LeChris Annual QA Outcome Measures Report

For the Fiscal Year 2021-2022

LeChris is committed to Total Quality Management in which to improve our organization and the service delivery to the persons served. Our outcomes this year included indicators in the areas of Efficiency, Effect, Access and Satisfaction. The collected data will be used to facilitate organizational decision making and strategic planning through; 1) Identifying areas needing improvement; 2) Developing action plans to address the improvements needed to reach desired goals; and 3) Outlining actions taken or changes made to improve our performance in delivering best possible services.

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Le'Chris, Inc.

LeChris Annual QA Outcome Measures Report for the Fiscal Year 2021-2022

Project Team Members: Amy Thorne - Executive Directors of Operations; Linda Weeks-McDonald - Clinical Director; Directors (Frankie Neal - Greenville, Bonni Stephenson, Relaine Reels - Morehead City, Martin Johnson- Rocky Mount and Angie Williamson – New Bern), PSR Coordinators (Robert Taylor – Morehead City, Frankie Neal, Jessica Hendrix- Greenville, Adrienne Sharpe- Rocky Mount), Day Treatment Director (Venitae Wallace – Morehead City), Bonni Stephenson QM/HR/Director, Martin Johnson Health& Safety/ Training Director.

Introduction: LeChris collected data on four outcome indicators for this annual year. This report will address all of the projects in separate sections. This FY provided challenges for the agency as the previous fiscal year due to COVID-19. This pandemic has no doubt impacted data collection, response, and analysis. There have been ongoing changes in billing codes and authorization process for services along with COVID isolations due to contacts and illness.

The purpose (project basis) for our annual outcome report is to determine:

- Service Access
- Effectiveness of services (results of the services)
- Efficiency of services (responsiveness, timeliness and cost effectiveness of services)
- Satisfaction of our consumers with our services and achievement of their personal goals
- Satisfaction of our employees and outside stakeholders
- Overall Business function and financial solvency

The Results of the Outcomes measured will be used to improve:

- Goal setting for quality services
- Strategic planning
- Staff development and subsequent morale
- Public relations

In preparation of this report, data was collected from the following sources:

- Consumer Satisfaction Surveys (conducted during the month of May, 2022)
- Employee Satisfaction Surveys (conducted during the month of May 2022)
- Stakeholder Surveys (conducted during the month of June, 2022)
- Referral Logs & Admission/Discharge Logs
- NC Topps & Aggregate data from the Division Webpage under the Simple Query Report”
- CST and PSR Outcome Management (OM) report cards
- Medical Records
- Financial Records

By measuring tangible outcomes and sharing them with our stakeholders, not only are we able to make more informed decisions about adapting specific services, we also hold ourselves accountable to the high standard of quality that we establish as our service goal when we developed our mission statement. A summary of our projects with overall results are below:

Domain	Performance Indicator	Performance Target	Data Source	Who Applied To	Timing	Obtained By	Outcome Results
Business Function	**All Programs meet or exceed weekly budget goals**	Monthly Surplus	Financial Records	All Services	Monthly	CEO	👎☹
Effectiveness Intensive In Home	There will be a 40% increase in control of their lives, hope about the future, and improved quality of life.	As a result of receiving intensive In-Home services, recipients will report an increase in each of the following areas: a) control over their lives; b) hope about the future and c) improved quality of life during treatment.	NC TOPPS	Clients	At admission, 3 mos., 6 mos., 12 mos. and at discharge Jul 2021– Jun 2022	IIH Staff	👍☺
Effectiveness Day Treatment Services	50% Decrease in suspensions/expulsions 50% decrease in suicidal thoughts	As a result of receiving Day Treatment services, recipients will report a decrease in suspensions/ expulsions and experiencing suicidal thoughts***	NC TOPPS	Clients	Quarterly	Day Tx Staff	👎☹
Effectiveness Community Support Team	**25 %Reduction in mental health symptoms**	CST clients will experience a reduction in symptoms as a result of utilizing the IMR Model as a best evidence based practice	CST OM Report Cards	CST Clients	Quarterly	CST Leads	👎⊗

Effectiveness Psychosocial Rehabilitation	**25 %Increased Goal Achievement**	PSR clients will report increased goal achievement	PSR OM Report Card	PSR Clients	July 1, 2021-June 30, 2022	PSR Coordinators	👎⊗
Effectiveness IDD Services	10% decrease will be evident in the IDD back-up staffing incident reports	decrease will be evident in the IDD back-up staffing incident reports	Incident Reports	IDD Clients	July 1, 2021-June 30, 2022	IDD Coordinators	**Inconclusive. There was not an increase or decrease. There were 2 incidents from back up staffing reported during this fiscal year and the previous.**
Effectiveness Assessment Referral	90% of Assessments completed will be in compliance with all required components and necessary recommendations and referrals made	Properly completed assessments and referrals will lead to increase service participation and decreased symptoms		Outpatient Clients	July 1, 2021-June 30, 2022	Clinician/ Outpatient Director	👍☺
Effectiveness Outpatient	. There will less than a 40% no show rate in out outpatient programs.	Improved service attendance will assist with decreased mental health symptoms and greater positive outcomes.	Client Survey	Outpatient Clients	July 1, 2021-June 30, 2022	Clinician/ Outpatient Director	👍☺
EFFICIENCY Assessment and Referral	Clients who have been assessed will have their follow up appointment within 14 days follow assessment			Wellsky	July 1, 2021-June 30, 2022		👍☺
EFFICIENCY Outpatient	Clinicians will spend 75% time providing direct care services/			Wellsky	July 1, 2021-June 30, 2022		👍☺
Efficiency All Enhanced Services	80% of the Authorized Hours or units approved by Authorizing Authority will be delivered to our Consumers		WellSky, authorizations	All clients with enhanced services.	July 1, 2021-June 30, 2022		**Inconclusive due to Covid Flexibilities**
SATISFACTION	**Client**	90% of sampled will report satisfaction with services received	Surveys	Consumers/ Guardians	June 2022	Directors, QM Dept.	👍☺

	Staff	90% Satisfaction with Employment with LeChris	Surveys	Staff	June 2022	QM Dept.	👍☺
	Stakeholder	90% of sampled will report satisfaction with services received	Surveys	Stakeholders	June 2022	QM Dept.	👎☹

Effectiveness

As effectiveness measures address the quality of care through measuring change over time, our proposed outcomes were to measure these through:

1. NC Topps for our Intensive In-Home (IIH) and Day Treatment (Day Tx) beneficiaries as it is a widely used instrument and required by the MCOs we serve;
2. Outcome Management (OM) Report Card - designed for our Community Support Team (CST) and Psychosocial Rehabilitation (PSR) recipients to determine the effectiveness of the service in utilizing the IMR Model
3. Wellsky for outpatient services to review appointments to determine the effectiveness of persons attending outpatient services.

Strategies:

1. LeChris sites that provided enhanced services to children and adolescents through IIH and Day Treatment services were asked to administer NC TOPPS to each of their consumers at intervals (initial upon 2 weeks of admission, then 3, 6 and 12 months later along with episode of completion) to monitor and report on the following measures.
    a. **Day Treatment recipients** in decreasing suicidal thoughts and suspensions from school during treatment. Measure Descriptions:
        i. *Suicidal Thoughts* - Percentage of consumers who reported experiencing suicidal thoughts in the 3 months before treatment versus during treatment.
        ii. *Suspensions or Expulsions* - Percentage of consumers who reported suspensions, expulsions, or being currently expelled in the 3 months before treatment versus during treatment.
    b. **Intensive In-Home recipient**s in increasing control over their lives; increasing hope about the future and improving their quality of life during treatment. Measure Descriptions:
        i. *Helpfulness of Program - Control over Life* - Percentage of consumers who reported program services were very helpful in helping them gain control over their lives during treatment.

ii. *Helpfulness of Program - Hope about Future* - Percentage of consumers who reported program services were very helpful in increasing hope about the future during treatment.
iii. *Helpfulness of Program - Quality of Life* - Percentage of consumers who reported program services were very helpful in improving their quality of life during treatment.

Reliability: NC-TOPPS interviews are the guides by which data items are collected consistently and can be reproduced similarly by different data gatherers in which training of personnel is the key. Validity: NC-TOPPS has chosen MH/SA indicators, measures, and data elements that measure what it intends to measure (face validity). Items are straight forward and are based on research and literature (construct validity). Evaluation of results is demonstrated for each of the programs separately.

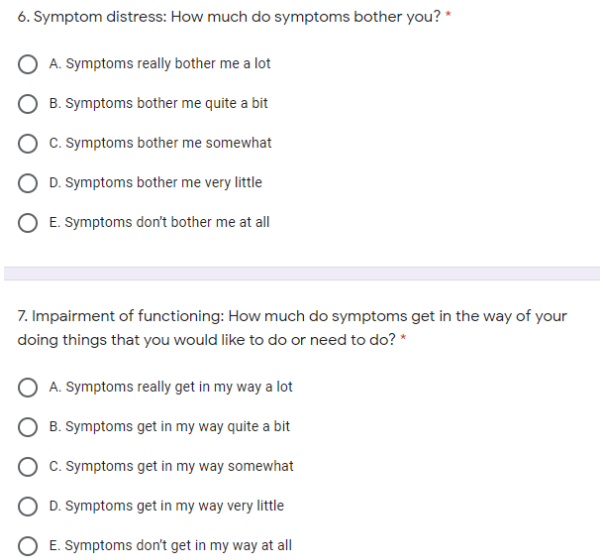
2. Beginning in January 2014, we started asking our CST and PSR clients to report directly about behaviors that we are trying to address through our services by utilizing the Illness Management Recovery (IMR) Model (hospitalizations/ emergency department visits, arrests, involvement in job/school, homelessness, medication compliance, mental health symptomology, satisfaction to their living environment and quality of their life). This fiscal year the CST Leads and PSR Coordinators collected results quarterly and then entered results directly into Google Forms and the QM Director compiled and analyzed the data on the following questions. Each question had a point value assigned to it's answers.

1. Progress toward goals: In the past 3 months, you have come up with ... * *

- A. No personal goals
- B. A personal goal, but have not done anything to achieve the goal
- C. A personal goal and made it a little way toward achieving it
- D. A personal goal and have gotten pretty far in achieving the goal
- E. A personal goal and has achieved it

2. Knowledge: How much do you feel like you know about symptoms, treatment, coping strategies (coping methods), and medication? * *

- A. Not very much
- B. A little
- C. Some
- D. Quite a bit
- E. A great deal


6. Symptom distress: How much do symptoms bother you? *

- A. Symptoms really bother me a lot
- B. Symptoms bother me quite a bit
- C. Symptoms bother me somewhat
- D. Symptoms bother me very little
- E. Symptoms don't bother me at all

7. Impairment of functioning: How much do symptoms get in the way of your doing things that you would like to do or need to do? *

- A. Symptoms really get in my way a lot
- B. Symptoms get in my way quite a bit
- C. Symptoms get in my way somewhat
- D. Symptoms get in my way very little
- E. Symptoms don't get in my way at all

3. Directors will utilize the report center in Wellsky to generate data to determine the no show rate for outpatient services. This will be done yearly.

Actions Taken:

For **NC-TOPPS:** As part of their responsibilities, staff was to ensure that NC Topps were completed for all consumers receiving enhanced services as specified by the Division of MH/SA/DD. Data was analyzed for the children and adolescent mental health population receiving Intensive-In-Home and Day Treatment services to determine if indicators such as 1) experiencing suicidal thoughts; and 2) suspensions/expulsions would be decreased with having supports in place;

For **CST and PSR project**, the completed Outcome Management (OM) Report Cards were gathered by the CST Leads and PSR Coordinators; the QM Director duplicated the report card into Google Docs which was used to analyze the collected data. The results of the data interpretation are covered under "Evaluation of results".

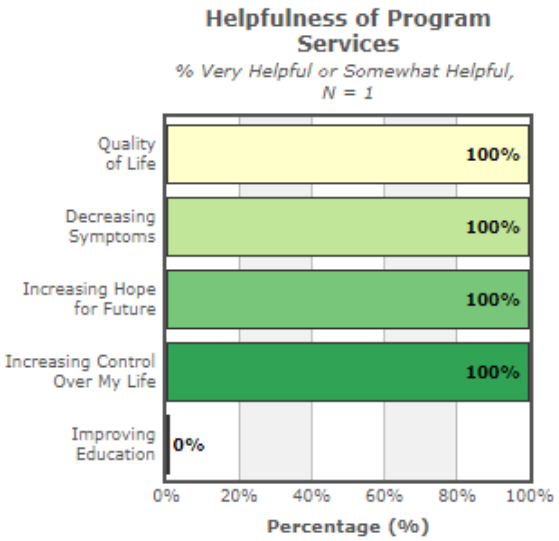
For outpatient the report will be generated in from our electronic medical record and is the responsibility of the QA Team to gather and analyze the data.

Evaluations of Results:

For NCTOPPS:
Simple Query from the NCTOPPS website was utilized.
The data for persons receiving Day Treatment services: During the FY 2021-2022 the Day Treatment program only had one admission to the program. Additional Day Treatment participants were enrolled in another enhanced service with a community agency that would act as the clinical home thus completing the

survey and utilizing, he data for their service. The information gather this year was insignificant. However, the child admitted is successfully discharging and returning to a regular school setting. There was decreased suspensions and he did not report suicidal thoughts.

For persons receiving Intensive In-Home Services: Regarding Helpfulness of program- Control over Life, Helpfulness of program- Hope about Future and Helpfulness of program-Quality of Life
100% of clients reported improvements in the Quality of life, Increasing hope for the future and Increased control over their lives
0% surveyed reported Improvement in Education.
100% of clients reported Decrease in mental health symptoms since starting treatment.



For CST and PSR Outcome Management Report Card Data:

For PSRs: We have three (3) PSRs from where we have 31 useable report cards gathered during this fiscal year. Most of these clients have been receiving the IMR/WMR for significant periods of time.

Overall, the average showed that of the clients surveyed 40% reports some progress toward goals they have chosen over the FY 2021-2022. 100% of clients reported having knowledge of symptoms, treatment, coping strategies (coping methods), and medication over the course of the FY.

For PSR, the results demonstrate that the model is achieving the desired outcome in improving the overall wellness for the individuals we serve, however with minimal impact. Clients receiving the service were overall stable. The questions asked were changed from previous years, but still utilizing surveys from the IMR Model,

however a different benchmark for program success should be identified in future outcome projects. The plan for a Control group was not utilized in all programs this year and not all data submitted was usable. Directors will be reminded to identify 10 clients for each program to follow then entire fiscal year.

For CST programs, we have one Community Support Team. The team provided some, yet not a significant amount of useful data. Approximately 12 clients were surveyed. Of those clients 60% of clients reported severe symptoms at initial assessment. At the end of the year 50 clients reported severe symptoms. 50% reported mild symptoms. Data is collected monthly, however, with new admissions and discharges data was analyzed by initial and final for more accurate results.

For Outpatient Services
We have one clinic that provides outpatient therapy and assessment and referral conducted at 3 offices. Out of 378 appointments that were scheduled 132 were no shows. This was a no show rate of 35% which means the agency met the goal of no more than a 40% no show rate. In the future that agency will look at strategies to lower that rate further.

Next Steps:

For NC-TOPPS: This outcome will be continued as it continues to assist us in interpreting the effectiveness of our services.

For CST and PSR Outcome Management Report Cards: The plan is to do more education regarding data collection as well as reminding staff the importance of collecting the data consistently and in a uniform way. This outcome will be continued.

For Outpatient we will continue to monitor the completeness of assessments to ensure that all clients are referred to necessary services. We will continue to survey clients related to symptoms at admission and periodically during treatment.

EFFICIENCY

Strategies:

Efficient use of authorized hours: Not only is it important from a business perspective, but also from the perspective of persons served. The agency attempted to achieve the outcome of "80% of the authorized hours approved by Authorizing Agent will be delivered to our Consumers." The strategy in getting this accomplished was first and foremost to inform all of the sites of our intent. Next, the Site Directors were tasked in collecting and reviewing the results quarterly from a report generated through Wellsky (our electronic medical record system). The report for each of the services was also to be generated by the QM Department at the end of fiscal year review for final data analysis.

Actions Taken:

The directors of all sites were informed of the intent. The report generated by Wellsky was utilized which lists: 1) Client record number; 2) Start date for authorizations; 3) End date for authorizations; 4) Number of units authorized; 5) Number of units delivered; and 6) Type of service in question. Directors were asked to explain any discrepancies as to why not all hours were being delivered. The percentage was achieved by dividing the number of units delivered by the number of units authorized. At the end of the fiscal year, all data was compiled and analyzed. Overall averages were calculated for each service, along with a trend analysis of any comments received.

Evaluation of Results:

The 2021-2022 agency continued to navigate operations during the pandemic. Due to amended billing codes and flexibilities most programs did not require authorizations for pandemic related codes therefore we were unable to calculate the percent of authorizations used.

Next Steps:

We will continue with this outcome for the next fiscal year but understand that dependent on the current landscape of service delivery and coding we may need to look at alternate ways to evaluate the use of the service by clients.

Access to Services

Timely access to services is important for our consumers. The division has guidelines as to the timeframes when a person needs to be seen. For routine care, the timeframe is 14 days, for urgent, it is 48 hours and for Emergent clients, the timeframe is 2 hours. It is evident that LeChris is meeting these timeframes for all assessments; however, when it comes to referrals to a specific service after the assessment, some improvement is still needed. The agency as a whole averaged 65% which is up from 42.7% the year before.

Strategies:

Directors and Coordinators of each site were instructed to keep data on new consumers to our agency from referral to admission in hopes of reaching the desired goal of 90% of consumers will be seen within 10 days of the referral.

Actions Taken:

Quality Management Department developed an Excel spread sheet to track this data along with existing referral and admission logs that Directors were instructed to use. Directors were asked to turn in data on a quarterly basis for this outcome, rather than wait until the end of fiscal year as was done previously in hopes of identifying any potential problems with data collection. QM will work to collect data through electronic resources (google) opposed to spreadsheets currently in use to decrease calculation errors or corrupt documents.

Evaluation of Results:

Regarding the next step in getting the consumer to the referred service within 10 days, the data shows a success rate of 65%. Staff will continue to be educated on timeframes expected to ensure improvement in

this percentage in all sites. The table below provides detailed information regarding the total number of referrals received, number of new admissions, and number of clients meeting the required timeframes, followed by the percentage of admissions meeting the timeframe per each quarter for the agency as a whole.

	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Totals for FY 21-22
# of Referrals received during this quarter	184	97	126	88	495
# of New Admissions	123	64	76	71	334
% of Referrals to Admissions --> GOAL 80%	54%	73%	87%	60%	67.4%
# of Clients that met the required timeframes for access to services	74	37	56	48	215
% of Admissions meeting required timeframes - GOAL 90%	60%	58%	74%	68%	65%

Next Steps:

Ensure that the required timeframes for an assessment are reviewed with staff and that accurate data is available to analyze this outcome. Continue to work on improving and monitoring the process as to how to track the data from assessment referral to service admissions by educating the site directors on how to accurately gather the data as well as work through any barriers that hinder the process. This outcome will be continued next year.

Satisfaction Surveys - Consumer

Consumer Satisfaction surveys are conducted annually to assist LeChris in maintaining and improving the quality of services provided to our consumers. Furthermore, it gives us an opportunity to discover if our services are effective, if consumers are achieving their outcomes, and identify areas of what's working and what is not working.

Strategies:

2 separate surveys were designed to cover the following services we provide throughout our agency:

Community Support Team (CST)
Intensive In-Home (IIH)
Assessments/Evaluations (Assmt)
Day Treatment (Day Tx)
Psychosocial Rehab (PSR)
Therapy (Ther)

IDD services (IDD)
Med Management/Doctor Services (Med Mgt)
Peer Support
Individual Support Services (PSS/ISS)

Questions on the surveys were varied somewhat as they were tailored to the specific service being surveyed. Questions were designed to address access, efficiency, effectiveness and overall satisfaction for the services provided. Participants (consumers, parents, guardians, and/or caregivers) were asked to choose a statement best describing their experience with LeChris. Four response choices were provided: strongly agree, agree, disagree or strongly disagree. We also continued to use the picture prompts in the form of smiley faces that coincided with the answer choice to assist respondents to choose their answer without only having to rely on reading the answer choices provided. The goal that we had set for ourselves was to achieve 90% of consumers/guardians sampled to report satisfaction with services received.

Actions Taken:

- Once surveys were designed and approved by the QM committee and the Corporate Team, they were given to Directors of each site for distribution to our consumers. Consumers were assured confidentiality of the results and given a choice of either placing their surveys in a sealed envelope or mailing them directly to the QA Department. Microsoft Excel was utilized to capture the data and to assist in interpreting the results. This FY clients were able to complete the survey online utilizing Google Forms

  Measures:

  - The percentage (%) of satisfaction was calculated by the number of consumers answering "Strongly agree" and "Agree" in the survey divided by the number of surveys completed for that site. In instances where no response was received for a specific question, the number of surveys was adjusted to reflect the number of responses received.
  - The percentage (%) of overall satisfaction was achieved by taking the average of satisfaction for all sites participating in the survey.

Evaluation of Results:

During this FY there were 57 clients enrolled in an enhanced service and ____ clients enrolled in outpatient services that completed surveys. There are two different survey designed one for enhanced services and one for outpatient. The overall satisfaction rate for the agency was 90% from both surveys.

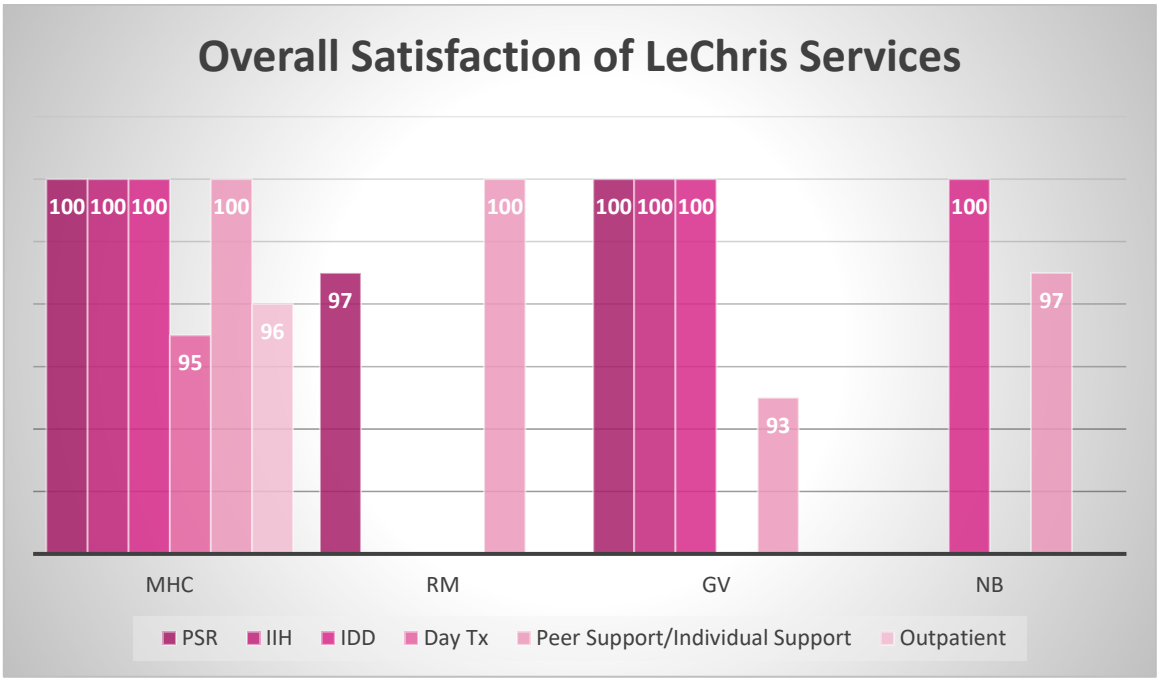
Table below provides a percentage of satisfaction per each site and service along with the overall satisfaction per service.

SITE	Day Tx	CST	PSR	IIH	PSS/ISS	I-DD	Therapy
RM			90%		100%		
GVL		90%	100%	100%	93%	100%	
NB					97%	100%	
MHC	95%		100%	100%		100%	96%

Overall %	95%	90%	97%	100%	96%	100%	96%

Graphs below will further demonstrate the results:

1. 90% of Overall Satisfaction per Service and Site



*The projected goal was met with a 90% or higher percentage per site and service.

Next Steps:

Continue conducting satisfaction surveys on an annual basis to evaluate our performance with the consumers we serve to ensure quality services are in place.

Satisfaction Surveys - Employee

Why conduct employee satisfaction surveys? The reason is simple; LeChris believes that a strong path to success begins with a great place to work. We solicit staff feedback through surveys on an annual basis to improve the workplace. Satisfaction of employees is important as it lowers employee turn-over, leads to higher consumer satisfaction, increases loyalty and improves profitability.

Strategies:

The questions on the survey were designed to assess level of agreement or disagreement in the areas of 1) understanding organization's mission; 2) opportunity to learn & grow; 3) receiving adequate training; 4) safe work conditions; 5) Being treated with respect; and 6) Feeling being listened to and receiving clear instructions by the supervisor. Four response choices were provided: strongly agree, agree, disagree or strongly disagree. The goal that we had set for ourselves was to achieve 90% of employees sampled to report satisfaction with their employment.

Actions Taken:

Once the survey was designed and approved by the QM committee and the Corporate Team, a flyer was e-mailed to Directors of each site for distribution to staff with instructions and timelines. Staff was encouraged to complete the survey on-line utilizing Google Forms; for staff that did not have access to the internet, a paper copy of the survey was provided. Both methods were used -- the paper survey responses received were then entered into the Google Forms by the Director to ensure that scoring would be uniform.

Measures:

- The percentage (%) of satisfaction was calculated by number of employees answering "Strongly Agree" and "Agree" in the survey divided by the number of surveys completed.
- The percentage (%) of overall satisfaction was achieved by taking the average of satisfaction for all of the responses received.
- Rating scale from 1-4 was utilized in interpreting the results. One (1) being the highest score indicating "strongly agree" and four (4) being the lowest indicating "strongly disagree".

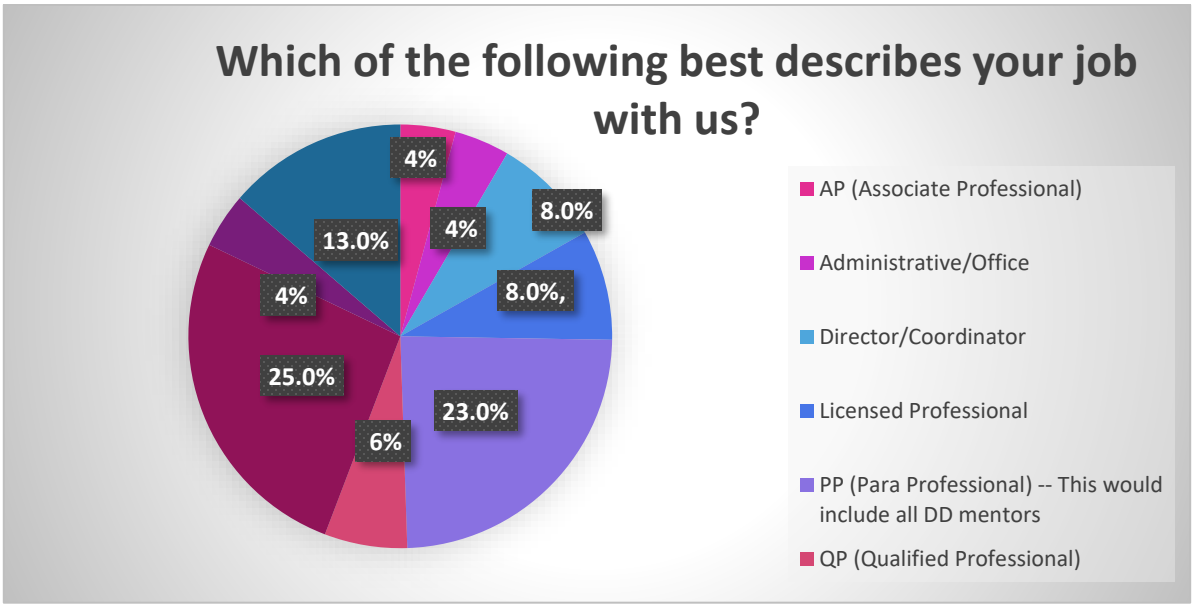
Evaluation of Results:

For this fiscal year, a total of 48 out of 148 employees completed the survey. Our overall percentage of satisfaction was calculated to be 94% across all regions. The projected goal of 90% employee satisfaction was met. In evaluating the combined summary results of all of the LeChris sites, the highest rating revealed to be "My supervisor treats me with respect" with a rating of 3.9, then "I am familiar with and understand the organization's mission and strategic goals" rating3.8, followed by "My supervisor listens to me and gives me clear instructions" with a rating of 3.8.

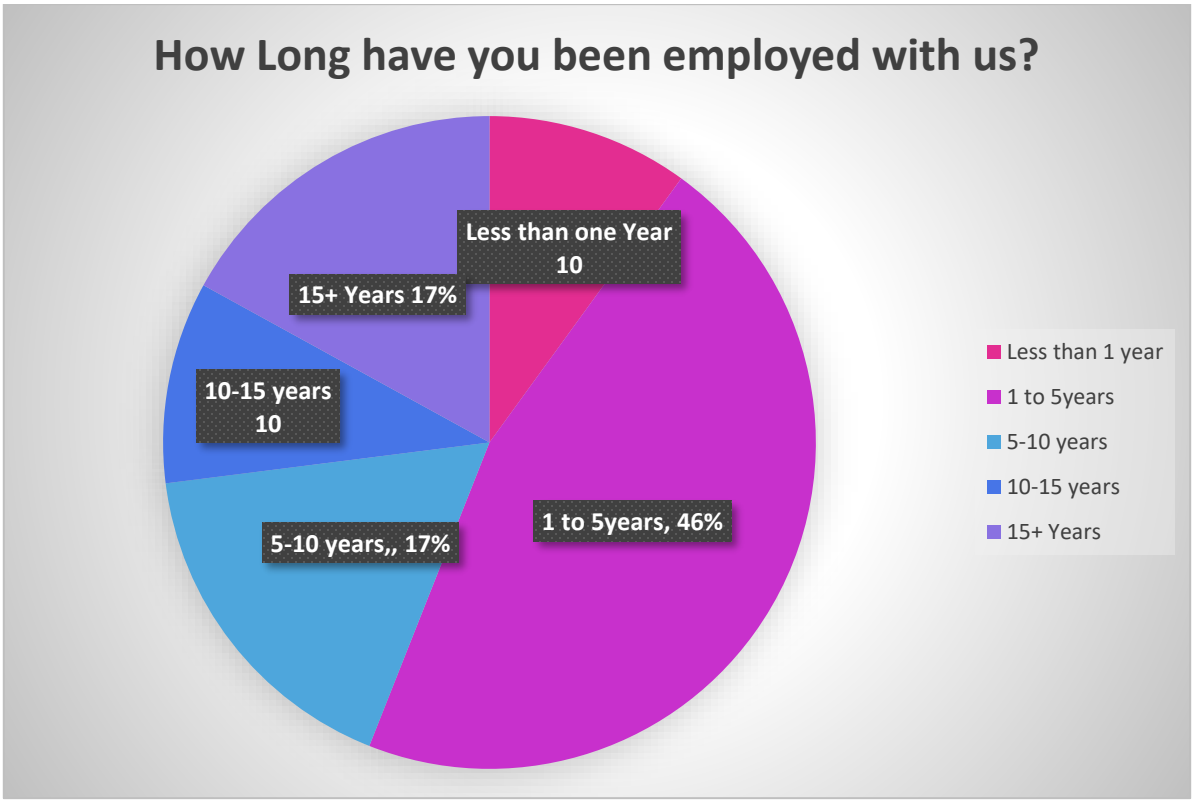
The next step was to review the employee comments as these provide invaluable feedback. When asked "What could LeChris do to increase your job satisfaction", 34 responses were received and reviewed. The following topic had the most comments made.

1) Increased salaries/wages and Direct Deposit. (15 responses received)

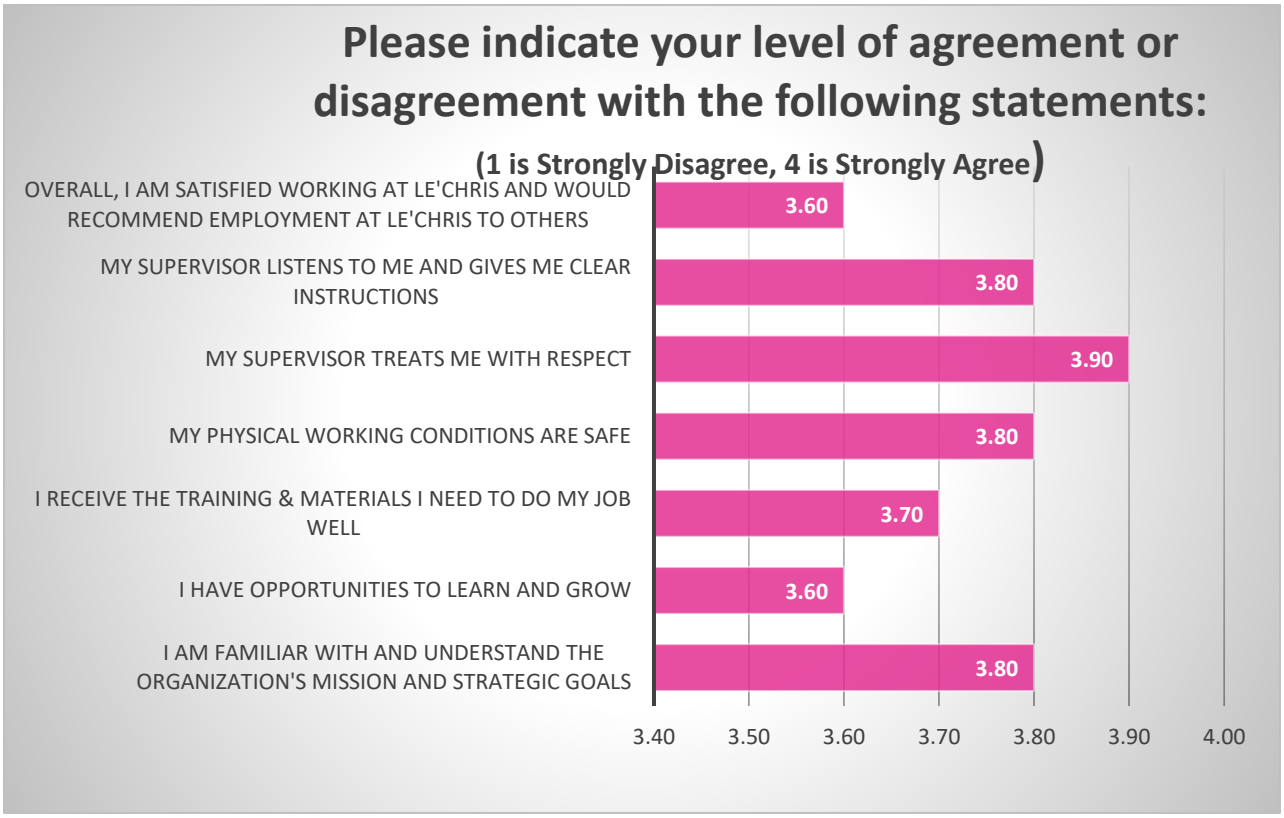
The following graph displays a breakdown of staff positions responding to the survey –



The graph below displays the length staff has been employed with LeChris -- it was noted that the majority 46% of the staff that responded to the survey have been with the company between one to five years, followed by 17% of the staff that had been with the company more than five years.



The next graph shows the summary of responses of all LeChris employees for this survey.



Next Steps:

The results were shared with the Corporate Team. Ideas are being solicited to address the areas of concern and to increase the overall satisfaction of the employees. LeChris continues its commitment to provide a great workplace for its employees and will continue to solicit feedback from the staff on an annual basis.

Satisfaction Surveys – Stakeholder

The Stakeholder Satisfaction Surveys are conducted annually to assist LeChris in maintaining and improving relationships with our stakeholders as well as identifying areas of what's working and what is not working. Furthermore, input is requested and collected to help determine the expectations and preferences of the organization's stakeholders and to better understand how the organization is performing from the perspective of its stakeholders.

Strategies:

LeChris chose to utilize "Google Forms" –on-line survey application in getting the survey out to our Stakeholders. The pros and cons were considered prior to executing the project. The cons of the system include: Spam/privacy issues, technical issues. The pros seem to outweigh the cons, they are the following: Has the same strengths as a paper version, it is better at addressing sensitive issues, it is cost efficient, it has faster delivery, quick response time and the ability to track and analyze the data is effortless. The survey was then designed to capture information about our stakeholders in general, such as type of agency they

represent, types of services they utilize through LeChris, and specific LeChris locations they work with. Then more specific questions as how they would rate our work (see graphs below for the questions) - six response choices were provided: "Excellent", "Good", "Adequate", "Poor" and "Not applicable". The last four questions addressed overall quality of our services, confidence in our services, if our performance was getting better, and how likely was it that they would utilize LeChris in the future. The goal that we had set for ourselves was to achieve 90% of overall satisfaction with our stakeholders.

Actions Taken:

Once the survey was designed and approved by the QM committee and the Corporate Team, QM Director requested names of stakeholders from each of the Site Directors in order to send out a Survey to find out "How we are doing." The following e-mail was sent to the Stakeholders:

Good Afternoon,
You have been identified as one of our external stakeholders. As such, you are invited to participate in our Satisfaction Survey designed to gauge your opinion on "how we are doing". This survey will ask about your interactions with LeChris within the past year, it will only take approximately three to five minutes to complete and all of your responses will remain anonymous. Your feedback will assist us in improving the quality of our services we provide. The link is uniquely tied to this survey and your email address; please do not forward this message. To access the survey, just click on the following link: https://forms.gle/GGL6QYX3MotVKcLG6. If you have any questions regarding the survey, please feel free to contact me. Thank you in advance for your participation!

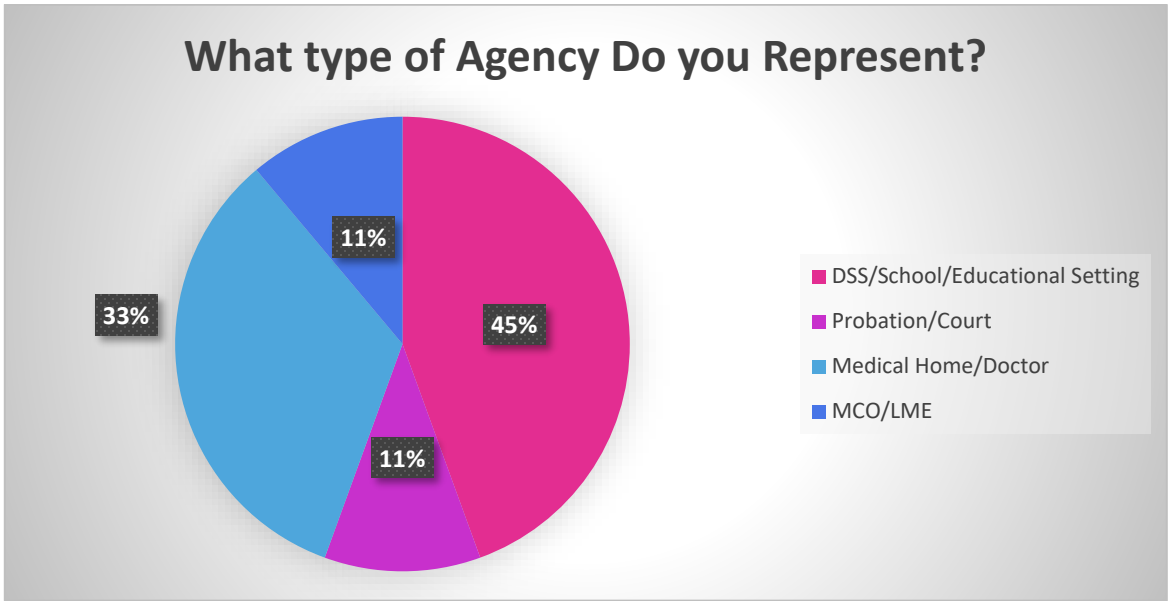
Measures:

- The percentage (%) of satisfaction was calculated by number of stakeholders answering "Excellent" and "Good" for Question #5 in the survey divided by the number of surveys completed. In the other questions, the same method was utilized (1st two positive responses were utilized divided by the number of surveys completed)
- The percentage (%) of overall satisfaction was achieved by taking the average of satisfaction for all of the responses received.
- Rating scale from 1- 5 was utilized in interpreting the results. One (5) being the highest score indicating "Excellent" and four (1) being the lowest indicating "Unacceptable".

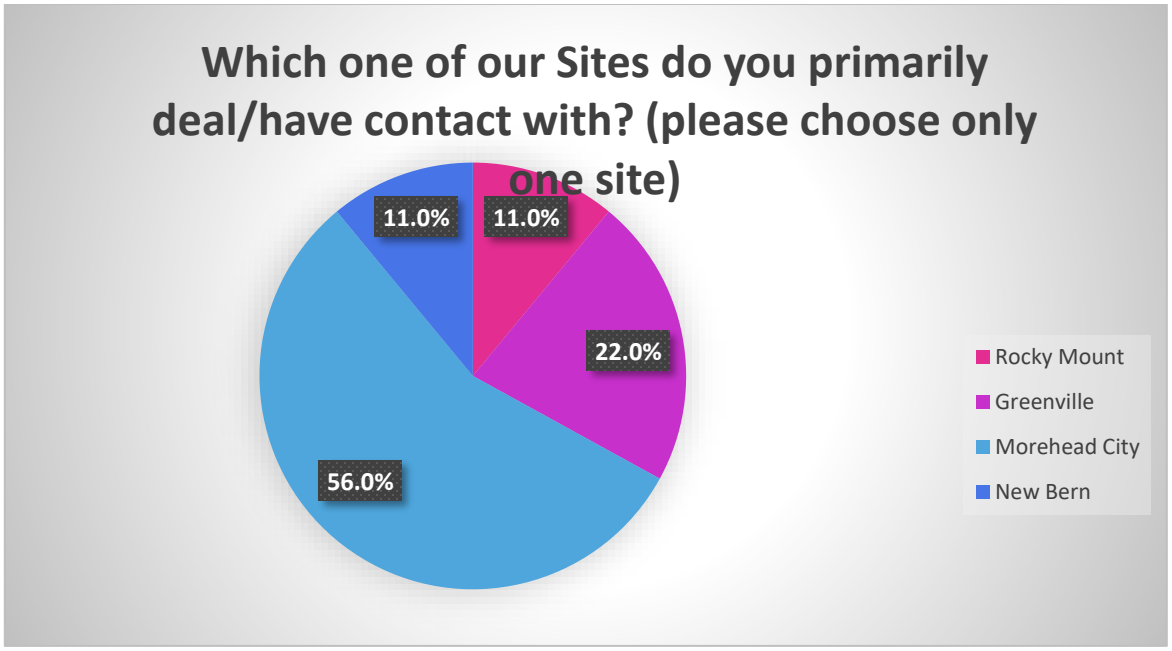
Evaluation of Results:

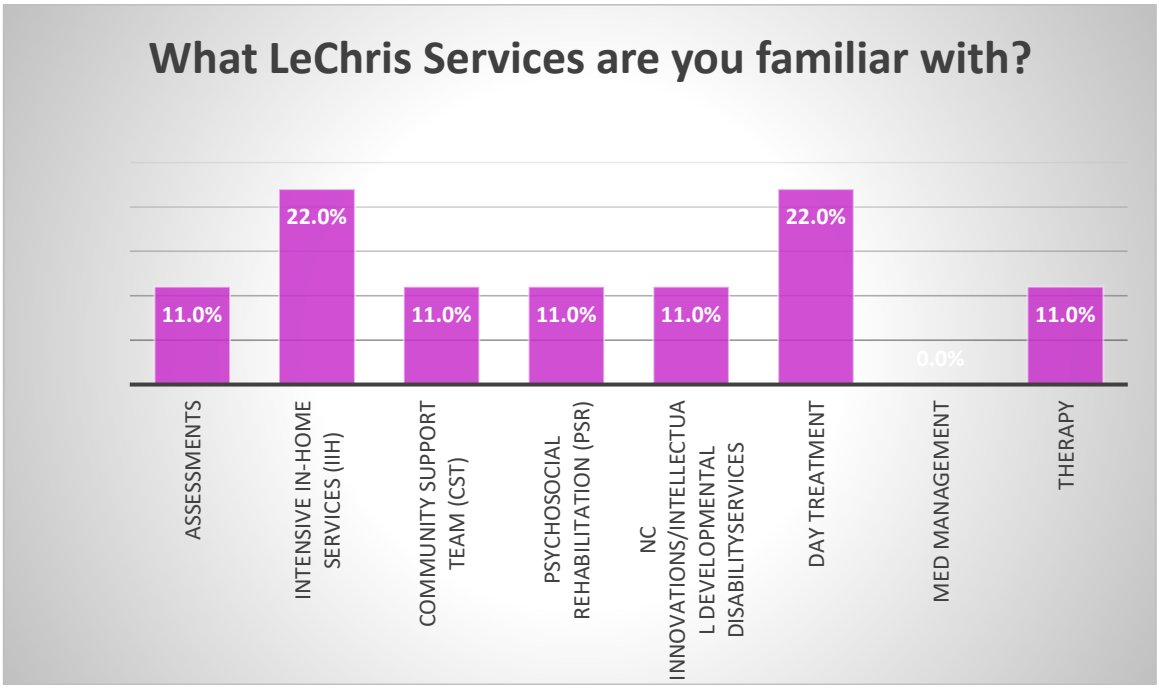
Participation of outside stakeholders to our survey this year was 33% (out of 13 requests for surveys 5 surveys were returned). The sites that had the most participation were 1) Morehead City (56%), followed by Greenville (22%). Most of the responses were received DSS/ School (45%). The service that received most responses were Day Treatment and Intensive In Home (44%). The average overall rating regarding the different aspects of our work revealed a score of 1.5 – rating of 1 being "Excellent" and 2 being "Good." In rating the quality of our services, 40% reported them being as "Excellent," 60% reported them as "Good." In collapsing the data for the Excellent and Good categories, it reveals an 88% positive score. When stakeholders were asked about their confidence level in our services, 60% revealed "Complete Confidence", followed by 40% response who replied with "A lot of confidence." According to the responses, 40% of the

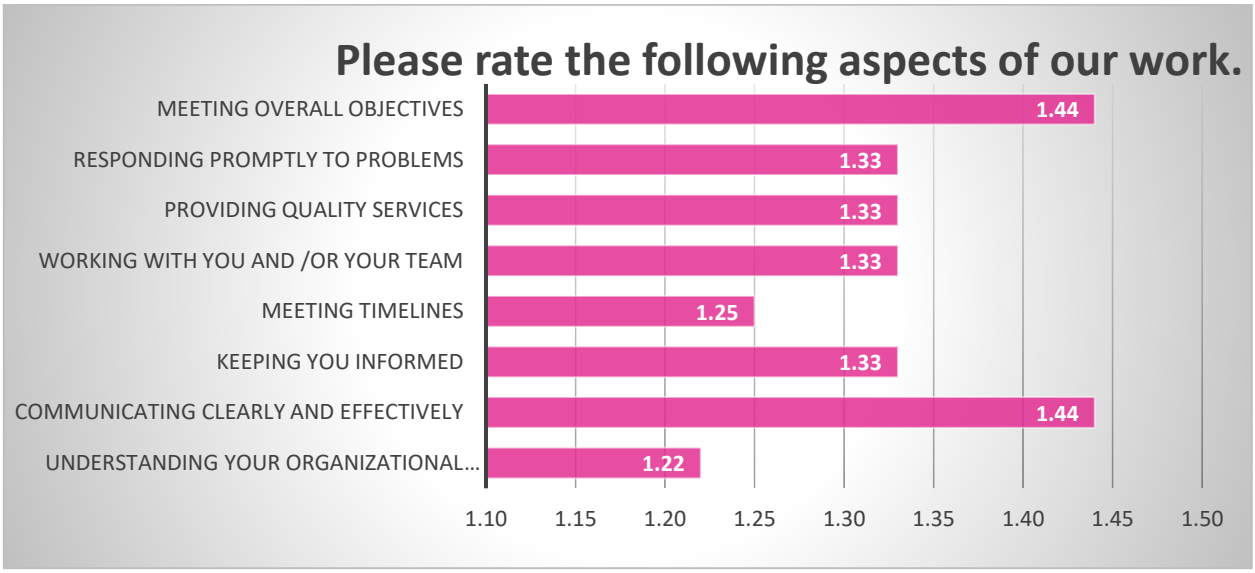
responses said the services were “Staying the Same”, followed by 60% of the responses that said the services were “Getting better”. In the last question, we wanted to find out the likelihood of them using LeChris services again. 100% stated “very likely” In evaluating the results, we did not achieve our goal of 90% overall, we received 89%. The tables and graphs following further illustrate the results of the survey. The questions asked are represented by the title of each graph.

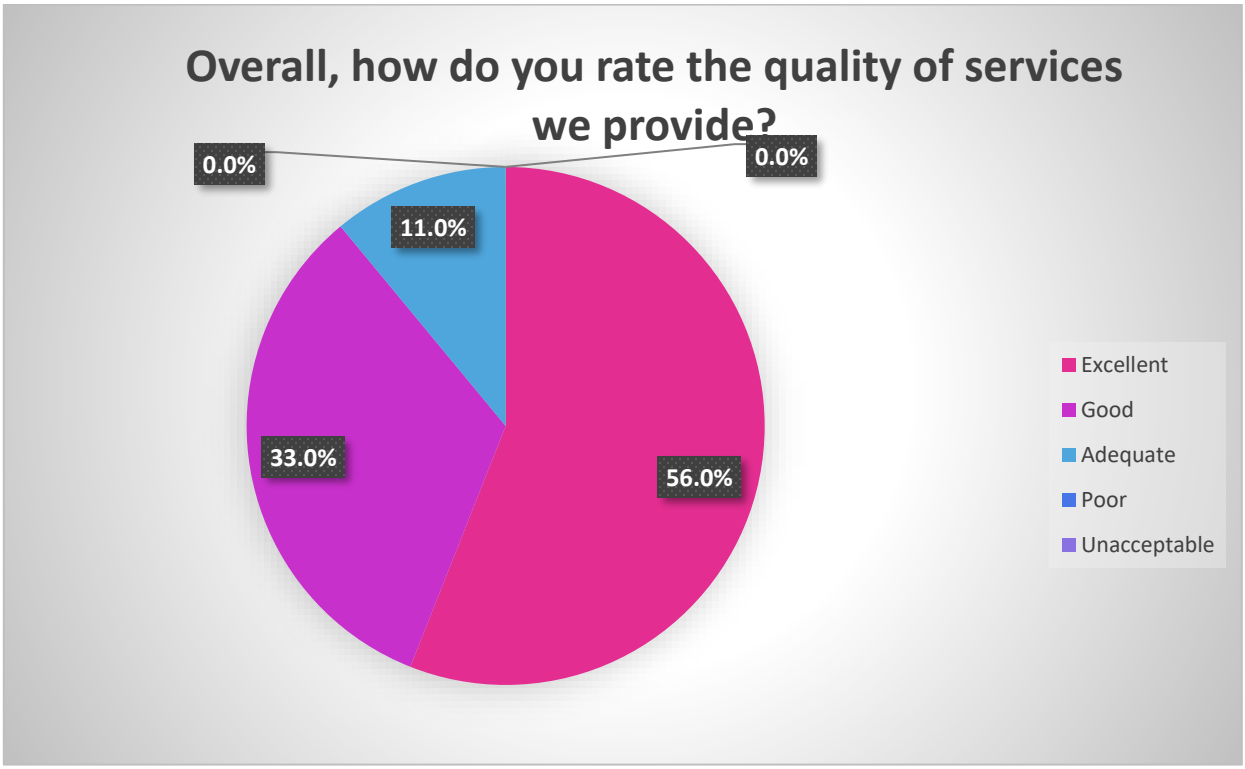


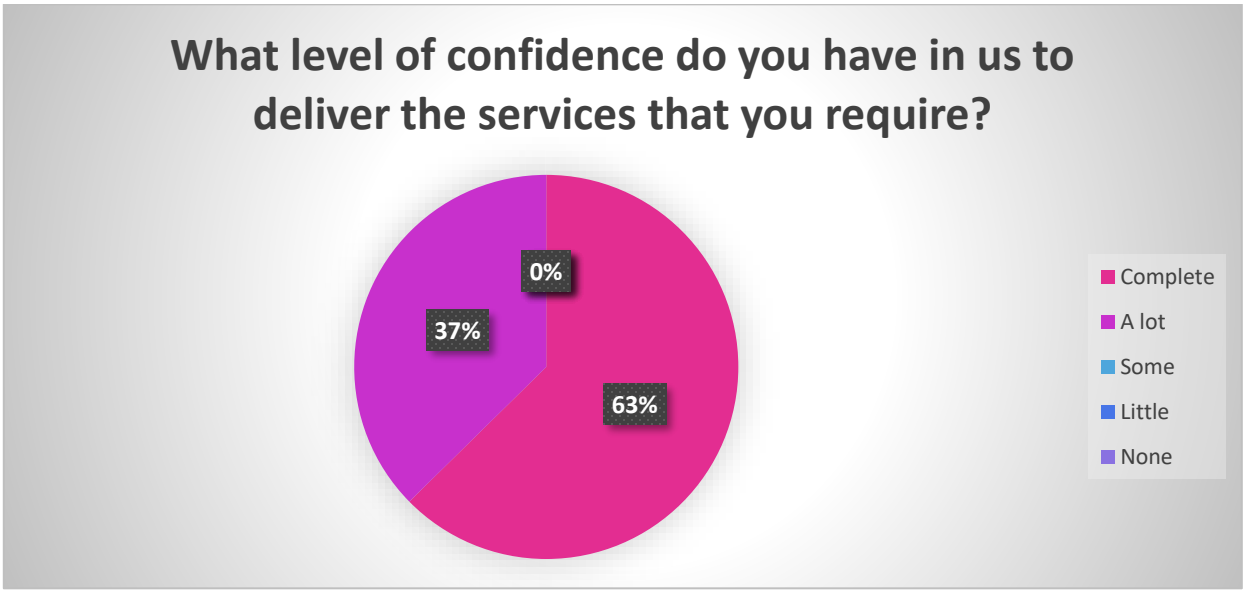
Other covers the following: Parent

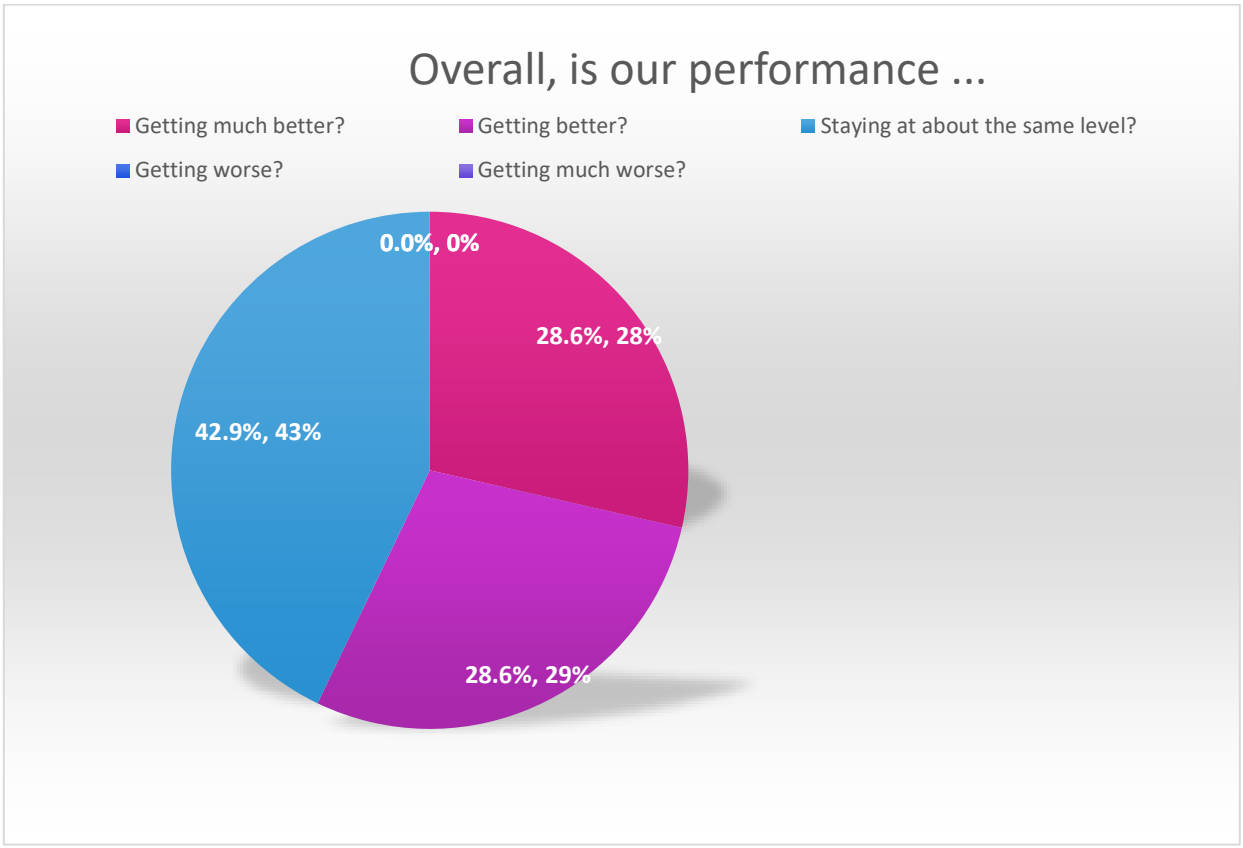


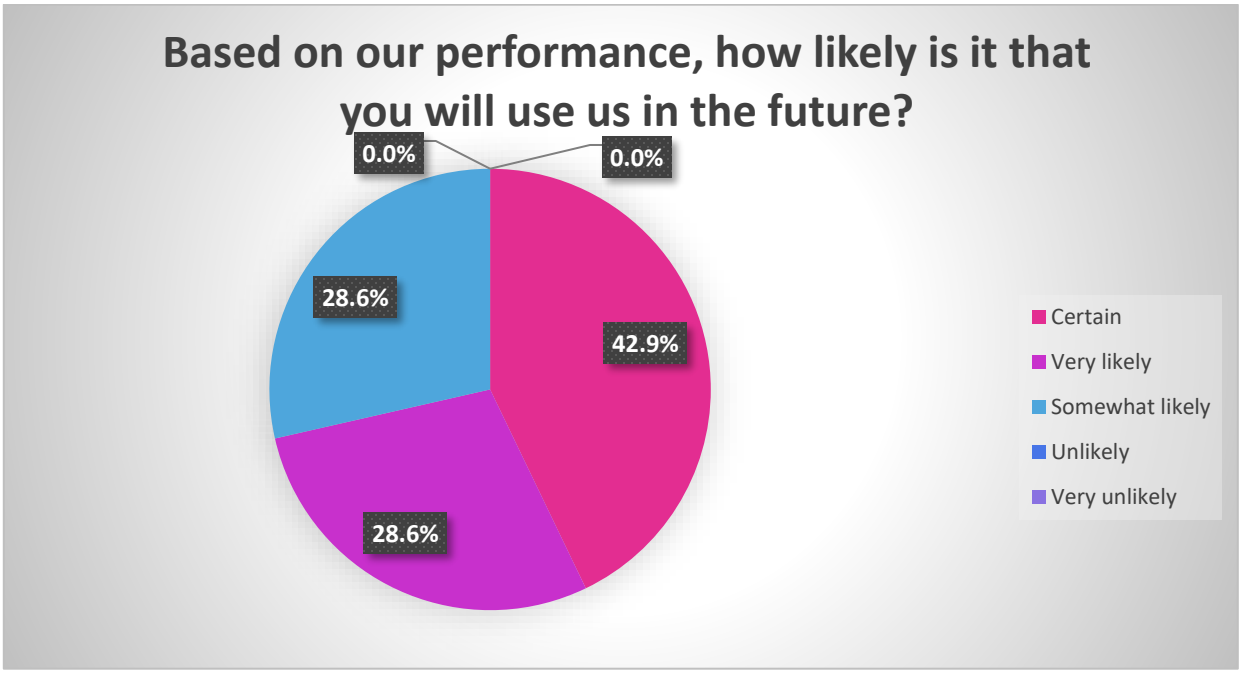

What LeChris Services are you familiar with?
11.0%
22.0%
11.0%
11.0%
11.0%
22.0%
0.0%
11.0%
ASSESSMENTS
INTENSIVE IN-HOME SERVICES (IIH)
COMMUNITY SUPPORT TEAM (CST)
PSYCHOSOCIAL REHABILITATION (PSR)
NC INNOVATIONS/INTELLECTUAL DEVELOPMENTAL DISABILITYSERVICES
DAY TREATMENT
MED MANAGEMENT
THERAPY


Please rate the following aspects of our work.
MEETING OVERALL OBJECTIVES
RESPONDING PROMPTLY TO PROBLEMS
PROVIDING QUALITY SERVICES
WORKING WITH YOU AND /OR YOUR TEAM
MEETING TIMELINES
KEEPING YOU INFORMED
COMMUNICATING CLEARLY AND EFFECTIVELY
UNDERSTANDING YOUR ORGANIZATIONAL...
1.44
1.33
1.33
1.33
1.25
1.33
1.44
1.22
1.10
1.15
1.20
1.25
1.30
1.35
1.40
1.45
1.50


Overall, how do you rate the quality of services we provide?
0.0%
0.0%
11.0%
33.0%
56.0%
Excellent
Good
Adequate
Poor
Unacceptable


What level of confidence do you have in us to deliver the services that you require?
0%
37%
63%
Complete
A lot
Some
Little
None


Overall, is our performance ...
Getting much better?
Getting better?
Staying at about the same level?
Getting worse?
Getting much worse?
0.0%, 0%
28.6%, 28%
42.9%, 43%
28.6%, 29%


Based on our performance, how likely is it that you will use us in the future?
0.0%
0.0%
28.6%
42.9%
28.6%
Certain
Very likely
Somewhat likely
Unlikely
Very unlikely

Next Steps:

LeChris continues to be committed to providing the best possible services. The results were shared with the Corporate Team. Ideas were solicited to address the areas of concern and increase the overall satisfaction of the stakeholders. LeChris will continue to solicit feedback from our Stakeholders on an annual basis to ensure quality of services and to assist us in identifying any areas of concern from outside sources.