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**Strategic Plan 2018**

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Executive Summary

2017 Highlights

Fiscal Year 2017 has been a year of milestones for First Step House (FSH). We launched the REACH program after nearly three years of hard work that involved program design, contract negotiations, collaborating with multiple stakeholders, fundraising, team building, and project implementation. REACH is a community-based program designed to reduce recidivism among high-risk, high-need people involved with the criminal justice system who have substance use disorders. The innovative Salt Lake County/Salt Lake City Special Project initiative was another major accomplishment for FSH in 2017. This project, which involved multiple community partners, created immediate access to substance use disorder treatment for homeless individuals involved with the criminal justice system. During our involvement, we served 68 individuals who were diverted from jail into treatment, we helped 43% of these individuals leave treatment employed, compared to 4% who were employed at admission, and we decreased homelessness from 81% at admission to 27% at discharge. FSH was recognized by community stakeholders for our ability to engage and retain the people we served through this program. Other milestones last year included the installation of fire suppression and alarm systems in all five of our recovery residences and in our residential facility at 411 North Grant Street; the completion of upgrades to the residential dormitories, creating a safer, more energy-efficient space; and completing full renovations to four out of five of our recovery residence facilities. These renovations involved complete updates to the kitchen and bathrooms, the installation of new heating and cooling systems, and the installation of new appliances, flooring, and hardwired fire-alarm systems.

Several FSH programs, projects, and initiatives were significantly evolved in FY 2017. The case management team formalized case management processes, updated housing case management procedures, and streamlined the pathway to housing. The Evidence-Based, Social-Impact Initiative took important steps forward with the hiring of an organizational data manager. Last year we also trained the organization in Motivational Interviewing, began fidelity monitoring and coaching for Moral Reconation Therapy, and tracked therapeutic alliance using Outcomes Questionnaire data. The FSH Peer Support Services and Recovery Residence programs were strengthened last year due to improved program management. Our Recovery Residence program saw significant improvements due to process changes related to property management and the enhancement of the recovery culture. Last year, nearly all FSH employees were trained on the administration of Naloxone, which is used to reverse opiate overdoses. Consistent with our efforts to expand our ability to serve individuals with private insurance, we completed the University of Utah Health Plans (UUHP) CAQH credentialing process, enabling FSH to address the substance abuse treatment needs of individuals with traumatic brain injuries and developmental disabilities. With this initiative, we began our entry into the health home model of care. With this partnership, a primary care manager from the University of Utah Medical Center HOME Clinic will coordinate care with FSH, while FSH serves as the behavioral health specialty care provider. FSH took another important developmental step towards increasing our capacity to deliver integrated care last year by entering the final stages of hiring the first Medical Director in FSH history.

Finally, in FY 2017 we continued targeted fundraising focused on growing our capacity to assist individuals in retaining and sustaining housing. The FSH Homeless Fathers Housed (HFH) program (funded through the Homeless to Housing TANF program) entered its second year of service. This program provides critical treatment and housing services to homeless fathers with the goal of reuniting fathers to their children in their home. FSH was awarded funding for its new Rapid Rehousing program (funded through the U.S. Department of Housing and Urban Development [HUD] Continuum of Care [CoC] program) to help individuals and families struggling with homelessness and substance use disorders. In addition, FSH was awarded Salt Lake County Community Development Block Grant (CDBG) funds to expand our housing case management services for people who are chronically homeless, homeless, or at risk for homelessness. Finally, we used a new Utah Transit Authority (UTA) transportation grant to increase transportation access for our patients. The expansion and growth of FSH was significantly aided by new grants that provided resources otherwise not available to our organization or our patients. Last year we saw our best year ever for retained earnings, and these earning will be reinvested in the organization in FY 2018 - reinvested in our patients, in our programs, in our employees, and most importantly in our capacity to carry out our mission of helping people build lives of meaning, purpose, and recovery.

The Organization

Our Mission

We help people build lives of meaning, purpose, and recovery.

This statement underlies all we do at First Step House (FSH). We believe that an essential element in the recovery process is helping people find, or rediscover, a deep sense of meaning and purpose in their lives. This begins by showing compassion and respect for every patient we serve. During the recovery process, we work to provide the scaffolding our patients need to thrive. Examples of this include increasing people’s connection to support groups, providing individual and group therapy, helping patients find affordable housing, helping with employment needs, addressing health concerns, and helping people who are involved in the criminal justice system. As the people we serve stabilize in their recovery, we encourage them to give back to the community. We work hard to provide recovery services for those with the greatest need and find a deep sense of purpose in this work.

Our Vision

Our goal is to serve 5,000 people per year by 2028 using the highest-quality, evidence-based, recovery-oriented services possible.

Our vision has always been guided by principles centered around meeting the needs of our patients. This drives us to deliver highly individualized care that is patient centered, utilize evidence-base interventions, develop housing capacity, deliver robust case management services that support stability, and provide long-term recovery care. We have evolved with the substance use disorder and behavioral health treatment fields, acquiring new knowledge and gaining a deeper understanding of effective strategies and models proven to help people address their addiction and become stable in their recovery. In recent years, these changes have driven us to implement a recovery oriented system of care that spans the continuum of care from pre-treatment, treatment initiation, recovery initiation, housing, and long-term recovery management in the community. This idea is solidly anchored in a chronic disease management approach. Because patient care is so important to us, our vision is to touch as many lives as possible in our community using the highest quality services available. That is why we have set the goal of serving 5,000 people per year, in 10 years, with a range of primary healthcare, behavioral health, employment, and housing services.

Our Values

The following core values are critical to the success of our organization and the accomplishment of our mission. These values are central to all that we do, regardless of any changes in what we do, or how we operate. These values create a culture that we can remain committed to and serve as guideposts that help us in making decisions in an ever changing world.

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| Integrity | We are committed to acting with honesty and integrity in all that we do and will apply the highest ethical standards to all our practices, even if the consequences are undesirable or unprofitable. We recognize that integrity is the foundation upon which transformative relationships are built. For us, integrity includes acting in ways that are consistent with our principles, keeping our promises, and being trustworthy. Integrity also involves being straightforward, sincere, and willing to face the facts of reality. Our interactions with all segments of society must reflect the high standards we profess. Our patients are encouraged to develop personal integrity as a guide for building meaningful lives. |
| Transparency | We will act in a transparent manner whenever possible, as long as necessary confidentiality and privacy concerns are maintained. Transparency is a complementary value to integrity and includes being open with our practices, goals, and decisions. We actualize this value by having supervisors and leaders report to employees as much, if not more than, employees report to their supervisors. This is important in stimulating open dialogue and eliciting feedback at all levels of our organization, allowing for continual growth and improvement. We further practice this value by being open with our patients, their families, community partners, and other stakeholders. Transparency builds trust, allows for verification by all, and communicates our purpose with clarity. Transparency breaks down silos and creates space for an open exchange of ideas, which increases collaboration, cooperation, and problem solving. |
| Positive Proactivity | Positive proactivity is defined as self-initiated, action-oriented behavior that anticipates events and the needs of others in a positive, solution-focused manner. We seek to work with enthusiasm and positivity, always being mindful of the impact we are having on those around us. Positive proactivity includes working as teams to find solutions in anticipation of problems rather than merely reacting to problems after the fact. Being positive does not mean that we ignore difficult truths. It is important that we are willing to face the facts of reality, point out issues and concerns, and bring ideas to the table with passion. However, we do not remain fixated on problems. It is critical that we face our problems from a proactive, solution-oriented mindset rather than a negative, pessimistic mindset that keeps people stuck. We want to work with people who are primarily concerned with accomplishing our mission rather than worrying about receiving accolades. |
| Humility | Humility is essential to maintaining a culture that is flexible and responsive, allowing for continual growth, adaptation, and improvement. Remaining teachable is an aspect of humility that is necessary to accomplish our mission. We strive to constantly learn from others and from our own mistakes. Humility helps us see the impact we are having on others, look inside, and take responsibility for our wrongs, rather than blaming others or being hypersensitive to criticism. When we are humble, we have an accurate sense of both our strengths and weaknesses and are able to see things in context of the larger whole. For us, humility is not weakness but true strength, allowing us to do what is right with quiet resolve. It allows us to have a clear understanding of our achievements and abilities rather than an overinflated sense of our importance. When we are humble we are willing to take credit, but we do not need to take credit from others. Humility allows us to see the dignity and inherent worth in all people, rather than evaluating others as being above or below ourselves. |
| Accountability | We accept responsibility on both an individual and an organizational level for our decisions, policies, practices, and performance. We do this by being accountable for the impact we have on our team members, our patients, and our community partners. It is important that we develop consistent habits with rigorous discipline so we can meet expectations and accomplish our mission. We hold ourselves accountable by having a vision and strategy that are clear and well communicated. We set well defined goals, track progress, and work to solve variances during regular management and team meetings. We maintain a culture of accountability by following a disciplined process to hire for competence and cultural fit. Accountability includes awareness, facing the truth, admitting faults, and holding each other accountable so that growth can occur. We encourage accountability by creating an environment where mistakes can be admitted and analyzed in an open and safe manner. |
| Altruism | Altruism involves acting with unselfish regard toward others and promoting the welfare of others even when doing so poses a risk or cost to the self. Our mission is best served by those who hold the value of altruism. We desire to work for a cause that is greater than ourselves, and help relieve suffering in the world. We place our unitive purpose above the individual desire for power, control, or self-aggrandizement. Altruism involves being alive to the needs and humanity in others, having genuine concern for others, having a heart for service, and being happy when others thrive. |
| Compassion | Compassion involves a deep awareness and concern for the suffering and distress of others accompanied by a desire to help alleviate that suffering. This value motivates us to help people build lives of meaning, purpose, and recovery. It further aids in our drive to recognize the impact we have on those around us. Compassion allows us to see others as people rather than objects and to respond to the needs, struggles, and challenges that others face. Compassion is related to caring, kindness, interdependence, and recognizing the intrinsic value in others. A compassionate attitude can greatly reduce the distress people feel in difficult situations, aids in creating interpersonal connections, and helps create a culture built upon service. |

Organizational Description

First Step House was founded in 1958 by members of Alcoholic Anonymous. A history of the founding period of FSH characterized the people served at that time as men, “brought to their knees” by alcoholism. We are an organization that is proud of our history and legacy. We are honored to still be focused on helping people who have struggled with serious behavioral health conditions.

Today, FSH is a dual diagnosis capable, behavioral health treatment provider. We specialize in delivering evidence-based interventions known to effectively address and mitigate the consequences of moderate- to high-severity substance use disorders. We have a long history of working with people who have co-occurring mental health conditions, unstable housing, criminal justice involvement, and primary health concerns. We also specialize in treating criminogenic factors with offenders who recidivate at high rates. We recognize that untreated, or undertreated substance use disorders, coupled with other criminogenic factors, contribute significantly to the high rates of reincarceration among this group. The scope of services that we offer include substance use disorder and mental health assessment, residential substance use disorder treatment, outpatient treatment, recovery residence services (i.e., transitional housing), case management services, and long-term recovery management.



*First Step House residential facility located at 411 North Grant Street*

Services

Case Management

Our comprehensive case management program works in collaboration with our clinical programs to help increase our capacity to address our patients’ diverse needs. Our case managers administer needs assessments to our patients and develop targeted, goal-driven case management plans. Our case managers are expertly trained to connect people with a wide range of resources. These include housing, financial resources, education services, career development, legal services, vocational training, employment, medical services, dental services, community support, and health insurance

**Community and Stakeholder Services**

We constantly strive to be engaged with the communities in which we provide services and with those who have a stake in our mission. We understand that we are part of a larger recovery community and working with community partners is vital to helping those we serve. This work takes many forms, including grant collaboration, serving on boards, service collaboration, serving on political and civic committees, and educating people about the needs of the people we serve.

Donor Services

First Step House works with donors who wish to support our mission to help people build lives of meaning, purpose, and recovery. We do this by conducting outreach to the philanthropic community and seeking partnerships with individuals, organizations, businesses, and foundations with common interests, values, and missions. We work to communicate clearly about our programs, goals, and outcomes with all donors and we continually strive to be wise stewards of the resources we are provided to deliver services and achieve our mission. We also seek to support our donors’ missions in whatever way we can through collaboration, data collection and reporting, presentations, tours, and community engagement.

Fatherhood Program

The First Step House fatherhood program helps stabilize families by providing a range of treatment and case management services to custodial fathers with substance use disorders. The fatherhood program also helps non-custodial fathers, who are diagnosed with substance use disorders, reunite with their children and become responsible, engaged parents who are reintegrated into their families. Our fatherhood program staff work to increase our patients’ parenting skills, capacity for stable employment, and financial accountability.

Homeless Fathers Housed Program

The First Step House Homeless Fathers Housed program helps fathers who are struggling with homelessness and substance use disorders by providing treatment and intensive housing case management services. The combination of these services, driven by each patient’s needs assessment, helps address and minimize barriers to housing. In addition to addiction treatment, the Homeless Fathers Housed program helps fathers obtain permanent housing, gain housing stability, increase employment, reunite with their children in their home, and end the cycle of homelessness for themselves and their families.

**Long Term Recovery Management (LTRM)**

Our LTRM program addresses the reality that addiction tends to be chronic in nature, similar to diabetes, HIV, or heart disease. This program provides services that match people’s needs over the course of the recovery process, including the transition to long-term recovery management practices such as weekly, monthly, quarterly, or yearly wellness checkups; clinical outreach programs; and assertive early intervention for criminal or substance-related relapses. We use assertive outreach protocols, recovery support groups, and individual case management services within LTRM programming.

Mental Health Court Housing at Fisher House

Our mental health housing program helps people in mental health court by providing stable housing that supports recovery. Through this program, we also provide general case management services, including medication distribution and monitoring, drug testing, housing oversight, and coordination of care with mental health court.

**Outpatient Treatment**

Our outpatient program allows us to serve those with substance use disorders who have completed residential treatment, or people whose substance use disorders are stable enough that outpatient services are clinically warranted. For people entering our outpatient program, we do a thorough assessment to determine if an outpatient level of care is best suited for their needs. Patients who receive services in our outpatient program typically receive between 5 to 15 hours of treatment per week. Outpatient services include a combination of group therapy, psychoeducation groups, individual therapy, and case management services.

**Peer Support Services Program**

The Peer Support Services Program provides peer-based supportive services, delivered by certified Peer Support Specialists, to reduce barriers to substance use disorder recovery and increase recovery stability. Services include assisting patients with creating and implementing a Wellness and Recovery Action Plan (WRAP), life skills and community resource classes, housing support, employment support, recovery coaching, and assertive linkage with community-based recovery resources. Program services result in the development of pro-social relationships and activities, housing stability, increased access to community resources, increased life skills, improved employment, reduced drug and alcohol use, positive behavior changes, increased knowledge of and access to resources and benefits, and improved health and wellness.

**Rapid Rehousing Program**

The First Step House Rapid Rehousing program, new in July of 2017, will provide a progressive engagement program for homeless individuals and families who may have been previously on the street or residing in a homeless shelter. Through this program, patients gain access to housing, case management, outpatient treatment, and supportive services with the aim to help them gain housing stability, obtain permanent housing, and ensure that they do not become chronically or persistently homeless. Many of the people we serve are homeless due to a crisis that resulted in the loss of housing; helping people resolve these types of crises and address barriers to housing can lead to successful housing independence for many patients.

**Recovery Residence**

First Step House provides affordable housing for patients who need a sober living environment that will support their recovery. We continually work to improve our facilities and develop new housing options. Housing is a critical component of long-term recovery and our data show that stable housing is related to successful treatment completion. The goal of our housing program is to help patients develop independent living skills and help them to transition to permanent housing.

**The REACH Program**

The First Step House REACH program is defined by the acronym REACH, which stands for Recovery, Engagement, Assessment, Career Development, and Housing. This Pay for Success program was launched in July of 2017 and serves adult males coming out of jail who are high-risk, high-need offenders diagnosed with substance use disorders. The REACH program utilizes the best available evidence for what works to reduce recidivism. Our program builds upon the risk-need-responsivity framework by addressing the major criminogenic needs that have the greatest impact on reducing recidivism.

Residential Treatment at 411 North Grant Stree**t**

Our Grant street facility is a residential treatment program located in a renovated church in Salt Lake City, Utah. At this location we serve adult men, ages 18 years and older, who are diagnosed with substance use disorders. We specialize in helping people with co-occurring mental health disorders, those involved in the criminal justice system, people with low to no income, and those who have unstable or no housing. Our goal is to create a community that allows people to engage in treatment on multiple levels using individualized treatment planning and evidence-based therapy. Residential services include a combination of group therapy, psychoeducation groups, individual therapy, medication management, peer support, primary health, and case management services.

**Residential Treatment at 440 South 500 East**

Our facility at 440 South includes both a 34-bed residential treatment center and an 18-unit transitional housing facility. At this location, our patients are offered veteran-specific treatment services for those with substance use disorders and co-occurring mental health disorders. We have a long history of helping veterans recover from the negative effects of substance abuse. As with all of our clinical services, our treatment for veterans begins with a comprehensive assessment and the information gathered in that assessment is then used to determine the best course of treatment for each person we serve. This process is done in a collaborative manner with the clinician and the veteran. Our staff have experience working with veterans and understand their unique needs. Clinical care and supportive services are delivered by staff who are trained to meet the complex needs of veterans, some of whom are veterans themselves. Residential services include a combination of group therapy, psychoeducation groups, individual therapy, medication management, peer support, primary health, and case management services.

**Veterans Special Needs**

First Step House provides services to special-needs veterans who have substance use and/or mental health disorders. This program provides housing, case management services, clinical services, medication distribution and monitoring, transportation, drug testing and monitoring, housing oversight, recovery-supportive recreational activities, and coordination with the Veterans Administration. Veterans receiving special needs services reside in our transitional housing units that are supported with Grant and Per Diem (GPD) funding from the Veteran’s Administration.

Operating Plan 2018

Executive Team Projects

Executive Team

* Integrate Arbinger principles throughout the organization by continuing to train all new hires internally, sending key staff to external Arbinger trainings, presenting Arbinger concepts at the yearly town hall meeting, and teaching the influence pyramid.
* Enhance our organizational culture by training on our mission, vision, values, strategic plan, hiring theory, and employee management concepts. This will be done in the town hall meeting, new hire trainings, and manager meetings.
* Begin regular meetings of a counsel that will work to evaluate the long-term strategic goals of the organization.
* Evaluate and implement a diversity and inclusion plan.
* Create a 10-year strategic plan.

Executive Director

* Lead the Permanent Supportive Housing (PSH) project by submitting a Low-Income Housing Tax Credit (LIHTC) application.
* Attract new board members who have expertise in the areas of fundraising, healthcare, clinical research, clinical practice, and personal experience as a FSH client and personal experience with homelessness.
* Cultivate housing and supportive services opportunities.

Associate Director

* Manage the PSH project, complete the service plan, and submit the LIHTC application.
* Complete an accreditation gap analysis and implementation plan.
* Locate and purchase new properties to increase capacity.
* Hire a housing director and begin a property acquisition, development, and management plan.
* Evaluate the new hire training program with the executive team.

Clinical Director

* Research and complete the PSH service plan.
* Implement a comprehensive quality improvement plan at 411 North Grant Street.
* Develop a comprehensive internship program that includes strategic hiring, onboarding, and training processes.

Clinical Operations Director

* Complete the full implementation of the REACH program past the pilot period.
* Complete an updated feasibility and cost-benefit analysis regarding the implementation of a new electronic health record.
* Research and design an employment program that is tailored to the individual needs of FSH patients.

Development Director

* Finalize and submit the LIHTC application.
* Increase the size of the development committee by five new members.
* Create a two-year plan for increasing major gift and foundation contributions.
* Complete the 2017 annual report.

Human Resources Director

* Create an interviewing and hiring policy and procedure based upon values and other evidence-based methods.
* Train managers across the organization on the interviewing process.

Medical Director

* Review the medication system and health care needs of the organization and make recommendations.
* Update the medical referral policy and procedure.

Operations Director

* Complete necessary upgrades to the 411 North Grant Street building.
* Complete all fire alarm upgrades.
* Oversee the remodel and licensing of the 8th West annex.

Funding Priorities

* 411 North Grant Street Renovations
* Treatment Scholarships
* Long Term Recovery Management
* Recovery Support Services
* Case Management
* Peer Support Specialist Program
* Evidence Based Social Impact Initiative
* Electronic Health Record and Data Manager
* Permanent Supportive Housing Gap
* Family Programing
* Employment and Volunteer Program
* Medical Services
* Art Donations

Service Lines – Projects and Outcomes

Our programs and departments are divided into service lines and function lines. A service line is a distinct program that provides services to a specific group of customers, including patients, donors, or community partners. Each service line is assigned a leader who is responsible for managing the service line’s budget, projects, and goals. Below is a list of each service line in our organization and the respective major projects and outcomes that will be achieved in the following year.

Case Management Services

* Projects
  + Create a standardized protocol for case management sessions.
  + Record, review, and provide coaching for case management sessions.
  + Create a pathway-to-housing program that includes client presentations and a comprehensive resource list.
* Outcomes
  + Provide case management services to 85% of all patients.
  + Achieve a 40% or higher productivity rate.
  + Utilize all case-management grants by 100%.
  + Increase stable housing by more than 13%.
  + Increase employment by more than 150%.

Community and Stakeholder Services

* Projects
  + Create a targeted list of individuals and organizations to invite for tours and presentations.
  + Identify six priority stakeholders and assess their goals and needs, as related to First Step House.
  + Analyze behavioral health providers in the community.
  + Analyze the utility of the 2017 presentations.
* Outcomes
  + Conduct 12 onsite presentations and/or tours of the organization.
  + Conduct 12 offsite presentations to community partners.

Donor Services

* Projects
  + Increase the size of the development committee by five members.
  + Create a two-year plan for increasing major gift and foundation contributions.
  + Complete the 2017 annual report.
* Outcomes
  + Increase grant revenue by 25% over the previous year’s goal.
  + Increase non-grant donations by 25%.
  + Increase major gift donors, those who donate $1,000 or more, to 30 donors.
  + Submit 54 grant proposals.

Fatherhood Program

* Projects
  + Review and implement evidence-based treatment practices that involve the participation of spouses, partners, and children.
* Outcomes: Addiction Intervention & Fatherhood Initiative
  + Achieve an average daily census of 12 patients enrolled in residential treatment.
  + Achieve an average daily census of 8 patients enrolled in outpatient treatment.
  + Increase abstinence by more than 65%.
  + Increase employment by more than 75%.
  + Achieve a 60% or higher successful treatment completion rate.
  + Increase relationship skills among participants by 75% or more.
  + Increase communication and coping skills among participants by 75% or more.
  + Achieve 75% or more participation in recovery support services.
  + Increase parenting skills among participants by 75% or more (for custodial fathers).
  + Increase child involvement among participants by 50% or more (for custodial fathers).
  + Increase the ability to resolve conflicts among participants by 75% or more (for custodial fathers).
  + Help 65% or more participants fulfill their parental financial obligations.
* Outcomes: Homeless Fathers Housed
  + Help 60% of adults gain or increase income from employment.
  + Help 20% of adults gain or increase non-employment cash income.
  + Enroll 75% of participants in mainstream benefits.
  + Help 60% of participants obtain or retain permanent housing.
  + Assess 75% of participants.
  + Assess 60% of participants within 30 days.
  + Help 65% of participants remain abstinent at discharge.
  + Help 75% of participants to obtain no new legal charges or arrests at discharge from treatment.

Long Term Recovery Management Program (LTRM)

* Projects
  + Complete the LTRM operating plan.
  + Start a volunteer program.
  + Create a system to track discharges and patient engagement.
* Outcomes
  + Enroll 30 patients per quarter.
  + Enroll 30 patients in 2 support groups per week.
  + Provide 30 drug tests per quarter.
  + Conduct 10 hours per week of outreach.
  + Keep 65% or more participants engaged for one year.
  + Help 75% or more participants adhere to their long-term recovery contract, while enrolled.
  + Help 55% or more participants remain abstinent while enrolled.
  + Help 65% or more participants to engage in community-based support groups, weekly, for one year.
  + Help 60% or more participants maintain employment for one year.
  + Help 65% or more participants maintain stable housing for one year.
  + Keep 60% or more participants from incurring new legal charges for one year or more.

Mental Health Court Housing at Fisher House

* Projects
  + Begin tracking and reporting monthly discharge outcomes.
  + Create a medication compliance monitoring system.
  + Review the mental health court reporting process.
* Outcomes
  + Achieve an average daily census of 95% or more.

Outpatient Treatment Program

* Projects
  + Improve the quality of existing psychoeducation groups by reviewing the curricula, monitoring groups, and implementing improvements.
  + Review, research, and implement a contingency management system to increase attendance to therapy appointments, scheduled drug tests, and groups.
  + Take part in the evidence-based social impact program by (1) training in relevant modalities, (2) having therapists record therapy sessions, (3) reviewing and coding sessions, and (4) providing feedback and coaching.
  + Improve the quality and structure of outpatient treatment by reviewing group curricula, identifying points of completion within each psychoeducation class, and clearly communicating program expectations to patients.
* Outcomes
  + Increase service capacity and enroll 100 patients.
  + Achieve an average daily census of 85 patients.
  + Achieve a 58% or higher productivity rate (i.e., percent time in direct, billable services).
  + Achieve a 50% or higher successful completion rate (i.e., treatment completions plus transfers to residential).
  + Maintain a drop-out rate of 20% or less.
  + Maintain a 15% or lower positive drug test rate.
  + Maintain a 10% or lower no-show rate for drug tests.
  + Increase abstinence by 130% or more.
  + Have 70% of Moral Reconation Therapy (MRT) participants successfully complete MRT.

Peer Support Services

* Projects
  + Create a life-skills group.
  + Successfully operate the program according to the grant.
* Outcomes
  + Complete a WRAP plan with 60% or more patients.
  + Help 70% or more patients report an improvement in health and wellness.
  + Help 60% or more patients who were homeless prior to treatment, exit treatment into stable housing.
  + Decrease the number of patients who leave treatment against clinical advice by 10% or more, compared to the 2017 rate.
  + Increase employment status by 10% or more compared to the 2017 improvement level.
  + Transport patients to 4 community-based recovery meetings per week.
  + Help 60% or more patients complete at least one community service project.

REACH Program

* Projects
  + Prepare for the Correctional Program Checklist (CPC) audit.
  + Take part in the evidence-based social impact program by (1) training in relevant modalities, (2) having therapists record therapy sessions, (3) reviewing and coding sessions, and (4) providing feedback and coaching.
* Outcomes
  + Achieve a score of 55% or higher on the first CPC audit.
  + Adhere to other REACH metrics as defined in the REACH contract.

Recovery Residence Program

* Projects
  + Improve the recovery culture by coordinating with the case management and peer support teams to increase recovery support, recovery activities, and volunteer activities.
  + Collaborate with the case management team to assist in recovery residence transitions to permanent housing.
* Outcomes
  + Maintain an average daily census of 90% or more.
  + Achieve an 80% or higher successful discharge rate (i.e., transitions to permanent housing or residential treatment).
  + Transfer 75% or more patients to permanent housing.
  + Maintain an eviction rate of 12% or less.

Residential Treatment Program at 440 South 500 East

* Projects
  + Create a family group for Veterans.
  + Take part in the evidence-based social impact program by (1) training in relevant modalities, (2) having therapists record therapy sessions, (3) reviewing and coding sessions, and (4) providing feedback and coaching.
* Outcomes
  + Achieve an average daily census of 94% or more.
  + Achieve a 58% or higher productivity rate (i.e., percent time in direct, billable services).
  + Achieve a 75% or higher successful completion rate (i.e., treatment completions plus transfers to outpatient).
  + Maintain a drop-out rate of 15% or less.
  + Maintain a 3% or lower positive drug test rate.
  + Maintain a 1% or lower no-show rate for drug tests.
  + Increase abstinence by 130% or more.

Residential Treatment Program at 411 North Grant Street

* Projects
  + Implement a comprehensive quality improvement plan that integrates offender-specific treatment protocols.
  + Take part in the evidence-based, social-impact program by (1) training in relevant modalities, (2) having therapists record therapy sessions, (3) reviewing and coding sessions, and (4) providing feedback and coaching.
  + Work with the peer support specialist to create a service-based environment by creating specific positions of responsibility and holding regular service projects.
* Outcomes
  + Achieve an average daily census of 95% or more.
  + Achieve a 58% or higher productivity rate (i.e., percent time in direct, billable services).
  + Achieve a 60% or higher successful completion rate (i.e., treatment completions plus transfers to outpatient).
  + Maintain a drop-out rate of 25% or less.
  + Maintain a 3% or lower positive drug test rate.
  + Maintain a 1% or lower no-show rate for drug tests.
  + Increase abstinence by 130% or more.

Veterans Special Needs Program

* Projects
  + Implement items identified in the gap analysis.
* Outcomes
  + Achieve an average daily census of 90% or more.
  + Help 65% or more Veterans transition to permanent housing upon discharge.
  + Help 85% or more Veterans complete all necessary documentation to transition into permanent housing within five months.
  + Complete follow ups with 85% of the Veterans who have transitioned into permanent housing at 30 days, 60 days, 90 days, and one year.
  + Maintain a negative exit rate of 23% or less.
  + Help 50% or more Veterans exit the program with competitive employment.
  + Offer 85% of Veterans one or more individual therapy session per week.
  + Offer 85% of Veterans two or more hours of group therapy per week.
  + Assess and create an individual service plan for 85% of eligible Veterans within 30 days of program placement.
  + Provide case management for 85% of Veterans with no less than one hour per week.
  + Offer 85% of Veterans two or more hours of life-skills groups each month.
  + Offer 85% of Veterans four or more hours of programming and recreational activities per week.

Function Lines - Projects

Our programs and departments are divided into service lines and function lines. Function lines consist of specific departments that support the service line teams in accomplishing their objectives. Function line leaders are responsible for managing the function line’s budget, projects, and goals. Below is a list of each function line in our organization and the respective projects that will be achieved and outcomes that will be measured in the following year.

Accounting Department

* Projects
  + Implement new accounting software.
  + Complete the accounting department policy and procedure manual.
* Outcomes
  + Distribute reports by the 21st of each month.

Admissions Department

* Projects
  + Review and update the assessment process.
  + Improve customer care for incoming patients and their families by completing documentation on intake protocols.
  + Improve customer care for people who call for services.
* Outcomes
  + Report results of customer satisfaction surveys.
  + Achieve census goals.
  + Report on intake no-show rates.

Billing Department

* Projects
  + Complete all past billing.
  + Update and implement all private insurance billing procedures.
  + Develop a billing department outcomes report.
* Outcomes
  + Complete Salt Lake County and Veterans Administration billing by the 10th of each month.
  + Complete billing for all other payors by the 20th of every month.

Client Advocate Department at 440 South 500 East

* Projects
  + Create and implement a client advocate training plan that includes new hire training, a new hire checklist, and ongoing training.
* Outcomes
  + Report monthly staff meeting attendance percentage.
  + Report on the number of days it takes new client advocates to complete the training checklist.
  + Maintain a drop-out rate of 25% or less.

Client Advocate Department at 411 North Grant Street

* Projects
  + Create and implement a client advocate training plan that includes new hire training, a new hire checklist, and ongoing training.
* Outcomes
  + Report monthly staff meeting attendance percentage.
  + Report on the number of days it takes new client advocates to complete the training checklist.
  + Maintain a drop-out rate of 25% or less.

Data Management Department

* Projects
  + Complete an updated feasibility and cost-benefit analysis for implementing a new electronic health record.
  + Update and review all current data systems.
  + Complete the data reporting calendar and structure.
  + Analyze metrics that predict patient dropouts.
* Outcomes
  + Complete and distribute reports by the 20th of every month.

Food Services Department

* Projects
  + Complete the food services policy and procedure manual and training plan.
  + Complete compliance and monitoring checklists.
* Outcomes
  + Report on customer satisfaction scores.

Human Resources Department

* Projects
  + Finalize standardized onboarding plans.
  + Create a tracking system for onboarding completion.
  + Research and implement an evidence-based HR customer satisfaction report.
  + Complete a wage, benefits, and organizational culture analysis and implement recommendations to attract the best possible employees.
* Outcome
  + Report on employee satisfaction results.
  + Report on the number of hires, interviews, terminations, and average tenure.
  + Report on the percentage of key positions filled.

IT Committee

* Projects
  + Move the phone server.
  + Analyze, plan, and update the IT infrastructure for future growth.
  + Refine the onboarding process.
* Outcomes
  + Report on server downtime.

Maintenance Department

* Projects
  + Refine and upgrade the preventative maintenance schedule.
  + Complete the remodel of 8th West.
  + Upgrade the climate control system at 411 North Grant Street.
  + Investigate electronic maintenance ticketing systems.
* Outcomes
  + Report on outcomes from the electronic maintenance ticketing system.

Medical Department

* Projects
  + Complete a gap analysis of the current medication system.
  + Finalize training documentation and schedule.
  + Finalize all policy and procedure documentation.
  + Create a standardized audit checklist and schedule.
* Outcomes
  + Report on audit results.
  + Report on medication training attendance and completion.

Quality Assurance Department

* Projects
  + Complete contract training documentation and implement a comprehensive staff training schedule to ensure organizational compliance with all contract requirements.
  + Review and update internal auditing procedures and schedules.
  + Develop a comprehensive audit report.
* Outcomes
  + Report on the number, type, and score of completed internal audits.
  + Report on the number of trainings completed.

Transportation Department

* Projects
  + Implement a functioning radio system.
* Outcomes
  + Report on the price per mile driven.

Urinalysis Department

* Projects
  + Investigate and implement a new urinalysis (UA) testing system.
  + Update policy and procedures according to updated rules and contracts.
  + Create and implement regular UA system trainings.
* Outcomes
  + Report on the number of trainings completed.
  + Report on UA reporting errors.

Reporting Structure



2018 Budget

### July 2017 through June 2018

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Income | | |  |  |
|  |  |  | Contributions and Support | | |  |
|  |  |  |  | Operations Contributions | | 176,500.00 |
|  |  |  |  | Capital Contributions | | 80,000.00 |
|  |  |  |  | In-Kind Contributions | | 210,000.00 |
|  |  |  | Total Contributions and Support | | | 466,500.00 |
|  |  |  | Treatment Revenue | | |  |
|  |  |  |  | Residential Treatment Revenue | |  |
|  |  |  |  |  | SLCo Block - Residential | 794,268.00 |
|  |  |  |  |  | SLCo - Special Project | 830,400.00 |
|  |  |  |  |  | SLCo DORA - Residential | 299,568.00 |
|  |  |  |  |  | SLCo Fund Codes - Residential | 306,000.00 |
|  |  |  |  |  | SLCo JRI - Residential | 250,000.00 |
|  |  |  |  |  | VA OSAT - Residential | 1,200,000.00 |
|  |  |  |  |  | Food Stamps - Residential | 87,612.00 |
|  |  |  |  |  | Self-Pay - Residential | 51,000.00 |
|  |  |  |  |  | Private Insurance - Residential | 60,000.00 |
|  |  |  |  | Total Residential Treatment Revenue | | 3,878,848.00 |
|  |  |  |  | Outpatient Treatment Revenue | |  |
|  |  |  |  |  | SLCo Block - Outpatient | 240,003.00 |
|  |  |  |  |  | SLCo DORA - Outpatient | 96,006.00 |
|  |  |  |  |  | SLCo Fund Codes - Outpatient | 21,660.00 |
|  |  |  |  |  | SLCo JRI - Outpatient | 62,640.00 |
|  |  |  |  |  | VA OSAT - Outpatient | 4,800.00 |
|  |  |  |  |  | Medicaid (Optum) - Outpatient | 30,000.00 |
|  |  |  |  |  | Self-Pay - Outpatient | 9,000.00 |
|  |  |  |  |  | Co-Pay - Outpatient | 8,400.00 |
|  |  |  |  |  | Private Insurance - Outpatient | 12,000.00 |
|  |  |  |  | Total Outpatient Treatment Revenue | | 484,509.00 |
|  |  |  |  | CoC | | 207,667.00 |
|  |  |  |  | FLOSS | | 46,000.00 |
|  |  |  |  | Salt Lake City CDBG | | 38,833.00 |
|  |  |  |  | Salt Lake County CDBG | | 42,000.00 |
|  |  |  |  | REACH | | 939,784.00 |
|  |  |  |  | Unified Funding - Outpatient | | 24,700.00 |
|  |  |  |  | TANF H2H | | 99,995.00 |
|  |  |  |  | TANF - AI/FI | | 276,000.00 |
|  |  |  |  | TANF - FR | | 30,600.00 |
|  |  |  |  | Veterans Special Needs (CTI) | | 239,634.00 |
|  |  |  |  | UTA | | 51,600.00 |
|  |  |  | Total Treatment Revenue | | | 6,360,170.00 |
|  |  |  | Housing Revenue | | |  |
|  |  |  |  | VA PD I | | 170,400.00 |
|  |  |  |  | VA PD II | | 85,200.00 |
|  |  |  |  | Housing Authority of SL County | | 67,968.00 |
|  |  |  |  | Transitional Housing Rent | | 57,194.00 |
|  |  |  | Total Housing Revenue | | | 380,762.00 |
|  |  |  | Revenue from Other Sources | | |  |
|  |  |  |  | Misc. Non-Contract Revenue | | 420.00 |
|  |  |  |  | Interest Income | | 360.00 |
|  |  |  | Total Revenue from Other Sources | | | 780.00 |
|  |  | Total Income | | | | 7,208,212.00 |
|  |  | **Expense** | | |  |  |
|  |  |  | Personnel Expenses | | |  |
|  |  |  |  | Regular Payroll Expenses | | 3,919,475.00 |
|  |  |  |  | Payroll PTO Expense | | 48,998.00 |
|  |  |  |  | Payroll Tax Expense | | 299,843.00 |
|  |  |  |  | Employee Benefits | | 390,394.00 |
|  |  |  |  | Workers Compensation Insurance | | 23,496.00 |
|  |  |  |  | Unemployment Insurance | | 15,684.00 |
|  |  |  |  | 401(k) | | 66,639.00 |
|  |  |  |  | Payroll Servicing Fees | | 13,200.00 |
|  |  |  |  | Misc. Employment Expenses | | 16,200.00 |
|  |  |  |  | Staff Development | | 53,652.00 |
|  |  |  |  | Contractual Services | | 176,200.00 |
|  |  |  |  | Employee Incentives | | 13,200.00 |
|  |  |  | Total Personnel Expenses | | | 5,036,981.00 |
|  |  |  | Non-Personnel Expenses | | |  |
|  |  |  |  | Food Service Supplies | | 135,500.00 |
|  |  |  |  | House Supplies | | 28,300.00 |
|  |  |  |  | Office Supplies | | 33,600.00 |
|  |  |  |  | UA Supplies | | 60,000.00 |
|  |  |  |  | Recreation | | 27,996.00 |
|  |  |  |  | IT Supplies | | 6,000.00 |
|  |  |  |  | Donated Materials & Supplies | | 210,000.00 |
|  |  |  |  | Telephone & Telecommunications | | 58,668.00 |
|  |  |  |  | Software Expense | | 47,139.00 |
|  |  |  |  | Events | | 5,500.00 |
|  |  |  |  | Vehicle Expenses | | 47,024.00 |
|  |  |  |  | Client Assistance | | 190,920.00 |
|  |  |  |  | Client Incentives | | 16,950.00 |
|  |  |  |  | Curriculum | | 21,380.00 |
|  |  |  | Total Non-Personnel Expenses | | | 888,977.00 |
|  |  |  | Facilities & Equipment Expense | | |  |
|  |  |  |  | House Maintenance | | 71,580.00 |
|  |  |  |  | Occupancy Expense | | 139,736.00 |
|  |  |  |  | Utilities | | 103,548.00 |
|  |  |  |  | Mortgage Interest | | 133,248.00 |
|  |  |  |  | Depreciation & Amortization | | 393,004.00 |
|  |  |  | Total Facilities & Equipment Expense | | | 841,116.00 |
|  |  |  | General Administrative Expenses | | |  |
|  |  |  |  | Meeting Expenses | | 16,100.00 |
|  |  |  |  | Marketing & Advertising | | 12,000.00 |
|  |  |  |  | Bank Service Fees | | 8,040.00 |
|  |  |  |  | Insurance - Non-Employee | | 58,920.00 |
|  |  |  |  | Travel Expense | | 13,000.00 |
|  |  |  |  | Equipment Rental | | 21,360.00 |
|  |  |  |  | Licenses and Permits | | 15,265.00 |
|  |  |  |  | Uniforms | | 1,908.00 |
|  |  |  |  | Misc. G & A | | 9,580.00 |
|  |  |  | Total General Administrative Expenses | | | 156,173.00 |
|  |  |  | Business Expenses | | |  |
|  |  |  |  | Bad Debt Expense | | 10,000.00 |
|  |  |  | Total Business Expenses | | | 10,000.00 |
|  |  | Total Expense | | | | 6,933,247.00 |
| Net Income | | | |  |  | 274,965.00 |

Implementation

Reporting Plan

The implementation plan at First Step House includes the following:

* Monthly Executive Team Strategic Meetings
* Monthly Supervisor Reports and Meetings
* Team Update Meetings
* Quarterly Board Reports