FY 2024 PERFORMANCE PLAN

BHD Wellness — Healthy Living Program	BHD	Marianna Cardozo x5191
Program Purpose	Reduce health risk factors for individuals with serious mental illness and substance use disorders through engagement in health-related programming and provide a supportive community for individuals in recovery to access opportunities to experience interpersonal connectedness and engagement around the development of personal health habits.	
Program Information	• There are seven wellness programs/services within the BHD Healthy Living Program (HLP): • **Wellness Screening and Engagement**: Entry level support for clients in engaging in wellness activities available through the Healthy Living Program. Following a required orientation providing an overview of the program, clients are invited to participate in program groups at a frequency that feels comfortable for them and allows them to get a feel for the program and for which services spark their interest. Clients may decide at this point that they would like to continue in the program at the screening and engagement level, in which case, they are asked to engage a minimum of one time per month in order to stay active in the program. They may engage individually in peer support, or in group-based services. • **Wellness Coaching**: Following initial engagement period, typically two to three months, clients who are engaging consistently are invited to enroll in a four-module group to support with initial goal setting around health habits and wellness. Following completion of this group, participants are invited to begin individualized health coaching, which begin at a twice a month frequency, tapering down over the course of a year, or as determined by client needs. Group and individual based supports are offered to include periodic progress assessments and goal setting, as well as optional peer support. Clients may engage in all available services, at a minimum of one time per month. • **Wellness Maintenance**: In FY 2024, the program formally added a service category for individuals who have completed wellness coaching and are more independently engaged. Within the program, this is referred to as "maintenance" or "alumni and includes ongoing opportunities to participate in groups, program activities, peer coaching, a monthly peer-led "alumni group", and intermittent individual health coaching as needed. • **Whole Health Action Management (WHAM)**: 10-week, peer recovery specialist-led groups that work to support the development of self-management goals and skills, to achieve improved health and wellness for adults experiencing challenges with mental health and substance use. • **Tobacco Cessation**: Evidence-based services to support individuals in improving their health through decreased tobacco use. • **Trauma-informed yoga**: Contracted service that provides a certified yoga therapist to facilitate weekly yoga instruction. Open to all BHD clients and co-managed with a BHD clinician. • **Referral only**: Support with linking clients to community-based resources including fee reductions for many recreation services, community-based movement classes, psychoeducational classes, including de-cluttering	

workshops, clinical programming outside of the program's scope, and more.
- Clients are also offered nutrition education classes, walking groups, an environmental health group, peer-led wellness workshops, group bike rides, and strength training groups.
- Referrals for these programs come primarily from the Behavioral Healthcare Division with occasional referrals from Neighborhood Health for clients linked to BHD. In FY 2024, Healthy Living partnered with other BHD programs such as OBOT, Jailed-based Mental Health, and EDGE, to provide support health literacy and health promotion.
- The Healthy Living Program partners with several community organizations, including:
  - Arlington County Department of Parks and Recreation
  - Arlington Public Schools Aquatics
  - Health-oriented organizations, including a bike shop, a running-equipment shop, a bike-share program, and a local hospital
  - Grocery stores and food non-profits

Service Delivery Model

- In FY 2024, the program continued to offer services in a variety of formats including in-person, virtual, and hybrid (in-person with virtual option available). Services include groups, community activities, individual clinical health coaching, and individual peer coaching.
- In FY 2025, the program anticipates continuing the model.

PM1: How much did we do?

Staff

2 FTEs
- 1.0 FTE Program Coordinator
- 1.0 FTE Peer Specialist

In FY 2024, one Master of Social Work student (MSW) intern contributed 20 hours per week, and three program volunteers contributed 5-8 hours per month.

Customers and Service Data

Clients per Program/Service	FY 2021	FY 2022	FY 2023	FY 2024
Total unduplicated clients	71	71	71	70
WHAM	17	9	8	0
Tobacco cessation	7	10	2	0
Wellness Coaching	31	25	49	44*
Wellness Engagement	21	25	26	32
Wellness Maintenance	n/a	n/a	n/a	27
Referral only	6	8	3	4
Waitlist for all services at end of the fiscal year	0	0	0	0

*Several of these clients were transferred to the new Wellness Maintenance category in September of 2023.

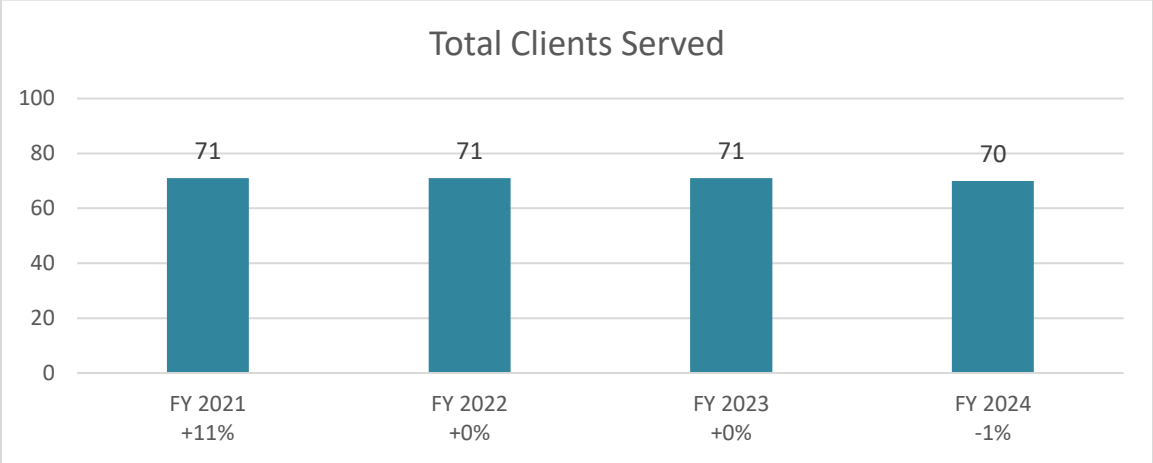
PM2: How well did we do it?

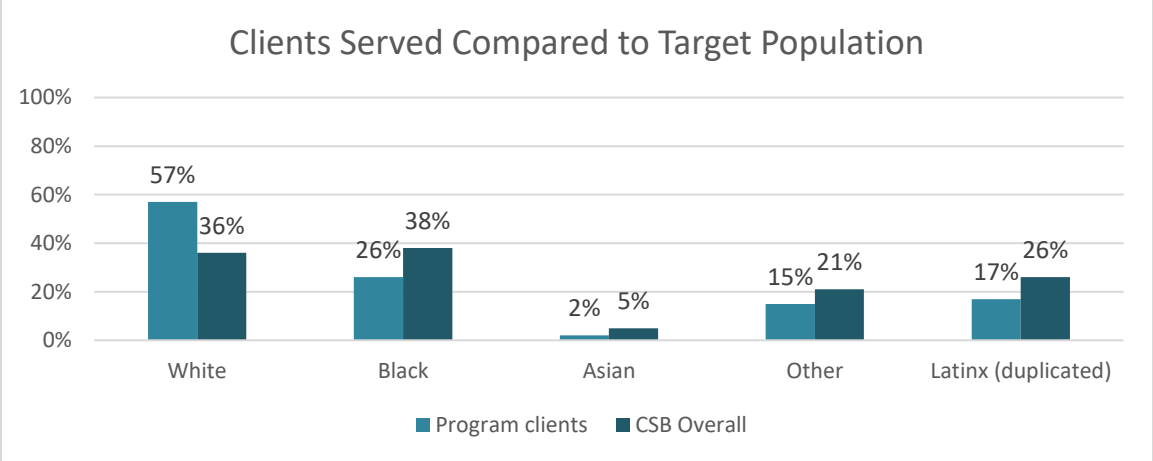
2.1	Clients connected to primary care
2.2	Program participants engage in at least one program activity per month
PM3: Is anyone better off?	
3.1	Clients reduce or quit tobacco use
3.2	Clients maintain/improve health outcomes
3.3	Clients improving scores on the Flourishing Scale

BHD Wellness Programs

Measure	1	Total clients served (unduplicated)

Data





Data Summary

- From FY 2021 to FY 2024, the number of clients served remained steady.
- The selected comparison population for the racial equity analysis is the CSB overall, as all Wellness clients are referred from another agency program. The Healthy Living Program seeks to serve a representative sample of agency clients.
- In 2024 the Tobacco Cessation program did not run due to consistent low to no enrollment over the course of multiple fiscal years; however, tobacco cessation support continued as an individual service offered to participants in the program via wellness and peer coaching.
- Data for this measure is collected in the agency's electronic health record.
- FY 2024 is the first year that data features Maintenance Clients in addition to Engagement and Coaching.

What is the story behind the data?

- The BHD Wellness programs are dynamic, often utilizing the latest research-based methodologies to provide innovative services to clients.

- The program relies on referrals from various outpatient programs linked to BHD. Referred clients are usually individuals who have been consistently in recovery for significant lengths of time.
- Clients who were transferred to the Aging and Disabilities Services Division (ADSD) for outpatient services in FY 2024 were kept open to the program to ensure continuity of care.
- The Whole Health Action Management (WHAM) group did not run this year due to staffing issues. Only a few peer specialists within BHD are certified to run this group, and none had availability this year.
- Services provided by the program in FY 2024 included psychoeducational wellness workshops, walk groups, strength-training/physical activity groups, mindfulness sessions, individual wellness coaching sessions, tobacco cessation support, and goal setting sessions. Additional support was provided to clients both inside and outside of the program with applying for fee reductions to parks and recreation services and Arlington pools, as well as for other community-based supports, such as discounted yoga classes, bike donations, and bikeshare programming.
- Participants in the program are given the opportunity in engage in a variety of formats outside of regular group programming, including group bike rides, farmers market trips, events at a local community garden, trips to local nature walks and rec centers, volunteer opportunities, and other events.
- The program is focused on increasing access to health programs to those who may not otherwise have access to that care. Particular emphasis is placed on outreach and support of people with marginalized identities. The program operates on a "weight neutral" paradigm that seeks to destigmatize weight and emphasizes that all bodies are deserving of equitable treatment services and justice within the healthcare system. This value is communicated in various ways throughout programming.
- The program also offers peer-based supports by having alumni or maintenance clients remain engaged and support newer clients. The program also offers Action Planning for Prevention and Recovery (APPR), an eight-week, peer recovery specialist led group service that began in FY 2024.
- Of those referred to the program, more non-white participants from orientation did not engage in the program. Many of these non-white participants had several challenges in their lives that prevented their ability to engage in the program. For instance, some referred clients were working full-time, some had family responsibilities, and some lacked transportation.
- The racial equity data asks intriguing questions around appropriateness of referrals to the Wellness Program, as BIPOC clients are underrepresented comparatively to the CSB Overall.
- Anecdotal experience suggests that the number of Latinx clients reported above may be underreported. Efforts to update and enhance data collection will continue in FY 2025.

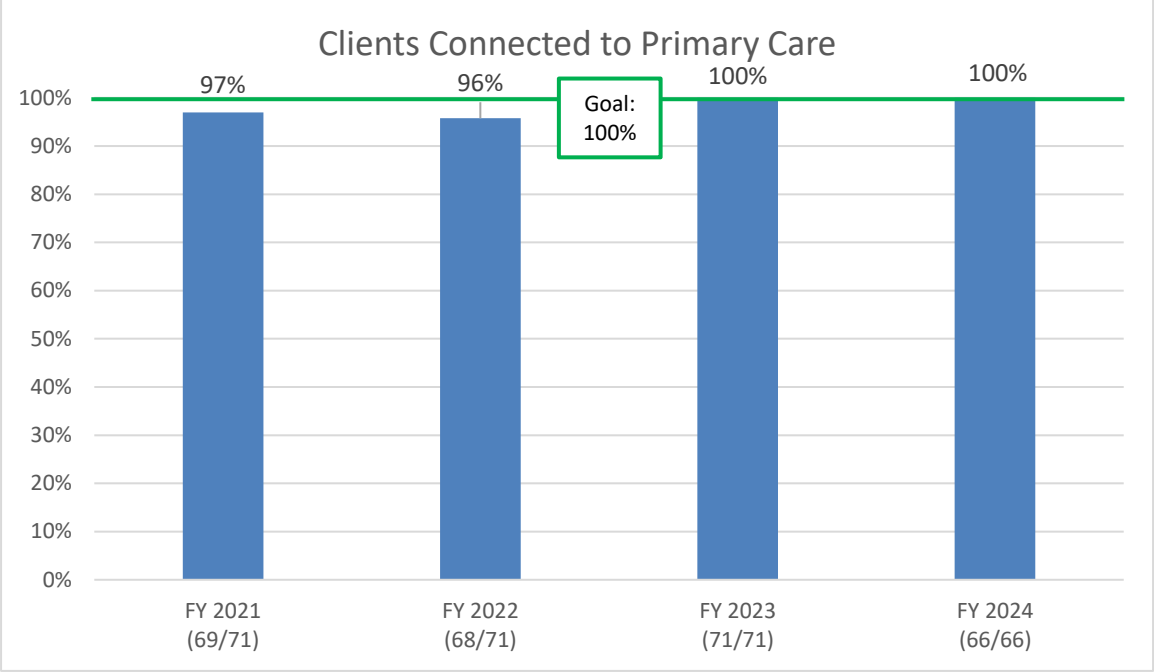
Recommendations	Target Dates
• Review incoming referrals through a racial equity and intersectional identity lens and consider ways to assess how initial engagement and attrition rates may or may not be reflected in racial equity metrics.	• Ongoing
• Review collected demographic information with clients to ensure it matches their racial and ethnic identity.	• Ongoing

• Make progress on the program's overarching goals, including expanding the clinical focus of the program, enhancing community relationships, and exploring a billable eating disorder harm reduction program.	• FY 2025 Q4
• Continue to refine the initial engagement process, with an eye toward providing relevant and responsive tools and opportunities to enhance ongoing connections and meaningful exploration of health habits.	• FY 2025 Q1 and Q2
• Explore further tailoring outreach to facilitate engagement among non-white participants who often face complex challenges preventing program engagement.	• Ongoing
• Explore ways to increase referral only clients.	• FY 2025 Q1
• Explore doing a survey of the clients who came to an orientation but did not engage to further understand why they did not engage.	• FY 2025 Q2
Forecast	
• In FY 2025, it is projected that 75 clients will be served across the wellness programs.	

BHD Wellness Programs

Measure	2.1	Clients connected to primary care

Data



Data Summary

- This measure tracks the number of clients who are documented as connected to primary care services in the agency's electronic health record.
- In FY 2024, 100% of clients (66/66) were connected to primary care services.
- This measure does not include four people who were referral clients only.

What is the story behind the data?

- Focusing on physical health is a key component of reducing health risks for clients with serious mental illness.
- Clients in many of the HLP services are required to have updated medical clearances from their primary care physician, necessitating a physical screening within 12 months, which aligns with StepVA requirements.
- The program continues to use an updated medical clearance form, rolled out in FY 2022, that requires providers to include the date of the last primary care screening. This helps the program identify the clients who need connections to primary care and ensure they receive their annual check-up.

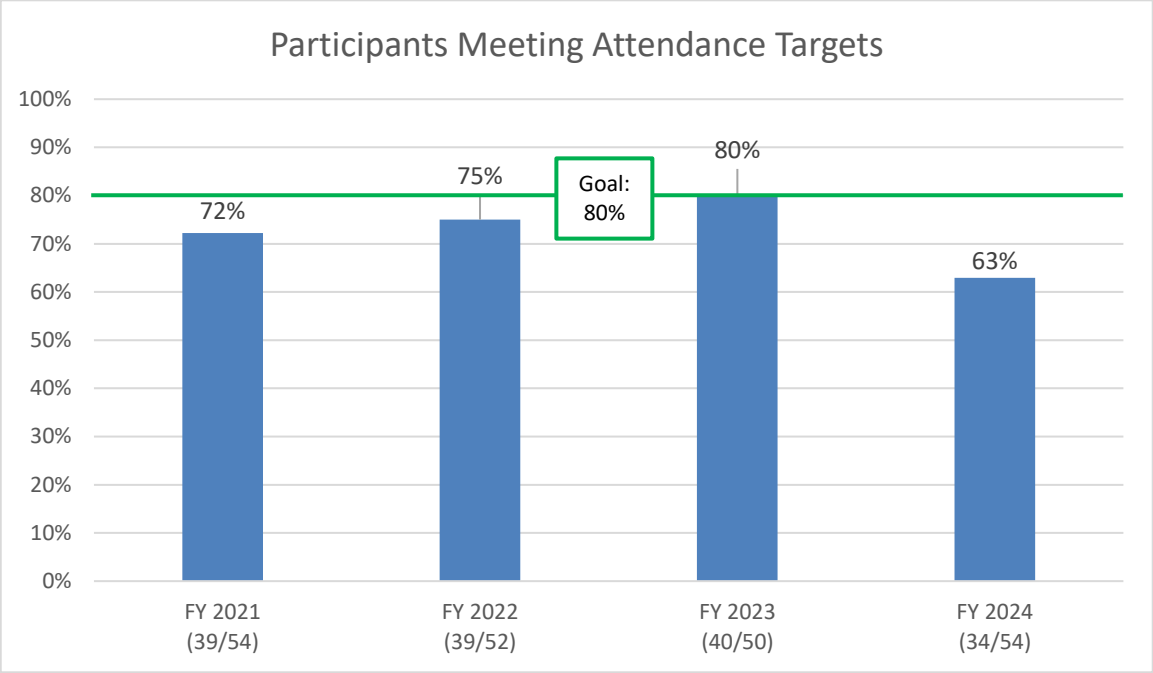
Recommendations	Target Dates
• Continue requiring that clients referred for any ongoing services supply contact information for their primary care physician, along with an updated release of information.	• Ongoing
• Continue working with clients to reduce or eliminate barriers to connecting with their primary care physician.	• Ongoing

Forecast

- In FY 2025, it is expected that at least 95% of clients referred will connect to primary care.

BHD Wellness Programs		
Measure	2.2	Program participants engage in at least one program activity per month

Data



Data Summary

- In FY 2024, engagement was measured for all clients who were open to a monitored wellness service (screening and engagement, coaching, and maintenance) at any time during the year. This totaled 54 clients, 34 of whom (63%) engaged at least one time per month while enrolled in the wellness service.
- In FY 2024, this measure excludes "orientation only" clients. In FY 2024, 21 people attended orientation to the program. 10 of these individuals began engaging in the program and were opened to engagement services. 8 individuals decided not to join the program and were either linked to community-based supports, or simply closed to services. 3 individuals attended orientation in May or June 2024 and were in the process of responding to outreach at the time the FY 2024 closed. These "orientation only" individuals who were not engaged in active services during the fiscal year are not counted in this measure.

What is the story behind the data?

- Engagement expectations are currently defined as a minimum of once a month for any coached program. However, as clients continue to move through the program toward independent engagement with health habits, the program has noted some changes in engagement levels for long-standing participants. Some of these individuals, "alumni" of the program, have independently begun setting up times to go to the gym, or to the pool, or on bike rides, with other participants in the program. In some cases, this has resulted in a drop in engagement frequency but is

viewed by the program as a positive indicator of more independent engagement with one's health habits.

- With the exception of scheduled "wellness check in sessions," and peer coaching sessions, all program activities are framed as "drop in," so that clients can select activities as they see fit. This allows the program to be easily customized to a participant's current level of functioning, interest, and abilities. Attendance in activities is tracked weekly and outreach is conducted on a regular basis.
- Participants in the wellness coaching service level receive individual health coaching sessions which start at a higher frequency and taper down over time. Participants in any level of service can receive individual peer coaching for additional support and intervention. These peer coaching sessions are scheduled on a frequency determined by client need, length of time in the program, and other client-centered determinants.
- Program participants and/or a self-selected contact person receive a weekly newsletter with program reminders, updates, community resources, and scheduling for the upcoming week.
- Of the 20 clients who did not engage at least once per month in FY 2024, four were closed to services during the year, and four were closing at the start of FY 2025. Of the remaining 12 clients, 5 only missed one month at anticipated engagement, and all were re-engaged in the program at a minimum of once per month.
- In addition, clients expressed engagement in the program in other ways. According to a client survey administered in FY 2024, 85% (35/41) of respondents agree the program supported their wellness goals and 93% (38/41) agreed the program provided a benefit to their life.
- In FY 2024, clients participated in the program at varying service levels:
  - **Wellness engagement**: minimum one time per month in any HLP service.
  - **Wellness coaching**: minimum one time per month usually comprised of one to two individual coaching sessions, in addition to group participation throughout the month.
  - **Maintenance**: at least once every 90 days to stay active in the program; engagement is usually in the form of groups, community activities, and intermittent individual check in sessions.
- To support clients in engaging at their own comfort level, all new clients are started with an orientation and overview to the program prior to referral, and an invitation to select just one program activity to begin attending, with the goal of minimum once a month engagement.

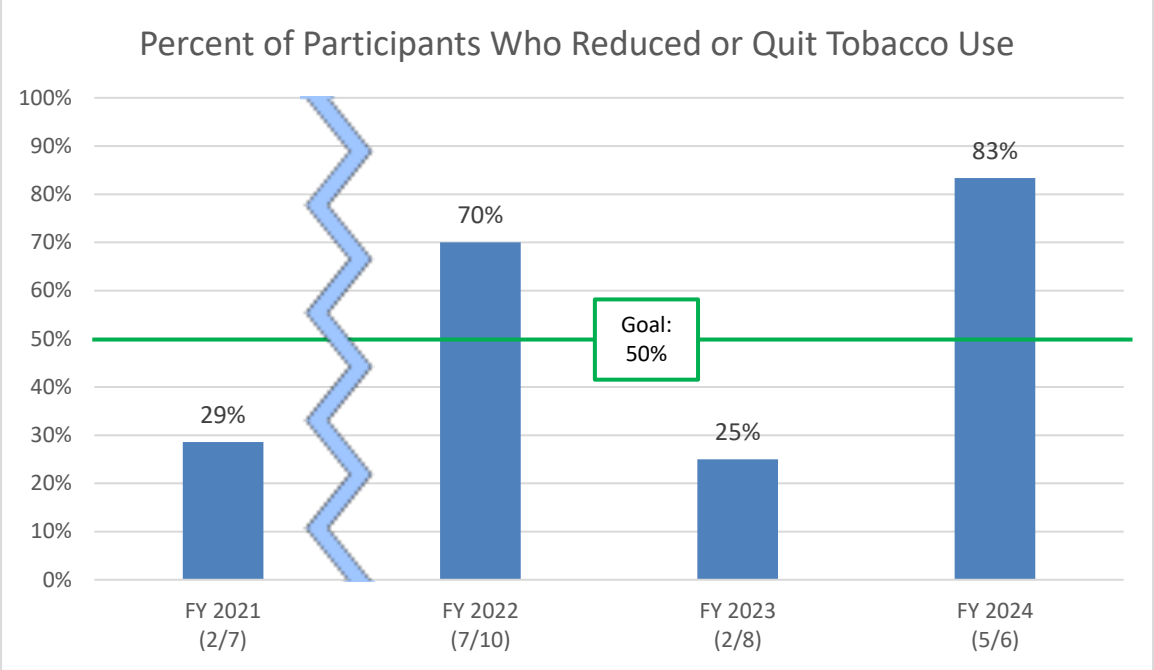
Recommendations	Target Dates
• Adapt and begin using new tracking system to track and respond to engagement trends. Continue to provide structured outreach to clients, in addition to the continuation of the current intake and onboarding process which is designed to increase client understanding of program services, and ability to engage with ease.	FY 2025 Q1
• Assess clients' satisfaction with the program in a format that fits their needs best to remain abreast of clients' self-reported wellness interests, access to HLP services and other community supports, and related feedback and suggestions.	• Ongoing

• Continue to explore ways to increase program responsiveness to initial wellness survey questions, to support increased engagement following orientation and during onboarding.	• FY 2025 Q2
• Improve program data collection by converting current data workbook into a more useful and consistent tool that is aligned with program manager's needs	• FY 2025 Q3
Forecast	
• In FY 2025, it is estimated that 75% of program participants will engage in at least one wellness activity per month.	

BHD Wellness Programs

Measure	3.1	Clients reduce or quit tobacco use

Data



Data Summary

- In FY 2024, five out of six participants who engaged in tobacco cessation reduced their usage. These clients participated in counseling through Healthy Living Program individual coaching. Per best practices for nicotine cessation, all six clients were engaged in individual discussion and coaching around their nicotine use as a regular part of their program engagement.

What is the story behind the data?

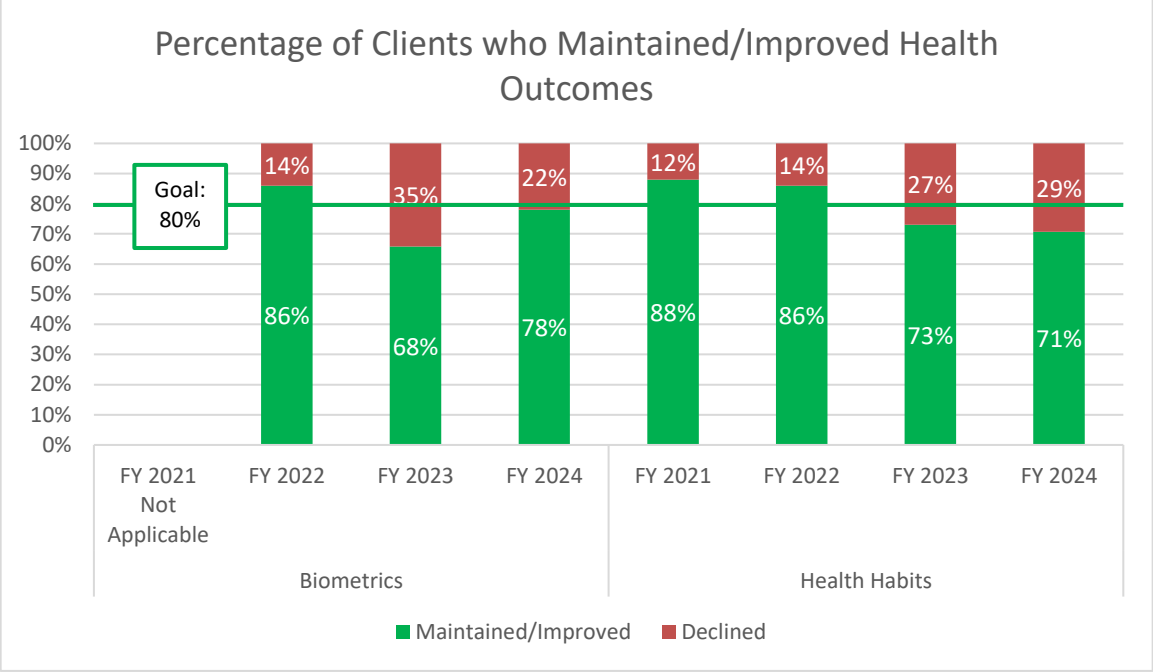
- Quitting or reducing tobacco use is a challenge for people from all walks of life, especially when concurrent with behavioral health issues and in the midst of the ongoing stressors of a global health crisis. Current public health reports indicate that there has been an increase in tobacco usage in the US since the start of the pandemic.
- In FY 2024, tobacco reduction and cessation support was provided on an individual basis with participants who self-identified as using nicotine in any form. The Tobacco Cessation group program did not run in FY 2024 due to consistent low enrollment over the course of multiple fiscal years.

Recommendations	Target Dates
• Continue to collect data on nicotine use within HLP.	• Ongoing
• If and when the Dimensions program is resumed, target outreach to young adult programs in addition to clients already active in HLP.	• Ongoing

• Explore the practicality of conducting surveys of relevant constituents (clients and BHD clinical staff) to assess interest in and barriers to participation in tobacco cessation services, as well as interest in and feasibility of training for clinicians on integrating tobacco cessation into their practice.	• FY 2025 Q2 and Q3
• Reach out to programs that focus on young adults, like the EDGE program, to determine if there are clients who would like to decrease their usage of cigarettes, vaping devices, or other tobacco products.	• FY 2025 Q2
Forecast	
• In FY 2025, it is expected that at least 60% of participants will quit or reduce tobacco use.	

BHD Wellness Programs		
Measure	3.2	Clients maintain/improve health outcomes

Data



Data Summary

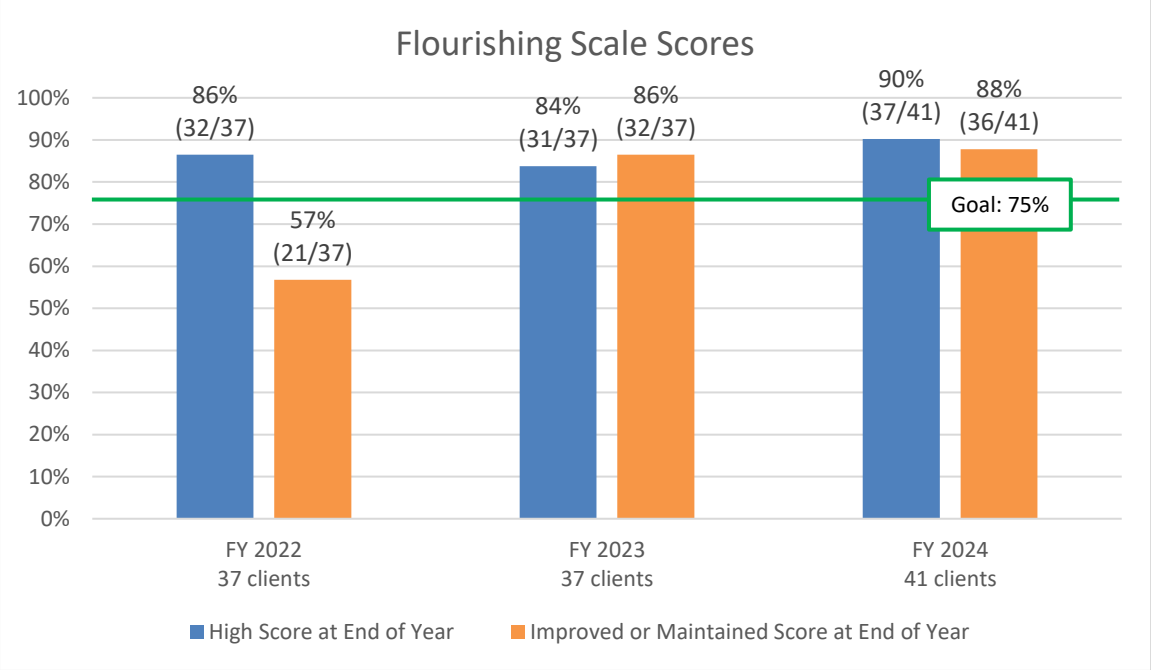
- In FY 2024, all clients in wellness coaching and wellness maintenance services were monitored on these metrics at consistent intervals. In addition to an assessment of current health habits and support with goal setting, assessments are intended to include a standard biometric – resting heart rate (RHR) - with additional biometrics available at client's discretion and choice.
- In FY 2024, the program began to include the RHR data as part of regular coaching sessions to support clients with more real time feedback and coaching.
- Clients were given the opportunity to self-report on their health habits in four primary dimensions of health – physical, emotional, environmental, and social, including medical health, nutrition habits, physical activity, and sleep/rest, as examples. This was assessed using the wellness satisfaction scale. Results from these health habits assessments are reported in the chart.
- 54 participants were served in screening and engagement, wellness coaching, and maintenance at any point during the year. Of those, 41 completed two or more biometrics and health habit assessments during the fiscal year. 32 (78%) improved their resting heartrate and 29 (71%) reported maintained or improved satisfaction with personal engagement in current health habits
- The program collected a baseline and follow up response for 41/54 individuals served.
- Of the 13 for whom we did not have two responses, 6 closed before a second response was collected. 4 opened too close to the end of the fiscal year for it to have made sense to collect a second response beyond baseline. 2 did not respond to multiple requests for completion of survey. 1 declined to complete.

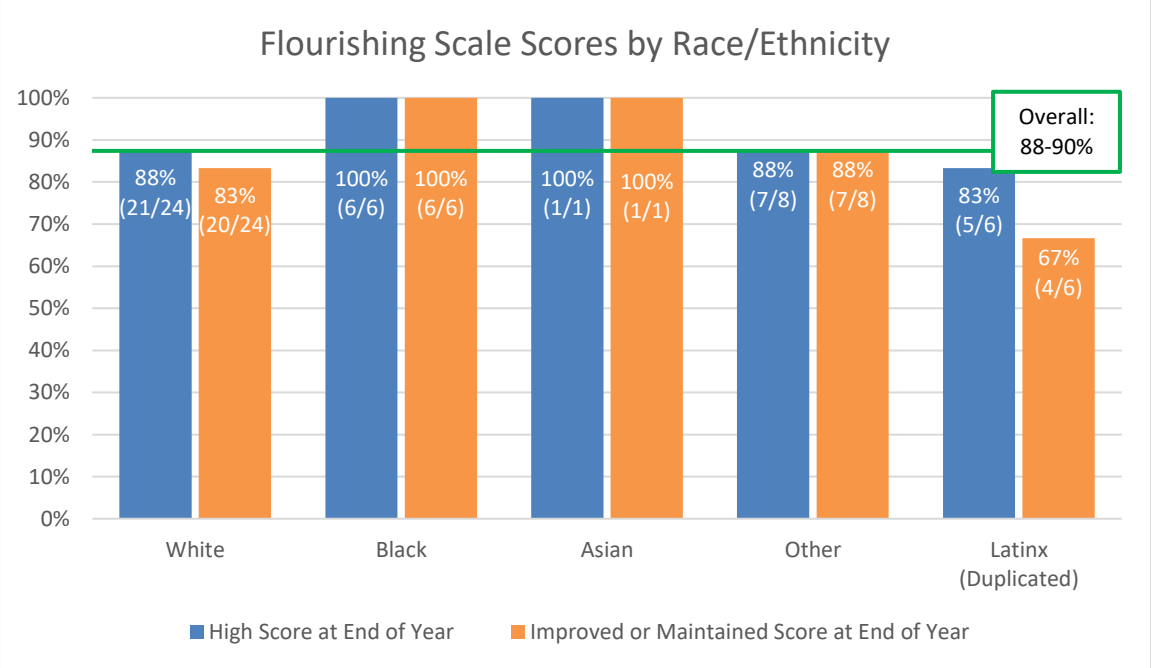
What is the story behind the data?	
• In FY 2024, the percentage of clients maintaining or improving their resting heart rate (biometrics) increased while the percentage of clients maintaining or improving on the health habits survey results slightly decreased. • Program staff have regular conversations with participants about bio indicators like resting heartrate. Health literacy is also taught to participants through health literacy workshops. The program held one of these workshops in FY 2024 and plans to have more in FY 2025. • FY 2023 was the first year in which the Resting Heart Rate (RHR) was collected via medical clearance, which the program expects was useful to collecting RHR change in FY 2024. • In FY 2024, the program continued to frame services around the Substance Abuse and Mental Health Services Administration's eight dimensions of wellness, with an emphasis on habit development around four in particular: physical, emotional, social, and environmental. • In order to support participant health and wellness in a more trauma-informed, person-centered manner, annual assessments continued to focus on the determination of health habits that the clients wished to practice, and clients' sense of satisfaction with adherence to these.	
Recommendations	**Target Dates**
• Monitor health outcomes data and engage clients in health habits monitoring consistently throughout the year.	• Ongoing
• Develop a strategy to conduct more targeted follow up and outreach around resting heart rate and health habits responses with participants around collected RHR data. •	• FY 2025 Q2 and Q3
• Continue to develop and utilize psychoeducational opportunities to support participant learning around the relationship between biometrics and health habits.	• FY 2025 Q2 and Q3
• Continue to develop and utilize psychoeducational opportunities to support program participants in developing more neutral, less shame-based approaches to physical and emotional health in adherence with ongoing research around the implications of weight stigma in healthcare.	• Ongoing
Forecast	
• In FY 2025, the forecast is that 80% of clients will see their biometric results maintained or improved and anticipate that health habits survey participants report 80% improvement or maintenance.	

BHD Wellness Programs

Measure	3.3	Clients improving scores on the Flourishing Scale

Data





Data Summary

- The Flourishing Scale is an 8-item summary measure of a respondent's self-perceived success. Client's rate each item with a score from 1-7, and the scale provides a single psychological well-being score.
- Any score above a 32 is considered a high score by the program. The highest possible score is a 56.

	• Clients complete the Flourishing Scale at the beginning and ending of each fiscal year. The program reviews these scores to measure change and determine what additional supports clients may need.

What is the story behind the data?

- FY 2024 was the third year that the Flourishing Scale was administered on a broad scale to program clients.
- In FY 2024, 41 program participants completed two Flourishing Scale assessments. Of that group, 90% (37/41) had a high score at the end of the year and 88% (36/41) improved or maintained their score from earlier in the year. This represents both an increase from FY 2023 and achievement of the measure goal.
- The high end of year scores indicate that most program participants are experiencing relative well-being in multiple dimensions. Participating in the Healthy Living Program enables clients to improve their health in various dimensions, which in turn can facilitate renewed energy and increased optimism for the future.
- More than half of program clients improved or maintained their score from earlier in the year, demonstrating that their time in the program improved their overall outlook and self-assessment. For those whose scores decreased, all five still maintained a high score.
- On the post-assessment, the highest agreement rates were seen for "I am a good person and live a good life." The lowest agreement rates were seen for "I am optimistic about my future."
- An equity analysis was conducted in FY 2024, to determine if changes in Flourishing Scale scores were different across race or ethnicity. Results were inconclusive, as sample size for most identities was low.

Recommendations	Target Dates
• Consider ways to evaluate correlation between Flourishing Scale responses and individual engagement, in order to develop strategies to provide more targeted outreach and support related to individuals' concerns.	• Ongoing
• Monitor trends in flourishing scores for Latinx and White clients to determine if additional action steps need to be taken to support clients who identify as Latinx or White.	• Ongoing

Forecast

- In FY 2025, it is projected that 88% of clients will have a high score at the end of the year, and 85% of clients will improve their score.