves to move progressively forward in the intense and increasingly complex service delivery system. Our Vision Statement is "*Link Associates will be the recognized leader in providing quality services to persons with intellectual disabilities.*" It is only through the establishment of aggressive goals we will continue to drive this vision forward to achieve our mission, "*Providing persons with intellectual disabilities opportunities to achieve their personal goals*".

Goals Achieved



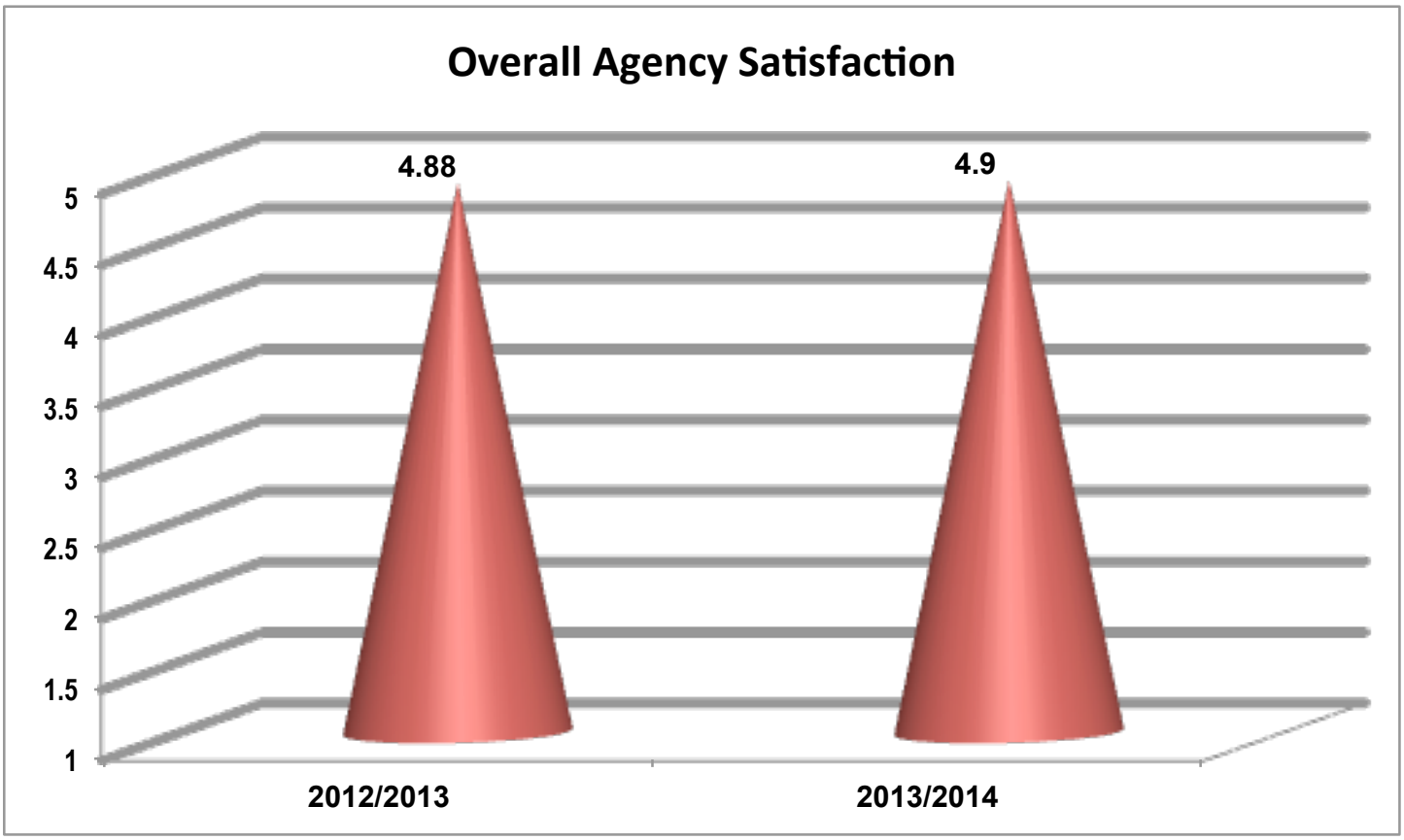
For FY 13/14, Link Associates established 101 goals to measure the efficiency, effectiveness, satisfaction and service access of all programs/services offered. Of those 101 goals we met 54, or 53.04%. In FY 12/13 we accomplished 61.61% and in 11/12 74% of established goals. This year shows a slight decrease in percentage achieved. Because we continue to raise the bar and set higher standards, this slight decrease does reflect a lessening of performance, instead a more aggressive set of objectives. I remain extremely impressed with the dedication of staff and commitment of the Board of Directors to ensure we are continually engaged in making progress.

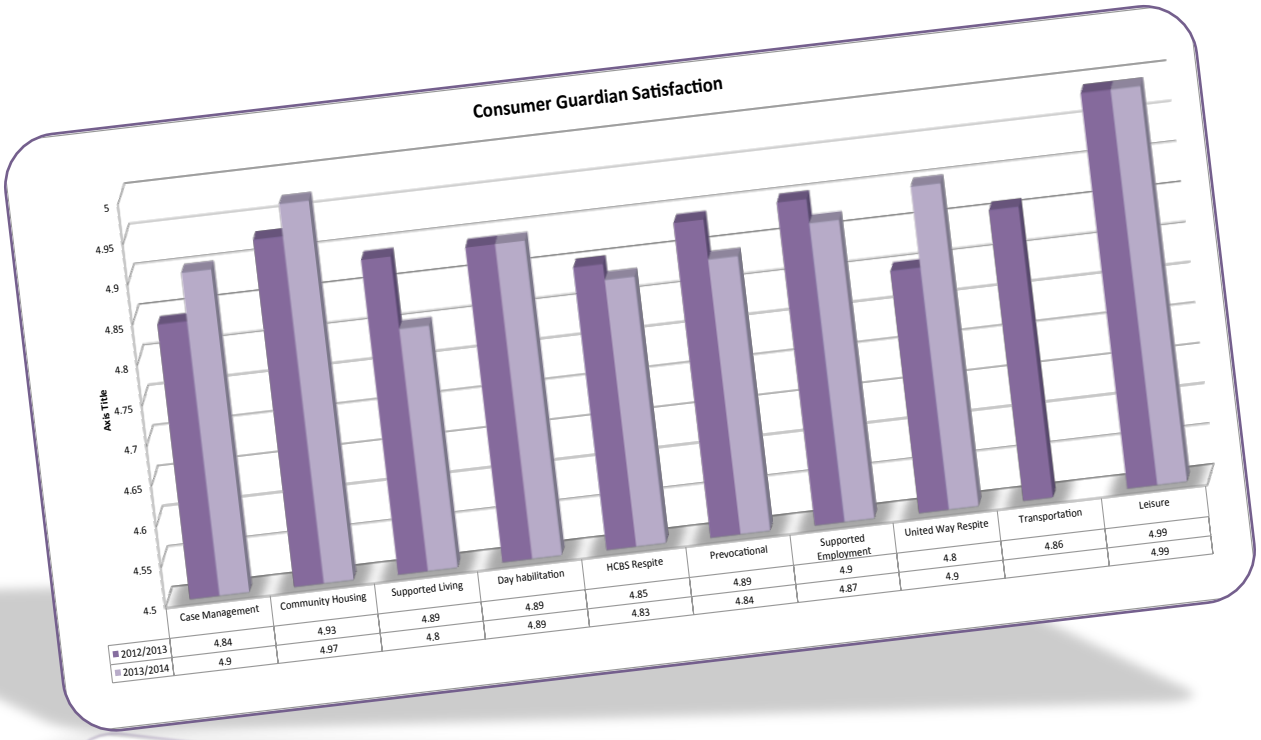
Organizational Satisfaction

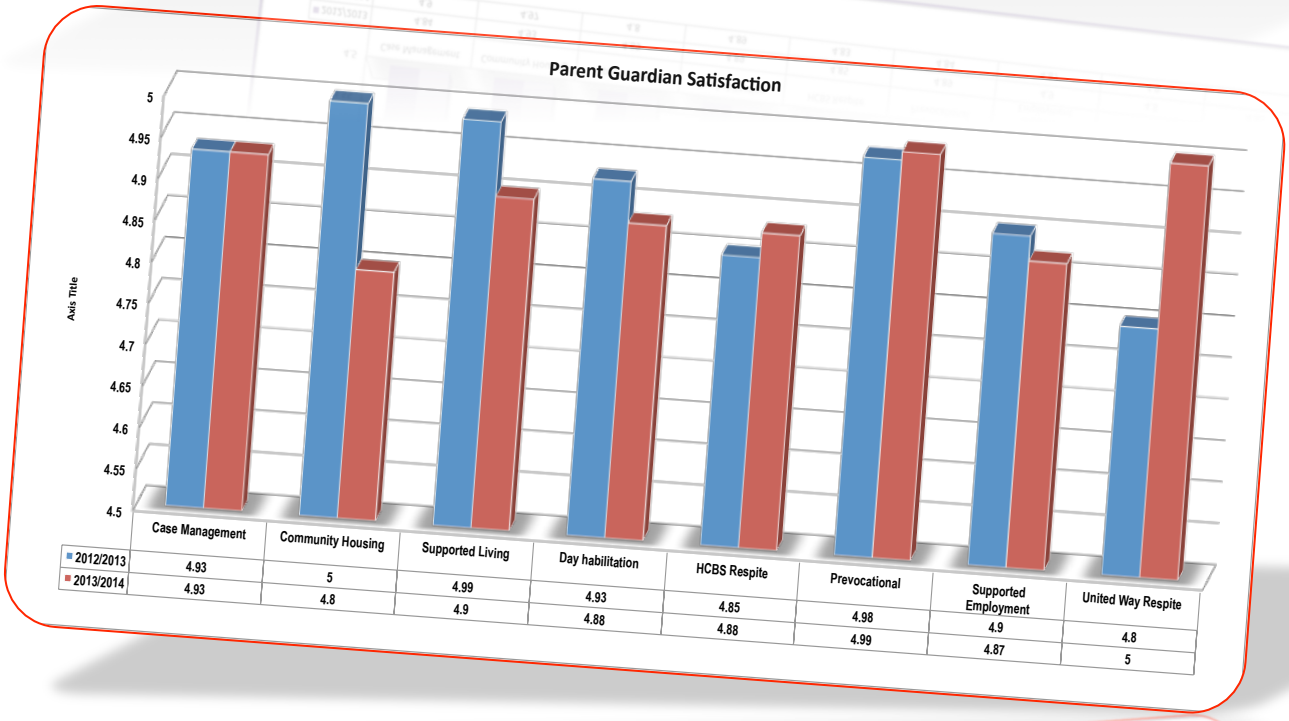
No indicator is more important than the satisfaction of the persons served, and that of their families who count on Link to provide for their care, safety, and security. Surveying our stakeholders regularly is a critical part of running our organization. Surveys measure satisfaction, or dissatisfaction, and either way the data is essential for futures planning. The process of gathering satisfaction information from all stakeholders offers an opportunity to effectively communicate and build truly personal relationships. We take both praise and criticism to heart in order to fulfill the true needs of those served and we respect the feedback from all stakeholders. Link Associates exists to make a difference in the lives of the persons served and obtaining satisfaction from a variety of perspectives gives us a well rounded picture of areas for improvement. Listening and learning will help improve our practices, which translate into better service provision and happier stakeholders. For FY 13/14 we again achieved amazing satisfaction outcomes averaging 4.9 on a scale of 1:5 agency-wide. This compared to a 4.88 from FY 2012/2013.

Breaking out the components:

- FY 2013/2014 consumers average satisfaction score-4.90 compared to FY 12/13 at 4.88.
- FY 2013/2014 the parent/guardian satisfaction for was 4.9 compared to FY 12/13 at 4.92
- FY 2013/2014 provider/employer average was 4.64 compared to FY 2012/2013 at 4.73.




Consumer Guardian Satisfaction
Axis Title
5
4.95
4.9
4.85
4.8
4.75
4.7
4.65
4.6
4.55
4.5
Case Management
Community Housing
Supported Living
Day habilitation
HCBS Respite
Prevocational
Supported Employment
United Way Respite
Transportation
Leisure
2012/2013
4.84
4.93
4.89
4.89
4.85
4.89
4.9
4.8
4.86
4.99
2013/2014
4.9
4.97
4.8
4.89
4.83
4.84
4.87
4.9
4.99

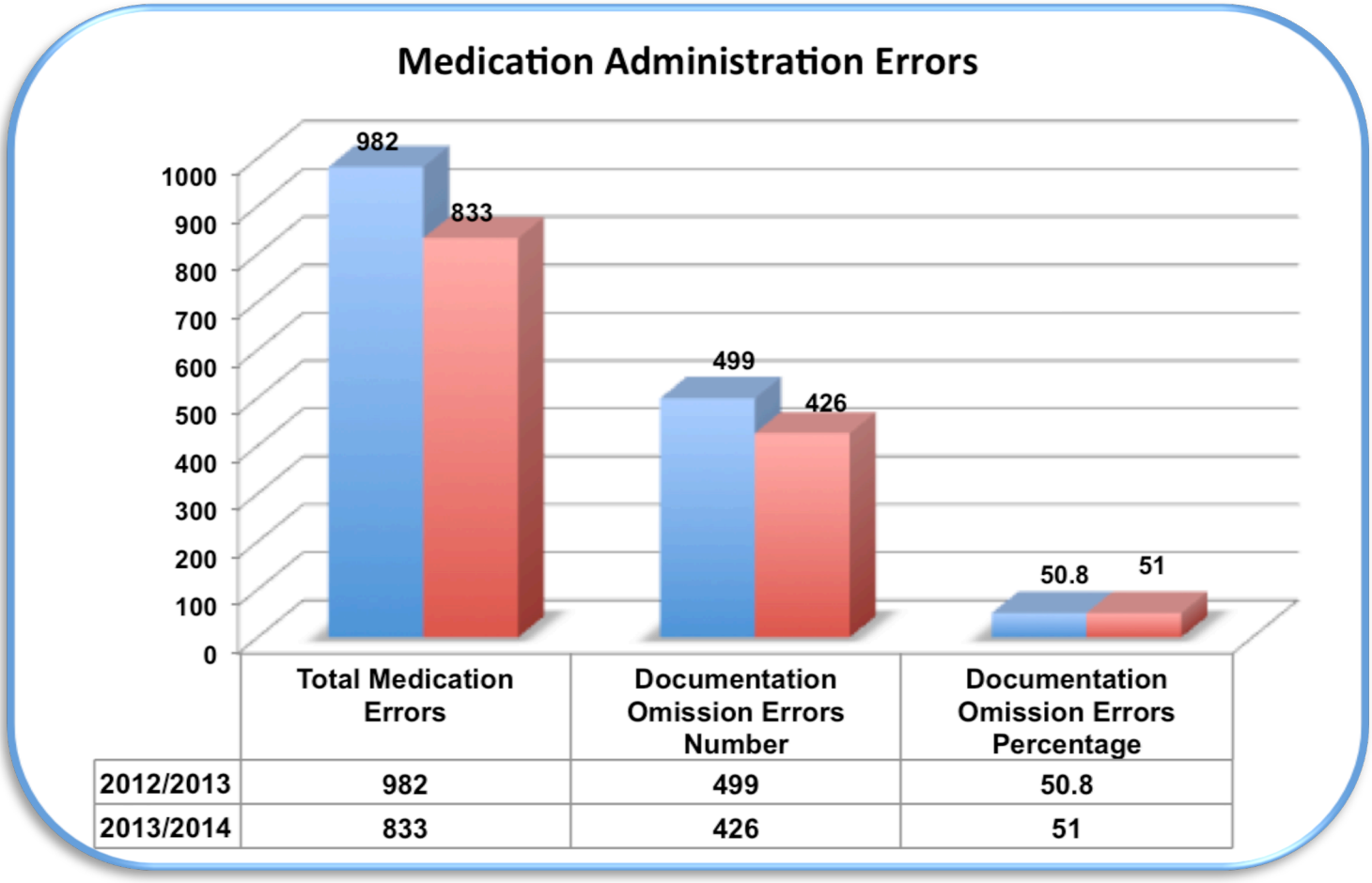

Parent Guardian Satisfaction
Axis Title
5
4.95
4.9
4.85
4.8
4.75
4.7
4.65
4.6
4.55
4.5
Case Management
Community Housing
Supported Living
Day habilitation
HCBS Respite
Prevocational
Supported Employment
United Way Respite
2012/2013
4.93
5
4.99
4.93
4.85
4.98
4.9
4.8
2013/2014
4.93
4.8
4.9
4.88
4.88
4.99
4.87
5

Medication Errors

The number and impact of medication errors has been a concern for both board and staff. Last year we discussed the evaluation of utilizing electronic Medical Administration Records (MAR). Unfortunately, the pharmacy we were contracted with last year does not have access to a electronic medical records. On October 1, 2014 we will begin utilizing a new pharmaceutical service and the evaluation of alternatives to their MAR's continues.

Link Associates considers any error to the following 7 rights of medication administration a medication error. These 7 rights include; right patient, right medication, right dose, right route, right time, right documentation, right day and date.

In this fiscal year link Associates experienced 833 medication errors, 426 of those were errors in documentation. The total number of errors is down from 982 in the last fiscal year. Documentation omissions (staff failed to complete documentation) accounted for 51% of all medication errors. Throughout the fiscal year 6 medication errors resulted in the need to contact a the physician.



	Total Medication Errors	Documentation Omission Errors Number	Documentation Omission Errors Percentage
2012/2013	982	499	50.8
2013/2014	833	426	51

Goals Not Met

Program specific goals are part of the concept of continuing professional development and service excellence. They are a means to identify areas of potential growth and addressing unmet goals is a continual process we will work on throughout the lifetime of Link Associates. The goals listed below were short of meeting expectations.

As you will see in the reviews, many standards are set incredibly high, like satisfaction scores. Despite the fact the scores are near perfect, these are goals we need to maintain to conduct an overarching program evaluation of efficiency, effectiveness, satisfaction and service access.

As we evaluate the unmet goals listed below, we evaluate:

1. Have we set the expectation too high?
2. Is the goal necessary?
3. What did this year's data show us about the goal?
4. What strategies for dealing with unforeseeable contingencies were identified?

Summary of Goals Not Met

Case Management	Average number of contacts made on behalf of the consumer
Community Housing	YTD cost of service will be at or lower than budgeted Reach and maintain maximum occupancy Improve the delivery of services to new admissions to no more than 10 days Improve parent satisfaction Improve consumer satisfaction with where they live Improve quality of service score Improve consumers quality-of-life average score 98% or higher
Day Habilitation	Improve consumer satisfaction – maintain or improve satisfaction score of 4.9 Maintain or improve parents satisfaction score
Pre Vocational	Maintain cost of services to budget projections Maintain or increase the number of new/existing contracts Increase time spent on paid work opportunities Improved consumer satisfaction Maintain or improve employer satisfaction
Supported Employment	Decreased amount of time waiting for job placement YTD cost of service at or lower than budgeted Maintain or increase number of hours worked weekly Maintain or improve employer satisfaction Maintain or improve consumer satisfaction Maintain or improve parent/guardian satisfaction Approved admissions for 20 persons
Supported Living	Maximize service utilization Increase independence of consumers Maintain or improve consumer satisfaction Improve parent/guardian satisfaction Improve consumer satisfaction with where they live Improve quality of service

	Increased number of consumers served – hourly Decrease number of FTE openings
Transportation/Safety	Maintain or improve number of work-related injuries for employees from previous year Have a vehicle accident rating of 7.0 or lower for accidents resulting in damage to only Link owned vehicles Operate agency vehicles with cash flow surplus Total evacuation time of 10 minutes with roll call being taken Average of 85% riders for all bus routes
Improve Employee Satisfaction	Obtain average score of 3.6. On a scale of 1:4 or higher
Improve Medication Administration	Reduce the number of errors requiring medical professional notification and action to one or less per year Reduce the number of documentation of omission errors to 15% or less in one year.
Positive Behavioral Support	Maintain or reduce the number of duplicate incident trends
Improve Service Documentation	All in NODs are present and contain 95% of required information
Improve Staff Qualifications	All new hires will contain 100% required components
Improve Quality Of Service	Have 95% compliance by ensuring all components of great restrictions are in place before implementation of restriction 100% of files that have a Q a review demonstrate agency appeal and grievance were provided to consumers annually
Improve Stakeholder Satisfaction	Obtained a mean score of 3.7 or higher (4.0 scale)

Change Recommendations

CASE MANAGEMENT

- Goal: Thirty-three percent of records are reviewed per year using the Quality Assurance process. It was recommended to changing the goal to 30% of records reviewed.
- Goal: 80% of goals reviewed via the Quality Assurance process will show progress toward meeting the individual's goal, it was recommended to increase the goal to 85%.
- Goal: Intake meetings will occur will occur within 10 business days of first contact 75% of the time, recommended to increase target to 80% of all meetings.

COMMUNITY HOUSING

- Goal: YTD cost of service will be at or lower than budgeted it is recommended to maintain goal only now reference to only include Highland Park Group Home.
- Goal: Improve delivery of service to new admissions to start within 10 days, it is recommend data only reflects situations where Link was responsible for the delay.

DAY HABILITATION

- Goal: Hold in at least 30 scheduled events per month, it is recommended to change the goal to hold a minimum of 35 scheduled events each month.
- Goal: To serve clientele to no less then 123 FTE it is recommended change goal to read serve clientele no less than 126 FTE.
  Goal: Maintain 93% of admissions to new referrals, it is recommended to change the goal to 95% of all admissions.

PRE-VOCATIONAL

- Goal: Maintain less than a .5% spoilage rate, it is recommended to change the gold to read maintain less than .3% spoilage rate.
- Goal: Maintain one or less documentation error per month, it is recommend to change the goal to read maintain less than one documentation error per month which affect billing.

SUPPORTED EMPLOYMENT

- Goal: To have two or more discharges annually due to competitive employment, it is recommended to change the goal to three or more discharges annually due to competitive employment.

TRANSPORTATION

- Goal: Total evacuation time of 10 minutes with roll call being taken, it is recommend to change the goal to total evacuation of the administrative offices with a time of 10 minutes or less.
- Goal: Average of 85% ridership for all bus routes it is recommend to changed the goal to read average of 75% ridership for bus route.
- Goal: Improve ridership satisfaction it is recommendation disseminate writer satisfaction survey yearly for Link bus routes.

POSITIVE BEHAVIORAL SUPPORT

- Goal: To maintain or reduce the number of duplicate incident trends it is recommended to change goal to reducing the number of consumers who have three or more trend reviews in a year

ADMINISTRATIVE STAFF QUALIFICATIONS

- Goal: All new hires will contain 100% of required components it is recommended to increase the goal percentage to 95%

Definitions

- **Comparison of Results/Action Steps Taken:** *(compare this year's actual results to the identified goals and the summary of last year, if it is a continuing goal)*
- **E-*Doc*** *– Documentation software used to record consumer programs, progress and goals.*
- **Expected Outcome:**
- **FTC –** *Full Time Consumer*
- **New Recommendations/Action Steps:** *xpected outcomes below)*
- **Person Responsible:** *(Job title)*
- **Timeframe for completion:**
- **Update on Previous Recommendations** *(recommendation from last year, update on steps taken to improve/monitor impact of the remediation/actions from previous year, including ones made in Administrative/Board Feedback)*
- **Update on Previous Action Steps** *(action step recommendations from last years.)*

Executive Director Recommendations

I have read the following report in depth. I support all recommendations made by the department directors for each service and in addition recommend evaluating additional leisure opportunities during the day. More potential participants are employed in the evenings and on weekends leaving them little or no opportunities to participate in activities.

Board of Directors Feedback

Various committees of the Board of Directors reviewed specific sections as it related to their area of responsibility. Their comments and feedback are listed below.

Building and Grounds:

a. Building and Grounds Committee is in agreement with the Program Committee that some goals may be set at an impossible level and the establishment of minimally accepted rates would be better.
b. Staff training was listed as a concern – must address those issues.

Personnel Committee:

a. Following the review of the Employee Satisfaction results the Personnel Committee asked for a summary of how departments will address the feedback. This information was presented to the committee and is included in the Strategic Plan.

Program Committee:

a. The committee discussed the fact that our goals are set incredibly high, resulting in a lesser number of goals achieved. This could give a reviewer who does not do an in depth study the impressions that we are not doing well. It was suggested we consider using goals that define the lowest acceptable standard and ensure and set the goal to meet or exceed that standard.
b. There was discussion on the community housing report and why so many of their goals were not achieved. We need to add the definition of community housing and supported living so readers know the difference. The item addressed in #2 above was the reason their achievement of goals was low

Measures of Achievement Section

Link Associates continually collects data from a variety of internal and external sources. These data and the results are used to make informed decisions about the needs of those we serve and other stakeholders as well as the business needs of Link Associates.

In this section you will find service delivery objectives, performance indicators, and performance targets. Service delivery performance indicators at a minimum include indicators for effectiveness of services, efficiency of services, service access, and satisfaction with service delivery from a variety of perspectives including the persons served.

The administration of Link Associates has reviewed and is presenting these reports to the Board of Directors for review and analysis of results. Information learned will be translated into focused actions to improve performance against targets.

The evaluation drives Link Associates to engage in a dynamic, proactive process to review, renew, or revise its strategy and tactics, while ensuring alignment of our organizational purpose, service and business practices, and organizational resources.

CASE MANAGEMENT MEASURE OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014
JOAN OSBORN, CASE MANAGEMENT DIRECTOR

ADMINISTRATIVE FEEDBACK

9 Goals
8 MET
1 NOT MET

The review of the data outlined below speaks loudly to the quality of service and oversight demonstrated by the Case Management Department. Despite the fact that the mental health redesign changed the numbers of possible consumers coming into Polk County the department experienced considerable growth over the year, currently serving 445 people. With a goal to do a file review on 33% of all files they actually completed 100% of all files. Consumer goal progress was at an all time high with 86% of all making progress on their individually identified goals. Although the goal of making 3.5 contacts/person/month was not met I believe the outcome was exceptional. The state requires 1/person/month and Link Case Management averaged 3.14/person/month. Satisfaction of people served, their families and other providers remained very high this year. Case Management has worked with a team to rewrite the questions for the next year and the focus will be on how the services feel to the person. I concur with the programmatic recommendations found in the data section of this narrative.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Meet needs of community through expansion, and maximize time available to Case Managers

Goal # 1 - Increase number of persons served by 20/year

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue the goal to increase the number of persons served by 20/year.

Update on Previous Action Steps

N/A

Current Status of Action Step and completion date:

N/A

* **Comparison of Results/Action Steps Taken:**

FY 13-14 results show that the program increased the number of persons served by assigning 56 individuals into case management. It should be noted that due to the mental health redesign as counties elect to accept referrals for case management within the county proper the pool of applicants was significantly reduced from the previous years 85 referrals. In order to determine program growth, discharges are also factored in. The program discharged 36 individuals for a net growth of 20, meeting our goal of increasing the number served by 20. As expected as part of the mental health redesign we transferred 11 people to other counties where they reside, which brought our two-year total of those discharged to other counties to 36 people. It can be assumed that the agency would have continued to serve most of these people had the residency rule not been implemented in the State of Iowa. The program is currently serving 445 children and adults. A typical process in the budget planning includes that the program director evaluates referrals, caseload sizes, quality of service, and staff feedback to ensure that a high quality of service is delivered alongside expansion.

New Recommendations/Action Steps:

It is recommended to continue the goal to increase the number of persons served by 20/year.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  N/A
  Expected Outcome:
* N/A

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Comply with state standards and policy regarding Quality Assurance

Goal # 1. Thirty-three percent of records are reviewed per year using the Quality Assurance process.

MET / NOT MET

Update on Previous Recommendations

Previous recommendations were to continue goal with revisions due to growth in program. The recommended goal is to QA 33% of the individual files. Included in the audit process is a billing review of 100% of all case files served as of July 2014.

Update on Previous Action Steps

N/A

Action Step: N/A

Current Status of Action Step and completion date:
N/A

* **Comparison of Results/Action Steps Taken:**
  The percentage of file reviews that received a quality assurance review was met at 33% this fiscal year with 141 of 428 individual files reviewed. Meeting the sample percentage challenged the program as the number of individuals served grows and the sample percentage gets larger and staff resources remain the same; however the goal percentage was obtained and provided a sufficient reflection of the QA findings.
  The Quality Assurance Administrator is responsible for completing the QA process on 33% of the pulled 33% sample; however the program faced new definitions of billing for administrative duties and in response reduced the percentage of QA reviews completely solely by the QA Administrator to 30% to reduce indirect costs. The agency receives quarterly file reviews from County Case Management Services, our Case Management Technical Assistance entity. CCMS thoroughly reads a sample of Case Manager's files and provides feedback and training individually to staff. Historically, the agency has not included the percentage of files that CCMS competes in our goal results. During the last quarter of this fiscal year the county CM Directors agreed that utilizing CCMS reviews as part of our QA process would be appropriate, which helped the agency reach the goal of thirty-three percent. Administrative staff feels that the 33% sample is not a realistic on-going sample and recommends the sample be reduced to 30%.
  The QA Administrator will continue to identify training trends by reviewing a large part of the annual reviews, making suggestions for individual and team training and targeting training topics for monthly meetings.

New Recommendations/Action Steps:

It was recommended to change goal to thirty percent of records are reviewed per year using the Quality Assurance process.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:**
  NA
  Expected Outcome:
* NA

OBJECTIVE Achievement of consumers identified goals

Goal # 2. 80% of goals reviewed via the Quality Assurance process will show progress toward meeting the individual's goal.

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue the goal of 80% of goals reviewed via the Quality Assurance process, will show progress toward meeting the individual's goal.

Action Step #1: N/A

Current Status of Action Step and completion date:
N/A

* **Comparison of Results/Action Steps Taken:**
  The agency has set high expectations for goal progress and values this program evaluation measure. This goal has been a part of the agencies program evaluation for many years and remains to be a prime indicator to staff regarding our person centered planning process. Quality assurance reviews are completed 9 of 12 months per year by trained staff. The department also employs a Quality Assurance Administrator who reviewed 33% of all records per year to aid in consistent reviews and to identify trends for training. Administrative Feedback following the last program evaluation indicated that the goal should continue as written with at least 80% of files reviewed demonstrating goal progress. Previous years scores have been 78% in 2011, 81% in 2012, and 84% in 2013. This fiscal year we met this goal with a score of 86%. This measure is critical in evaluating if the people we serve are directing their service by identifying their own goals. Goal planning is an on-going process and should not be seen as a one time a year event. Annually, teams do meet to develop goals for the upcoming year and this is seen as the start of this process. Frequently, through follow-up and monitoring of goal progress it is determined that the person has changed their focus and so must the goals change. It is essential that the person served, not the staff, choose the goals identified. When there is a lack of input by the person served the investment in reaching the goal will be hindered. The first through fourth quarter reporting periods reflected scores of: 88%, 84%, 85%, and 78% respectively, with an overall average of 86%.

New Recommendations/Action Steps

It is recommended to increase goal to 85% of goals reviewed via the Quality Assurance process will show progress toward meeting the individual's goal.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:**
  NA
  Expected Outcome:
* NA

OBJECTIVE Maintain consumer contact

Goal # 3. The average number of contacts made on behalf of the consumer = 3.50 or higher per month.

MET / **NOT MET**

Update on Previous Recommendations

It was recommended to change the number of contacts made on behalf of the consumer to 3.50 from 3.75. Data for the last three years suggests that the targets we have set, 3.75 or higher is unattainable for a program this size. It was recommended that the average number of contacts made on behalf of the person served goal be revised to equaling 3.50 or higher per month.

Action Step #1: N/A

Current Status of Action Step and completion date:

N/A

* **Comparison of Results/Action Steps Taken:**

A definition of a contact ranges from a single progress note that details contact with the person served or another team member. A contact may be a face to face meeting or a collateral phone call; however in order for a contact to be billable the discussion of goal progress must have taken place and be documented, and must be included as one of these monthly contacts. The purpose of this measure is to determine how often the case manager is working on behalf of the person served, not whether there is a billable contact. This data is collected monthly and averaged for the year for the final result. FY 13-14, the program did not meet the goal of an average of 3.50 contacts, per month for each person served. The programs average for 13-14 is 3.14, which is the third year in a row that the program did not meet the goal set for contacts. During the last twelve months, the lowest monthly average was 2.86 and the highest was 3.31.

In the previous program evaluation years, the program achieved an average of 3.20 for FY 12-13, 3.47 in FY 11-12, 3.70 for FY 10-11.

Similar to last program evaluation year, it is important to note that the program experienced significant system changes over the past year, which required time away from direct contacts to complete projects assigned by the county and state. The program also experienced a significant increase in personal leave time, which creates caseload coverage needs that impact the results of this goal. It is expected that when staff resources are minimized, the ability to make increased contacts be minimized as well. Nevertheless, the program has a satisfactory performance in this outcome area, beyond the score, by providing the person's served with a high number of contacts on their behalf each month, as state minimum is one collateral contact per month and one face to face contact per quarter.

New Recommendations/Action Steps:

It was recommended to continue the goal.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  N/A

Expected Outcome:

* N/A

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Improve Consumer Satisfaction.

Goal # 1. Maintain or improve a satisfaction score of 4.5 (5 point scale)

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue goal as written to maintain or improve satisfaction score of 4.5 (5 point scale); however examine tool for next FY for revisions and updating.

Update on Previous Action Steps

Action Step #1: Meet with staff and Department Directors as needed to seek input into updating the survey tool.

Current Status of Action Step and completion date:

The language used in the tool had not been updated in recent years. Although the tool is functional to its purpose, it is expected that updated terms will assist the consumer/guardian in providing meaningful feedback. A committee was formed and new survey questions were developed that refreshed the tool and focused from solely satisfaction to gaging how one "feels" about services. The tool was approved by program directors and will be implemented July 2014, in the next fiscal year.

* **Comparison of Results/Action Steps Taken:**

Each person served, guardian, or parent of a minor child who cannot fill out the form independently, is asked to complete a survey annually to provide the agency with information regarding the case management service provided to them throughout the year. The "Listen to Me" survey measures 20 quality of life statements covering the areas of safety, leisure, community living, work, transportation, and overall satisfaction with services. The form varies in language for an adult and a child.

For adult satisfaction with services, 274 surveys were recorded this fiscal year. The first through fourth quarter reporting periods reflected scores of: 4.9, 4.8, 4.8, and 4.9 respectively, with an overall average of 4.9.

For child satisfaction with services, 20 surveys were recorded this fiscal year. The first through fourth quarter reporting periods reflected scores of: 4.6, 4.7, 4.8, and 4.8 respectively, with an overall average of 4.8. In comparison to the previous fiscal year, results for adult satisfaction with services were reported at 4.87 and child satisfaction with services at 4.82. Scores from year to year are high and relatively stable from year to year. There was slight decline in the child survey; however no trends were identified other than a reduction in the number of surveys that were returned leading to a smaller sample. Staff does attempt multiple times to collect the data throughout each quarter. Scores that fall in the range of 1 or 2 indicate dissatisfaction and follow-up is required to ensure that staff are acknowledging the dissatisfaction and putting processes in place to address it. There were no trends in dissatisfaction that would lead to programmatic changes per say as low scores reflected personal issues for the person served such as wanting more time with family or more spending money.

New Recommendations/Action Steps:

It is recommended to continue goal as written.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  N/A
  Expected Outcome:
* N/A

OBJECTIVE Improve Parent/Guardian Satisfaction.

Goal # 2. Maintain or improve a satisfaction score of 4.5 (5 point scale)

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue goal as written; however examine tool for next FY for revisions and updating.

Update on Previous Action Steps

Meet with staff and Department Directors as needed to seek input into updating the survey tool.

Current Status of Action Step and completion date:

The language used in the tool had not been updated in recent years. Although the tool is functional to its purpose, it is expected that updated terms will assist the consumer/guardian in providing meaningful feedback. A committee was formed and new survey questions were developed that refreshed the tool and focused from solely satisfaction to gaging how one "feels" about services. The tool was approved by program directors and will be implemented July 2014, in the next fiscal year.

* **Comparison of Results/Action Steps Taken:**

Each parent/guardian of an adult or child that is in our program is asked to complete the survey annually. The "Listen to Me" survey for parents and guardians measures 12 quality of life areas including safety, leisure, community living, work, transportation, school, and overall satisfaction with services. Parents are asked to relate their impression of how the service has benefited the person served.

For adult parent satisfaction with services, 230 surveys were recorded this fiscal year. The first through fourth quarter reporting periods reflected scores of: 4.9, 4.9, 4.9, and 4.9 respectively, with an overall average of 4.93.

For child parent satisfaction with services, 40 surveys were recorded this fiscal year. The first through fourth quarter reporting periods reflected scores of: 5.0, 4.9, 4.86, 5.0 respectively, with an overall average of 4.94. Scores that fall in the range of 1 or 2 indicate dissatisfaction and follow-up is required to ensure that staff are acknowledging the dissatisfaction and putting processes in place to address it. Primarily service dissatisfaction is expressed relative to delayed service access into residential and vocational programs. Polk County providers have wait lists across service spectrum; however are committed to being more responsive and expanding programs, which takes time to hire and train staff. The Case Manager's role in this process is to ensure that referrals are made in a timely manner and consistent follow-up and engagement in services occurs.

New Recommendations/Action Steps:

Continue goal.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  N/A

Expected Outcome:

* N/A

OBJECTIVE Improve Provider Satisfaction.

Goal # 3 Maintain or improve satisfaction score of 4.5 (5 point scale)

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue goal.

Update on Previous Action Steps

N/A

Current Status of Action Step and completion date:

N/A

* **Comparison of Results/Action Steps Taken:**
  Annually a provider survey is sent to each agency and/or each staff within an agency that the case management program staff works with. The purpose of the survey is to collect information from our stakeholder's regarding our performance as a case management provider. The survey contains eleven questions that provide feedback to the program about our performance and reputation as a case management provider. The survey focuses on how well we know the people we serve, our advocacy and team membership, professionalism, how responsive we are, timeliness with paperwork and funding, and general knowledge of the service system. In comparison to the previous fiscal year, 42 surveys were returned with a satisfaction score of 4.64, which is a comparable return rate from the previous year of 47 surveys with a satisfaction score of 4.73.
  Feedback from stakeholders suggests that we are doing a good job in meeting the outcomes set forth in the survey. Our highest ratings of satisfaction are in the areas of being knowledgeable of the service system, treating other team members professionally and courteously, addressing consumer driven goals, and understanding the consumer's strengths, needs, and desires. The program also received high scores for using the opinions in the planning and service delivery process. Areas in need of improvement included feedback from providers stating that they are receiving plans after the implementation date, NOD's need to be timelier, and two statements encouraging the case manager to be more team oriented. Comments were recorded and this feedback is shared with the department. Praise and constructive feedback is used in the staff's annual evaluation when they are named in the survey.

New Recommendations/Action Steps:

It is recommended to continue goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:**
  NA

Expected Outcome:

* NA

OBJECTIVE Decrease discharges due to dissatisfaction or inability to engage in services.

Goal # 4. Experience no more than four discharges annually to dissatisfaction or inability to engage in services.

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue goal of no more than four discharges annually to dissatisfaction or inability to engage in services.

Update on Previous Action Steps

N/A

Current Status of Action Step and completion date:
N/A

* **Comparison of Results/Action Steps Taken:**
  Targeted Case Management is a voluntary service and is successful because of the team approach necessary to build trusting relationships between the person served, family, case manager, and other providers. Discharge from targeted case management services is a goal of the program as it is a service based on need. If an individual no

longer needs the service, they have gained independence or significant natural supports in areas of their life. Due to level of disability, there will be people served that need this service on a lifelong basis. The program finds success in building long-term relationships with all team members. A negative discharge occurs when a person leaves our program dissatisfied with the service delivered or they quit the service system entirely when there is an identified need for the service. This year, 36 discharges occurred due to needs of the person's served, consumer death, or relocation out of our service area. Two individuals chose to discharge from services entirely when the Case Manager suggested they stay engaged due to service needs. The program had three discharges in the previous fiscal year, and three discharges in FY 11-12. For the two individuals noted, they refused service opportunities. Repeated attempts are made to keep the individual engaged in the service, but due to the voluntary nature of the program, at some point a discharge is required because a service is not delivered.

New Recommendations/Action Steps:

It is recommended to continue goal

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** *(Job title)*
  NA

Expected Outcome:

* NA

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Minimize time between referral call and intake meeting.

Goal # 1. Intake meetings will occur will occur within 10 business days of first contact 75% of the time

MET / NOT MET

Update on Previous Recommendations

Continue goal and increase target to complete the intake meeting occurring within 10 business days of first contact to 75% of the time from 60%.

Update on Previous Action Steps

Action Step #1: na

Current Status of Action Step and completion date: na

* **Comparison of Results/Action Steps Taken:**
  Program referrals have been significant with 72 referral calls tracked for this measure. Our intake worker is efficient in scheduling initial meetings, assisting in determining eligibility, and assigning the case to a worker who will assist in linking people to services. In our third year of tracking service access, of 72 new service referrals, on average 75% met with the intake worker within 10 business days. This is an improvement from the previous year in which 71% of referral calls met with the intake worker within 10 business days. The most common reason why the initial meeting occurred beyond the ten-day goal is scheduling issues for consumers and families; transitions from Money Follows the Person grant or other CM agencies; or the need for disability determination proof. Reported data for percentage of referrals that met with intake worker within ten days for first through fourth quarter is as follows: 88%, 83%, 65%, and 65%. The program has practiced a formal "coverage" system this year in the

event that the intake worker is absent to ensure service access in not interrupted.

New Recommendations/Action Steps:

Continue goal and increase target to complete the intake meeting occurring within 10 business days of first contact to 80% of the time from 75%.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:**
  NA

Expected Outcome:

* NA

SUPPLEMENTAL MEASURES

1. INCIDENT REPORTS – REPORT OF TRENDS

Targeted Case Management is regulated by standards set forth in Chapter 24 of the Iowa Administrative Code. Section 24.4: Standards for Services, requires organizational staff, to write an incident report for incidents of a critical nature which include:

An occurrence involving the individual that:

- Results in an a physical injury to or by the individual that requires a physician's treatment or admission to the hospital
- Results in someone's death
- Requires emergency mental health treatment for the individual
- Requires the intervention of law enforcement
- Results from any prescription medication error
- Is reportable to protective services

As a supplement, the department will report annually trends identified in incident reports that are maintained in the centralized file. The Director will review critical incidents in the file at least quarterly with an annual summary of trends at the end of the fiscal year prepared by the department. Trends will be reviewed with the case management staff and Link Associates management team so that trends can be addressed.

CONSUMER DEMOGRAPHICS

DEMOGRAPHIC TRENDS IN THOSE EXITING SERVICES

As a supplement, the department will collect data and share information regarding trends identified in discharges. The program is interested in reasons for discharges and putting a weight to discharges in terms of positive, neutral, and negative from an agency role in the discharge. In addition, we track demographic trends which may alert us to the changing needs of those we serve and why people chose to leave the program.

Annually, a report will be submitted to agency directors to allow them to assess collectively why people are discharging from the agency and transferring within the agency.

Demographic Highlights:

- Of those that discharged from the program 24% were individuals under the age of 21, and 24% were ages 30 to 54. No trends were identified as reasons were varied and individualized.
- Of the numbers discharged, 65% were male and 35% female.
- Ethnically, those who discharged were largely Caucasian with the percentage of 76%.
- Sixty-one of those discharged lives in a provider based supported community living program and 22% live with their parent or guardian.

- 67% of those served have a court appointed guardian, 33% have no guardian. Clearly choosing another agency is an act of having choice.

3. CONSUMER DEMOGRAPHICS-REPORT OF TRENDS

Demographic Highlights:

- There was no significant growth or decline in the age groups we serve this fiscal year. All age group numbers stayed consistent from last year and from each quarter to the next. There are no trends in growth apparent by age; however 12% of those served are under the age of 16, which signifies expansion to this age group from previous years at 9%.
- Ethnic background of this program continues to be predominately Caucasian at 84%. The majority of individuals receiving case management live in homes in the community with funding through HCBS-ID Waiver, or in their parental/guardian home. The percentage of people living in HCBS homes remained stable at 31%.
- Vocationally, 8% of person's served by Link Associates Case Management work in pre-vocational settings a decline from 41% in the 2010 due mainly to funding definition changes, 27% have no placement at all, followed by 25% in day habilitation programs. Competitive Employment figures remain stable from year to year with 6% and Supported Employment declines from 20 to 15%. The program continues to recognize the slow growth in this area for opportunities for people with disabilities to be employed in community-based settings. Outcome areas for employment are identified as part of our performance improvement plan with Polk County Health Services.

- There were no observable trends in the following demographic areas: Ethnicity, Legal Status, Legal Settlement, Diagnosis', and level of disability.

- Recommendations: Recommend continuing to monitor demographic information of person's served for the identification of trends and needed programmatic changes.

- Demographics:
    - People served are 58% male and 42% female.
    - 11% of person's served are age 0-16
    - 22% of person's served are age 17-21
    - 13% of person's served are age 22-24
    - 18% of person's served are age 25-34
    - 25% of person's served are age 35-54
    - 9% of person's served are age 55-64
    - 2% of person's served are age 65-74
    - <1% of person's served are age 75-84

- Ethnically, we are:
    - 84% Caucasian
    - 10% African-American
    - 2% Asian
    - 3% Hispanic
    - <2% mid Eastern

- Legal Status
    - 63% of person's served have a court appointed legal guardian (family)
    - 8% have a court appointed guardian (non-family)
    - 26% do not have a legal guardian

- 2% do not have a legal guardian, but a guardian is needed.
- 99% of our person's served have a primary diagnosis of mental retardation, and 1% with a primary diagnosis of developmental disability.

- Level of Disability:
  - 59% have a diagnosis of mild retardation
  - 26% have a diagnosis of moderate mental retardation
  - 9% have a diagnosis of severe mental retardation
  - 5% have a diagnosis of profound mental retardation
  - 1% have a diagnosis of developmental disability

COMMUNITY HOUSING MEASURE OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014
Beth Gillespie, Residential Administrator

ADMINISTRATIVE FEEDBACK

12 Goals
5 MET
7 NOT MET

During this fiscal year, the Program Director position was restructured into two positions: Supported Living Director and Employment/Day Program Director. This has enabled the Supported Living Director to focus solely on the needs of the residential programs: Community Housing and Supported Living. This will and has significantly impacted the growth and direction of these programs in the coming months and year(s).

The recommendations in the administrative feedback for 2013-2014 were:

- to finalize and implement a new format for the consumer meeting minutes, which was completed;
- to continue to make improvements to the biannual medication manager which was done (and continues to be on-going) as the agency nurse sought feedback from the program supervisors to identify areas that needed further review/training, which was then used to development the agenda for the med manager review; as well as identify the need to keep the format of this training with hands-on components vs. online;
- to adapt the Quality Outcome Indicator tool to be more user friendly and an all encompassing document – the draft was reviewed and cross referenced to CARF standards, along with additional areas identified to reflect the standards important to Link Associates; yet has not been implemented. Late in the fiscal year initial efforts were made to evaluate how to make this an electronic document that is editable, and email-able, which failed. And is now being coordinated with the IT Director.
- Evaluate if utilizing the E-Doc software to complete medical and behavioral incident reports is feasible/efficient – and it was decided to proceed in transitioning away from paper incident reports to using E-Doc in November 2013. This has enabled information to be routed to multiple personnel faster.

Each of these endeavors was to improve the effectiveness and efficiencies of current processes within the program department. Although there is more work to be done, the program is pleased with the outcomes produced this past year.

It was also recommended to:

- Evaluate the need for tracking data on referrals to the RCF group homes that opted not to tour to assess if there were any patterns/trends of the referrals to identify if there was a gap in service delivery, where Link could then assess what was needed to meet that need. There was a discussion with the Admissions Chairperson on how to capture this information, however the implementation of the information discussed has not been implemented yet.
- Discontinue the tracking of consumer's increasing and decreasing support needs on the supplemental measures – this was implemented.

Entering the 2014-2015 FY, the Community Housing and Supported Living programs have identified two primary goals –

- Focus on training to include agency trainings and competencies; supervisory

training expectations with DSP's; specific training topic needs including but not limited to: diagnosis specific, basic cooking/meal prep, Medicaid requirements, and crucial conversations.

- Increase focus on customer service philosophy by finding ways to make sure employees feel heard, create a "standard operating procedure" on how to interact with each other, timely responses to stakeholders, how to recognize that everyone is important, and general interactions (greetings). The customer service concepts will be applied to consumers, families, team members, and coworkers.

These two goals will drive the direction of the program. Efforts have already begun to address the goals noted such as: the administrative team has outlined a new format for training new employees, and have begun reviewing the current training practices by supervisors (a survey was distributed and input gathered), and the tools they use. Additionally, several sections of the Residential Supervisor manual have been updated and topics continue to be identified that need to be developed to promote consistency in practices among all program supervisors. Discussions are occurring within the program department regarding daily documentation practices, and in May 2014 a memo was redistributed to staff outlining the expectations for documentation entry and documentation corrections. Regarding customer service, efforts at this juncture focus on identifying best practices and empowering our supervisors and staff to go that extra mile to make our stakeholders feel special. These discussions will continue to guide the management team on setting clear expectations that align with consistency and quality outcomes.

It is also recommended to further evaluate the need for the data regarding where new consumers served come from (ex. move from parent/guardian home; move from another HCBS setting, etc.) on the supplemental measures. If not necessary, then it is recommended to discontinue tracking this information. It is also recommended to evaluate the start of tracking med errors, if not tracked/monitored elsewhere, or if it would be beneficial to track specific information relevant to the residential programs. It is also being considered to track staff retention, or a version of staff retention. The programs want to identify data to collect that would help demonstrate the effectiveness of the training and tools implemented to achieve our goals. The residential department continues to strive to provide the highest quality of service and enhance the quality of life possible for those Link Associates supports.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Maintain cost for services to budget projections

Goal # 1 YTD cost of service will be at or lower than budgeted

NOT MET

Update on Previous Recommendations Recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: NA

Comparison of Results:

This objective reflects only Highland and McKinley data.

For the 2012-2013 fiscal year, the budget variance for Highland Park Group Home was (6,188) and so Highland Park did not meet this goal. Highland had openings sporadically throughout the fiscal year but did end the year with 10 occupants. The

budget variance for McKinley at the end of the fiscal year was $75,597 and therefore McKinley did met this goal. McKinley had rate change in April of 2013 due to a new consumer but still ended the fiscal year with two openings.
For the 2013-2014 fiscal year, the budget variance for the Highland Park Group Home ended the year at $5,043.58 and so Highland Park met this goal. The budget variance for the McKinley Group Home at the end of the fiscal year was (22,455.99) and therefore McKinley did not met this goal. McKinley closed 6/30/14 as the individuals who resided there moved into smaller 24-hour HCBS locations.
Action Steps Taken: Email is a useful resource for getting information about open shifts to all direct care staff and aids in increasing communications for peer-to-peer coverage as well. Both group homes did well utilizing part time or on call staff for open shifts to reduce overtime. Highland Park was at full capacity for more than half of the fiscal year while McKinley's occupancy number dwindled as consumers began moving out into smaller, less restrictive HCBS settings.
New Recommendations/Action Steps:
Recommend continuing this goal as written, however this goal will only reflect data from the Highland Park Group Home.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A
  Expected Outcome:
* N/A

OBJECTIVE Reach and maintain maximum occupancy

Goal # 2 Highland: # of persons served to 10,
McKinley: # of persons served to 10,
Community Housing: # of persons served maintained at 32

NOT MET

Update on Previous Recommendations It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*
Action Step #1: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results:**
  For the 2012-2013 fiscal year, this goal was met for the Highland Park Group Home (10 served) but not for the McKinley Group Home (8 served) or Community Housing (31 served).
  For Fiscal Year 2013-2014 this goal was met for the Highland Park Group Home (10) and for Community Housing (32). McKinley did not meet this goal. McKinley's person's served lessened as consumers moved out into HCBS settings. Polk County Health Services purchased two homes for the individuals that were residing at McKinley. Link supported the closing of the McKinley Group Home to promote greater independence for consumers able and excited to reside in a less restrictive 24-hour HCBS setting. McKinley's closing increased the number supported under Community Housing from 32 to 39 with the addition of the two Polk County owned homes.
  Action Steps Taken: The Admissions Committee Chair was notified monthly of updates on the openings at current locations. A representative from the Admissions Committee

continued to attend the Roommate Connection meetings on a monthly basis. (The Roommate Connection is a PCHS coordinated meeting where providers within the county come together to identify possible roommates for location openings.) Residential Administrators also attend Residential Options through Polk County Health Services twice monthly. Residential Options is a meeting of community providers brainstorming options for individuals seeking placement for services in a residential setting. A representative to the Admissions Committee remained in communication with the residential administrators regarding openings and potential roommates. As it was determined in the 3rd quarter of the fiscal year that the closing of McKinley would occur, no referrals for McKinley were considered. Highland quickly filled two openings when they arose and maintained a full capacity status. Community Housing encouraged visits to develop relationships with two referrals for one female only opening. The roommates currently residing their independently decided on which consumer they most wished to live with as roommates.

New Recommendations/Action Steps:

It is recommended to continue this goal as written. However, McKinley closed as of 6/30/14 and therefore will not be included in this goal for the 2014-2015 fiscal year. Additionally, Community Housing is now at 39 persons served, hence the target should be written to reflect Community Housing to maintain the number of persons served to 39. No change to Highland Park at this time.

* **Action Step:** Evaluate if closing Highland park would provide more benefits to the persons served.

* **Timeframe for completion:**
  June 30, 2015
* **Person Responsible:** ***(****Job title)*
  Supported Living Director
  Expected Outcome:
* To purchase 2-3 smaller home settings to promote more individualized services, and reduce the restrictive setting that inadvertently accompanies DIA regulations.

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Improve the delivery of services to new referrals

Goal # 1 Maintain or increase % of admission approvals

NOT MET

Update on Previous Recommendations Recommended continuing this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: NA

* **Comparison of Results:**
  In 2012-2013, Community Housing had 1 of 1-admission approvals, Highland Park had 3 of 3 admissions approvals and McKinley had 1 of 1 admissions approval, therefore meeting this goal.
  In 2013-2014, Community Housing had 16 referrals and 12 approvals. Of the number approved, as a result of the McKinley Group Home closing, 7 individuals moved to 24-hour HCBS setting. Two referrals were made to an opening at a female site and one approval. McKinley had two referrals and two approvals during the fiscal year. Highland Park had 5 referrals and 3 admissions, one of which was approved in the 4th quarter of the previous fiscal year and the other two being based on having only two openings.

Action Steps Taken: For Community Housing, there was one new admission from outside of Link. Community Housing increased by 7 more individuals as a result of McKinley closing 6/30/14. Polk County Health Services purchased two homes for the individuals at McKinley to reside at. Highland had one male admission and one female admission, both from within the agency. The Admissions Committee continues to meet regularly to review referrals and discuss admissions. An emphasis is placed on prompt initial tours of an opening and then referrals and potential roommates are encouraged to visit together at least a few times to determine if a good relationship is possible.

New Recommendations/Action Steps:

Recommend continuing this goal as written

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** *(Job title)*
  N/A

Expected Outcome:

* N/A

OBJECTIVE Improve the delivery of services to new admissions.

Goal # 2 No more than 10 days

NOT MET

Update on Previous Recommendations Recommended to continue goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: NA

* **Comparison of Results:**
  In 2012-2013, Community Housing had 1 of 1-admission, however the start of services didn't begin until the first quarter of the 2013-2014 fiscal year. Highland Park had 3 of 3 admission approvals; with one there was 28 days from approval to start of services, one there was 22 days from approval to start of services and with the last there were 70 days from approval to start of services. McKinley had 2 of 2-admission approval and there were 2 days in-between approval and the start of services.
  In 2013-2014, McKinley had three referrals and two admissions. One with one day between approval and start of services. The other admissions had 25 days in-between approval and admissions. This was the result of guardianship paperwork issues that had to be worked out prior to starting services. Regarding Highland Park, one person had 25 days before services started after approval. This was a result of that individual finishing the month out where he currently lived. Another admissions had 50 days in-between approval and start of services because of the family's desire to wait until after the holidays to move as example. The one individual who moved into the female only site had 45 days from approval to start of services due to prep time and paperwork to complete. The delay for a start of services for those moving from McKinley into a Community Housing 24-hour HCBS site was the result of PCHS needing to do some renovations to the purchased homes. A move date was given by PCHS when the sites were ready. The total average for a person to move in after admissions approval is 26 days.
  Action Steps Taken: Various factors determine the start date of services. For example, for one individual, it required becoming her own guardian through a court process because her current guardian was not participating while another person had a family

request to wait. The residential supervisor and administrator worked closely with PCHS to find fantastic homes and prep the individuals moving for the move. Any delays for those individuals moving from McKinley to Community Housing were a result of renovation delays at the new HCBS homes.

New Recommendations/Action Steps:

Continue goal as written; however recommend to only reflect situations where Link was responsible for any delays in coordinating a move in date on the Measures of Achievements. This would more accurately reflect the success of the programs ability to serve someone timely upon admissions.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A

Expected Outcome:

* N/A

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Decrease discharges due to dissatisfaction

Goal # 1 No more than one discharge annually due to dissatisfaction

MET

Update on Previous Recommendations Recommended continuing this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results:**

For the 12-13 fiscal year there were no discharges due to dissatisfaction in Community Housing.

For the 2014-2015 fiscal year, there were no discharges due to dissatisfaction in Community Housing.

Action Steps Taken: During the fiscal year, if any consumer or team member shared concerns, those teams met to discuss options to improve unsatisfactory situations. For example, one consumer did not enjoy living with his roommates in a Supported Living setting and moved into an opening under Community Housing in April 2014 and has since enjoyed his new living location. Teams continue to work with the admissions committee and Residential Administrators to arrange for tours and meeting and greets and to discuss options. Residential supervisors and staff continue to work to provide quality services and meet the needs and wishes of those being supported.

New Recommendations/Action Steps:

Continue goal as written

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A

Expected Outcome:

* N/A

OBJECTIVE Improve Consumer Satisfaction

Goal # 2 Maintain or improve satisfaction score of 4.9 (5 point scale)

MET

Update on Previous Recommendations Recommended continuing this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results:**

For the 12-13 fiscal year, the overall Community Housing score was a 4.93 and so this goal was met. One consumer at the McKinley Group Home answered with a 1 for satisfaction with where he lives and this in turn affected the satisfaction score. When this consumer was approached on several occasions regarding moving or ways to improve the situation he would then indicate his desire to stay at McKinley.

For the 2014-2015 fiscal year, the average overall Community Housing score for consumer satisfaction in the last quarter was a 5 of 5 as Community Housing, McKinley and Highland all had a score of 5 from returned surveys for the last quarter. For the entire fiscal year, the average score was a 4.97.

Action Steps Taken: Monthly consumer meetings continue to occur and supervisors review any concerns or questions consumers have. If a concern was noted, supervisors made efforts to work with staff and teams to find the best course of action to take to ensure a positive outcome. Also, when consumers identified specific activities that they wished to participate in efforts were put in place to ensure these activities occurred. Examples include camp, baseball games, concerts, the State Fair and other community activities.

With regards to services at Highland Park Group Home specifically, two surveys are conducted with the individuals living there by the Leisure staff. The Highland Park Community Living Program Consumer Satisfaction survey was conducted in October and December and the Leisure Interest Surveys were done in July and December by Leisure staff. The purpose of these surveys is to ensure the consumers of Highland Park continue to have the chances to participate in activities they enjoy. Most of the individuals at the Highland Park Group Home indicated they enjoyed music related activities, hence partnered with Joe Parrish to provide a 10 week interactive music program. Upon the end of the 10 weeks, Joe and the consumers performed for family and friends during a Thanksgiving celebration.

New Recommendations/Action Steps:

Recommend to continue goal as written

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A

Expected Outcome:

* N/A

OBJECTIVE Improve Parent Satisfaction

Goal # 3 Maintain or improve satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations Recommended continuing this goal as written to maintain or improve satisfaction of 4.9

Update on Previous Action Steps *(action step recommendations from last years.)*
Action Step #1: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results:**
  For Fiscal Year 12-13 the overall Community Housing average score was a 5, which is a slight increase from the previous fiscal year's average score, with 23 of 43 total surveys received between Community Housing and the two group homes. For McKinley there were no respondents in the third and fourth quarters and Highland had no respondents during the first quarter. There were respondents each quarter for Community Housing Satisfaction Surveys.
  For the 2014-2015 fiscal year, the average parent satisfaction score was a 5 for the final quarter of the fiscal year. The average parent satisfaction score for the whole fiscal year was a 4.8 for all of Community Housing.
  Action Steps Taken: If concerns were identified, the individual's team would meet to talk through concerns and review options and plans to address the concern. Guardians help determine the amount of needed communication and supervisors will contact guardians with any important updates regarding the consumers life. When / if medical or health and safety issues occurred with consumers, guardians were notified in a timely manner and support was provided if an increase of care was needed due to medical reasons.
  New Recommendations/Action Steps:
  Recommend to continue goal as written
  * **Action Step:**
    N/A
  * **Timeframe for completion:**
    N/A
  * **Person Responsible:** ***(****Job title)*
    N/A
    Expected Outcome:
  * N/A

OBJECTIVE Improve consumer satisfaction with where they live.

Goal # 4 Maintain or improve satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations Recommended continuing this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*
Action Step #1: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results:**
  For the 12-13 fiscal year the overall Community Housing score, including Highland Park and McKinley, was a 4.57, which is a fairly significant drop in score from the previous fiscal year. This is a result of an answer of 1 by a consumer residing at the McKinley Group Home.
  For the 2014-2015 fiscal year, the overall Community Housing average score for consumer satisfaction for where they live for the whole fiscal year was a 4.6, which is a slight improvement from last year.

Action Steps Taken: There were situations where roommates no longer wanted to live together. Teams met and worked together to find alternative solutions to living situations. The Admissions Committee was utilized to assist with possible matches or openings. Referrals for service were made to the Admissions chairperson for consideration as potential matches with those currently served seeking new roommates. Consumer meetings were encouraged if a possible roommate match was identified but those meetings did not result in any living arrangement changes but teams continue to evaluate possibilities. Supervisors worked diligently with teams to resolve any concerns brought up regarding satisfaction with living situations. Highland Park had two quarters with uncharacteristically low scores. One consumer who started the fiscal year at McKinley and scored his survey low for McKinley also scored Highland Park low after moving into Highland. This consumer has a history of reporting he does not like where he lives and when addressed he generally did not provide specific reasons why. Another consumer indicated he wanted to move due to his dislike of a roommate. The teams have worked at improving this relationship.

New Recommendations/Action Steps:

Recommend to continue goal as written

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A

Expected Outcome:

* N/A

OBJECTIVE Improve quality of service

Goal # 5 Average score of 97% or higher

NOT MET

Update on Previous Recommendations Recommended continuing this goal as written and add two action steps.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: To quarterly gather staff feedback on what could be done to improve MAR and E-doc documentation.

Action Step #2: Review with supervisors what trainings they are providing for new staff and staff struggling with these tasks in response to the feedback provided.

Current Status of Action Step and completion date: In regards to the two action steps, feedback from staff on how to improve MAR and E-Doc documentation was not done quarterly. New employees were asked about how E-Doc was going during their 45-day reviews, however no specific feedback was provided, nor was there any action steps taken. Staff members were provided training on both topics this fiscal year with the use of staff memos and C20 program training forms when needed as identified by their supervisor.

* **Comparison of Results:**
  For the 2012-2013 fiscal year the overall Community Housing score was a 78.75%, which is a decrease from the previous fiscal year and therefore not meeting this goal. Low scores continue to be attributed to MAR documentation errors and daily documentation errors as well as a variance of opinion on what defines clean and what is marked as needs improvement for site cleanliness.

For the 2013-2014 fiscal year the overall Community Housing score was an 82%, which is an increase from the previous fiscal year, however this goal was not met. As with the pervious year, the lower scores are the result of daily documentation errors and medication administration documentation errors.

Action Steps Taken: No specific action was taken during this fiscal year to improve the Quality Outcome Indicator form to allow for better accuracy of data. The Quality Outcome Indicator is a form used by Residential Supervisors when visiting sites either at least twice per month for 24 hour sites or at least once per month for consumers receiving hourly supports. Focus areas regarding quality of life for consumers and quality of service are marked as either satisfactory or needs improvement based on the supervisor's observation when on site and when reviewing the daily documentation and the MAR's. Staff members were re-issued the Link Memo regarding daily documentation expectations. The program department continues to work at hands on training for bi-annual on medication manager. The administrative team has been meeting regularly to review and possibly update training tactics to improve performance.

New Recommendations/Action Steps:

Recommend continuing goal as written and monitor feedback from staff for training opportunities

* **Action Step 1:** Assess with supervisors regularly regarding the type of training provided in response to feedback.
* **Timeframe for completion:**
  June 30, 2015
* **Person Responsible:** ***(****Job title)*
  Residential Administrator
  Expected Outcome:
* Increase in the quality of service score on the monthly Outcome Indicators

OBJECTIVE Improve consumers quality of life

Goal # 6 Average score of 98% or higher

MET

Update on Previous Recommendations Recommend continue goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)* NA

Current Status of Action Step and completion date: NA

* **Comparison of Results:**
  For the 2012-2013 fiscal year, the overall Community Housing score was 96.5%, which is a significant increase from the previous fiscal year but still not meeting this goal. For the 2013-2014 fiscal year, the overall Community Housing score was a 98%, therefore meeting this goal. This is the second year in a row where there has been a significant increase in results.

  Action Steps Taken: Each month supervisors completed a Quality Outcome Indicator for each of their sites related to quality of life issues applicable to the consumers. Supervisors were to evaluate observations and address any concerns noted.

  New Recommendations/Action Steps:

  Recommend continue goal as written

  * **Action Step:**
    N/A
  * **Timeframe for completion:**
    N/A
  * **Person Responsible:** ***(****Job title)*
    N/A

Expected Outcome:

* N/A

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Decrease usage of overtime

Goal # 1 Overtime hours at 135 per month or less

MET

Update on Previous Recommendations Recommended continuing this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results:**

For the 12-13 fiscal year the average monthly overtime for Community Housing was 126.7, with Highland specifically averaging 169.9 and McKinley averaging 83.5. For the 2013-2014 fiscal year, the average monthly overtime for McKinley was 65.54 and for Highland Park the average monthly overtime was 86.05; a significant reduction in overtime usage from 2012-2013.

Action Steps Taken: Supervisors approached part time or on call staff in an effort to fill hours and generally stayed within the allotted 20 hours for overtime for employees. Supervisor's continued to work at filling and hiring for open shifts. In January, Link hosted a hiring fair / blitz with excellent turn out and several hires occurring as a result, hence reducing overtime.

New Recommendations/Action Steps:

Recommend discontinuing this goal. McKinley is closed as of 6/30/14 and Highland has consistently met this goal.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A

Expected Outcome:

* N/A

OBJECTIVE Increase independence of consumers

Goal # 1 Three or more consumers who have had a reduction in the number of restrictions

MET

Update on Previous Recommendations It is recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results:**

For the 2012-2013 fiscal year and then 2 consumers had an increase in independence. During the course of this fiscal year, there were a total of 5 consumers with an increase in independence. Examples include an increase in alone time, becoming their own rep payee or a reduction in staffing hours.

During the 2013-2014 fiscal year, there were a total of 8 consumers throughout the year with a reduction in the number of restrictions resulting in an increase of independence of consumers. Seven of the 8 consumers moved from an RCF Group Home to a less restrictive 24-hour HCBS setting, resulting in restrictions being removed from their

CCSPs, such as the RCF/MR Group Home rules that states due to safety reasons, in the group home all knives, chemicals and scissors are locked up.
Action Steps Taken: Several consumers in Community Housing had self-medicating goals to address a medication restriction.
New Recommendations/Action Steps:
Recommend to continue goal as written.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A
  Expected Outcome:
* N/A

SUPPLEMENTAL MEASURES

**The supplemental measures were calculated for the entire residential program including data for both Community Housing and Supported Living.

Total number of consumers: The Community Housing program ended the fiscal year with 49 participants, 10 of these persons residing in the Highland Park Group Home. The 3 individuals who resided at McKinley Group Home on June 30, 2014 were also accounted for in this total.

Number of consumers moving from group home to HCBS; from family home to HCBS; moving from other to HCBS: Total number of consumers moving to HCBS from an RCF was 10 during the 2012-2013 year; 8 of those individuals moved to Link HCBS (4 of which resided at the RCF until 6/30/14), two moved to another agency for HCBS. The total number of consumers moving from family home to HCBS Community Housing was 2 and the number of consumers moving from other (such as a different agency) to HCBS Community Housing was 3.

Discharges from program (not due to dissatisfaction):
There were 16 discharges from the residential department during the 2013-2014 fiscal year. Eight of those discharges were from the McKinley RCF to Link HCBS services. Eight discharges were outside of Link; two needing a higher level of care, one involuntary discharge, 4 to another agency, and one for no longer needed services; However that person reapplied and was approved in the same quarter. Of the 4 who went to another agency, one was because of a desire to move back to Warren County and one because the RCF was closing and she found a roommate match at another agency. There were no discharges due to dissatisfaction from Community Housing.

There is no specific demographic pattern from the discharges under Community Housing. Four were female and 7 were male, primarily Caucasian and primarily between 35 and 54 years of age. The 7 males were a result of the McKinley Group Home closing and all 7 males attend a Link Day Program.

CONSUMER DEMOGRAPHICS

The average individual supported by Link's Community Housing program is a Caucasian (83%) male (62%), 35-54 years old (60%), who receives Day Hab services (45%) through Link Associates and has a primary diagnosis of Mild MR (47%), and has no secondary diagnosis (28%).

DAY HABILITATION MEASURE OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014
Laura Housel, Day Habilitation Administrator

ADMINISTRATIVE FEEDBACK

8 Goals
6 MET
2 NOT MET

The Day Habilitation program was able to add an additional supervisor in November of 2013. This allowed for the reduction of the consumer caseload for one supervisor to focus on curriculum development. One new curriculum, Music-n-Movement, was completed and implemented despite this supervisor being on leave for two months during this fiscal year. Two additional curriculums, Discover Des Moines and Sexuality are near completion. Two brand new curriculum ideas have already been targeted. This includes a volunteer program that would involve partnering with other organizations to provide consumers the opportunity to learn about themselves, others, how to give back, and be active members of their community. The other new curriculum would be an educational and interactive introduction to various cultures and forms of diversity through the form of leisure activities, such as cooking, clothing/fashion, art, dance, sport, games, social customs, traits, celebrations/holidays, and more. The program plans to add a third curriculum time to the programming day this upcoming fiscal year by first getting three of these curriculums completed and ready for implementation. The Day Habilitation Department was able to create and implement an online Curriculum Training video during the 2013-2014 fiscal year. All current Direct Support Professionals working in the program will complete the training by the first quarter of the 2014-2015 fiscal year. Moving forward, all new Direct Support Professionals will complete the training within their first 90 days for program understanding, quality, and consistency.

Beginning the first quarter of fiscal year 2014-2015, the Day Habilitation Department will be able to hire on a full-time Leisure Specialist, devoting 37.5 hours per week of service in addition to the current 26.25 hours per week already being received. Furthermore, this will not only enhance and increase in-house and community based leisure activity offerings, it will also assist with meaningful curriculum development as we continue the partnership we already started with the Leisure Department on the Discovering Des Moines and Sexuality curriculums. The Leisure Specialists will be able to utilize their therapeutic recreation background for assessing, planning, implementation, and evaluation of curriculum and activity programming.

The new Day Habilitation Administrator started at the close of February 2014. This position solely oversees the Day Habilitation program and has started to focus on how to move the Day Habilitation program forward and widening the vision for the program. In March of 2014, the Day Habilitation Administrator was able to write and secure a grant offered by the United Way of Central Iowa to collaborate with the Ankeny Garden Association to offer garden programming at the Garden of Hopes and Dreams community garden on the Ankeny DMACC Campus starting in June 2014. This grant provided $1,500 towards the planning, materials, and construction of three accessible garden beds. The remaining cost of the garden beds were donated by the landscaping company, Country Landscapes. The participants in the Day Habilitation program were scheduled twice each week in June, July, and August of 2014 to visit the Garden of Hopes and Dreams to plant, water, weed, and experience the therapeutic benefits of gardening in a community setting. The program will continue again in the next

upcoming gardening season. The Ankeny Garden Association provided the plantings, an introduction to the garden, and assistance with programming. The Day Habilitation Administrator worked with the grant writer and the Leisure Manager to write and secure a grant offered by the Iowa Arts Council for $3,000 to provide an intensive art series program at the Des Moines Art Center taught by two local working artists that will take place September–December 2014. This is an art program unlike anything we have been able to offer before. The participants will learn not only about the art mediums and disciplines but also about themselves, each other, and the community. The art disciplines include drawing with a focus on portraiture, sculpture, and printmaking. The program will end with two public exhibits of the participants' work at The Des Moines Social Club.

The Day Habilitation program was also able to open one more additional 1:3 ratio area this fiscal year, which was determined to be of greatest need based on admissions requests. Starting in January of 2014, The Day Habilitation Department began discussing program expansion needs in monthly supervisor meetings. These discussions included accessing the use of current physical space and consumer to staff ratio to allow for internal growth as well as how services could be expanded in the community. The department also met in addition to the regular bi-monthly meetings to determine the next steps for in-house expansion. The next steps would be to take over use of an additional room to open up three new 1:3 areas and one additional 1:4 area for the 2014-2015 fiscal year. This would increase our service capacity by 13 participants. The department will continue to meet to determine the next phase of expansion regarding community integration offerings, such as with the new volunteer program and evening/weekend leisure programming to help serve the needs of the population.

The directors and administrators of the Employment, Day Habilitation, and Community Living programs meet monthly to discuss and address universal concerns and ideas to improve program service delivery and quality. In August of 2014, the group decided there was an evident need to build consistency in training practices across programs and in the first quarter of the 2014-2015 fiscal year, have begun identifying what those training pieces are, how they will be organized, and how they could be presented. The group also hopes to inspire, motivate, and develop positivity and professionalism into the program culture. In August of 2014, it was determined that an area of focus would be on drawing that direct line to customer service and Positive Behavioral Supports, for the consumers, staff, and stakeholders.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Maintain cost of services to budget projections

Goal 1: YTD cost of services will be at or lower than budgeted

MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last year)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

Comparison of Results:
The 2013-2014 fiscal year ended with a rounded variance of $22,199 and a slight deficit of $460.00. For the fiscal year 2012-2013, cost of services were at or below what was projected, with a surplus of $1,907.

Action Steps Taken: Upon receiving the monthly financials the Day Habilitation Administrator completes a review of the financials and follow-up with the appropriate persons as needed. The Day Habilitation Administrator sends monthly emails to the Admissions Committee chair to assist in filling openings within the department. Day Habilitation Supervisors block off designated times for interviews monthly and keep their online Google calendars updated to assist Human Resource personnel in scheduling interviews to fill open positions within their areas of oversight. The agency continues to enforce the policy that direct care staff are not to work over 20 hours of overtime per week unless approved by a Department Director to help reduce overtime costs. Effective July 1, 2013, Day Habilitation authorizations changed to 15-minute unit rates and the half-day rate was eliminated. The full-day rate increased to $58.38 and the 15-minute billing rate was set at $2.65. Effective July 1, 2014, the full-day rate increased to $58.67 And the 15-minute rate was set to $2.44.

New Recommendations/Action Steps: *xpected outcomes below)*
It is recommended to continue this goal as written.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** *(Job title)*
  N/A
  Expected Outcome:
* N/A

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Increase community participation

Goal 1: Minimum of 30 scheduled events per month

MET

Update on Previous Recommendations:
It was recommended to change the goal to read 'minimum of 30 scheduled events per month.'

Update on Previous Action Steps *(action step recommendations from last years.)*
Action Step #1: Send home monthly calendars with scheduled activities on it for each program area.

Current Status of Action Step and completion date: MET, October 2013
The Day Habilitation Supervisors began the implementation of sending monthly calendars home with all participants with scheduled activities for each program area on October 1st, 2013 and will continue this practice in the future.

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  For the 2013-2014 year, community participation ranged from 24-43 events per month

with an average for the year of 35 events per month. For the 2012-2013 year, community participation ranged from 22-35 community events per month with an average for the year of 30 events per month.
Action Steps Taken: The activity calendars in the program areas continue to be updated on a monthly basis to include all scheduled activities to ensure there are no overlapping times and for the group to be aware of what is occurring throughout the month. The group uses the leisure interest surveys and consumer meeting minutes to assist in planning outings. Calendars are also emailed to other members of the consumer's team such as guardian or residential provider, when requested.

The Day Habilitation Supervisors and Day Habilitation Administrator continue to meet with the Leisure department on a quarterly basis to discuss any areas of concern as well as ideas on how to enhance the partnership. One of these partnerships included regular programming twice a month, beginning in May 2014, at Courage League, an adaptive sports facility to offer new and unique group fitness activities in the community. Another new partnership came from a grant written by the Day Habilitation Administrator and received by the United Way of Central Iowa to collaborate with the Ankeny Garden Association to offer garden programming at the Garden of Hopes and Dreams community garden on the Ankeny DMACC Campus starting in June 2014. Another new partnership that the Day Habilitation Administrator also introduced the Day Habilitation Supervisors to in May of 2014 was Joy King, a Public Service Librarian with the Kirkendall Public Library, which provided resources on new program offerings to individuals with disabilities.

The program attendees participated in various outings throughout the year such as: the American Cancer Society to drop off a donation, Blank Park Zoo, Johnston Public Library, Scratch Bakery, Walker Park, Historical Building, Omnicare to drop off a donation, Plaza Lanes, Fort Des Moines, Ronald McDonald House to drop off a donation, Howell's Pumpkin Patch, Party City, Southridge Mall, West Des Moines Library, ARL, Cici's Pizza, Gold Star Museum, Hobby Lobby, Bass Pro Shop, Smokey Row Coffee, Courage League, Botanical Center, Goode Greenhouse, Smash Burger, Wildlife Education Center at Merle Hay Mall, Canine Craze, Caribou Coffee, ChildServe Swimming, Clive Fire Department, Red Barrel Routes, Neil Smith Wildlife Refuge, Walnut Hills Elementary School, WHO Radio Station, and Yellow Banks Park.
New Recommendations/Action Steps:
It is recommended that the goal be changed to read 'minimum of 35 scheduled events per month.'

* **Action Step:**
  Day Habilitation Department will seek out and secure four new community partners or expand the offerings from four current community partners per year.
* **Timeframe for completion:**
  June 30, 2015
* **Person Responsible:** ***(****Job title)*
  Day Habilitation Supervisors and Day Habilitation Administrator
  Expected Outcome:
* Seeking new community partnerships or expanding existing ones will provide more opportunities of possible interest or need for participants to go on outings and or engage in their community.

OBJECTIVE Improve documentation compliance

Goal 2: Maintain 1 or less documentation errors per month which affect billing

MET

Update on Previous Recommendations:
It was recommended to change this goal to read 'maintain 1 or less documentation errors per month that affect billing.'

Update on Previous Action Steps *(action step recommendations from last years.)*
Action Step #1: N/A
Current Status of Action Step and completion date: N/A
N/A
Action Step #2: N/A
Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
For the 2013-2014 year, the goal changed to 1 or less documentation errors that affected billing. Errors ranged from 0-2 per month with an average for the year of .58 per month. For the 2012-2013 year the program achieved the previous goal to have 2 or less documentation errors that affected billing.
Action Steps Taken: On a monthly basis the Day Habilitation Administrator continues to complete a 2nd level review audit of a minimum of 5% of documentation completed for the program throughout the year. The Day Habilitation Administrator shares the results of these audits with the Day Habilitation Supervisors for further review/follow-up and/or billing adjustments. The Day Habilitation Supervisors share any identified patterns with direct support staff to help decrease errors and provide any necessary training. The supervisors complete their follow-up pieces and report those to the Day Habilitation Administrator at their 1:1 meetings. This information is also shared with the Employment/Day Program Director.
New Recommendations/Action Steps:
It is recommended to continue this goal as written.
* **Action Step:**
N/A
* **Timeframe for completion:**
N/A
* **Person Responsible:** ***(****Job title)*
N/A
Expected Outcome:
* N/A

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Decrease discharges due to dissatisfaction

Goal 1: No more than one discharge annually due to dissatisfaction

MET

Update on Previous Recommendations
It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*
Action Step #1: N/A
Current Status of Action Step and completion date: N/A
N/A
Action Step #2: N/A
Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  During the 2013-2014 year, there were 14 discharges, none of which were due to dissatisfaction. There were 13 discharges during the 2012-2013 year, none of which were due to dissatisfaction.
  Action Steps Taken: There was an individual that discharged who wanted to switch to Day Hab in 2013 to do more social activities and outings but frequently denied suggestions from her team. She was not happy in the program any more and was referred to Easter Seal's Life Club. The discharge summary stated that another agency was better suited to serve her.

  The department continues to assess ratios and consumer support needs on a monthly basis and make changes as needed. The department has moved several consumers to different groups/rooms throughout the year to assist with consumer satisfaction. The department has also been able to post for a new float position to assist with identified consumer needs such as supports in the restroom, individualized range of motion, and other exercises.
  New Recommendations/Action Steps:
  It is recommended to continue this goal as written.
  * **Action Step:**
    N/A
  * **Timeframe for completion:**
    N/A
  * **Person Responsible:** ***(****Job title)*
    N/A
    Expected Outcome:
  * N/A

OBJECTIVE Improve consumer satisfaction

Goal 2: Maintain or improve consumer satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: Implement 1 additional curriculum time to the programming day.

Current Status of Action Step and completion date: NOT MET
The department continues to meet to discuss curriculum implementation progress and benchmark update progress. One new curriculum, Music-n-Motion has been implemented. Two curriculums are near completion. Two brand new curriculum ideas are being developed, one for a volunteer program and one for an introduction to culture and diversity. The Day Habilitation Supervisor overseeing curriculum development was on leave two months during this fiscal year. However, the new Day Habilitation Administrator set a task deadline for one of these curriculums and met with a potential partner for the brand new curriculum during this time.

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  The 2013-2014 consumer satisfaction score averaged 4.88 for the year, which is just slightly below the goal of 4.9.The 2012-2013 consumer satisfaction score averaged 4.89 for the year.
  Action Steps Taken: The program was able to add two additional iPads, making it four

total that are continuing to be utilized for programming purposes as well as for augmented communication. The department continued to purchase the on-line subscription, activityconnection.com, which helps the supervisors and Leisure department personnel to generate age appropriate, stimulating activities for the consumers served. The Music-n-Movement curriculum was implemented and two other curriculums that are near completion are Sexuality and Discovering Des Moines. Two brand new curriculum ideas are being developed, one on volunteering and one on culture and diversity, which will allow for additional options for meaningful engagement for participants.

Throughout the year several volunteer groups came to visit the department to work together on various projects and participate in activities with the consumers. In August of 2013, a group of teachers from Hoover High School came and assisted a group of consumers with a craft project and read a poem with the group. In October of 2013, a group from Iowa Christian Academy came and assisted consumers to sort crayons for projects to donate to the community. In January of 2014, 11 people from the community came to visit on Martin Luther King Day and spent time servicing others by reading an inspiring love themed book while providing social interaction and assistance with a hands on activity in three Book Clubs. In February of 2014, a group from John Deere Des Moines Works visited and assisted in Card Club, Wood Working and Cooking Club. Participants also had the opportunity in February of 2014 to attend an Iowa Energy Basketball game at Wells Fargo Arena. Additionally, they also participated in games and activities at Courage League with a group from Central College and made canvas art with 7th grade students from the Iowa Christian Academy in April of 2014.

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

* **Action Step:**
  Day Habilitation Department will implement three additional curriculums throughout the year.
* **Timeframe for completion:**
  June 30, 2015
* **Person Responsible:** ***(****Job title)*
  Day Habilitation Supervisor
  Expected Outcome:
* Adding three new curriculums to the current list will make adding a third curriculum time to the day possible. The additions to the curriculums will increase meaningful engagement through program offerings and provide more opportunities for participants to learn about areas of interest, others, themselves and their community.

OBJECTIVE Improve parent/guardian satisfaction

Goal 3: Maintain or improve parent/guardian satisfaction score of 4.9 (5.0 point scale)

NOT MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A
N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  The average parent/guardian satisfaction score for 2013-2014 was 4.88 with scores ranging from 4.63-4.98. The average parent/guardian satisfaction score for the 2012-2013 year was 4.93 and ranged from 4.83-4.94.
  Action Steps Taken: The Day Habilitation Supervisors continue to meet with the internal Case Coordinators monthly to provide updates on consumer goal progress. The supervisors also continue to meet with parents/guardians/care providers at 30 day and annual staffing for consumers as well as pull teams together as needed. The Day Habilitation Supervisors continue to communicate with parents/guardians via email and/or phone to ensure they were informed of service delivery and events that occurred within the department. The supervisors also compose and send home monthly calendars with scheduled outings and leisure activities on them for parents/guardians/care providers' awareness.
  New Recommendations/Action Steps:
  It is recommended to continue to continue this goal as written.
  * **Action Step:**
    The Day Habilitation Department will offer a training/in-service on client/customer centered service delivery once per year.
  * **Timeframe for completion:**
    June 30, 2015
  * **Person Responsible:** ***(****Job title)*
    Day Habilitation Supervisors and Day Habilitation Administrator
    Expected Outcome:
  * Offering a training/in-service on service delivery with a focus on positive interactions will serve to educate and or remind employees about the importance of client and or customer centered service with demonstrations on what this should look like. With a heightened awareness of this expectation, employees will be better equipped for success for consumer/parent/guardian/stakeholder satisfaction.

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Maintain or increase number of consumers served

Goal 1: Serve clientele to no less than 123 FTC

MET

Update on Previous Recommendations

It was recommended to change the goal to read serve clientele to no less than 123 full time consumer equivalents (FTC).

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A
N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  The number of FTC's for 2013-2014 ranged from 118-123 and ended the fiscal year with 123 served. The number of FTC's for 2012-2013 ranged from 110.2 – 120.2 and ended the fiscal year with 120.2 FTC served.
  Action Steps Taken: Starting in January of 2014, The Day Habilitation department also began discussing program expansion needs in monthly supervisor meetings. These

discussions included accessing the use of current physical space and consumer to staff ratio to allow for internal growth as well as how services could be expanded in the community. During the 2013-2014 fiscal year the program was able to open one more additional 1:3 ratio area, which was determined to be of greatest need based on admissions requests. The Day Habilitation department supervisors continue to assess area ratios on a monthly basis and report any concerns/changes to the Day Habilitation Administrator. This allows the Day Habilitation Administrator to keep the ratio list up to date and send openings within the department to the Admissions Committee Chair to assist with scheduling meetings to fill the open spots. There were 22 admissions into the program over the past year, 6 of which were internal referrals from the Prevocational program.

New Recommendations/Action Steps:

It is recommended to change the goal to read 'serve clientele no less than 126 FTC.'

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A

Expected Outcome:

* N/A

OBJECTIVE Improve the delivery of services to new referrals

Goal 2: Maintain 93% of admissions to new referrals

MET

Update on Previous Recommendations

It was recommended to change the goal to read, maintain 93% of admissions to new referrals.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: Track the reason/s why a new referral was not admitted to the program quarterly.

Current Status of Action Step and completion date: MET, September 2013
Members of the Admissions Committee and Day Habilitation Administrator attend admissions meetings monthly. Beginning the first quarter of this fiscal year, the Admissions Committee Chair started tracking all data and compiles a report quarterly of all admissions activity, including reasons why a new referral was not admitted to the program to evaluate how to accommodate the changing needs/levels of support of those requesting services. The report is sent out to the Day Habilitation Administrator. During this fiscal year, there were no denials for services.

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**

During the 2013-2014 fiscal year 22 admissions were approved out of 22, for an average of 100% delivery of service to new referrals. During the 2012-2013 year 22 admissions were approved out of 23 for an average of 95.7% delivery of service to new referrals.

Action Steps Taken: The Day Habilitation Administrator attends all admission meetings for those requesting Day Habilitation services to help determine if the current programs being offered can meet the services being requested by individuals and their teams. During the 2013-2014 fiscal year the program was able to open one more additional 1:3

ratio area, which was determined to be of greatest need based on admissions requests. Starting in January of 2014, The Day Habilitation department also began discussing program expansion needs in monthly supervisor meetings. These discussions included accessing the use of current physical space and consumer to staff ratio to allow for internal growth as well as how services could be expanded in the community. Out of the 22 new referrals made this year 22 of them were approved.

New Recommendations/Action Steps:

It is recommended to change the goal to read 'maintain 95% of admissions to new referrals.'

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** *(Job title)*
  N/A

Expected Outcome:

* N/A

SUPPLEMENTAL MEASURES

Discharges from the program (not due to dissatisfaction):

There were a total of 14 discharges from the program through this fiscal year, none of which were due to dissatisfaction. The reasons for discharges were: 2 medical supports/safety, 6 no longer in need/want of services, 3 returned to school, and 3 went to another Link program. Out of the 14 discharges 8 of them transferred out of Link services. Of the discharges the primary demographic information indicates: male Caucasian, age 17-21 with legal settlement in Polk County with a family guardian.

CONSUMER DEMOGRAPHICS:

The average participant in the Day Habilitation program is a Caucasian male between the ages of 35-54 years of age, with a primary diagnosis of Moderate MR and a secondary diagnosis of Cerebral Palsy, who is a resident with legal settlement in Polk County and has a family guardian.

LEISURE MEASURE OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014
Stevie Steimel, CTRS Leisure Services Manager

ADMINISTRATIVE FEEDBACK

4 Goals
4 MET
0 NOT MET

The Highland Park Leisure Specialist remained at a full time position and continued to show benefits for the consumers and the program, despite another change in Leisure Specialist. The program continues to evolve and improve but also experiences some challenges. The program will continue to be monitored and evaluated to see if any changes are necessary.

The demand for quality Leisure services continues in all three areas Day Hab, Highland Park, and the Community Program. Expansion of the community program to meet the expressed needs of participants is directly related to United Way funding. United Way, once again, is funding Leisure services at the same level of three years ago, with no increases to account for wage increases or increased program costs. Level funding equates to increased deficits without sufficient funding to even cover the 2% pay increases awarded to all Link employees. The community program continues to be stretched to its greatest lengths to meet the demands of the community. Program offerings will likely be reduced this year as a result of the level funding, increased expenses, and ever increasing demand.

The demand for Leisure Services in the Day Habilitation program continue to grow as the program increases the numbers served. A request has been made to the program director for additional funds providing a Leisure Specialist to meet the growing needs of the program. As this fiscal year closes there is opportunity to grant this request, which will be reported in the upcoming year when the outcome is clear.

In addition, a new registration tool and tracking method was initiated. ETO (Efforts To Outcome web-based program) is now being used through the support and assistance of United Way personnel. Continued training for this program is ongoing as United Way and Leisure Service personnel collaborate to refine a system that best suit the needs of Leisure.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Increase Number of Consumers Served

Goal # Provide service for 15 new consumers

MET / NOT MET

Update on Previous Recommendations:
It was recommended to continue this goal.

Update on Previous Action Steps and completion date: NA

Comparison of Results/Action Steps Taken:
The goal was met and surpassed recording a total of 49 new participants. The Leisure program continues to be the only comprehensive leisure program for individuals with disabilities in Central Iowa, serving 406 total participants this year. This, along with continued variety in program offerings, locations and price ranges, as well as new high

school graduates and the utilization of Link Leisure Services by other provider agencies, contributes to the continued program expansion.
Leisure maintained the partnerships with Special Olympics for recreation competition opportunities as well as athlete and volunteer referral, Willow Creek Golf Course for discounted facility usage and instructor fees, Ankeny Parks & Recreation for free use of Softball fields, YMCA for free facility usage, West Des Moines Parks and Recreation for free use of Raccoon River Nature Lodge and shelters, Boy Scouts of America for volunteers, MVP Sports/Champions Sports Center for facility use, Dowling Catholic High School for free facility usage and volunteers, Urbandale Parks and Recreation for free use of Soccer fields and Senior Center, Hoover High School for facility use and volunteers, ChildServe for access to therapeutic pool, Des Moines Playhouse for discounted or free tickets to events, and the Botanical Center for discounted admission. Leisure maintained the partnership with Ankeny Parks and Recreation for facility rental for Special Olympics. A new partnership with Bowlerama was established for Bowling. Leisure also continues to compile a Community Calendar for area opportunities and provides that to all Link staff as well as information for discounted tickets for upcoming events. Leisure has developed a partnership with Valley Community Center for use of their facilities. Leisure continues to use Facebook, Twitter, and Pinterest pages to increase communication and be a resource for leisure and recreational happenings and insights.

New Recommendations/Action Steps:

Continue goal as written.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  N/A

  Expected Outcome:
* N/A

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Consumers accessing social alternatives

Goal # An annual average 43% of consumers on the Leisure mailing list with 0-30 hours per week of support will access Leisure Services

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue goal.

Update on Previous Action Steps and completion date:

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results/Action Steps Taken:**
  The goal was met and surpassed recording an annual average of 54% of consumers on the mailing list with 0-30 hours of support per week accessing Leisure Services. The results of the data ranged throughout the year between 52-57%. The lowest percent of individuals attending Leisure programs with 0-30 hours of support was recorded during the second quarter. The fluctuation in attendance numbers recorded each quarter is related to seasonal preferences and the natural tendency to stay in during winter months in Iowa.

Established programming options were maintained and new options offered. Varied program options were provided to create and maintain interest by all consumers, including the targeted consumer groups. Programs and activities were designed to not only increase awareness of community resources and reduce social isolation, but also incorporate the teaching of lifetime leisure skills. New destinations were offered by the Discover Des Moines program and L.A. Social Club along with additional new program offerings including Horseback riding, Zumba, Tailgate Party, Cooking with Kindness, You've Got Talent, Cinco De Mayo Celebration, Summer Explorations. Transportation was provided on a first come first served basis for participants meeting the transportation criteria. The Leisure Manager continued to work with the Transportation Department to fulfill requests to maximum number of participants.

New Recommendations/Action Steps:

Continue goal as written.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:** ***(****Job title)*
  Title
  Expected Outcome:
*

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Improve consumer's life satisfaction

Goal # Achieve 90% or greater on satisfaction survey

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue goal and that Leisure Services develop a new goal to seek out personalized testimonials and success stories of participants and their families.

Update on Previous Action Step:

New goal implemented.

Current Status of Action Step and completion date: Implemented on July 1, 2013.

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

* **Comparison of Results/Action Steps Taken:**
  The goal to achieve 90% or greater on satisfaction survey was met and surpassed all 4 quarters. Satisfaction ranged from 97-100% with an overall average of 99%. Leisure Personnel and staff complete Post Program surveys at the conclusion of an activity/program. The Leisure Manager compiled all the surveys on a quarterly basis. The survey includes six questions; responses for questions #1-4 are reviewed and "yes" responses to three out of four questions are tallied to determine the outcome for this objective. The total is then divided by the number of surveys completed to calculate the average score. The Leisure Services Department offered and received 553 completed Post Program Surveys. Meetings and resource information are offered as needed to further assure the availability of leisure options contributing towards life satisfaction for the consumers served. United Way continues to train agency personnel in Results Based Assessment (RBA) and Link Leisure continues to refine tracking methods in attempts to provide greater outcomes that contribute to life satisfaction.

New Recommendations/Action Steps:
It is recommended to continue this goal
Action Step:
NA
Timeframe for completion:
NA
Person Responsible
NA
Expected Outcome:
NA

OBJECTIVE Improve consumer's life satisfaction

Goal # Obtain Testimonials from 4 consumers over one year

MET / NOT MET

Update on Previous Recommendations

This was a new goal recommended last year.

Update on Previous Action Steps

NA

Current Status of Action Step and completion date: NA

Comparison of Results/Action Steps Taken:

Staff asked individuals about their interest in completing a written testimonial and were successful in identifying 4 persons. This was completed throughout the year with the final testimonial acquired in April 2014.The goal to obtain testimonials from four consumers was met. The first quarter was used to identify participants to take part in the testimonial process. The first successful survey/testimonial was completed in the second quarter, 2 in the third quarter and one in the 4th quarter. The survey includes six questions that Leisure staff asks the leisure participant and records their response. The surveys are kept on file for reference by the Leisure Manager and leisure team.

New Recommendations/Action Steps:

Action Step:

Timeframe for completion:

Person Responsible:

Expected Outcome

SUPPLEMENTAL MEASURES

CONSUMER DEMOGRAPHICS

Program evaluation data reveals that the consumer demographics have remained consistent for many years. The participants range in ages from under 12 to over 80 years old with an average of 58% coming from the 35-64 year old age range. Participants are closely divided between males and females with males representing 55% and females 45% on average. Ethnicity is diverse, but the majority of participants are Caucasian. Leisure provides services regardless of residency or geographic boundaries. The majority of consumers accessing Link's Leisure programs reside in communities identified as offering little to no special populations programming.

PRE-VOCATIONAL MEASURE OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014
Jess White, Employment Administrator

ADMINISTRATIVE FEEDBACK

9 Goals

4 MET
5 NOT MET

With all employment programs now under the Employment Administrator, the department will continue to assess how to make the transition from Prevocational services to a Skills Training program and/or Supported Employment services more seamless. The employment department successfully began the Project Search training program at ChildServe on January 20th, 2014. It was identified that one Vocational Supervisor would supervise both Skills Training programs (Project Search and the Link General Store) as well as an in-house Prevocational area. It was identified that this was not the most successful approach. The decision was made in May 2014 to transition the Project Search program to a different Vocational Supervisor, which allowed each of the supervisors to maintain their responsibilities in supervising two in-house Prevocational areas, and one Skills Training program. This transition also gave each supervisor the insight/knowledge as to what skills/supports are necessary for individuals to transfer from Prevocational services to a Skills Training program.

The Community Placement Manager, formerly Marketing Manager, position was vacant for the majority of the fiscal year. The position was offered in May 2014 and it is expected that over the next year they collaborate with the Prevocational program to increase contract work opportunities for persons in the program. The Employment Administrator will continue to evaluate growth and collaboration with various projects to have one central, guiding vision.

The program will continue to develop/incorporate competency-based components into the Employment Readiness curriculum, which was not accomplished over the 2013-2014 review year. A goal for the upcoming fiscal year is to break the Employment Readiness curriculum in to smaller sections and add a sexuality section to the Building Relationships curriculum. The program will continue working on a letter to share with parents/guardians to share the objectives of the sexuality curriculum and what the program hopes for the participants to gain from the curriculum. The Prevocational program was awarded a grant from Principal Financial for $5,000 and which will allow more training tools to be purchased for the curriculums. The grant will allow Link to purchase two desktop Mac computers, Microsoft Office, and an iPad among other things. The participants within the Prevocational program will benefit from these purchases as they will gain additional knowledge on how to use a computer to assist with completing resumes/applications online.

Over the next year the Prevocational program would like to assess the option of completing contract work offsite with current &/or new community businesses. The Community Placement Manager and Employment Administrator will also continue to evaluate ways to incorporate volunteer/internship opportunities into the program. A Google document will be created to help track patterns/trends of employment barriers Prevocational program participants are experiencing which are preventing them from being successful in the program. The document will also track ways to enhance/improve programming and individual skill sets.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Maintain cost of services to budget projections

Goal 1: YTD cost of services will be at or below budgeted

NOT MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

N/A

Comparison of Results:

The 2013-2014 YTD cost of service was at a loss of $17,028. The 2012-2013 YTD cost of service was lower than budgeted with a surplus of $61,095.

Action Steps Taken: The Employment Administrator sent monthly emails to the Admissions Committee chair to assist in filling openings within the department. Vocational Supervisors allowed Human Resource personnel access to their Google calendars adding availability from 12:30pm-2:30 pm on Tuesdays and 9:00am-11:00am on Thursdays. This has allowed Human Resource personnel to schedule interviews to fill open positions within their areas of oversight. The agency continues to enforce the policy that direct support professionals are not to work over 20 hours of overtime per week unless approved by a Program Director to help reduce overtime costs.

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

* **Action Step:**
  Review monthly financials/provide follow-up as needed.
* **Timeframe for completion:**
  Monthly through June 30th, 2015
* **Person Responsible:** ***(****Job title)*
  Employment Administrator
  Expected Outcome:
* Maintain budgeted cost of services.

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Maintain less than .5% spoilage rate

Goal 1: Total spoilage for quarter (.5% or less)

MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

N/A

* **Comparison of Results:**
  The average spoilage rate for the 2013-2014 fiscal year was .0033% and ranged from .0002% - .0079%. During the 2012-2013 review year, the spoilage rate, stayed below .8% with an annual average of .0048%.
  Action Steps Taken: Throughout the year the Employment Administrator, Vocational Supervisors and Vocational Instructors (M-F Direct Support Professionals) were able to meet and discuss various aspects of contract work. During these meetings the importance of accurately recording all spoilage on the V-5 form was discussed to ensure proper monitoring. On a monthly basis both Vocational Supervisors that oversee Prevocational areas route all V-5's (production rosters) to the Employment Administrator to review and calculate spoilage rates.
  New Recommendations/Action Steps:
  It is recommended to change the goal to read 'maintain less than .3% spoilage rate.'
  * **Action Step:**
    N/A
  * **Timeframe for completion:**
    N/A
  * **Person Responsible:** ***(****Job title)*
    N/A
    Expected Outcome:
  * N/A

OBJECTIVE Maintain and increase the number of new/existing contracts

Goal 2: Total number of contracts = 5 or more per month

NOT MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: Update Marketing flyer and send out to potential businesses monthly.

Current Status of Action Step and completion date: NOT MET
Goal not met due to open Marketing Manager position September 2013 to May 2014. Marketing Manager title changed to Community Placement Manager and the position was filled during the 4th quarter.

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  For the 2013-2014 review year contracts ranged from 2 – 5 per month and averaged 3.58 contracts per month. The average was the same during the 2012-2013 review year, 3.58.
  Action Steps Taken: During the 1st quarter there was an employment opportunity offered. Both Vocational Supervisors within the Prevocational department toured Scholastic Book Fairs in June 2014 to observe the work site to determine the possibility of work being completed at this community business location. This tour/meeting did turn into a mutually beneficial partnership between Link Associates and Scholastic Books to complete piecework for them annually in July.

  During the 3rd quarter one Vocational Supervisor and the Employment Administrator met with Xpedex to discuss a potential contract opportunity. A bid was completed and submitted and multiple attempts to contact them were made by the Employment

Administrator, but no return contact was made. The Vocational Supervisors within the Prevocational department continue to re-prioritize their schedules, with little notice, to complete time studies so the Employment Administrator can provide a quick response to employers for contract work bids.

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

Action Step:

* Update Marketing flyer and send out to potential businesses monthly.
* **Timeframe for completion:**
  November 30th, 2014
* **Person Responsible:** ***(****Job title)*
  Community Placement Manager

Expected Outcome:

* To establish new work contracts.

OBJECTIVE Increase time spent on paid work opportunities

Goal 3. Minimum of 50% of time spent on paid work

NOT MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: Meet with the Marketing Manager at least quarterly to discuss potential contract opportunities.

Current Status of Action Step and completion date: NOT MET

Goal not met due to open Marketing Manager position open September 2013 to May 2014. Marketing Manager title changed to Community Placement Manager due to misperception from applicants and the general public about what the job/position entails; the position was filled during the 4th quarter.

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

N/A

* **Comparison of Results:**

The average program time spent on paid work opportunities for 2013-2014 was 16.9%. During 2012-2013, an average of 25.64% of the consumer's time was spent on paid work opportunities.

Action Steps Taken: The Prevocational program will continue to assess incorporating paid work contracts into the day as we move toward curriculum-based programming. The Marketing Manager position was open from September 2013-May 2014. Title changed to Community Placement Manager and position was filled during the 4th quarter on 5.5.14.

New Recommendations/Action Steps:

It is recommended to continue the goal as written

* **Action Step:**
  Meet/discuss current contracts with employers to discuss the possibility to complete work at their business location.
* **Timeframe for completion:**
  December 31st, 2014
* **Person Responsible:** ***(****Job title)*
  Community Placement Manager and Employment Administrator

Expected Outcome:

* Work with employer to complete paid contract work throughout the fiscal year.

OBJECTIVE Improve documentation compliance

Goal 4. Maintain 1 or less documentation errors per month which affect billing

MET

Update on Previous Recommendations

It was recommended to keep this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

N/A

* **Comparison of Results:**

The average number of documentation errors, which affected billing for 2013-2014 was 0, also the same as the 2012-2013 average.

Action Steps Taken: On a monthly basis the Employment Administrator continues to complete a 2nd level review audit of 5% of documentation completed for the program throughout the year. The administrator shares the results of these audits with the program supervisors for further review/follow-up and/or billing adjustments during their scheduled 1:1 meetings bi-monthly. The Vocational Supervisors will continue to provide training on identified patterns with direct support professionals during monthly 1:1 meetings to help prevent errors and continue providing quality documentation.

New Recommendations/Action Steps:

It is recommended to change the goal to read 'maintain less than 1 documentation error per month which affect billing.'

* **Action Step:**

  NA
* **Timeframe for completion:**

  NA
* **Person Responsible:** *(Job title)*

  NA

Expected Outcome:

* NA

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Improve consumer satisfaction

Goal 1: Maintain or improve consumer satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations

It was recommended to keep this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

N/A

* **Comparison of Results:**

The 2013-2014 data calculated to have an average satisfaction score of 4.84. The previous year, 2012-2013, had an average satisfaction score of 4.89.

Action Steps Taken: Direct Support Professionals within the department met with all program participants on an individual basis in July 2013 and January 2014 to review their productivity for the previous 6 months. During these meetings they also discussed what measures they can put into place to increase their production, which will increase their earnings. There is a white board in each Prevocational program area, which lists each contract, that the group is working on and how much they get paid for each piece they complete.

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

* **Action Step:**
  Discuss and document consumer satisfaction while completing M-4: Consumer Meeting Minutes.
* **Timeframe for completion:**
  Quarterly beginning October 1st, 2014
* **Person Responsible:** ***(****Job title)*
  Vocational Instructors and Vocational Supervisors
  Expected Outcome:
* Receive consumer input and put measures in to place immediately to improve.

OBJECTIVE Improve parent/guardian satisfaction

Goal 2: Maintain or improve parent/guardian satisfaction score of 4.9 (5 point scale)

MET

Update on Previous Recommendations

It was recommended to keep this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A
N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  The 2013-2014 data calculated to have an average satisfaction score of 4.99. The previous year, 2012-2013, had an average satisfaction score of 4.98.
  Action Steps Taken: Department supervisors continue to communicate with parents/guardians via email and/or phone to ensure they were informed of service delivery and events that occurred within the department. Team meetings have been scheduled as needed to discuss programming and goal progress for individuals who need additional support.
  New Recommendations/Action Steps:
  It is recommended to continue this goal as written.
  * **Action Step:**
    N/A
  * **Timeframe for completion:**
    N/A
  * **Person Responsible:** ***(****Job title)*
    N/A
    Expected Outcome:
  * N/A

OBJECTIVE Improve employer satisfaction

Goal 3: Maintain or improve satisfaction score of 4.5 (5 point scale)

NOT MET

Update on Previous Recommendations

It was recommended to keep this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A

N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

N/A

* **Comparison of Results:**

The 2013-2014 data calculated to have an average satisfaction score of 4.3. The 2012-2013, had an average satisfaction score of 4.63.

Action Steps Taken: The Employment Administrator sends information to the Program Administrative Assistant on a monthly basis of which businesses to send contract performance surveys to for work completed. There were a total of 9 surveys sent out over this review period and feedback was received back on 4 of them. The Employment Administrator attempted to complete 2 surveys over the phone as no feedback was received via mail or email. Both contacts were unavailable. One of the surveys included an area of improvement for direct support staff to do a better job of completing lamination in a timely manner, but did state 'the quality of items being laminated is excellent.'

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

* **Action Step:** Email performance surveys to business contacts & follow-up by phone if not received within 4 weeks.
* **Timeframe for completion:**
  October 1st, 2014
* **Person Responsible:** ***(****Job title)*
  Program Administrative Assistant
  Expected Outcome:
* To acquire timely feedback from businesses/employers.

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Improve the delivery of services to new referrals

Goal 1: Maintain 90% of admission approvals or better

MET

Update on Previous Recommendations

It was recommended to continue this goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date:

NA

Action Step #2: N/A

Current Status of Action Step and completion date: N/A

N/A

* **Comparison of Results:**
  The average admissions approval rate for 2013-2014 was 100%. The average admissions approval rate for 2012-2013 was 100% as well.
  Action Steps Taken: The Employment Administrator attends all admission meetings for those requesting Prevocational services to help determine if the current programs being offered can meet the services being requested by individuals and their teams. Out of the 19 new referrals made 19 of them were approved.
  New Recommendations/Action Steps:
  It is recommended to change the goal to read 'maintain 95% of admissions approval or better'.
  * **Action Step:**
    N/A
  * **Timeframe for completion:**
    N/A
  * **Person Responsible:** ***(****Job title)*
    N/A
    Expected Outcome:
  * N/A

SUPPLEMENTAL MEASURES

Average consumer wages per hour:
The average consumer wage for the Prevocational program for the 2013-2014 year was $1.61/hour.

Total number of persons transferred to Supported Employment services:
During the 2013-2014 review year no persons transferred to Supported Employment services.

Total consumers transferring from PreVoc to a training program:
During the 2013-2014 review year three participants transferred to the Link General Store training program.

Discharges from program (not due to dissatisfaction):
There were 22 discharges from program throughout the 2013-2014 year. Discharges were due to the following reasons: 1 moved out of service area, 8 were no longer in need/want of services, 4 returned to school, 1 prior authorization denial/does not meet PreVoc eligibility and 8 to another Link program. Out of the 22 discharges, 8 persons transferred to another program and/or back to school. There were no discharges due to dissatisfaction. The average participant who discharged from the program was a Caucasian male with legal settlement in Polk County.

Total number of contract bids submitted and accepted:
Throughout the 2013-2014 there were 14 contracts for paid work submitted and 13 were accepted. Contracts were submitted and accepted by the following local businesses: Mom's Meals (4), Marsh Affinity Group, All Spice (2), In the Bag, Johnston Economic Development, ABI (2), Accent Tag and Label and Scholastic Book Fairs. The bid that was not accepted was for Xpedex, after the bid was submitted the Employment Administrator made multiple attempts to contact them but never received any contact back.

CONSUMER DEMOGRAPHICS:

The average participant in the Prevocational program was a Caucasian female between the ages of 35-54 years, with a primary diagnosis of Mild MR, secondary diagnosis of Down's Syndrome, who is a resident with legal settlement in Polk County and has a family guardian. The average participants longevity in the Prevocational program is 12-24 months.

RESPITE (HCBS) MEASURE OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014

Jessica Kirts, Family Support Services Administrator

ADMINISTRATIVE FEEDBACK

6 Goals

6 MET
0 NOT MET

The value of in-home services to the primary care givers of consumers served continues to be high as illustrated by the scoring on the parent and consumer's satisfaction survey. The maintenance of 100% of all family's children in the family home further speaks to the success of the in-home respite service option. To further insure family and consumer feedback and satisfaction, follow up phone calls were made to family members that had not returned the quarterly survey.

The results of the satisfaction survey and positive feedback from families were reviewed at each quarterly meeting with care providers to create an increased awareness of the family's satisfaction and appreciation for the support provided. Any suggestions shared by family care givers were also shared for the benefit all care providers. The Care Provider of the Quarter continues to acknowledge employees whom families have deemed exceptional and to again inspire others.

The correlation between direct family referrals and the reduction of wait lists continues to be greater than any other recruitment effort. The list of families awaiting services as well as families needing additional care providers is mailed or emailed to all care providers monthly and was reviewed during each quarterly meeting. New hires are advised additional hours and families are available. Link representatives continue to participate in Parent Informational Fairs, speaking engagements to introduce and review services as well as job and volunteer Fairs.

The Family Support Services Administrator continues to collaborate with other area providers and case managers to assure the successful coordination of respite services designed to meet each individual family's needs. Network providers consistently work together rather than compete with each other, always with the consumer and family's needs at the forefront.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Maintain or Improve the Number of Family Responses

Goal: 48% of satisfaction surveys will be returned.

MET / NOT MET

Update on Previous Recommendations:

It was recommended to keep this goal as written.

Update on Previous Action Steps: NA

Current Status of Action Step and completion date: N/A

Comparison of Results/Action Steps Taken:

Each quarter met or surpassed the goal of 48%. The first quarter score was 50%, the second quarter score rose to 53% and the third and fourth quarters ended with 50% of satisfaction surveys being returned. Last year's average was 51% of surveys returned. The FSS Administrator collected and tracked the number of surveys sent and the

number of responses returned. An average of 4 calls each quarter were made by the Administrator to families not returning the survey.

New Recommendations/Action Steps:

No recommendations, continue goal.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  NA
* **Person Responsible:**
  NA
  Expected Outcome:
* NA

OBJECTIVE Maintain Approved Number of Hours of Service

Goal 100% of Family's Service Use will be At or Below the NOD Approved Hours

MET / NOT MET

Update on Previous Recommendations:

It was recommended to keep this goal as written.

Update on Previous Action Steps:

Action Step #1: N/A

Current Status of Action Step and completion date:

NA

Comparison of Results/Action Steps Taken:

For waiver year 2012-2013, 100% of families/consumers continued to utilize at or below the number of hours approved on their service NOD. 100% was met this year as well.

New Recommendations/Action Steps:

No recommendations, continue goal.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  NA
  Expected Outcome:
* N/A

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Promote Maintenance of the Child with Disabilities in the Family Home

Goal 100% of all Consumers will Remain in the Family Home

MET / NOT MET

Update on Previous Recommendations:

It was recommended to keep this goal as written.

Update on Previous Action Steps:

Action Step #1: N/A

Current Status of Action Step and completion date:

NA

* **Comparison of Results/Action Steps Taken:**
  Goal expectancy of 100% was met 2012 – 2013. Goal expectancy of 100% was met this year.

New Recommendations/Action Steps:

Keep goal as written.

* **Action Step:**

N/A

* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  NA
  Expected Outcome:
* N/A

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Maintain or Improve Parent/Guardian Satisfaction and Ability to Cope with Stress

Goal Maintain or Improve Satisfaction Score of 4.6 or higher on a 5 point scale

MET / NOT MET

Update on Previous Recommendations:

It was recommended to keep this goal as written.

Update on Previous Action Steps: NA

Current Status of Action Step and completion date: NA

* **Comparison of Results/Action Steps Taken:**
  The average score for the year 2012 – 2013 was 4.85. 127 satisfaction surveys were mailed to families and 65 of those surveys were returned. The average score this year was 4.83. For the year, 148 satisfaction surveys were mailed to families and 75 of those surveys were returned. Family responses were positive stating they feel less tense about caretaking responsibilities and better able to engage in other endeavors they were not able to do before receiving respite services. The results of parent satisfaction surveys were reviewed with Care Providers during each Quarterly Care Provider Meeting (October 16 & 17, 2013, January 22 & 23, 2014, April 23 & 24, 2014 and July 23 &24, 2014).
  New Recommendations/Action Steps:
  No recommendations
* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  NA
  Expected Outcome:
* N/A

OBJECTIVE Maintain or Improve Consumer Satisfaction

Goal Maintain or Improve Satisfaction Score of 4.6 or higher on a 5 point scale

MET / NOT MET

Update on Previous Recommendations:

It was recommended to keep this goal as written.

Update on Previous Action Steps: NA

Current Status of Action Step and completion date: NA

* **Comparison of Results/Action Steps Taken:**
  The average score for the year 2012 – 2013 was 4.85. 127 satisfaction surveys were mailed to families/consumers and 65 of those surveys were returned. The average score this year was 4.88 of consumers very satisfied with services. For the year 148

satisfaction surveys were mailed to families/consumers and 75 of those surveys were returned. The results of consumer satisfaction surveys were reviewed with Care Providers during each Quarterly Care Provider Meeting (October 16 & 17, 2013, January 22 & 23, 2014, April 23 & 24, 2014 and July 23 &24, 2014).

New Recommendations/Action Steps:

No recommendations

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  NA
  Expected Outcome:
* N/A

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Increase Number of Families Served

Goal 5 Additional Families per Year

MET / NOT MET

Update on Previous Recommendations:

It was recommended to keep this goal as written.

Update on Previous Action Steps:

Action Step #1: NA

Current Status of Action Step and completion date:

N/A

* **Comparison of Results/Action Steps Taken:**
  The goal was met this year by initiating services for five new families. Currently, there are seven consumers/families on the waiting list for ID Waiver respite and/or SCL services.

New Recommendations/Action Steps:

No recommendations

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  NA
  Expected Outcome:
* N/A

SUPPLEMENTAL MEASURES

Improve family perception of Care Provider Training. Maintain Family Perception of Care Provider Training with a score of 4.5 or higher on a 5-point scale. The average score for the 2012 – 2013 fiscal year was 5.0. The average score for this fiscal year was 4.95 of families reporting they feel confident in their current Care Provider's training and skills to perform their job in a professional manner.

DISCHARGED CONSUMER DEMOGRAPHICS

Five consumers were discharged from Link's Family Support Services program this year. Two females and three males no longer needed respite services. All five residing in Polk County. Four Caucasian and One Hispanic-American ethnicity. Ages were 8, 9, 20, 21, and 24. The youngest consumer needed ABA therapy and the family decided an agency offering the intense ABA

structure is what they needed. The nine year olds family decided the Ill and Handicapped Waiver would better meet their needs. The twenty year old is so busy with school that respite was no longer needed. The twenty-one year old and his family moved to Arizona and the twenty-four year old is very independent, works full-time and decided respite is not a need.

CONSUMER DEMOGRAPHICS

Respite demographics only changed slightly over the years. The program typically consists of half females and half males, age's range from 0-4 up to 35-64 years old, the majorities are of Caucasian ethnicity, and the majority of consumers reside in Polk County. Due to the requirement imposed by the ID Waiver, all consumers have a primary diagnosis of Intellectual Disability with a wide range of secondary disabilities.

UNITED WAY RESPITE MEASURES OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014

Jessica Kirts, Family Support Services Administrator

ADMINISTRATIVE FEEDBACK

6 Goals

5 MET

1 NOT MET

The value of in-home services to the primary care givers of consumers served continues to be high as illustrated by the scoring on the parent and consumer's satisfaction survey. United Way respite continues to be a "favorite" due to the flexibility of the program versus some of the restrictions imposed by Waiver funding. The maintenance of 100% of all family's children in the family home further speaks to the success of the in-home respite service option. To further insure family and consumer feedback and satisfaction, follow up phone calls were made to family members that had not returned the quarterly survey.

The results of the satisfaction survey and positive feedback from families were reviewed at each quarterly meeting with care providers to create an increased awareness of the family's satisfaction and appreciation for the support provided. Any suggestions shared by family care givers were also shared for the benefit all care providers. The Care Provider of the Quarter continues to acknowledge employees whom families have deemed exceptional and to again inspire others.

The correlation between direct family referrals and the reduction of wait lists continues to be greater than any other recruitment effort. The list of families awaiting services as well as families needing additional care providers is mailed or emailed to all care providers monthly and was reviewed during each quarterly meeting. New hires are advised additional hours and families are available. Link representatives continue to participate in Parent Informational Fairs, speaking engagements to introduce and review services as well as job and volunteer Fairs.

The Family Support Services Administrator continues to collaborate with other area providers and case managers to assure the successful coordination of respite services designed to meet each individual family's needs. Network providers consistently work together rather than compete with each other, always with the consumer and family's needs at the forefront.

The United Way funded program continues to meet a critical need for families not eligible for Waiver services as well as emergent needs. Case managers in central Iowa are aware of the United Way support as an alternative and access it when appropriate.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Maintain or Improve the Number of Family Responses

Goal: 48% of satisfaction surveys will be returned.

MET / NOT MET

Update on Previous Recommendations:

It was recommended to keep this goal as written.

Update on Previous Action Steps:

Action Step #1:

Current Status of Action Step and completion date: N/A

Comparison of Results/Action Steps Taken:
Each quarter met or surpassed the goal of 48%. The first quarter score was 50%, the second quarter score rose to 53% and the third and fourth quarters were 50% of satisfaction surveys being returned. Last year's average was 51% of surveys returned. The FSS Administrator collected and tracked the number of surveys sent and the number of responses returned. An average of 4 calls each quarter were made by the Administrator to families not returning the survey.

New Recommendations/Action Steps:
No recommendations, continue goal.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  NA
* **Person Responsible:**
  NA
  Expected Outcome:
* NA

OBJECTIVE Maintain Approved Number of Hours of Service

Goal 100% of Family's Service Use will be At or Below the Approved Hours

MET / NOT MET

Update on Previous Recommendations:
It was recommended to keep this goal as written.

Update on Previous Action Steps:
Action Step #1: N/A

Current Status of Action Step and completion date:
NA

Comparison of Results/Action Steps Taken:
For waiver year 2012 - 2013, 100% of families/consumers continued to utilize at or below the number of hours approved. 100% was met this year as well.

New Recommendations/Action Steps:
No recommendations, continue goal.

* **Action Step:**
  N/A
* **Timeframe for completion:**
  N/A
* **Person Responsible:**
  NA
  Expected Outcome:
* N/A

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Promote Maintenance of the Child with Disabilities in the Family Home

Goal 100% of all Consumers will Remain in the Family Home

MET / NOT MET

Update on Previous Recommendations:
It was recommended to keep this goal as written.

Update on Previous Action Steps:
Action Step #1: N/A

Current Status of Action Step and completion date:
NA

* **Comparison of Results/Action Steps Taken:**
Goal expectancy of 100% was met 2012 – 2013. Goal expectancy of 100% was met this year.

New Recommendations/Action Steps:
Keep goal as written.

* **Action Step:**
N/A
* **Timeframe for completion:**
N/A
* **Person Responsible:**
NA

Expected Outcome:

* N/A

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Maintain or Improve Parent/Guardian Satisfaction and Ability to Cope with Stress

Goal Maintain or Improve Satisfaction Score of 4.6 or higher on a 5 point scale

MET / NOT MET

Update on Previous Recommendations:
It was recommended to keep this goal as written.

Update on Previous Action Steps: NA

Current Status of Action Step and completion date: NA

* **Comparison of Results/Action Steps Taken:**
The average score for the year 2012 – 2013 was 4.8. 127 satisfaction surveys were mailed to families and 65 of those surveys were returned. The average score this year was 4.9. For the year 148 satisfaction surveys were mailed to families and 75 of those surveys were returned. Family responses were positive stating they feel less tense about caretaking responsibilities and better able to engage in other endeavors they were not able to do before receiving respite services. The results of parent satisfaction surveys were review with Care Providers during each Quarterly Care Provider Meeting (October 16 & 17, 2013, January 22 & 23, 2014, April 23 & 24, 2014 and July 23 &24, 2014).

New Recommendations/Action Steps:
No recommendations

* **Action Step:**
N/A
* **Timeframe for completion:**
N/A
* **Person Responsible:**
NA

Expected Outcome:

* N/A

OBJECTIVE Maintain or Improve Consumer Satisfaction

Goal Maintain or Improve Satisfaction Score of 4.6 or higher on a 5 point scale

MET / NOT MET

Update on Previous Recommendations:
It was recommended to keep this goal as written.

Update on Previous Action Steps: NA

Current Status of Action Step and completion date: NA

* **Comparison of Results/Action Steps Taken:**
  The average score for the year 2012 – 2013 was 4.8. 127 satisfaction surveys were mailed to families/consumers and 65 of those surveys were returned. The average score this year was 5.0 of consumers very satisfied with services. For the year 148 satisfaction surveys were mailed to families/consumers and 75 of those surveys were returned. The results of consumer satisfaction surveys were review with Care Providers during each Quarterly Care Provider Meeting (October 16 & 17, 2013, January 22 & 23, 2014, April 23 & 24, 2014 and July 23 &24, 2014).
  New Recommendations/Action Steps:
  No recommendations
  * **Action Step:**
    N/A
  * **Timeframe for completion:**
    N/A
  * **Person Responsible:**
    NA
    Expected Outcome:
  * N/A

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Increase Number of Families Served

Goal 5 Additional Families per Year

MET / NOT MET

Update on Previous Recommendations:
It was recommended to keep this goal as written.

Update on Previous Action Steps:
Action Step #1: NA

Current Status of Action Step and completion date:
N/A

* **Comparison of Results/Action Steps Taken:**
  This is the third year that this goal has not been met. Services were initiated for 3 new families with United Way funds this year, however there is no waiting list for this service. Five new families began receiving ID Waiver Services.
  New Recommendations/Action Steps:
  Will continue to work with Case Managers to identify families/consumers that would benefit from United Way funded respite.
  * **Action Step:**
    FSS Administrator will work with Case Managers to promote this option.
  * **Timeframe for completion:**
    Yearlong
  * **Person Responsible:**
    Family Support Services Administrator
    Expected Outcome:
  * To serve families/consumers not eligible for ID Waiver Services.

SUPPLEMENTAL MEASURES

Improve family perception of Care Provider Training. Maintain Family Perception of Care Provider

Training with a score of 4.5 or higher on a 5-point scale. The average score for the 2012 – 2013 fiscal year was 4.83. The average score for this fiscal year was 5.0 of families reporting they feel confident in their current Care Provider's training and skills to perform their job in a professional manner.

DISCHARGED CONSUMER DEMOGRAPHICS

Five consumers were discharged from Link's Family Support Services program this year. Two females and three males no longer needed respite services. All five residing in Polk County. Four Caucasian and One Hispanic-American ethnicity. Ages were 8, 9, 20, 21, and 24. The youngest consumer needed ABA therapy and the family decided an agency offering the intense ABA structure is what they needed. The nine year olds family decided the Ill and Handicapped Waiver would better meet their needs. The twenty year old is so busy with school that respite was no longer needed. The twenty-one year old and his family moved to Arizona and the twenty-four year old is very independent, works full-time and decided respite is not a need.

CONSUMER DEMOGRAPHICS

Respite demographics only changed slightly over the years. The program typically consists of half females and half males, age's range from 0-4 up to 35-64 years old, the majorities are of Caucasian ethnicity, and the majority of consumers reside in Polk County. Due to the requirement imposed by the ID Waiver, all consumers have a primary diagnosis of Intellectual Disability with a wide range of secondary disabilities.

SUPPORTED EMPLOYMENT MEASURE OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014
Jess White, Employment Administrator

ADMINISTRATIVE FEEDBACK

9 Goals
2 MET
7 NOT MET

The 2013-2014 fiscal year has brought about many positive changes for the Employment Department. During the first and second quarter the new Employment Administrator, Jess White, transitioned into her new role of overseeing the Pre-Vocational, Skills Training and Supported Employment Programs. This is a very exciting change as this is the first time that all employment-related services have been under the oversight of one administrator. Another major change occurred during the 3rd quarter of the fiscal year when the Executive Director made the decision to add an additional Department Director to the Program Department due to the recent growth of the department. Tiffany Steenblock, the new Employment/Day Program Director, was offered the position & began her transition. The leadership team of the Supported Employment program are continuing to learn their roles and working together to identify the vision for the employment program as a whole.

The Community Placement Manager, previous title, Marketing Manager, was filled during the last quarter of the fiscal year, which was a major accomplishment as the position had been vacant since September 2013. While this position was open the Supported Employment Supervisor stepped in to provide Job Development services but due to responsibilities of his primary role he was only able to provide individuals approximately 1.5 hours of service/month. The Employment Administrator will continuing working with the Community Placement Manager to identify desired outcomes for the program as well as more clearly defining her marketing role to assist individuals for preparing for community employment. With the addition of the Community Placement Manager the Supported Employment Supervisor had the opportunity to focus on his roles and begun holding monthly meeting with all the Employment Training Specialists (ETS's) he supervises. These meeting are vital for effective communication and has allowed the team to discuss concerns and brainstorm ideas with each other on how to positively support the consumers in meeting their goals & maintaining employment. All of the ETS's are paired together and assigned a zone to cut down on travel time & indirect expenses. Now that the zones are firmly established, over the next year it is a goal to work with the Fleet & Facilities Director, who oversees the Link Associates Transportation program, to begin providing transportation services for individuals receiving Supported Employment services. This will allow individuals to arrive timely to their scheduled work shift & allow the ETS's to spend more time on service implementation. Over the last fiscal year all ETS's were provided an ipad to assist in completing their assigned responsibilities while working outside the main office. This has helped to ensure documentation is completed in a timely manner and will also assist with the implementation of the consumer database, to allow the ETS's to access pertinent consumer information while working in the community. It was requested in the 14-15 fiscal year budget to purchase data plans for all the ipads for access to the internet at any time, the Employment Administrator will continue to monitor the monthly financials to assess where the program is at compared to the projected fiscal year budget.

The Employment Administrator and Supported Employment Supervisor have been

meeting with the Polk County Employment Network monthly to discuss/ask questions about the Ticket to Work program. Recently the Supported Employment Supervisor has been utilizing a document called 'monthly earnings estimator' to help efficiently track consumer wage information necessary for submittal for additional funds. The program will continue to set realistic outcomes with the intent to utilize this as an additional funding stream to help cover associated costs within the program. The Community Placement Manager & the Supported Employment Supervisor also meet with members of the Polk County Employment Network monthly to discuss Supported Employment services and any trends the providers are experiencing, best practices for service implementation, networking &/or to bounce ideas off each other. Members of the Link Associates Employment team will continue to meet with the Polk County Employment Network over the next fiscal year.

Over the next year the program would like to continue the discussion of possibly expanding and offering additional training programs to assist with further bridging the gap between the Prevocational services and competitive employment. A google document will be created to help track what is preventing Supported Employment participants from being successful in the program. The document will track barriers and ways to enhance/improve skills. The Employment Administrator will continue to evaluate growth and collaboration with various projects to have one central, guiding vision.

The department would like for the following items to be added to the supplemental measures to better track reasons why job changes occurred for consumers within the program: job advancements, job title change/change of responsibilities, resignation, lay-off & termination. Adding these reasons for job changes will help department personnel to identify patterns/trends, which could assist in making positive changes to service delivery.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Decrease amount of time waiting for job placement

Goal 1: 15 weeks or less

NOT MET

Update on Previous Recommendations *write actual recommendation*

It was recommended to continue goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: Modify the tracking tool to capture referral dates and employment dates of each person served.

Current Status of Action Step and completion date: MET by September 30th, 2013

A Google document was created to efficiently track referral and employment dates. This document is in the process of being updated by the Supported Employment Supervisor, Community Placement Manager and Employment Administrator.

Action Step #2: NA

Current Status of Action Step and completion date: NA

NA

Comparison of Results:

The average was 29 weeks to find a job placement during the 2013-2014 fiscal year. There were a total of 6 placements. The fiscal year 2012-2013 ended with an average of

24 weeks to find placement, and there were a total of 23 placements.

Action Steps Taken: The Marketing Manager position was open from September 2013-May 2014. The position title changed to Community Placement Manager in February 2014. The Community Placement Manager position was filled on 5.5.14. While the position was open the Supported Employment Supervisor generally worked an average of 1.5 hours per month with persons seeking employment. He also met with potential employers to educate them regarding the opportunities available to them with regards to hiring persons with disabilities.

New Recommendations/Action Steps:

It is recommended to keep this goal as written.

* **Action Step:**
  Devise & implement marketing strategies.
* **Timeframe for completion:**
  Quarterly through June 30th, 2015
* **Person Responsible:** *(Job title)*
  Community Placement Manager and Employment Administrator
  Expected Outcome:
* Increase community awareness & potential community business relationships.

OBJECTIVE Maintain cost of services to budget projections

Goal 2: YTD cost of service will be at or lower than budgeted

NOT MET

Update on Previous Recommendations

It was recommended to continue the goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: To implement practices to ensure tracking to support timely submittals for Ticket to Work, an additional funding stream.

Current Status of Action Step and completion date: MET by September 30, 2013
The Supported Employment Supervisor tracks the hours/wages of persons employed on the updated Link SE-20 form, Link Associates may be eligible to receive additional funding to offset expenses.

Action Step #2: NA

Current Status of Action Step and completion date: NA
NA

Comparison of Results:

The fiscal year 2013-2014 goal was not met and ended with an additional loss of ($38,203) compared to the YTD budgeted loss of ($63,623). During the fiscal year 2012-2013 the goal was met with a loss of ($61,782), compared to the YTD budgeted loss of ($79,041), hence a variance of $17,259.

Action Steps Taken: The Employment Administrator and Supported Employment Supervisor monitored the job coaching services provided by each Employment Training Specialist closely, to ensure they were meeting the targets in which the budget was built. The department continues to work with the Polk County Employment Network (EN) to submit for additional funds through the Ticket to Work Program.

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** *(Job title)*

NA

Expected Outcome:

* NA

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Maintain or increase number of hours worked weekly

Goal 1: To maintain or increase # of hours worked weekly to 20 or more

NOT MET

Update on Previous Recommendations

It was recommended to continue the goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: Evaluate the current tool(s) being used to track the average hours per week to prevent duplication.

Current Status of Action Step and completion date: MET by September 30th, 2013

A google document was updated to help effectively track this information.

Action Step #2: NA

Current Status of Action Step and completion date: NA

NA

* **Comparison of Results:**

  During the fiscal year 2013-2014 the consumer's average number of hours worked was 14.75. The average hours worked during the fiscal year 2012-2013 was 16 hours per week.

  Action Steps Taken: The Supported Employment Supervisor and Employment Training Specialists continued to work closely with the employers, consumers and team to determine if working additional hours per week would be in the best interest of the employer and consumer.

  New Recommendations/Action Steps:

  It is recommended to continue the goal as written.

  * **Action Step:**
    Meet with Supported Employment Supervisor at least quarterly to discuss the number of hours consumers are working per week and meet with employer to increase if requested.
  * **Timeframe for completion:**
    Quarterly through June 30th, 2015
  * **Person Responsible:** ***(****Job title)*
    Supported Employment Supervisor and Employment Administrator

    Expected Outcome:
  * Increase individual scheduled hours per week.

OBJECTIVE Increase number of consumers transferring to competitive employment

Goal 2: Two or more discharges annually due to competitive employment

MET

Update on Previous Recommendations

It was recommended to continue the goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: NA

NA

Action Step #2: NA

Current Status of Action Step and completion date: NA
NA

* **Comparison of Results:**
During the fiscal year 2013-2014 there were 5 persons who discharged into competitive employment. During the 2012-2013 fiscal there were 2 persons who discharged into competitive employment.
Action Steps Taken: The program provided 18 months of follow along when a consumer no longer needed an Employment Training Specialist onsite for supports. This follow along often occurs by a phone call from the Supported Employment Supervisor to the employer to verify no additional supports are needed. If a need was identified then an ETS will provide onsite supports. After 18 months of follow along with no additional supports, the program recommends for discharge as the person has demonstrated they are competitively employed.
New Recommendations/Action Steps:
It is recommended to change the goal to read 'three or more discharges annually due to competitive employment.'
* **Action Step:**
NA
* **Timeframe for completion:**
NA
* **Person Responsible:** ***(****Job title)*
NA
Expected Outcome:
* NA

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Maintain or increase quality service relationships with employers

Goal 1: Maintain or improve satisfaction score of 4 (5 point scale)

NOT MET

Update on Previous Recommendations
It was recommended to change the goal to read 'maintain or improve satisfaction score to 4 from 4.5.'

Update on Previous Action Steps *(action step recommendations from last years.)*
Action Step #1: NA
Current Status of Action Step and completion date: NA
NA
Action Step #2: NA
Current Status of Action Step and completion date: NA
NA

* **Comparison of Results:**
The average satisfaction score for fiscal year 2013-2014 is 3.95. The notations on the surveys ranged from, "We enjoy having David and Terry as part of our team," to staff does not show up to work in a timely manner and spends his hours here on his ipad/computer or cell phone. Immediate follow-up occurred with the employee about getting to work in a timely manner and use of ipad/cell phone; with follow-up to that employer that they had no longer observed that staff on his ipad/phone. This is a decrease in satisfaction from fiscal year 2012-2013 with a score of 4.13.
Action Steps Taken: Employment Training Specialists do try to be available to the employer, as well as be attentive to the performance of the consumer/employee. If the performance does not seem to align with the responsibilities previously outlined to Link

personnel, then the ETS will step in and provide supports as needed without interfering with the role of the supervisor.

New Recommendations/Action Steps:

It is recommended to keep the goal as written.

* **Action Step:**
  Send surveys to new businesses after 60 days of consumer employment & one time per year for others, which will be spaced throughout all quarters.
* **Timeframe for completion:**
  Through June 30, 2015
* **Person Responsible:** *(Job title)*
  Supported Employment Supervisor
  Expected Outcome:
* To acquire feedback from new businesses timely to remedy concerns and increase satisfaction as well as seeking feedback throughout the year to enhance relationships.

OBJECTIVE Decrease discharges due to dissatisfaction

Goal 2: No more than one discharge annually due to dissatisfaction

MET

Update on Previous Recommendations

It was recommended to continue the goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: NA
NA

Action Step #2: NA

Current Status of Action Step and completion date: NA
NA

* **Comparison of Results:**
  There were no discharges due to dissatisfaction during both fiscal year 2012-2013 and 2013-2014.
  Action Steps Taken: None indicated.
  New Recommendations/Action Steps:
  It is recommended to continue this goal as written.
  * **Action Step:**
    NA
  * **Timeframe for completion:**
    NA
  * **Person Responsible:** *(Job title)*
    NA
    Expected Outcome:
  * NA

OBJECTIVE Improve consumer satisfaction

Goal 3: Maintain or improve consumer satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations

It was recommended to continue the goal as written.

Update on Previous Action Steps *(action step recommendations from last years.) RE*

Action Step #1: NA

Current Status of Action Step and completion date: NA
NA

Action Step #2: NA

Current Status of Action Step and completion date: NA

NA

* **Comparison of Results:**

During the 2013-2014 fiscal year the score decreased to 4.87 from the 2012-2013 fiscal year score of 4.9.

Action Steps Taken: It is not uncommon for the ETS to make themselves available at various times of the day and week to be onsite to support a consumer/employee when needed. The ETS' also have made themselves available to take phone calls outside of scheduled support times.

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

* **Action Step:**

  Meet individually with consumers who are receiving Job Coaching services at least one time during the next year to gauge satisfaction.
* **Timeframe for completion:**

  Through June 30th, 2015
* **Person Responsible:** ***(****Job title)*

  Supported Employment Supervisor

  Expected Outcome:
* Receive additional consumer input and put measures in to place to improve satisfaction prior to annual survey if needed.

OBJECTIVE Improve parent/guardian satisfaction

Goal 4: Maintain or improve parent/guardian satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations

It was recommended to continue the goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: NA

NA

Action Step #2: NA

Current Status of Action Step and completion date: NA

NA

* **Comparison of Results:**

During the 2013-2014 fiscal year the parent/guardian score decreased to 4.87. The parent/guardian satisfaction goal was met during the fiscal year 2012-2013 with a score of 4.9.

Action Steps Taken: The Employment Administrator, Supported Employment Supervisor and Employment Training Specialists continued to take steps to be available to parents/guardians to answer questions, as well as educate them on the purpose and role of Supported Employment. There are often misgivings that an ETS should always be present, where the goal is to support the consumer/employee as needed, yet help develop the supports on the job to reduce the need of a job coach.

New Recommendations/Action Steps:

It is recommended to continue this goal as written.

* **Action Step:**

  NA
* **Timeframe for completion:**

  NA

* **Person Responsible:** *(Job title)*
  NA
  Expected Outcome:
* NA

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Increase number of consumers served

Goal 1: Approve admissions for 20 persons

NOT MET

Update on Previous Recommendations

It was recommended that the goal reflected on the MOA is the new admissions into the program vs. the number of persons served in totality.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: NA
NA

Action Step #2: NA

Current Status of Action Step and completion date: NA
NA

* **Comparison of Results:**
  During the 2013-2014 fiscal year there were 16 persons admitted into the Supported Employment program; however there were 14 discharges for a growth of 2, bringing the year end number of persons served to 59. The program experienced growth of 20 new admissions during fiscal year 2012-2013; however there were 15 discharges for a growth of 5, bringing the year end number of persons served to 65.
  Action Steps Taken: The Employment Administrator and Supported Employment Supervisor worked closely with the Admissions Chairperson to assess if and when the program was able to approve any referrals to the program. The Employment Administrator also worked with the Admissions Chairperson to accept Job Development referrals for individuals who 'graduated' from the Link General Store training program.
  New Recommendations/Action Steps: *xpected outcomes below)*
  It is recommended to continue this objective as written.
  * **Action Step:**
    Meet with Admissions Committee Chair to assess persons on referral list requesting Job Coaching services.
  * **Timeframe for completion:**
    September 30th, 2014
  * **Person Responsible:** *(Job title)*
    Employment Administrator
    Expected Outcome:
  * Increase number of approved admissions into program.

SUPPLEMENTAL MEASURES

1. Number of consumers earning benefits:
   An average of 5 consumers earn benefits from their place of employment. Benefits were generally the accruing of PTO, sick leave, and/or retirement.
2. Number of consumers with job advancements:
   There were no job advancements for the persons Link Associates served this fiscal year.
3. Number of consumers with job changes:
   There were 13 consumers who experienced job changes. Job changes were defined as

transfer from one position to another, termination, resignation, or layoff. Due to the current data collection practices it is possible the 13 consumers who experienced job changes may be duplicated indicating they may have resigned from one place of employment and laid off from another place of employment.

4. Average number of hours of staff intervention per month:
   The average hours a consumer in the program receives is 13.4 hours a month. This is approximate 1.4 hours more than the 2012-2013 fiscal year.
5. Report consumer average monthly earnings:
   The average weekly earnings a consumer earned this year was $123.64. This is less than the 2012-2013 fiscal year average of $134.65.
6. Discharges from program (not due to dissatisfaction)
   - medical supports/safety = 0
   - moved out of service area = 2
   - no longer in need of services = 11
   - increase in supports (non medical) = 1
   - number of involuntary discharges = 0
   - no funding available = 0
   - total number outside of Link services = 2

   There were only 2 persons who discharged from Link's SE program who sought services elsewhere; these discharges were not due to dissatisfaction. Both persons were to participate in either a training program such as Project SEARCH or continued with day programming elsewhere.

CONSUMER DEMOGRAPHICS

The average participant in the Supported Employment program is a Caucasian male between the ages of 35-54 years old with a primary diagnosis of Mild ID. The participant does not have a guardian and is of Polk County legal settlement.

Of the persons who discharged services, the demographics are as follows: a Caucasian male between the ages of 25-34 years old with a primary diagnosis of Mild ID. The participant does not have a guardian and is of Polk County legal settlement.

SUPPORTED LIVING OF ACHIEVEMENTS

July 1, 2013 – June 30, 2014
Robert Aiken, Residential Administrator

12 Goals

4 MET
8 NOT MET

During this fiscal year, the Program Director position was restructured into two positions: Supported Living Director and Employment/Day Program Director. This has enabled the Supported Living Director to focus solely on the needs of the residential programs: Community Housing and Supported Living. This will and has significantly impacted the growth and direction of these programs in the coming months and year(s).

The recommendations in the administrative feedback for 2013-2014 were:

- To finalize and implement a new format for the consumer meeting minutes, which was completed;
- To continue to make improvements to the biannual medication manager which was done (and continues to be on-going) as the agency nurse sought feedback from the program supervisors to identify areas that needed further review/training, which was then used to development the agenda for the med manager review; as well as identify the need to keep the format of this training with hands-on components vs. online;
- To adapt the Quality Outcome Indicator tool to be more user friendly and an all encompassing document – the draft was reviewed and cross referenced to CARF standards, along with additional areas identified to reflect the standards important To Link Associates; yet has not been implemented. Late in the fiscal year initial efforts were made to evaluate how to make this an electronic document that is editable, and email-able, which failed. And is now being coordinated with the IT Director.
- Evaluate if utilizing the E-Doc software to complete medical and behavioral incident reports is feasible/efficient – and it was decided to proceed in transitioning away from paper incident reports to using E-Doc in November 2013. This has enabled information to be routed to multiple personnel faster.

Each of these endeavors was to improve the effectiveness and efficiencies of current processes within the program department. Although there is more work to be done, the program is pleased with the outcomes produced this past year.

It was also recommended to:

- Evaluate the need for tracking data on referrals to the RCF group homes that opted not to tour to assess if there were any patterns/trends of the referrals to identify if there was a gap in service delivery, where Link could then assess what was needed to meet that need. There was a discussion with the Admissions Chairperson on how to capture this information, however the implementation of the information discussed has not been implemented yet.
- Discontinue the tracking of consumer's increasing and decreasing support needs on the supplemental measures – this was implemented.

Entering the 2014-2015 FY, the Community Housing and Supported Living programs have identified two primary goals –

- Focus on training to include agency trainings and competencies; supervisory training expectations with DSP's; specific training topic needs including but not limited to: diagnosis specific, basic cooking/meal prep, Medicaid requirements, and

crucial conversations.
- Increase focus on customer service philosophy by finding ways to make sure employees feel heard, create a “standard operating procedure” on how to interact with each other, timely responses to stakeholders, how to recognize that everyone is important, and general interactions (greetings). The customer service concepts will be applied to consumers, families, team members, and coworkers.

These two goals will drive the direction of the program. Efforts have already begun to address the goals noted such as: the administrative team has outlined a new format for training new employees, and have begun reviewing the current training practices by supervisors (a survey was distributed and input gathered), and the tools they use. Additionally, several sections of the Residential Supervisor manual have been updated and topics continue to be identified that need to be developed to promote consistency in practices among all program supervisors. Discussions are occurring within the program department regarding daily documentation practices, and in May 2014 a memo was redistributed to staff outlining the expectations for documentation entry and documentation corrections. Regarding customer service, efforts at this juncture focus on identifying best practices and empowering our supervisors and staff to go that extra mile to make our stakeholders feel special. These discussions will continue to guide the management team on setting clear expectations that align with consistency and quality outcomes.

It is also recommended to further evaluate the need for the data regarding where new consumers served come from (ex. move from parent/guardian home; move from another HCBS setting, etc.) on the supplemental measures. If not necessary, then it is recommended to discontinue tracking this information. It is also recommended to evaluate the start of tracking med errors, if not tracked/monitored elsewhere, or if it would be beneficial to track specific information relevant to the residential programs. It is also being considered to track staff retention, or a version of staff retention. The programs want to identify data to collect that would help demonstrate the effectiveness of the training and tools implemented to achieve our goals. The residential department continues to strive to provide the highest quality of service and enhance the quality of life possible for those Link Associates supports.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Maximize Service Utilization

Goal # 1 Utilize 90% of services authorized

NOT MET

Update on Previous Recommendations It was recommended to keep goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A
N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

Comparison of Results:

The median average for 2012-2013 was 78.5% making the goal unmet in the previous fiscal year. The median average for 2013-2014 is 70.25%. This is a reduction of 8.25% in service utilization from the previous fiscal year. An overall trend towards lower

utilization percentages across all quarters occurred during 2013-2014. The goal to achieve 90% utilization of services authorized was unmet. The lowest utilization percentages for 2013-2014 were in 2nd quarter with 63%. The highest percentage charted was during the 1st quarter at 75%.

Action Steps Taken:

High turnover rates of supervisors within the residential department correlate with a decline in hourly service utilization. The ability to identify, hire, and train qualified staff is hindered when seasoned supervisors leave their position. A "lack of available staff" (where hours are left unfilled) became a factor in the loss of utilization. Residential supervisors are expected to work unfilled shifts according to their availability. This is not always feasible, and in the instance where hours are left unfilled, supervisors are working closely with consumers and families to assure that critical health and safety needs are being met. In response to the "lack of staff" available, a hold was in place during the fiscal year for generalized admissions into the Supported Living hourly program, the intention being to focus on hiring and retaining staff to work with consumers already in the program. A primary contributing factor towards service underutilization however remains "consumer choice" (in which consumers refuse services). Consumers being unavailable due to camps, vacations, holidays, incarceration, or by parent/guardian choice negatively impacted service utilization throughout the year. For consumers consistently failing to meet their authorized units for these reasons, supervisors are encouraged to share historical data on utilization with case managers and parents in an effort to 'right size' the authorization. However, it is unclear if these conversations with teams occurred. This process needs to be formalized in the coming year to be sure Medicaid monies and agency efforts are aligned with consumer needs. There were a handful of consumers that did not receive any service at all during various periods during the fiscal year. Consumer TH began refusing staff in December 2013 and received no services (0% utilization) until her discharge from the program in April 2014. Similarly, consumer CJ had received no services since January 2014 up until discharge on April 30th, 2014. These instances were a result of consumers declining services. In a program serving approximately 30 persons, when 5 consumers are regularly receiving <20% service utilization, the overall utilization numbers will suffer, and not accurately reflect the program performance. The goal to provide 90% of services authorized will not be reached as long as these outliers are utilizing little to none of their authorized services.

New Recommendations/Action Steps:

It is recommended to keep this goal as written.

* **Action Step #1:**
  Evaluate financial status to hire and train a residential supervisor whose area of oversight will solely encompass the quality provision of service to hourly consumers. This supervisor will assure services provided are aligned with a consumer's approved plan, strive to maximize service utilization, and work direct care shifts as needed.
* **Timeframe for completion:**
  January 1, 2014
* **Person Responsible:** ***(Job title)***
  Residential Administrators
  Expected Outcome:
* An increase in service utilization during the 2014-2015 fiscal year.

* **Action Step #2:**
  Evaluate historical utilization percentages to determine if units authorized are appropriate and make recommendations to teams as needed. Flag for review

consumers utilizing <90% of their authorized services in consecutive months.

* **Timeframe for completion:**
  June 30, 2015
* **Person Responsible:** ***(****Job title)*
  Residential Administrators, Residential Supervisors
  Expected Outcome:
* Collaboration between teams and residential supervisors to better represent and serve the needs of the consumer. Increase utilization percentages by reducing the margin between services authorized versus services utilized.

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Increase independence of consumer

Goal # 1 Three or more consumers who have had a reduction in the # of restrictions

NOT MET

Update on Previous Recommendations It was recommended to keep goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: N/A

Current Status of Action Step and completion date: N/A
N/A

Action Step #2: N/A

Current Status of Action Step and completion date: N/A
N/A

* **Comparison of Results:**
  For 2012-2013 the number of consumers in the Supported Living hourly program who saw a reduction in the number of restrictions was 5 while the number of consumers in the Supported Living site program who saw a reduction in the number of restrictions was 2. This brings the total number of persons who had a decrease in restrictions for the Supported Living program to 7. For 2013-2014 the number of consumers in the Supported Living hourly program who saw a reduction in the number of restrictions was 0 (zero). The number of consumers in the Supported Living site program who saw a reduction in the number of restrictions was 1. MM had a restriction regarding overnight visits with a family member lifted at her annual staffing in July 2013. A number of consumers had an increase in their number of restrictions. The goal to have three or more consumers with a reduction in restrictions was not met.
  Action Steps Taken: Consumer restrictions are reviewed at minimum once per year during the annual staffing process. Steps are taken by a consumer's team to remove restrictions that are deemed unnecessary or outdated. Teams should be reviewing and assessing how to remove restrictions.
  New Recommendations/Action Steps:

  Recommended to continue goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** ***(****Job title)*
  NA
  Expected Outcome:
* NA

OBJECTIVE Increase the number of Consumers Moving Into a least Restrictive Employment

Program

Goal # 2 3 or more consumers moving into a least restrictive employment setting

MET

Update on Previous Recommendations It was recommended to keep goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A

NA

Action Step #2: NA

Current Status of Action Step and completion date: N/A

NA

* **Comparison of Results:**

Two consumers in supported living moved to a least restrictive employment program in 2012 – 2013. For 2013 – 2014 there were seven consumers who moved into a least restrictive employment program. Three of those consumers were from the Supported Living hourly program and four from the Supported Living site program. One consumer began community employment with job coaching, one consumer transitioned from Link PreVoc into a Project Search placement with Hy-Vee, and five consumers began training in the Link General Store program.

Action Steps Taken: Residential supervisors continued to support and encourage consumers in moving towards least restrictive employment programs. New employment opportunities presented themselves in the form of the Link General Store program and a Project Search partnership between Link and Childserv. Supervisors worked with the supported employment department and Case Managers to identify employment opportunities. Residential staff worked with consumers to assist with developing routines such as creating weekly schedules, setting alarms, selecting and wearing appropriate clothing, proper hygiene, reviewing skills for alone time, work and home safety, and practicing transportation procedures. In addition staffing patterns were reviewed by supervisors and adjusted accordingly in order to support consumers' needs when employment situations changed.

New Recommendations/Action Steps:

Recommended to continue goal as written.

* **Action Step:**

  NA

* **Timeframe for completion:**

  NA

* **Person Responsible:** ***(****Job title)*

  NA

  Expected Outcome:

* NA

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Decrease discharges due to dissatisfaction

Goal # 1 No more than one discharge annually due to dissatisfaction

MET

Update on Previous Recommendations It was recommended to continue goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A

NA

Action Step #2:

Current Status of Action Step and completion date: N/A

NA

* **Comparison of Results:**

There were two discharges due to dissatisfaction during the 2012 – 2013 year. Once from the Supported Living hourly program and one from Supported Living site program. In 2013 – 2014 there was one discharge due to dissatisfaction therefore the goal was met. During the 3rd quarter there was a discharge (J.T.) in the Supported Living hourly program due to dissatisfaction. According to the Change of Status form, the consumer states he wants to change providers because his staff was making fun of his hair.

Action Steps Taken: Reason and disposition at time of discharge are identified on the C35 Change of Status and CM18 Discharge Summary forms. Discharges that reflect poorly on the agency count against the achievement of this goal. When consumers, parents, guardians or team members identified areas of concern, supervisors and administrators worked to address issues and develop plans to support the needs of the consumer. Administrators continue to emphasize the importance of teams and team meetings to address areas of dissatisfaction to support the consumers. For the individual discharging due to dissatisfaction in the 3rd quarter, efforts were made to repair the relationship between that consumer and his staff. It could not be verified that statements were made by staff poking fun at the consumer's hair. When questioned by the residential supervisor, both consumer and staff denied that the incident had occurred. Further examination discovered that the consumer had grown fond of a direct care professional working in the same apartment complex, employed by another provider. The consumer sought placement with that provider upon discharge. Monthly outcome indicators by supervisors explored the satisfaction of consumers with where they lived, with whom they lived with, and their staff. Supervisors and/or administrators followed up with parents/guardians with the progress being made and attended team meetings as needed. Supervisors and administrators worked with teams to clarify issues and develop plans to progress forward.

New Recommendations/Action Steps:

Recommended to continue goal as written.

* **Action Step:**

  NA

* **Timeframe for completion:**

  NA

* **Person Responsible:** ***(****Job title)*

  NA

  Expected Outcome:

* NA

OBJECTIVE Improve Consumer Satisfaction

Goal # 2 Maintain or improve satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations It was recommended to keep goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A

NA

Action Step #2:

Current Status of Action Step and completion date: N/A

NA

* **Comparison of Results:**
  In Supported Living hourly and site programs the average consumer satisfaction score for the 2012-2013 year was 4.89 on a five-point scale. This score was derived from 50 consumer responses. For 2013-2014 the average consumer satisfaction score was 4.80 on a five-point scale. This score is derived from 57 consumer responses from the Supported Living hourly and site programs. The average for consumer satisfaction in the Supported Living hourly program, in which 30 individuals responded, was 4.83. The average for consumer satisfaction in the Supported Living site program, with 27 responses, was 4.775.

  Action Steps Taken: This data is gathered from responses by Supported Living program consumers to a survey administered by Case Management. No specific action was taken during the fiscal year to improve satisfaction scores as they fluctuate greatly from quarter to quarter. Furthermore average quarterly scores are not offset to account for the number of responses. The first quarter average score for the Supported Living site program of 4.43 was based on only 3 responses (11% of total), however it counts towards 25% of annual satisfaction for that program. Residential supervisors monitor consumer satisfaction levels through regular site visits. Supervisors continued to assure monthly consumer meetings were held to provide opportunities for consumers to share their concerns and desires, to discuss rights and responsibilities, and arrange activities as consumers desired. With the monthly outcome indicators, supervisors provide consumers the opportunity to share their wants and needs and their perception of services provided. Consumers are also supported in having a voice within the hiring process through which they interview and provide their feedback on the hiring of potential staff.

  New Recommendations/Action Steps:
  Recommend keeping the goal as written.

  * **Action Step:**
    Identify practices to implement should satisfaction scores continue to decline
  * **Timeframe for completion:**
    June 30, 2015
  * **Person Responsible:** ***(****Job title)*
    Residential Supervisors
    Expected Outcome:
  * To increase consumer satisfaction with regards to services they receive.

OBJECTIVE Improve Parent/Guardian Satisfaction

Goal # 3 Maintain or improve satisfaction score of 4.9 (5 point scale)

MET

Update on Previous Recommendations It was recommended to keep goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A
NA

Action Step #2:

Current Status of Action Step and completion date: N/A
NA

* **Comparison of Results:**
  The average score for both Supported Living hourly and site programs in 2012-2013 was 4.99 on a 5-point scale. That was based on 36 survey responses. The average parental satisfaction score in 2013-2014 was 4.9 on a 5-point scale. That score is based on 35

responses. This goal was met for the year. 17 parents/guardians responded for the Supported Living hourly program with an average score of 4.86. 18 parents/guardians responded for the Supported Living site program with an average score of 4.94.
Action Steps Taken: Residential supervisors are encouraged by administrators to communicate regularly with parents/guardians. Supervisors and administrators maintained communication with parents/guardians via phone or email conversations to address any concerns. Parents and guardians are regularly invited to contribute to team meetings and service planning. In the absence of a residential supervisor, parents/guardians are encouraged to contact residential administrators. For the new Supported Living daily site that opened in September, the site supervisor sends on a monthly basis consumer routine checklists and activity updates. Parent/guardian satisfaction has improved greatly for this group since choosing Link as their residential provider.
New Recommendations/Action Steps:
Recommend keeping the goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** ***(****Job title)*
  NA
  Expected Outcome:
* NA

OBJECTIVE Improve Consumer satisfaction with where they live

Goal # 4 Maintain or improve satisfaction score of 4.9 (5 point scale)

NOT MET

Update on Previous Recommendations It was recommended to keep goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A
NA

Action Step #2: NA

Current Status of Action Step and completion date: N/A
NA

* **Comparison of Results:**
  The average score for both Supported Living hourly and site programs in 2012-2013 was 4.81 on a 5-point scale. Supported Living hourly services had an average score was 4.88 with 20 responses. Supported Living site services had an average score of 4.75 with 30 responses. During 2013-2014 the average score for consumer satisfaction across both site and hourly programs was 4.49. This score is based on 57 responses. This is decrease of nearly a third of a point. Supported Living hourly services had an average score of 4.53 with 30 responses. Supported Living site services had an average score of 4.455 with 27 responses.
  Action Steps Taken: Supported Living hourly consumers are visited a minimum of once per month and Supported Living site consumers twice or more per month. Consumers are given the opportunity to voice concerns/dissatisfaction with living situations during these visits. Consumers are encouraged to share their concerns or preferences at a minimum monthly through consumer meetings. Residential staff are instructed to share consumer's discontent for their living arrangement during staff meetings, through direct contact with supervisors, or in their documentation. During 2013 – 2014, many more

consumers expressed discontent with their living arrangement than did in previous years. Residential supervisors and administrators worked with discontented consumers in order to remedy housing concerns. There were numerous moves by consumers in both Supported Living programs during the latter quarters of 2013-2014. Consumers were supported by supervisors and staff in identifying new living arrangements by touring apartment complexes, completing application paperwork, paying fees and moving to their new locations. Hopefully these moves will contribute to improved scores in the coming year. A number of resources are available to consumers unhappy with their current living arrangements. Link representatives regularly attend Polk County Health Services' Roommate Connections and Residential Options meetings in hopes of finding suitable housemates and housing.

New Recommendations/Action Steps:

Recommend keeping the goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** ***(****Job title)*
  NA
  Expected Outcome:
* NA

OBJECTIVE Improve quality of service

Goal # 5 Average score of 97% or higher

NOT MET

Update on Previous Recommendations It was recommended to continue goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A
NA

Action Step #2: NA

Current Status of Action Step and completion date: N/A
NA

* **Comparison of Results:**
  For 2012-2013 in the Supported Living hourly program the average quality of service score was 91.48%. For the Supported Living site program the average quality of service score was 88.25%. The average quality of service score for the year 2012 -2013 across both Supported Living programs was 89.86%. For 2013-2014 the average for both Supported Living hourly and site programs was 85%. This marks a reduction of 4.86%. The goal again was not met. The failure by supervisors to complete monthly outcome indicator visits at hourly sites remains a primary contributor to negative scores. Daily documentation errors, cleanliness, and medication administration errors were also detrimental. By program, the quality of service for Supported Living hourly averaged 76.56%, and the quality of service for Supported Living sites averaged 92%. These percentages represent the proportion of positive scores to negative scores; 100% would indicate an entirely positive response.

  Action Steps Taken: Residential supervisors are instructed to perform site visits during which quality of service scores are obtained (Outcome Indicator visits). The scores gathered during those visits result primarily from subjective observations of consumers interacting with their staff and the supervisor. Additionally there are measurable appraisals of documentation, medication administration, the handling of consumer funds.

The documentation of those visits is reviewed on a monthly basis by administrators. When Outcome Indicator site visits do not occur during a month in which services were provided, the quality of service scores recorded at that site for that month are entirely negative (0%). Administrators and supervisors engage in conversations about how to improve staff performance and service quality during biweekly face to face meetings. Dialogue between Case Managers and Residential Supervisors occurs during monthly goal update meetings and helps to identify shortcomings and potential improvements to service quality. In-service trainings are provided regularly to supervisors and staff to increase their knowledge of various aspects of consumer care (brain injury, dental hygiene, crisis management, motivational interviewing, Trauma Informed Care).

New Recommendations/Action Steps:

Recommended to continue this goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** ***(****Job title)*
  NA
  Expected Outcome:
* NA

OBJECTIVE Improve consumer's quality of life

Goal # 6 Average score of 98% or higher

NOT MET

Update on Previous Recommendations It was recommended to continue goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A
NA

Action Step #2: NA

Current Status of Action Step and completion date: N/A
NA

* **Comparison of Results:**
  For 2012 - 2013 the Supported Living Hourly consumers averaged 97.75% in the quality of life while those in Supported Living Sites averaged 92.9% in the quality of life category. The combined average score for Supported Living programs for 2012-2013 was 95.33%. For 2013 – 2014 the combined average quality of life score for Supported Living hourly and site programs was 84%. Appropriate dress, consumers selecting upcoming meals, and consumers answering the door were the common deficiencies noted for quality of life. By program the Supported Living hourly average was 79% and the Supported Living site average was 92%. These percentages represent the proportion of positive scores to negative scores; 100% would indicate an entirely positive response. This makes for a more than 10% drop in combined Quality of Life scores between the fiscal years. Deficiencies within the Supported Living Hourly program (> 20% reduction) account most profoundly for this reduction. The failure by supervisors to complete monthly outcome indicator visits at hourly sites is the primary contributor to that reduction.

  Action Steps Taken: Residential supervisors are instructed to perform Outcome Indicator site visits during which quality of life scores are obtained. During these visits observations are made and examples of dignity and respect modeled for residential staff. When Outcome Indicator site visits do not occur during a month in which services

were provided, the quality of life scores recorded at that site for that month are entirely negative (0%). Because there are half as many measures for quality of life when compared to quality of service (4 versus 8), the failure to complete an outcome indicator visit by a supervisor is twice as detrimental on the overall percentages. This factor had a profound negative effect on the Supported Living hourly quality of life scores. Issues of dignity and respect are addressed during biweekly sit-downs between individual Supervisors and their Administrator, for instance encouraging and supporting consumers in answering their own doors when visitors knocked and when consumers identified that they are not always having their needs and wants met, were identified. During Agency Orientation training each residential counselor is reminded by the director that they are guests in a consumer's home and therefore should not be granting others entry. Ongoing training on improving quality of life occurs during departmental staff meetings and in-service trainings.

New Recommendations/Action Steps:

Recommended to continue this goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** ***(****Job title)*
  NA
  Expected Outcome:
* NA

MEASURES OF SERVICE ACCESS – PRIMARY OBJECTIVES

OBJECTIVE Increase number of consumers served

Goal # 1

Increase number of consumers served to 1 or more for Supported Living hourly services.
Increase number of consumers served to 3 or more for Supported Living sites.

Hourly - NOT MET
Site - MET

Update on Previous Recommendations It was recommended to continue goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A
NA

Action Step #2:

Current Status of Action Step and completion date: N/A
NA

* **Comparison of Results:**
  The number of consumers in the Supported Living hourly program reduced from 34 to 31 in 2012 – 2013; the goal was not met. The number of consumers in the Supported Living site program grew from 32 to 35 between in 2012 – 2013; the goal was met. For 2013-2014 the Supported Living hourly program failed to meet the goal of increasing its number of consumers served by 1 or more consumers. The hourly program experienced a net loss of 3 consumers, thus ending the year with 28 consumers. Two new consumers began receiving services in 2013-2014, meanwhile three consumers discharged from the program and another two transferred into the Supported Living daily program. The Supported Living daily program did however meet the goal of increasing its number of consumers served by 3 or more. There was a net gain of 3 consumers,

from 35 to 38 for the site program in 2013-2014. There are a total of 66 consumers served in the Supported Living programs. The losses in the Supported Living hourly program were cancelled out by the gains in the site program.

Action Steps Taken: A new daily site opened in September. This brought three new consumers into the Supported Living site program. In the 4th quarter a second new site opened. As result, two consumers receiving hourly services were identified as needing increased supports so transitioned into the 24 hr. site/daily services. In this instance concerted efforts were made by Residential supervisors to find appropriate placement for consumers requiring a higher level of care. Consumers joining the Supported Living hourly program were in the first and fourth quarters. One consumer received services related only to the running of medical appointments, while the other requires staff able to communicate using American Sign Language. Aside from these exceptions, there was a hold on new admissions into the Supported Living hourly program during the 2013 – 2014 fiscal year, hence limiting the program's growth. Residential supervisors continue to communicate open beds to their administrators, who in turn notify the chair of Link's admissions committee. A representative from Link attends the Roommate Connection and Residential Options meetings on a biweekly basis. Roommate Connection and Residential Options are PCHS coordinated meetings where providers within the county come together to identify possible roommates for location openings. Referrals for Supported Living program placement will tour with residential supervisors and meet prospective housemates.

New Recommendations/Action Steps:

Recommended to continue this goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** ***(****Job title)*
  NA
  Expected Outcome:
* NA

OBJECTIVE Decrease number of FTE openings

Goal # 2 Number of FTE openings to 6 or less.

NOT MET

Update on Previous Recommendations It was recommended to keep goal as written.

Update on Previous Action Steps *(action step recommendations from last years.)*

Action Step #1: NA

Current Status of Action Step and completion date: N/A

NA

Action Step #2: NA

Current Status of Action Step and completion date: N/A

NA

* **Comparison of Results:**
  The average number of FTE openings during the 2012-2013 year was 2.99. The month with the highest average FTE openings was September with 3.92. The month with the fewest number of openings was April with 2.02. During 2013-2014, the annual average for FTE openings across both Supported Living programs was 9.61. This marks a significant increase over the previous year. The goal was not met. The lowest monthly

average for FTE openings was in April with 4.57, while the highest was November with 18.89 FTE openings. The average for FTE openings for the Supported Living hourly program was 2.46. Due to the part-time status of positions in the Supported Living hourly program, a vacant FTE equivalent here can encompass multiple positions and negatively effect the service utilization of numerous consumers. The annual average for FTE openings for the Supported Living site program was 7.15. The highest quarter for open positions in the Supported Living site program (Oct – Dec at 16.50 FTE) was skewed in part due to vacancies posted for two new sites, one that did not open and a second that failed to begin providing services until May 2014. The failure to open these sites as planned can be attributed to difficulty in identifying appropriate housing and housemates respectively.

Action Steps Taken: Agency leadership recognized the importance of attracting quality applicants as evidenced by wage increases and the concerted efforts by the Human Resources department. Job fairs and employee referral programs were implemented during the third quarter. Those can be credited for dramatic improvement in the number of FTE openings during the closing months of the fiscal year. Between its inception and the beginning of 2014 – 2015 fiscal year, the Employee Referral Program had lead to the hire of 31 active employees. A predetermined interview schedule (Tue/Thu) was put in place to streamline the scheduling of candidates with supervisors. Residential supervisors continue to communicate open positions to Human Resources weekly and postings are updated accordingly.

New Recommendations/Action Steps:

Recommended to continue this goal as written.

* **Action Step:**
  NA
* **Timeframe for completion:**
  NA
* **Person Responsible:** ***(****Job title****)***
  NA

  Expected Outcome:
* NA

SUPPLEMENTAL MEASURES

**The supplemental measures were calculated for the entire residential program including data for both Community Housing and Supported Living.

Total number of consumers: The total number of consumers in the Supported Living program at the end of the 2013-2014 fiscal year was 105 according to the case management access database.

Number of consumers moving from group home to HCBS; from family home to HCBS; moving from other to HCBS: The total number of consumers moving from family home to HCBS Supported Living was 2 and the number of consumers moving from other (such as a different agency) to HCBS Supported Living was 3.

Discharges from program (not due to dissatisfaction):

There were 16 discharges from the residential department during the 2013-2014 fiscal year. Eight of those discharges were from the McKinley RCF to Link HCBS services. Eight discharges were outside of Link; two needing a higher level of care, one involuntary discharge, 4 to another agency, and one for no longer needed services; However this person reapplied and was approved in the same quarter. Of the 4 who went to another agency, one was because of a desire to move

back to Warren County and one because the RCF was closing and she found a roommate match at another agency. There was one discharge due to dissatisfaction in Supported Living Hourly program.

There is no clear demographic pattern from the discharges under Supported Living. Two were female and three were male. The females were Caucasian, <25-yrs old, both mild ID. Discharging males ranged in ages from 25 to 58, all Caucasian, with primary disability ranging from mild to moderate ID.

CONSUMER DEMOGRAPHICS

The average individual supported by Link's Supported Living programs during the 2013-2014 fiscal year was a Caucasian (87.5%), male (51.75%), between the ages of 35-54 (47.75%), who receives Day Hab services with Link (28.75%), has a primary disability of Mild ID (66.75%) and has no secondary diagnosis (30.75%). The consumer database demographic data seems to fluctuate dramatically from quarter to quarter. Discharges, intakes, and transitions between programs do not account for this degree of variance. The new agency database tracking system is being evaluated for internal consistency.

TRANSPORTATION MEASURES OF ACHIEVEMENTS

July 1, 2013– June 30, 2014
Jim Wilkie, Fleet & Facilities Director

ADMINISTRATIVE FEEDBACK

9 Goals
4 MET
5 NOT MET

For FY 2013-2014 there was a net loss of 6 consumers accessing Link's transportation services. Link provided 97,748 trips while traveling 589,604 total miles. In reviewing the transportation ridership survey the overall consensus is the riders are happy with the transportation services provided by Link. 95% of the respondents like their bus driver, 91% feel issues are handled adequately, 89% are picked up on time, 10% say the are on the bus longer than one hour (this can be attributed to the transfers, and logistics of the routes), 85% are happy with their pick up time, 100% responded that they get to work on time, 75% know to call the bus driver, 94% feel safe riding the bus and 86% are happy with the service. It is expected that the number of riders will increase this next year and a 16th route will be added when the demand calls for the expansion. Also, with the implementation of the E-doc Transportation program for documentation we are receiving more detailed information when it comes to time actually spent on the bus. The HCBS homes were added to the E-doc Transportation system in April. There still remains training issues with staff, but believe we will see more reliable data when it comes to actual ride times from the HCBS staff. The Fleet and Facilities Administrator is constantly monitoring the routes and making adjustments as needed while trying to reach the goal of 1 hour or less. With the approval from the Iowa Department of Human Services Link will begin to offer transportation for those consumers employed in the community and gradually grow these routes.

The fire captains and the walkie-talkies have helped with the evacuation of the building for fire drills. The evacuation of the buildings is completed in a timely fashion. During this Fiscal year it was determined to forgo having staff check in with the front office staff during fire drill evacuations. With each floor being checked by the floor captain, we are assured that the only people left in the building are those that are in the fire safe rooms. Roll/attendance continues to be taken for these 3 rooms. Having floor captains that are outside begin taking roll of the fire safe rooms until the Incident Commander takes over has speeded up this process.

With the tracking of accidents, we worked with our insurance carrier and the Buildings and Grounds committee to establish an industry standard for tracking vehicle accidents. This change was completed during the fiscal year and will provide the baseline for data collection. The standard is to take the number of accidents multiplied by the total miles driven and divide by the standard of 1,000,000 miles.

MEASURES OF EFFICIENCY – PRIMARY OBJECTIVES

OBJECTIVE Maintain or improve the number of work related injuries for employees from previous years

1 **Goal #** To have 44 or fewer staff work related injuries
MET / **NOT MET**

Update on Previous Recommendations

The recommendation was to revise the goal to have 44 or fewer staff work related injuries. The goal was changed on the MOA for FY 2013/2014 to reflect the recommendation.

Update on Previous Action Steps

Comparison of Results/Action Steps Taken Throughout the Year:

For FY 2012-2013 there was a total of 56 staff injuries reported compared to 60 staff injuries for fiscal year 2013-2014. Of the 60 reported staff injuries 13 of them required external evaluation and or medical treatment through Link's Occupational Medical Clinic. Staffs continue to show improvement with documenting any and all types of injures on the Safety committee incident report form. The increase of staff injuries can be attributed to educating staff on reporting all incidents, specifically reporting an incident where a consumer is involved, striking, hitting a staff member with no apparent signs of injury. Staff's injuries are investigated for the root cause of the injury and if the injury could be prevented. All findings and recommendations are shared with the employee and their supervisor. The safety committee continues to review all staff injuries, as well as all new hires receive the Safety Awareness Resource in their employee orientation book. Also, we continue to work with our Insurance provider to inspect the homes a minimum of two times per year to identify any potential safety hazards. Any deficiencies noted are placed on the work system for repairs.

New Recommendations/Action Steps:

Continue Goal written as

OBJECTIVE Maintain or reduce the number of vehicle accidents resulting in injury from the previous year

2 **Goal #** To have 1 or less vehicle accidents that result in injury to consumers or staff

MET / NOT MET

Update on Previous Recommendations

It was recommended to continue this goal.

Update on Previous Action Steps

Comparison of Results/Action Steps Taken Throughout the Year:

For FY 2012-2013 there were zero (0) accidents that resulted in an injury to a consumer or staff. In comparison for FY 2013-2014 there were zero (0) accidents that resulted in an injury to staff or consumers. Upon hire all new staff are required to complete the Defensive Driving training. Also, all fixed route bus drivers are required to obtain a CDL license before they are allowed to drive a route bus. Should a bus route driver be hired without their CDL, we assist them in attaining their CDL within 30 days and they are not allowed to drive the route bus until they have obtained their CDL.

New Recommendations/Action Steps:

Continue goal as written

OBJECTIVE Maintain or improve the number of vehicle accidents resulting in damage to only Agency Vehicles from the previous year

3 **Goal #** To have a vehicle accident rating of 7.0 or lower for accidents resulting in damage to only Link owned vehicles.

MET / **NOT MET**

Update on Previous Recommendations

It was recommended to change the goal to read "To have a vehicle accident rating of 7.0 or lower for accidents resulting in damage to only Link owned vehicles."

Update on Previous Action Steps

Comparison of Results/Action Steps Taken Throughout the Year:

For FY 2012-2013 there were 11 accidents that resulted in damage only to a Link vehicle. For FY 2013-2014 there were a total of 14 accidents resulting in damage to only a Link vehicle. The vehicle accident rate for FY 2012-2013 was 6.24 (11 accidents

x 567,267 agency miles /1,000,000 miles) For FY 2013-2014 the accident rate was 8.26 (14 accidents x 589,604 agency miles /1,000,000 miles). Of the 14 accidents that resulted in damage to only a Link vehicle, there were 3 accidents that involved the same vehicle in more than one accident. There were 3 incidents that involved the same Link staff twice while driving the same vehicle. There was 1 accident that involved the agency trailer rolling in the parking lot and hitting a staff's vehicle.

New Recommendations/Action Steps:

Continue goal as written.

OBJECTIVE Maintain or improve the number of vehicle accidents resulting in damage to a third party vehicle from the previous year

4 **Goal #** To have a vehicle accident rating of 8.0 or lower for accidents resulting in damage to a third party vehicle.

MET / NOT MET

Update on Previous Recommendations

It was recommended to change the goal to read, "To have a vehicle accident rating of 8.0 or lower for accidents resulting in damage to a third party vehicle."

Update on Previous Action Steps

Comparison of Results/Action Steps Taken Throughout the Year:

For FY 2012-2013 there were a total of 17 accidents that resulted in damage to a third party vehicle. The vehicle accident rating for FY 2012-2013 was 9.65. In comparison for FY 2013-2014 there were a total of 13 accidents involving a Link vehicle and a third party vehicle. The vehicle rating for FY 2013-2014 was 7.67 (13 accidents x 589,604 miles /1,00,000 miles) there was 5 accidents that involved a staff's personal vehicle and a third party vehicle. There was 1 accident that involved a staff vehicle and Link's trailer. All accidents involving a third party vehicle are tracked even if the damage is negligible to the third party vehicle or to the Link vehicle.

New Recommendations/Action Steps:

Continue goal as written

OBJECTIVE Maintain or improve the operating expenses from the previous year by operating the agencies vehicles at or above budget

5 **Goal #** Operate Agency vehicles with a cash flow surplus

MET / **NOT MET**

Update on Previous Recommendations

It was recommended to continue the goal and to rotate vehicles out of the fleet every 5 years.

Update on Previous Action Steps

Action Step #1: Rotate vehicles out of the fleet that are 5 plus years old.

Current Status of Action Step and completion date:

The action step called for replacing the vehicles below to meet the action step of rotating vehicles out of the fleet every 5 years. For FY 2013/2014 we were able to replace vehicles #1, #12, #17, #18, #39 and purchase two new vehicles for Case Management #40 & #41. Due to budget constraints not all of the vehicles over 5 years old were replaced. The identified vehicles that were to be replaced for FY 2013-2014 were:

#1 1996 Ford 15 passenger van
#2 2005 Dodge Minivan
#3 1993 Cube Van
#4 2004 Eclipse Conversion Van
#8 2006 Ford Aerotech Bus
#9 2010 Grand Caravan Wheelchair
#11 2008 Hyundai Entourage Minivan
#12 2003 Ford Windstar Van

#17 2004 Ford Windstar minivan
#18 1993 GMC Conversion Wheelchair van
#19 2009 Dodge Amerivan Wheelchair van
#23 2005 Aerolite Bus – moved to back up vehicle and purchased new #39
#24 2006 Eclipse Conversion Van
#25 2006 Grand Caravan Wheelchair
#26 2001 Dodge wheelchair minivan
#27 2004 Ford F-150
#30 2005 Aerotech Bus
#32 new vehicle
#34 2008 Hyundai Entourage Van
#38 2009 Aerotech Bus

Action Step #2:

Current Status of Action Step and completion date:

n/a

Comparison of Results/Action Steps Taken Throughout the Year:

For FY 2013-2014 the department ended with a negative cash flow of $16,285.35 as compared to FY 2012-2013 with a negative cash flow of $22,674.41. With the budget constraints and the age of the fleet a total of 7 vehicles were replaced or added to the fleet. Repair cost for FY 2012-2013 totaled $114,517.34 while for FY 2013-2014 repair costs totaled $154,705.87. The increase in repair cost can be attributed to the fleet increasing in age as well as damage to vehicles from accidents.

New Recommendations/Action Steps:

Continue with the goal to read, “Operate the agency vehicles with a break even or surplus cash flow.”

* **Action Step:**
  Replace the following 5 plus year old vehicles with new

Vehicle #	Year	Make/Model
#3	1993	Cube Truck
#4	2006	Eclipse Conversion Van
#8	2008	Aerotech Bus
#9	2010	Dodge Grand caravan SE
#11	2008	Hyundai Mini van
#19	2009	Dodge Amerivan wheelchair van
#23	2005	Aerolite Bus
#24	2005	Eclipse Conversion Van
#25	2006	Grand Caravan Wheelchair van
#26	2001	Dodge Caravan wheelchair van
#27	2004	F-150 Truck
#28	2007	Honda Accord
#29	2009	Hyundai Sonata
#31	2009	Aerotech Bus
#32	new	new vehicle # to assign
#33	2010	Aerotech Bus
#34	2005	Hyundai Entourage minivan
#38	2009	Aerolite Bus

* **Timeframe for completion:**
  June 30, 2015
* **Person Responsible:** *(Job title)*
  Fleet & Facilities Director

Expected Outcome:

* Reduce maintenance and repair cost, resulting in a breakeven or positive cash flow.

Repeat for additional objectives or goals

MEASURES OF EFFECTIVENESS – PRIMARY OBJECTIVES

OBJECTIVE Maintain or improve fire evacuation drills at Administration Building

6 **Goal #** Total Evacuation time of 10 minutes with roll call being taken

MET / **NOT MET**

Update on Previous Recommendations

It was recommended to continue this goal.

Update on Previous Action Steps

* **Comparison of Results/Action Steps Taken Throughout the Year:**
  For FY 2012-2013 the average evacuation time of the building was 12:09 minutes. FY 2013-2014 the average time was 13:07 minutes to evacuate the building and have everyone accounted for in the fire safe rooms. The average evacuation time for FY 2013-2014 is 58 seconds longer than FY 2012-2013. It remains to be seen if the current evacuation goal of 10 minutes is unrealistic due to the logistics of evacuating three (3) floors. In December a decision was made to not have all staff check in (roll call) after evacuating the building, as each floor is physically checked by the floor captains to ensure that everyone has evacuated the building or are in their assigned fire safe room. It is hoped that this change will assist in meeting the goal of evacuating the building in 10 minutes or less. FY 2014-2015 should provide us with a better understanding if this goal is obtainable or need to be reevaluated and lengthened due to the mobility of the consumers we serve.

  New Recommendations/Action Steps:

  Change to goal to read "Total Evacuation of the Administrative Offices with a time of 10 minutes or less."

* **Action Step:**
  n/a
* **Timeframe for completion:**
  n/a
* **Person Responsible:** ***(****Job title)*
  n/a
  Expected Outcome:
* **n/a**

OBJECTIVE Maintain or improve the average ride time on Link bus routes

7 **Goal #** 1 Hour or less

MET / NOT MET

Update on Previous Recommendations

The goal was continued as written stating an average ride time of hour or less for both the am and pm routes.

Update on Previous Action Steps

Action Step #1:

* **Comparison of Results/Action Steps Taken Throughout the Year:**
  For FY 2012-2013 the average ride time for the morning bus routes were 1:09 hours, 1:02 hours for the pm route for a total combined average of 1:06 hours. In comparison FY 2013-2014 the average morning bus routes were 49 minutes and 38 minutes for the pm trips for a combined average ride time of 42 minutes. With the implementation of the E-Doc Transportation system, we are able to obtain a more accurate pick up time and drop off time as the program time stamps the entry and tracks them. It remains to be seen if human error and mobile electronic connection issues will effect the times in the

future. Also we need to continue to be mindful of the ever-changing traffic patterns, construction work and weather issues. Routes are still constantly adjusted to accommodate new riders, existing riders moving or leaving the transportation service.

New Recommendations/Action Steps:

Continue goal as written

* **Action Step:**
  n/a
* **Timeframe for completion:**
  n/a
* **Person Responsible:** ***(****Job title)*
  n/a

Expected Outcome:

* n/a

OBJECTIVE Maintain or improve the efficiency of the Agency's route vehicles

8 **Goal #** Average an 85% ridership for all bus routes

MET / **NOT MET**

Update on Previous Recommendations

The goal was continued as written for FY 2013-2014 to average a ridership of 85% for all bus routes.

* **Comparison of Results/Action Steps Taken Throughout the Year:**
  FY 2012-2013 saw an average ridership of 73.25% in comparison the ridership for FY 2013-2014 averaged 73.75%. For FY 2013-2014 the bus routes provided 74,438 trips out of a possible 97,717 trips for the year. There were 97,748 total rides provided for FY 2013-2014. While it is hard to exactly pinpoint the reason for not meeting the goal of 85% ridership, it can be surmised that several factors such as inclement weather, consumers not feeling well, consumers retiring and leaving services and no longer requiring transportation, death, changing transportation providers as well as increasing the number of routes operating. The Fleet & Facilities Administrator is constantly monitoring the routes and making the necessary adjustments to accommodate new riders as well as those riders that leave services. The routes are adjusted accordingly to meet the needs of the riders.

New Recommendations/Action Steps:

Change the goal to read "Average a 75% ridership for the bus routes"

MEASURES OF SATISFACTION – PRIMARY OBJECTIVES

OBJECTIVE Improve ridership satisfaction, reducing the amount of riders not wanting to ride Link Transportation

9 **Goal #** Baseline data collection period

MET / NOT MET

Update on Previous Recommendations

Implement a satisfaction measure for bus riders.

Update on Previous Action Steps

Action Step #1: Develop a quarterly rider satisfaction survey.

Current Status of Action Step and completion date:

The satisfaction survey was developed and distributed to all consumers who utilize Link's transportation services for FY 2013-2014. It was determined to change the survey from quarterly to yearly.

Action Step #2:

Current Status of Action Step and completion date:

n/a

* **Comparison of Results/Action Steps Taken Throughout the Year:**
  FY 2013-2014 will set the standards for the satisfaction survey. It was determined to change the action step from once a quarter to onetime per year. For FY 2013-2014 we received 107 surveys back from the consumers/riders. Of the respondents 95.3% stated that they liked their bus driver, 94% felt safe riding the Link bus, 100% responded that they get to work on time and 86% are very happy with Link's Transportation service.
  New Recommendations/Action Steps:
  Disseminate a rider satisfaction survey yearly for Link bus route riders
  * **Action Step:** Distribute a Satisfaction Survey on a yearly basis
    Once a year handout a satisfaction survey to each consumer that rides a Link route bus.
  * **Timeframe for completion:**
    Yearly (before June 30, 2015).
  * **Person Responsible:** ***(****Job title)*
    Fleet & Facilities Administrator
    Expected Outcome:
  * Survey the needs of the riders on how to improve their overall satisfaction of the riding a Link route bus.

CONSUMER 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 281 riders with 26 people using wheelchairs. The breakdown of the residential providers that access transportation services are as follows

FY 2012-2013		***FY 2013-2014***	
Residential Provider	***# of Consumers***	***Residential Provider***	***# of Consumers***
Behavior Technologies	*7*	*Behavior Technologies*	*7*
Candeo	*4*	*Candeo*	*4*
CCO	*3*	*CCO*	*1*
CDAC	*0*	*CDAC*	*0*
ChildServe	*2*	*Childserve*	*2*
COC	*7*	*COC*	*7*
Comprehensive Community Support	*0*	*Comprehensive Community Support*	*0*
Crest	*30*	*Crest*	*26*
Easter Seals	*9*	*Easter Seals*	*10*
Homestead	*4*	*Homestead*	
Hope	*2*	*Hope*	*2*
Host Home	*0*	*Host Home*	*1*
Intrepid	*0*	*Intrepid*	*0*
Lexington Home Base	*1*	*Lexington Home Base*	*0*
Link Associates	*62*	*Link Associates*	*68*
Lutheran Services	*2*	*Lutheran Services*	*3*
Mainstream	*37*	*Mainstream*	*35*
Mosiac	*12*	*Mosiac*	*16*
Optimae	*1*	*Optimae*	*1*
Parent/Family	*85*	*Parent/Family*	*76*
Progress Industries	*12*	*Progress Industries*	*11*
REM	*1*	*REM*	*2*

ResCare	*0*	*ResCare*	*0*
Respite Connection	*0*	*Respite Connection*	*0*
Westminster	*0*	*Westminster*	*0*
Woodward Resource	*4*	*Woodward Resource*	*5*
Unknown Provider	*3*	*Unknown Provider*	*0*

Home and Community Based Services (HCBS) Waiver Quality Improvement Plan (QI) Section

All HCBS providers are required to develop and implement a QI Plan. This plan must have a systematic, organization wide, planned approach to designing, measuring, evaluation and improving the agency performance. This includes collecting and reviewing data in order to assess:

- The ongoing implementation of the program
- Identifying strengths as well as opportunities for improvement
- Include methods used to identify specific issues to be monitored for quality improvement including:
    - Identification of outcomes and outcome indicators
    - Acceptable thresholds
    - Specific methodology for collecting data
    - Sample size.
- Remediation which involves taking action to remedy specific problems or concern
- Improvement includes:
    - Steps taken to monitor the impact of rendition plans
    - Identification of completed actions steps
    - Identification of staff titles responsible for monitoring the progress of action steps
    - Documentation that identifies whether or not action steps taken were effective
    - The completion date.

Improve Agency Services (formerly Complaints Annual Review)

JULY 1, 2013 – JUNE 30, 2014
JAY BRUNS, CORPORATE OPERATIONS DIRECTOR

ADMINISTRATIVE FEEDBACK

1 Goal Link Associates had no internal appeals or grievances occurred from the period July 1, 2013 through June 30, 2014. I recommend continuing the current practices of Department Heads communicating any potential upset stakeholders at weekly senior management meetings for prompt attention and oversight of concerns to alleviate any stakeholder feeling like a more formal grievance or complaint is needed.

1 MET
0 NOT MET

Improve Agency Services (formerly Complaints Annual Review)

1. **Goal** No more than two appeals and/or grievances per year — **MET** / NOT MET
   No appeals and/or grievances

Update on Previous Recommendations/Results from Action Steps:

There were no grievances or appeals last fiscal year. It was recommended to continue our current practice of Department Heads communicating any potential upset stakeholders at weekly senior management meetings for prompt attention and oversight of concerns to alleviate any stakeholder feeling like a more formal grievance or complaint is needed.

Action Step: NA

Status of Action Step: NA

Completion date: NA

Comparison of Results:

No internal appeals or grievances occurred from the period July 1, 2013 through June 30, 2014. Upon admission to Link services and annually thereafter, consumers and family members are provided with the current Handbook for Consumers, Legal Representatives, Advocates, and Family Members. This handbook contains specific information on appeals and grievances and reinforces that our goal is to help consumers 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.

One external complaint was brought to Link Associates attention in March that stated that a complaint was received by the Home and Community Based Services (HCBS) Quality Oversight program that pertained to: "the safety, health and welfare of a consumer (who received transportation and supported living services from Link)". While the identity of the complainant was and is confidential from us, it dealt with a situation that had already been identified by Link Associates on or about February 14, 2014 and the staff involved was reported to the Iowa Department of Human Services. That summary information involved a residential counselor who was placed on suspension as she was reported by Link to the Iowa Department of Human Services for their external investigation into whether dependent adult abuse or neglect occurred (they investigated it under critical care). The employee sent a consumer (who had no alone time) to go wait for her bus (Link transportation route). It was also learned that this was a common occurrence dependent upon the outdoor temperatures. This was an unsupervised

location and in this case, the driver for Link Associates arrived and also failed to follow company procedures by not waiting the required amount of time for consumers, or making phone contact or leaving a message for staff that were reported to be on site yet. The residential staff left after the consumer was downstairs waiting for the bus after approximately 45 minutes, but exited a different staircase and did not visually confirm the consumer had been picked up. Another staff member found the consumer outside waiting approximately 3 ½ hours later. Both employees received disciplinary action and the Iowa DHS determined that our mandatory report for denial of critical care was unfounded. Additional training for staff was directed to be completed by the Executive Director to employees in both the residential and transportation departments. This information, our policies, and the consumers service planned were shared with the HCBS Quality Oversight program and their findings on April 1, 2014 stated: "At this time, no additional information or follow-up is necessary by IME HCBS Quality Oversight Program".

Action Steps Taken:

Additional staff training occurred for the staff supporting consumers in supported living and policy reviews also occurred for all drivers of Link Associates fixed routes.

Recommendations/Action Steps: Continue current practices of Department Heads communicating any potential upset stakeholders at weekly senior management meetings for prompt attention and oversight of concerns to alleviate any stakeholder feeling like a more formal grievance or complaint is needed.

Action Step: None
Timeframe for completion: NA
Person Responsible: NA
Expected Outcome: NA

Improve Employee Satisfaction

JULY 1, 2012 – JUNE 30, 2013
LINDA DUNSHEE, EXECUTIVE DIRECTOR

ADMINISTRATIVE FEEDBACK

1 Goal
0 MET
1 NOT MET

I recommend continuation of the survey and the distribution of the outcomes to the employees and members of the Personnel Committee. Despite some apparent apathy and lack of employee participation, we do obtain information that will help up assess different aspects of our organization.

Last year the filtering of employee data cause some concern about attempts to identify employees. This year the Personnel Committee of the Board of Directors sent out the survey directly from the chairpersons Link Associates email address. We were successful in obtaining more responses this year, however were not able to meet the average score we were looking for. I am recommending adding an additional goal to improve the staff participation in the survey process. This year we obtained 44.3%.

Goal #1 Improve Employee Satisfaction To obtain an average of 3.6 on a scale of 1:4 or higher agreement with survey statements.

MET / **NOT MET**

Update on Previous Recommendations . Keep the survey tool as is and obtain an average score of 3.6 or higher. In addition this year the survey included a few question suggested by the CARF survey team, including:

1. What do I do that most contributes to the mission of Link Associates?
2. Despite the challenges with wages, why do I keep working at link associates?
3. What are what is the most important issue the Executive Director needs to focus on to ensure Link remain successful?
4. Are there any policies you think need to be reevaluated? If so please list them and indicate if you would be willing to discuss ideas.

Update on Previous Action Steps

Action Step #1: Sort data by filter so each Department Head not only receives overall satisfaction scores, but also filtered by department and title of employees.

Current Status of Action Step and completion date: The sorting of the data did not prove to be a valuable asset in determining areas of concern. Completed: 8-1-2012

Action Step #2: On specific points invite staff to discuss and formulate plans to better address the issues.

Current Status of Action Step and completion date: Despite multiple options staff did not engage in opportunities to discuss or brainstorm. Throughout the year as the Executive Director received ideas or suggestions they were shared with management staff. Although many could not be changed as either financial or regulatory issues prohibited, the concepts were shared in information sent out in the monthly employee newsletter. Completed 1-2013

Comparison of Results: The survey was done again this fiscal year with the change of separating out the benefits questions from the organizational performance section. The organizational performance average score was 3.51 and average score on the benefits section was 3.31. The combined average was 3.41. This year we scored lowest in the

following areas:

- I have shared concern/suggestions with members of management
- Supervisor listens and responds timely
- I know co-workers are available and willing to help me
- Supervisor treats people fairly and without favoritism
- Supervisor provides updates and information timely
- Supervisor recognizes good actions and results in others
- I get clear directions about how I should do my job

And our highest scores were:

- Supervisor protects confidentiality
- I know what is expected of my job and me
- Supervisor shows respect for all team members
- Supervisor encourages and supports the work of other departments
- Supervisor demonstrates professional behavior
- I am accepted as a member of our team
- I have friendly co-workers
- Supervisor encourages/supports my participation in agency committees/events

During management meetings departments reported updates on issues they identified among their staff. The results of the survey were sent to all staff with an invitation to make suggestions for improvement in any area. The information was also presented to the Personnel Committee of the Board of Directors

Action Steps Taken: The survey was done again this fiscal year with the change of separating out the benefits questions from the organizational performance section. All employees were given a confidential link to complete the survey in privacy. Of the 350 employees on 101 opted to complete the survey.

New Recommendations/Action Steps:

I recommend continuation of the survey and the distribution of the outcomes to the employees. Despite some apparent apathy, we do obtain information that will help up assess different aspects of our organization.

* **Action Step #1:** Increase the number of staff responding to the survey.
* **Timeframe for completion:** 10-2015
* **Person Responsible:** ***(****Job title)* Executive Director
  Expected Outcome: . 45% participation
* The identification of themes consistent among employees of all departments that may not identify themselves and other questions.
* **Action Step #2:** Invite staff to participate in further discussion and planning.
* **Timeframe for completion:** 6-2015
* **Person Responsible:** ***(****Job title)* Executive Director
  Expected Outcome: .
* Provide staff with a more personal and comfortable format to sitting down and asking questions, making suggestions, and brainstorming.


Fiscal Year 2012-2013 Employee Satisfaction Rating
Questions
I have shared concern/suggestions with members of management 3.23
I get clear directions about how I should do my job 3.37
Supervisor recognizes good actions and results in others 3.39
Supervisor provides updates and information timely 3.44
Supervisor treats people fairly and without favoritism 3.44
I know co-workers are available and willing to help me 3.45
Supervisor listens and responds timely 3.45
Supervisor focuses on fixing problems rather than finding blame 3.47
Supervisor does not engage in or accept gossip 3.49
Supervisor recognizes my job and its contribution to the consumers 3.49
Supervisor gives support where and when needed 3.50
Supervisor deals with issues that need to be addressed 3.51
Supervisor effectively deals with conflict 3.51
Supervisor seeks input from all team members 3.51
Supervisor encourages/supports my participation in agency committees/events 3.55
I have friendly co-workers 3.59
I am accepted as a member of our team 3.61
Supervisor demonstrates professional behavior 3.63
Supervisor encourages and supports the work of other departments 3.63
Supervisor shows respect for all team members 3.64
I know what is expected of me and my job 3.70
Supervisor protects confidentiality 3.71
0.00 0.50 1.00 1.50 2.00 2.50 3.00 3.50 4.00
1=never, 2=seldom, 3=frequently, 4=always


Fiscal Yeat 2012-2013 Employee Satisfaction of Benefits
Benefits I know who to contact if I have
Benefits I believe I have enough flexibility to
0.00 1.00 2.00 3.00 4.00
1=disagree, 2=somewhat agree, 3=agree, 4=strongly

Improve Medication Administration

JULY 1, 2013 – JUNE 30, 2014
AMY STRONG, HEALTH SERVICES ADMIISTRATOR

ADMINISTRATIVE FEEDBACK

2 Goals It is my recommendation to continue the goal and explore methods to decrease errors. The Health Services Administrator and Outreach Director should continue to meet with
0 MET the Supported Living Director to discuss ways to improve accountability with med
2 NOT MET passing and training and/or educational alternatives for the bi-annual review.

Improve Medication Administration

1. **Goal** Reduce the number of errors requiring medical professional notification and action to one or less in one year — MET / **NOT MET** 6 errors requiring medical notification

Update on Previous Recommendations/Results from Action Steps:

It is recommended that we identify additional methods to reduce errors.

Last Fiscal Year Action Step 1 Health Services Administrator and Outreach Director will meet with the Program Director (Supported Living Director) to discuss ways to improve accountability with med passing and alternatives for the bi-annual review.

Status of Action Step 1: Outreach Director met with Program Director on three occasions during the year to discuss medication administration accountability and further refined the expectations and skills to be demonstrated at the bi-annual medication manager's review.
Completion date: June 1, 2014
Last Fiscal Year Action Step 2: Tour Omnicare's processing facility to gain first hand knowledge of how medication orders are completed and delivered.
Status of Action Step 2: Health Services administrator and Outreach Director toured Omnicare on September 18, 2013 and observed their operations. Gained knowledge of the process that takes place when a medication order is received at the pharmacy.
Completion Date: September 18, 2013
Last Fiscal Year Action Step 3: Implement the revised Self Medication Policy
Status of Action Step 3: The revised Self Medication Policy was implemented September 1, 2013. Team started reviewing and assessing a consumer's skills as outlined in the revised policy at that time and as the annual staffing dates rolled around. Case Managers were provided with additional explanation and clarification as teams reviewed and had case specific questions or concerns
Completion Date: September 1, 2013

Comparison of Results:

The total number of errors in all categories in FY 2013-14 was 833, which is a decrease of 149 over last year. A total of six errors occurred in which a physician was notified and is an increase by one from 2012-13. All six of the errors that resulted in physician notification were the result of staff error. In one case, a

physician ordered a dose increase of a medication. The med manager wrote the new order on the medication administration record but failed to discontinue the previous order. The consumer received both doses for three days.
Another physician notified error occurred when a consumer received an accidental double dose of a medication. Physician ordered the next dose be held. No adverse side effects were noted. Another error occurred when staff put eardrops into a consumer's eye. Other than a stinging sensation in the eyes, no other side effects developed. An error occurred when staff gave a prescription blood thinner to a consumer for two days after their physician had ordered it be held due to an impending medical procedure. Although the physician ultimately made the decision to continue with the procedure, the consumer experienced more bleeding than normal during and after the procedure. Two other times staff error resulting in physician notification occurred when the consumer were given medications that belonged to their roommate. No adverse side effects were noted in either of these cases.

Action Steps Taken throughout this fiscal year:

The medication managers responsible for the errors that required notification of outside medical professionals were counseled by their supervisors and were given warnings. Mandatory medication administration reviews were held bi-annually for all med managers with a review of common, recurring and actual med errors. In FY 2013-14 the Health Services Administrator set up hands-on demonstration stations and residential and vocational supervisors facilitated each station assessing the employee's skills. At each of the stations, medication managers had to demonstrate skills and knowledge with, starting and stopping medications on the medication administration records, identifying documentation errors, and the demonstration of administering oral and topical medications.

The Health Services Administrator continued to perform a first level review of all medications prior to distribution to residential sites. This system of review allows the Health Services Administrator to identify missing meds; wrong dosages and/or wrong medications while assuring all medications ordered are available. Medication managers upon check in of rotation medications complete a second level review.

There were also meetings between the Outreach Director and the Supported Living Director to discuss specific concerns the Residential Supervisors had In regards to various reasons medications that were not filled in a timely manner and what we could do in cooperation with the pharmacy to assist these concerns. The pharmacy continues to send a list of cycle meds that would not arrive with the majority of the cycle meds, yet we continue to not receive miscellaneous medications that are not on said list. The Outreach Director and Health Services Administrator collaborated with the Residential Administrator to further define a system to minimize and eliminate missing medications at the start of rotation and throughout the month. The guidelines established were put on hold for distribution as discussions of changing the vendor pharmacy became more serious. In June 2014, three long-term care pharmacies, including the current vendor pharmacy, were contacted to submit a bid for Link's pharmacy services. The proposals were reviewed, pharmacy representatives interviewed and the decision to change pharmacy was made.

New Recommendations/Action Steps: Continue goal and explore methods to

decrease errors.

Action Step #1: Complete transition to new vendor pharmacy
Timeframe for completion: October 1, 2014
Person Responsible: Health Services Administrator and Outreach Director
Expected Outcome: Improved medication administration
Action Step #2: Health Services Administrator and Outreach Director will meet with the Supported Living Director to discuss ways to improve accountability with med passing and alternatives for the bi-annual review.
Timeframe for completion: 12/1/14
Person Responsible: Health Services Administrator and Outreach Director
Action Step #3: Have the new pharmacy representatives meet at least twice during the year with residential supervisors
Timeframe for completion: April 1 2015
Person Responsible: Health Services Administrator, Outreach Director, Residential Supervisors and Supported Living Director
Expected Outcome: Improved medication administration practices and collaboration

2. **Goal** Reduce the number of documentation omission errors to 15% or less within in one year. **Not Met**

It was recommended to continue to work on identifying or building an Emar system that would prohibit a medication manager from signing off if missing documentation on a MAR exists.

Last Fiscal Year Action Steps #1: Health Services Administrator will continue to work with E-Doc to develop a system.

Status of Action Step: Link's current doc software provider was engaged to develop an electronic MAR system for use at Link, but the design did not meet our needs, especially for reducing or eliminating doc omission errors.
Completion date: February 2014

Comparison of Results:

The total number of documentation omission errors this year was 426, which is a decrease of 73 over last year's total of 499. The average percentage of doc omission errors was 51% which is 36% higher than the desired the goal of 15%. In review of data reflecting significant errors during any given month, different sites, personnel, and supervisors show no significant trends extending over several consecutive months' time. Both new and longer term employees account for doc omission errors.

Action Steps Taken throughout this fiscal year:

Medication managers identified with habitual errors were given warnings and some were required retake the med manager clinical. Retaking the clinical reiterates what their duties are as med managers and provides them opportunity to clarify issues they are unsure of. Mandatory medication administration reviews were held bi-annually for all med managers in order to review common and recurring med errors. The Health Services Administrator was available to council one-on-one for those who continued to struggle. Residential supervisors implemented supervised med passes at sites or with staff with large numbers of errors. The Health Services Administrator also reviewed MARs at the end of the month to identify errors not

identified by Supervisors. Copies of these errors were kept by the Health Services Administrator in order to more closely monitor the timelessness of receiving the reports back. These steps were successful in determining just how many errors were truly occurring for follow up.

Both of the bi-annual reviews consisted of three and four, hands-on stations set up by the Health Services Administrator and facilitated by all residential and vocational supervisors. At one station, medication managers had to demonstrate skills in identifying documentation errors including the omission of documentation.

A contracted instructor continues to be utilized by Link to teach the approved course onsite in a shortened period of time. Although staff is more favorable about the training then the previous offsite community college course, doc omission errors continue at an elevated rate.

Link's current doc software provider was engaged to develop an electronic MAR system for use at Link, but the design did not meet our needs, especially for reducing or eliminating doc omission errors.

In June 2014, three long-term care pharmacies, including the current vendor pharmacy, were contacted to submit a bid for Link's pharmacy services. The proposals were reviewed, pharmacy representatives interviewed and the decision to change pharmacy was made.

New Recommendations/Action Steps: Continue goal and explore methods to decrease errors.

Action Step: Health Services Administrator and Outreach Director will continue to meet with the Supported Living Director to discuss ways to improve accountability with med passing and training and/or educational alternatives for the bi-annual review.
Timeframe for completion: June 2015
Person Responsible: Health Services Administrator and Outreach Director
Expected Outcome: Decrease in overall medication errors and documentation omission errors.

Improve Positive Behavioral Supports to Consumers

JULY 1, 2013 – JUNE 30, 2014
MICHELLE WEBB, TRAINING FACILITATOR

ADMINISTRATIVE FEEDBACK

1 Goals
0 MET
1 NOT MET

It is my recommendation to continue the goal and have the PBS committee meet quarterly to review Incident Report data and complete the PBS Incident Report Trend Review Form (PBS-1) as needed. PBS chair will tabulate the total number of Trend reviews completed each quarter as well as identify the number of people with duplicative Trend reviews completed in prior quarters.

Improve Positive Behavioral Supports to Consumers

1. **Goal** Maintain or reduce the number of duplicate incident trend reviews completed by the PBS Committee. **NOT MET**

Update on Recommendations/Results from last fiscal year: It was recommended to change the goal to read maintain or reduce the number of duplicate Incident Trend reviews.

Last Fiscal Year Action Step: Revamp the PBS Incident Report Trend Review Form (PBS-1) to better capture the incident trends and to add the inclusion of direct care staff in the team process. Thus improving the positive behavior supports to consumers. PBS Committee will review data quarterly and complete Trend review forms.

Status of Action Step: Completed
Completion date: October, 2013

Comparison of Results: Last year there were 16 duplicative trend reviews that were used as the baseline out of 62 reviews conducted (26%). This was a revised goal and training conducted this year and additional scrutiny may have resulted in this baseline data being under reported. This fiscal year during the 1st quarter, 25 trend review forms were completed, no duplicative as this was the first fiscal quarter, in the 2nd quarter, 28 trend reviews with 11 of those being duplicative from the previous quarter were completed, in the 3rd quarter, 50 trend reviews with 25 duplicative reports, and finally in the 4th quarter, 27 trend reviews with 11 duplicative trend reviews were completed. Total for the year was: 105 trend reviews, and 55 of those being duplicative (52%). When breaking down the data further by consumers; 37 people had trend reviews completed for 1 of the quarters, 18 people had trend reviews completed for 2 quarters, 11 people had trend reviews completed for 3 quarters, and 6 people had trend reviews completed for all 4 quarters. The data also reflected that 17 consumers had 3 or more trend reviews conducted on the same indicators in the course of the year.

Action Steps Taken Throughout this fiscal year: The PBS committee updated the PBS Incident Trend Review form. PBS Committee met quarterly to review Incident Report data. If a potential trend was identified, a trend review form was completed and 2 PBS committee members were assigned to assist the team. Consumer teams met and reviewed the forms and the data and submitted their follow up to the PBS team. PBS chairs insured information was entered on the PBS tracking sheet on the P Drive. PBS Chair recorded the information quarterly on to the Measures of Achievement sheet.

New Recommendations/Action Steps: The PBS committee recommends modifying

the goal to maintain or reduce the number of consumers who have 3 or more trend reviews in a year.

Action Step 1: PBS committee will meet quarterly to review Incident Report data and complete the PBS Incident Report Trend Review Form (PBS-1) as needed. PBS chair will tabulate the total number of Trend reviews completed each quarter as well as identify the number of people with duplicative Trend reviews completed in prior quarters.

Timeframe for completion: June 2015

Person Responsible: PBS Chairpersons

Expected Outcome: PBS Committee will evaluate the number of trend reviews for each person across this fiscal year. This will help us identify and evaluate if additional supports are needed. It is expected that the goal will be met by working with consumer teams to try all positive programming approaches thus decreasing the number of incidents and trends.

Improve Service Documentation

JULY 1, 2013 – JUNE 30, 2014
STEVE OBRIEN, FINANCE DIRECTOR

ADMINISTRATIVE FEEDBACK

2 Goals It is recommended to continue goals as written, and continue to work with staff on proving documentation outcomes.
1 MET
1 NOT MET

Improve Service Documentation

1. **Goal** All NOD's are present and contain 95% of the required information. MET / **NOT MET** 92% achieved

Update on Previous Recommendations/Results from Action Steps: It was recommended that better attention by the case managers and administrators is needed to ensure that the NOD information is updated in all systems and spreadsheets utilized by staff and auditors. A double check that correct period NODs are provided when requested for review.

Action Step 1: Continue emphasizing on the internal review report the results of any deficiencies in this area. Work with department/program directors to address with their staff responsible for NODs.

Status of Action Step: The Finance Director routinely addressed the results of Internal Review Committee at Management Meetings in addition to the distribution of the results/minutes. An increase in compliance was recognized as the previous period had 88.8% achieved.
Completion date: June 2014

Action Step 2: Move the review months away from the start of new rate Implementation – i.e. July and January

Status of Action Step: Completed. Reviews of August, November and February
Completion date: August 2013

Comparison of Results:

The year averaged 92% and for fiscal year 2012/2013 averaged 88.8% Moving the review periods away from months that traditionally have rate changes has helped. Expired NODs were an issue. Not updated or the wrong period NOD was provided using the E-DOC summary reports.

Action Steps Taken:

Each quarter a summary report is prepared and distributed to program directors and mangers with the statistics. The different programs are broken out and any NOD concerns are noted.

Recommendations/Action Steps: Getting the updated NOD information approved by case managers and input into the E-DOC system is crucial. The summary report off the E-DOC system is the only tool utilized by all in the review process.

Action Step 1: Continue emphasizing on the internal review report the results of any deficiencies in this area. Work with department/program directors to address with their staff responsible for NODs and inputting into the E-DOC system.
Timeframe for completion: quarterly
Person Responsible: Department Directors
Expected Outcome: Better coordination of NOD approval and input into

E-DOC. More accurate information.

2. **Goal** At least 95% of the required detail information is present on the service records (to bill). **MET** / NOT MET 98.7%

Update on Previous Recommendations/Results from Action Steps:

It was recommended to continue education of the auditors and staff on thorough documentation, including E-DOC records. All staff involved in the review need to take time to analyze thoroughly the information and not rush through.

Action Step 1: Continued training on proper documentation is key and must be emphasized

Status of Action Step: This is an on going challenge with training new staff and working with existing staff. Routine comments every review period are on lack of documentation, repetitive documentation and documenting goals better.

Completion date: Done quarterly after each committee meeting**.**

Comparison of Results:

The annual average was just under 99% accuracy for this year. Previous reviews have been 99%.

Action Steps Taken:

Each quarter the individual review packet for each consumer are given back to the programs for review. Supervisors note they will address issues with staff and further training.

Recommendations/Action Steps: Continue training of staff on thorough documentation. All staff doing documentation must understand the basics involved and the expectations for complete, accurate records. It is recommended to increase this goal to 98%.

Action Step 1 Continued training on proper documentation is key and must be emphasized by supervisory staff when deficiencies are shown.

Timeframe for completion: This can be reviewed after each quarterly audit period.

Person Responsible: Chairs Internal Review Committee, Department Directors, Administrators and Supervisors.

Expected Outcome: Better documentation. Less audit notation of poor documentation.

Improve Staff Qualifications

JULY 1, 2013 – JUNE 30, 2014

MARILYN McBRIDE, ADMINISTRATIVE OFFICE ASSISTANT

ADMINISTRATIVE FEEDBACK

2 Goals
1 MET
1 NOT MET

I support the recommendation to increase the goal percentage from 90% to 95% for the measure of annual evaluations.

To Improve Staff Qualifications

1. **Goal** All new hires will contain 100% of the required components — MET / **NOT MET**

Update on Previous Recommendations/Results from Action Steps:

Continue goal and evaluate changes to the method of collecting and reporting data

Action Step: Administrative Assistant will develop a reporting mechanism that more precisely identifies the missing items from the complete file audit process

Status of Action Step: Missing items are now precisely identified and results are given to supervisors.

Completion date: June 30, 2014

Comparison of Results:

Last year the first quarter was 98%, the second quarter was 95%, the third quarter was 94%, and the fourth quarter was 100% for an average of 97%.

This year the first quarter was 98%, the second quarter was 99%, the third quarter was 99%, and the fourth quarter 88% of the required components were in the file for an average of 96%.

Action Steps Taken:

An audit form was built and data is entered on a regular schedule. All new hires are entered into the report.

Recommendations/Action Steps: Continue goal and engage Department Directors for remedial action steps for areas not in compliance.

Action Step: Administrative Assistant will continue to review all files of new hires and report deficiencies to appropriate staff and applicable Department Director.

Timeframe for completion: Initiate by 10/1/14

Person Responsible: Administrative Office Assistant

Expected Outcome: Meet goal set for personnel files. Specific detail will be derived from reports and the needed action to address with persons responsible.

2. **Goal** Current employment files will have 90% compliance for a) annual review timeliness and b) required trainings. — **MET** / NOT MET

Update on Previous Recommendations/Results from Action Steps:

It was recommended to continue this goal as written.

Action Step: NA

Status of Action Step: NA

Completion date: NA

Comparison of Results:

Last year the first quarter had 83% for evals on time and 100% of required trainings; 2nd quarter was 94% evals on time and 99% required trainings; 3rd quarter was 93% evals on time and 100% for required trainings, 4th quarter was 92% of evals on time and 100% for required trainings. Average for evals on time is 90.5% and required trainings are 99.75%.

This year the first quarter had 71% for evals on time and 98% of required trainings; 2nd quarter had 65% of evals on time and 99% of required trainings, 3rd quarter had 79% of evals on time and 97% of required trainings, 4th quarter had 80% of evals on time and 98% of required trainings. Overall average for year was 74% of evals on time and 98% of required trainings.

Action Steps Taken:

All current employee files were reviewed after their annual evaluation. Data was recorded as to the timeliness of the eval (one month after employee anniversary date) and if the required trainings (CPR, First Aid, Universal Precautions, Mandatory Reporter, Documentation and Rights) are in the file. Supervisors are notified of any deficits. The new tracking system that was implemented with direct support staff assigned to our electronic documentation system is now in place for all agency staff.

Recommendations/Action Steps: It is recommended to increase the goal percentage from 90% to 95% for the measure of annual evaluations.

Action Step: NA

Timeframe for completion: NA

Person Responsible: NA

Expected Outcome: NA

Improve Stakeholder Satisfaction

JULY 1, 2013 – JUNE 30, 2014
JAY BRUNS, CORPORATE OPERATIONS DIRECTOR

ADMINISTRATIVE FEEDBACK

1 Goal

0 MET
1 NOT MET

Seventy-eight stakeholder satisfaction surveys were e-mailed to Case Managers (outside of Link Associates), funders, providers of services to consumers that also receive a service/program from Link, and various community partnerships with leisure services with a total of 17 responding. This represents a return rate of 22%, which is similar to the return rate of 19% from the previous year. The mean score this year was 3.3, which was lower than goal of 3.7 and also the score from last fiscal year that was 3.7. It is my recommendation to have Department Directors review the results and comments of the stakeholder satisfaction survey with their departments for quality improvement opportunities.

To Improve Stakeholder Satisfaction

1. **Goal** To obtain mean score of 3.7 or higher (4.0 scale) MET / **NOT MET**
Mean score of 3.3

Update on Previous Recommendations/Results from Action Steps: NA

Action Step:
Status of Action Step: NA
Completion date: NA

Comparison of Results:

Seventy-eight stakeholder satisfaction surveys were e-mailed on June 16, 2014 with a closing date of June 27. Our survey enables us to send targeted reminders to only people who did not complete our survey upon the first and subsequent requests. This also provides details on the number of e-mails that were bounced. While no specific reasons were identified for the bounced e-mails, this may include spam or junk mail filters that prevented our inquiries from reaching the recipients. Five such e-mails were bounced and for statistical purposes we will use the number of seventy-three for any statistical references. Eleven responses were received right away and an additional reminder was sent on July 1 to sixty-two recipients and the collection period was extended until July 6. Six additional responses were collected which resulted in a total of 17 responses received. This represents a return rate of 22%, which is similar to the return rate of 19% from the previous year.

The majority of the surveys were sent to Case Managers (outside of Link Associates). Additional stakeholder groups included funders, providers of services to consumers that also receive a service/program from Link, and various community partnerships with leisure services. The majority of respondents (94%) indicated that they were representing case management organizations.
Our survey attempts to ascertain what programs stakeholders may be providing feedback on and that response count can be seen on the attached summary. This can show whether the services being commented on have a desirable balance across the agency in proportion to the size (number of people served) of the

programs as referenced in question number 10. Responses were collected in all service categories with the majority reflecting feedback on the services under the Residential and Vocational categories.

The mean score this year was 3.3, which was lower than goal of 3.7 and also the score from last fiscal year that was 3.7. While all nine of the core questions received ratings at 3.0 or above (score that represents slight agreement), every one of these questions showed a decrease in satisfaction when compared to last year. Questions seven and nine each had three respondents indicate slight disagreement to the questions of; concerns brought to the attention of Link Associates are welcomed and handled professionally, and Link Associates provides services consistent with my organization governing standards. Comments were provided on many of the questions that will help Department Directors concentrate on areas of concern with their staff. In general a theme may exist that suggests communication is an area in which improvement can always be made. No respondents indicated a desire to be contacted about their survey submission.

Action Steps Taken: NA

Recommendations/Action Steps: Improve communication with case management agencies.

Action Step: Department Directors will review the results and comments of the stakeholder satisfaction survey with their departments for quality improvement opportunities.
Timeframe for completion: October 1, 2014
Person Responsible: Department Directors
Expected Outcome: Review of the comments and areas of concern will be reviewed with supervisory staff in efforts to improve communication and understanding of stakeholder expectations and concerns leading to improved satisfaction of Link Associates services.

Improve Quality of Service

JULY 1, 2013 – JUNE 30, 2014

JOAN OSBORN, CASE MANAGEMENT DIRECTOR

ADMINISTRATIVE FEEDBACK

4 Goals Recommend to continue the goals to ensuring all components of rights restrictions are place as well as ensuring individual plans identify health and safety needs. It is also
2 MET recommended to continue the goal to do a quality review of consumer files and ensure
2 NOT MET consumers' are making progress towards their goals.

Improve Quality of Service

1. **Goal** To have 95% compliancy by ensuring that all components (due process) of rights restrictions are in place before the implementation of a restriction. MET / **NOT MET**

Update on Previous Recommendations/Results from Action Steps:

The agency will have 95% or higher compliancy by ensuring that all components of rights restrictions are in place before implementation of a restriction.

Action Step: Case Management staff will reflect on the interpretation issues, the quality assurance process, and our forms to develop a revised table to measure compliance. QA Administrator will provide training to staff as issues arise as well as add a segment to our team meetings to review strengths and areas in need of improvement with our QA results.

Status of Action Step: The QA tool was altered to ensure that the QA grid provided a visual breakdown of each section required to meet due process as well as trigger questions were added to the form to prompt staff as added focus. Staff support during individual and team meetings was provided as needed in response to QA trends. Staff was also provided quarterly feedback on the goal achievement.

Completion date: The table was revised 07/13. The support to staff was ongoing through 06/14.

Comparison of Results:

First through fourth quarter results indicated that 389 of 471 rights restrictions or 83% contained all five components of due process. This is a one percent increase in compliance from the score of 82% in the previous year. The five criteria are approval of the plan by the IDT, use of least restrictive methods possible, plan to diminish, annual re-evaluation, and rational of the restriction. In order to meet due process the restriction had to address all five components in the narrative. The most common omissions were that staff did not address "why a restriction in place is least restrictive" and " why there is no plan to diminish the restriction". Last year although the tool was revised staff struggle with including all components. It should be noted that in most cases it can be inferred from what the staff writes regarding why the restriction is least restrictive and why there is not plan to diminish, but it is not specifically stated.

Action Steps Taken:

Monthly staff was given results of file reviews for corrections. Patterns of omissions of the five components were discussed with staff for further training. QA trends and concerns were also reviewed by the QA Administrator in monthly team meetings.

Recommendations/Action Steps: It is recommended to continue goal and evaluate systems to improve results

Action Step: Case Management staff will reflect on the interpretation issues, the quality assurance process, and our forms to ensure staff training is improved. QA Administrator will provide training to staff as issues arise as well as expand the review in our team meetings to review strengths and areas in need of improvement with our QA results. A guidance sheet will be developed to provide added training to staff on the sections of Quality Assurance. The QA Administrator will also evaluate how to change the development of the CCSP process to be more proactive in our goal achievement, develop a process, and train and monitor the staff. Because the CCSP is typically done annually and the implementation of changes to a CCSP document template is often challenging, it is expected that this process could expand over two fiscal years.

Timeframe for completion: June 2015

Person Responsible: Case Management Administrator and Case Managers

Expected Outcome: 95% compliancy by ensuring that all components (due process) of rights restrictions are in place before the implementation of a restriction.

2. **Goal** Consumer's individual plans identify health and safety needs. **MET** / NOT MET
100% of plans will comprehensively identify health and safety needs of the individual served.

Update on Previous Recommendations/Results from Action Steps:

Administrative feedback following last year's program evaluation indicated that the goal should continue as written with 100% of plans reviewed comprehensively identified the health and safety needs of the individual served.

Action Step: NA

Status of Action Step: NA

Completion date: NA

Comparison of Results:

During the quality assurance process the peer reviewer will seek verification to ensure that the consumer record identified all past and present health concerns and safety needs. Once concerns and needs are identified the team must then decide how to address the concern/need through programming or supports. A total of 141 plans were reviewed to ensure health and safety needs were being identified, 141/141 or 100% were compliant. The program has met this goal at 100% for five out of the 6 previous years, 2009-2012; scoring 100% in 2013.

Action Steps Taken:

N/A

Recommendations/Action Steps: Continue goal.

Action Step: NA

Timeframe for completion: NA

Person Responsible: NA

Expected Outcome: NA

3. **Goal** 100% of files that have a quality assurance review demonstrate that the agency appeals and grievance procedures were provided to consumers at least annually. MET / **NOT MET**

Update on Previous Recommendations/Results from Action Steps:

Administrative feedback following last year's program evaluation indicated a

recommendation that 100% of files that have a quality assurance review demonstrate that the agency appeals and grievance procedures were provided to consumers at least annually.

Action Step: The quality assurance process will be used to ensure that staff distributes the consumer handbook, which includes the agency appeals and grievance policy, and that it is distributed at least annually. Any changes to the handbook will be communicated promptly at the next face-to-face meeting with the individual served via a list of changes made. Department staff will review the process to ensure that all know that it is key to obtain proof of receipt of the appeals and grievance procedure. The QA Administrator will provide training to staff as issues arise as well as add a segment to our team meetings to review strengths and areas in need of improvement with our QA results. It was also recommended to increase and improve staff training on how to properly document the acknowledgement in case files so that the reviewer can easily determine the information was given.

Status of Action Step: QA Administrator provided monthly updates on findings of quality assurance reviews focusing specifically on patterns found during the QA process. Patterns include staff mailing the signature sheet and not following up to ensure it is received and forgetting to date the acknowledgement that is placed in the file to prove receipt of the procedure.

Completion date: The support to staff was ongoing through 06/14.

Comparison of Results:

At least annually the case manager is required to meet with the team to update the service plan and all documents completed on an annual basis. The Link Associates Handbook for Consumers, Guardians, Advocates, and Family Members is distributed annually and the consumer/guardian signs an acknowledgement of receipt of the handbook, which contains the agency appeals and grievance procedure. The program achieved 90% compliance in which the agency appeals and grievance procedure was distributed. This is the sixth year of measuring this outcome area. All previous years reported that 98% of those served had documentation in their file that proved they had been given the agency appeals and grievance procedures; however for FY 11-12 that dropped to 94 and again down to 93.75% in 2013. Since FY 10-11, the program has seen an 8% decrease in the documentation of or the distribution of the appeals and grievance procedure to teams.

Action Steps Taken:

QA Administrator provided monthly updates on findings of quality assurance reviews focusing specifically on patterns found during the QA process as well as concentrating initial training in this area to new hires.

Recommendations/Action Steps: Continue goal and evaluate systems to improve results.

Action Step: It is also recommended to increase and improve staff training on how to properly document the acknowledgement in case files so that the reviewer can easily determine the information was given. The QA Administrator will evaluate how to change the development of the CCSP process to be more proactive in our goal achievement, develop a process, and train and monitor the staff. Because the CCSP is typically done annually and the implementation of changes to a CCSP document template is often challenging, it is expected that this process could expand over two fiscal years. The quality assurance process will be used to ensure that staff distributes the consumer handbook, which includes the

agency appeals and grievance policy, and that it is distributed at least annually. Any changes to the handbook will be communicated promptly at the next face-to-face meeting with the individual served via a list of changes made. Department staff will review the process to ensure that all know that it is key to obtain proof of receipt of the appeals and grievance procedure. The QA Administrator will provide training to staff as issues arise as well as add a segment to our team meetings to review strengths and areas in need of improvement with our QA results.

Timeframe for completion: June 2015.

Person Responsible: Case Management Administrator and Case Managers

Expected Outcome: Through the quality assurance process, 100% of files reviewed demonstrate that the agency appeals and grievance procedures are provided to consumers at least annually.

4. **Goal** 80% of consumer goals reflect progress toward the achievement of personal outcomes and are supported by staff in doing so. **MET** / NOT MET

Update on Previous Recommendations/Results from Action Steps:

Goal will continue as written.

Action Step: NA

Status of Action Step: NA

Completion date: NA

Comparison of Results:

The agency has set high expectations for goal progress and values this program evaluation measure. This goal has been a part of the agencies program evaluation for many years and remains to be a prime indicator to staff regarding our person centered planning process. Quality assurance reviews are completed 9 of 12 months per year by trained staff. The department also employs a Quality Assurance Administrator who reviewed 33% of all records per year to aid in consistent reviews and to identify trends for training. Administrative Feedback following the last program evaluation indicated that the goal should continue as written with at least 80% of files reviewed demonstrating goal progress. Previous years scores have been 78% in 2011, 81% in 2012, and 84% in 2013. This fiscal year we met this goal with a score of 83%. This measure is critical in evaluating if the people we serve are directing their service by identifying their own goals. Goal planning is an on-going process and should not be seen as a one time a year event. Annually, teams do meet to develop goals for the upcoming year and this is seen as the start of this process. Frequently, through follow-up and monitoring of goal progress it is determined that the person has changed their focus and so must the goals change. It is essential that the person served, not the staff, choose the goals identified. When there is a lack of input by the person served the investment in reaching the goal will be hindered. The first through fourth quarter reporting periods reflected scores of: 84%, 84%, 85%, and 78% respectively, with an overall average of 83%.

Action Steps Taken:

N/A

Recommendations/Action Steps: Continue goal as written.

Timeframe for completion: NA

Person Responsible: NA

Expected Outcome: NA

Additional informational reports

In addition to the reports required by CARF and the HCBS Waiver, Link Associates has identified other measure we find essential to the comprehensive provision of quality services. These supplemental reports are located in this section.

SERVICE ACCESS – REFERRALS & TRENDS ANNUAL REVIEW

July 1, 2013 – June 2014

SUBMITTED BY, CRISTY JENNINGS, ASSISTANT OUTREACH DIRECTOR

ADMINISTRATIVE FEEDBACK

No recommendations are forthcoming for additional changes to agency policy on referral calls. It is important to continually review and monitor trends in referral calls at the time a significant impact is noticed and overall for the year. The tracking form is reviewed and modified as needed to insure the data needed for analysis is captured and processed effectively and efficiently.

REVIEW OF REFERRAL CALLS

An annual review of referral calls for the period of July 1, 2013 to June 30, 2014 was completed documenting receipt of 293 calls (8% more calls than the previous year). The review reveals during the first quarter, HCBS Waiver sites were in greatest demand with 17%, followed by Day Habilitation with 13% and then Transportation with 11%, remaining services ranged between 3%-8%; total calls received was 74. 42% of calls were Male and 58% Female with the highest percentage of calls for people 22-34 yrs. (41%) and 35-54 yrs. old (22%). Of the 52 calls received in the second quarter, Transportation Services were in the highest demand at 28% followed by HCBS Waiver sites at 15% and then Day Habilitation at 13%. 54% of calls were Male and 46% Female with the highest percentage of calls for people 22-34 yrs. old (40%) and 17-21 yrs. old (19%). During the third quarter, 75 calls were received with Transportation Services reporting the highest at 26%; Prevocational Services had 19%, and Day Habilitation was at 13%. 68% of calls were Male and 32% Female with the highest percentage of calls for people 22-34 yrs. (35%) and 17-21 yrs. old (19%). The fourth quarter received 92 calls; HCBS Waiver sites was of greatest demand with 24%, Transportation was at 17%, Service Coordination/CM Services was at 13%. 64% of calls were Male and 36% Female with the highest percentage of calls for people 17-21 yrs. old (28%) followed by 22-34 yrs. (23%).

Calls requesting services that Link does not provide (i.e. mental illness, physical disabilities, brain injury, financial support, etc.) ranged from 11% to 8%; averaging 9.75% a quarter. Alternatives were offered in all situations. Callers were directed elsewhere due to the referral not meeting Link's admission criteria.

Emergency calls ranged between 2%-6% and urgent/non-emergent calls ranged from 1%-6%. Both types of calls peaked in the second quarter.

Trends continue to show an increase in total number of calls. During this past year another provider closed some of their services, which likely attributed to the number of increased calls. Link also added a new Project Search Training program that began in the third quarter and increase a Dayhab program area that also likely attributed to the number of increased calls. The formal tracking and reporting system is capturing the necessary information needed for reporting.

Management team members routinely review referral calls at the time a significant impact is noticed and take action if necessary. Service needs, if identified are assessed and acted upon immediately, or included in the organization's strategic planning process for future emphasis.

Results of referral calls are summarized quarterly and distributed to management team. Results are also analyzed on an annual, more global basis for Board review and recommendations.

Formal Denials for services are tracked and for 2013-14 there were a total of seven (7) denials. There were no trends noted with regards to race/ethnicity, gender, language, age or religion for reasons to deny services. All denials were also given recommendations to better fit the applicants support needs. It is notable to report the denials occurred for requests in

Project Search and General Store services in which an over abundance of referrals/applicants were received for a limited number of openings.

TRENDS IN REFERRAL CALLS:

Referral sources vary throughout the year; however, the majority of referral calls during each quarter came from a Case Manager or service worker with calls ranging from 59% to 71%. The second major referral source was calls placed by a family member, ranging from 15% to 25%.

The remainder of referral calls received came from self-referrals (average 6% for the year) and calls placed by "others" (average 9% for the year).

As noted above, there appears to be an increase in calls over the past three years. There has been no trends in services requested other than the routine and primary services offered; Prevocational Services, Day Habilitation Services, Supported Employment, HCBS ID Waiver services and the new General Store & Project Search Training programs. However, it does appear Link's services are in high demand as there are limited to no openings in many of the services. The smaller ratio program areas in Day Habilitation are a high need area and continues to have a waitlist of referrals. The closing of another provider's services and the new General Store & Project Search Training program may influence the larger volume of phone calls. Link remains open to developing new 24-hour sites if necessary and is reviewing ways to expand some services. Transportation self monitors and tracks the need for any expansion of its services. New Hourly SCL and Supported Employment referrals remain on hold due to staff shortages and turn over with exception to those transferring internally.

The Admissions Committee is reviewing its policy and procedures to provide best practices for all referrals/applicants. Enclave Services remain eliminated from Link's service provision, however Link remains receptive to providing Enclave Services if the program can be supported.

- **Update on Previous Recommendations/Results from Action Steps**: No recommendations were reported.
  Action Step: N/A
  Status of Action Steps: N/A
  Completion date: N/A

- **Recommendations/Action Steps**: No recommendations are forthcoming for additional changes to agency policy on referral calls. It is important to continually review and monitor trends in referral calls at the time a significant impact is noticed and overall for the year. The tracking form is reviewed and modified as needed to insure the data needed for analysis is captured and processed effectively and efficiently.
  Action Step: N/A
  Timeframe for completion: N/A
  Person Responsible: N/A
  Expected Outcome: N/A

Services Requested	1st Qtr Sept '13	2nd Qtr Dec '13	3rd Qtr Mar '14	4th Qtr Jun '14	1st Qtr Sept '14	2nd Qtr Dec '14	3rd Qtr Mar '15	4th Qtr Jun '15
TOTAL NUMBER OF CALLS	**74**	**52**	**75**	**92**				
Not provided by Link *Alternatives offered*	11%	8%	11%	9%				
Supported Employment	5%	2%	3%	2%				
Pre Vocational	7%	6%	13%	9%				
Enclaves	0%	0%	0%	0%				
General Store	7%	2%	3%	6%				

Project Search	7%	2%	0%	3%				
Day Habilitation	13%	13%	19%	8%				
SCL hourly - adult	5%	4%	1%	4%				
HCBS/Waiver sites	17%	15%	9%	24%				
RCF/MR – group homes	3%	8%	4%	1%				
SCL hourly/respite - child	3%	6%	1%	2%				
Leisure	3%	0%	3%	2%				
Service Coordination/CM	8%	6%	7%	13%				
Transportation	11%	28%	26%	17%				
Emergency	4%	6%	4%	2%				
Urgent, non emergent	1%	6%	1%	2%				
Self referrals	8%	6%	5%	5%				
Call placed by family member	22%	15%	19%	25%				
Call placed by CM/Soc. workers	59%	67%	71%	62%				
Call placed by other	11%	12%	5%	8%				
Ages: 0-16 years	8%	8%	1%	4%				
17-21 years	16%	19%	19%	28%				
22-34 years	41%	40%	35%	23%				
35-54 years	22%	15%	12%	19%				
55-64 years	3%	12%	9%	2%				
Unknown	13%	6%	24%	24%				
Males	42%	54%	68%	64%				
Females	58%	46%	32%	36%				