# Transformation Completion Report
# Status and Future Plans

**November 2012**

***Report to the Fairfax-Falls Church Community Services Board regarding the implementation of the Josiah H. Beeman Commission recommendations and subsequent CSB system transformation***

## The Plan Going Forward

For various reasons driven by both mission and resources, the Fairfax-Falls Church Community Services Board (CSB) will focus on those individuals who are **significantly disabled** by their mental illness, substance dependence, and/or intellectual disability. The services will focus on rapid, intensive resolution of crises at the front door of the system and integrated community-based options throughout the system. Any treatment or services provided are a means to the desired outcomes of adequate housing, meaningful daily activities including employment and education, and healthy living.

**Key areas for growth** in this service system will be the acute care continuum (emergency, mobile crisis, detox, crisis stabilization and partial hospitalization), residential (where people live), employment/ education oriented day programs, intensive outpatient, school-based treatment services, access to primary health and psychiatry, and case management, including intensive community treatment. Moving the CSB in this direction was indicated as a priority in the Beeman Commission report and the CSB's subsequent Implementation Plan. Over the last four years, the CSB has moved to structure around these recommendations. However, in order to continue to make progress on these recommendations, and even accelerate the progress, there needs to be an **increased commitment to this direction.**

## Introduction

Following over one year of investigation and study, a blue ribbon panel of national experts, appointed by the Fairfax County Board of Supervisors as the Josiah H. Beeman Commission published a report identifying key areas of the Community Services Board system for Fairfax and Falls Church where transformation was needed, primarily in the area of mental health services. The subsequent implementation plan, based on the report recommendations, acknowledged that a full transformation of the mental health service system and leadership could not occur without the involvement of the entire CSB system, including intellectual disability and substance use disorder services. This implementation plan, approved by the CSB Board, the Fairfax County Board of Supervisors, and the city leaders of Fairfax and Falls Church, identified the need for a full transformation of the CSB services and leadership so that organizational disability-defined silos would no longer restrict anyone's access to services.

The following report reviews the status of all the recommended strategies for implementation and outlines the next steps needed to continue the transformation process. Significant changes in business

and service processes have occurred, many of which reflect the report recommendations. However there are overall economic and policy considerations that will limit the success of some of the other goals established by the commission report.

## Status Report

Attached to this report is an addendum that identifies every strategy listed in the original Beeman Commission report and the status of implementation, based on actions taken over the last three years. With the exception of four strategies, the CSB has addressed all of the recommendations sufficiently to provide for a foundation for continued implementation. Leadership and governance changes reflect an emphasis on integrated services, staff and leadership training, and consumer empowerment. In fiscal management we have established benefits coordinator positions through the Financial Assistance and Screening Team (FAST) program and have gradually increased Medicaid revenues.

In the area of service and supports, we have increased access to community-based services such as Intensive Care Coordination for youth and Intensive Community Treatment for adults. Peer driven services have increased, both through private not-for-profit organizations and through increased employment of peer support staff within the CSB. Overall access to housing has increased, and a complete housing and service needs plan has been published with annual goals for the CSB. Even employment and training opportunities for people with mental illness have increased slightly, despite the difficult overall economic conditions. The CSB also continues to expand access to integrated services and primary health care for people served throughout our system.

The CSB has purchased a more robust, user friendly electronic health record software system. This should enable the CSB leadership, staff and individuals receiving services to access data and information in usable formats. The only areas in which the Beeman Commission recommendations have not been fully implemented are those where economic or policy considerations have limited further action.

## Current Environment

### *Economic*

All of the current economic projections indicate limited growth and the possibility of a major negative impact to Virginia, especially Northern Virginia, if the federal government significantly reduces its budget. In the past, Virginia state government has tended to increase funding for one priority service area in the CSB system, such as emergency services, at the expense of another, such as community supports. It is anticipated that the largest area for growth in the next few years will be in providing Medicaid funded community-based services for people with Intellectual disability who are leaving the state training centers as a result of the agreement with the U.S. Department of Justice.

By making a concerted effort to help eligible individuals enroll for Medicaid, the CSB has slowly and steadily increased overall Medicaid revenues in recent years. However, this effort has not resulted in a significant increase in the overall percentage of CSB service recipients whose cost is paid through Medicaid—the percentage remains around 30%. A recently hired consultant is helping the CSB find ways to improve processes to capture more Medicaid revenue, and help grow working relationships with Federally Qualified Health Centers that can charge higher rates for some services, such as outpatient. Improvements are also anticipated in the areas of Medicare and Dual Eligible (Medicaid and Medicare) collections. Revenue growth in any of the above areas, however, will not likely cover all of the cost of maintaining the current service system. If you factor in the need for growth of services, the current non-county revenues will not be capable of meeting those needs.

The current trend in local government is to reduce funding or maintain it at current levels. For the CSB, local funding has both expanded and decreased at the same time. It has expanded to meet growing personnel costs for salaries and benefits. But local funding has also been reduced as part of countywide budget management reductions that have occurred regularly during the last decade with increased reductions over the last four years. A significant change in county policies and priorities would be required for there to be growth in local funding that could cover the costs of anticipated service growth needs.

### *Services*

Service systems in both the public and private sectors have moved steadily toward greater service integration, both within the public (such as the CSB) service system (e.g. services for people with co-occurring substance use disorders and mental illness) and in systems that provide other services such as primary health care. Large integrated service systems and health payment systems will continue to move toward these integrated models, with or without the full implementation of federal health reform (Affordable Care Act). Another aspect of these changes will be increased focus on payments for service outcomes. Services need to be structured so that those desired outcomes are achieved and documented.

The overall approach of health systems has also evolved from a facility-centric model where services are provided at hospitals and offices with the individual as the patient, to a self-directed model where the individual receiving services is the customer and is provided services in the community. While treatment is still vital, it is focused on short term resolution of acute symptoms followed by a more extended model of community supports that help individuals manage their symptoms as part of their lifestyle. These programs sometimes referred to as disease management or chronic care management have characteristics that are similar with our system's stated goals of recovery and self-determination. Future service systems and health payment systems will continue to place greater emphasis on community-based, self-directed services.

## Values

The CSB Board and staff have consistently confirmed that the most important value is that the services address the actual needs of those we serve and their families. That also means that we must design our services to meet those identified needs. It also means that everyone needs to be treated in a respectful, caring manner.

Another key value is that services need to be provided in a timely, efficient and quality-focused manner. Future planning and CSB Board policies, as well as communication, will need to include clear identification of how this value is measured and what actions are needed to improve.

The CSB will also need to focus on service outcomes. Increasingly that focus will be on community integration measures such as adequate housing, meaningful daily activities such as employment, day programming or school, and overall health status.

We value all of our employees and those working with our partners and contractors. Many of these individuals dedicate their careers to serving the very vulnerable people who need CSB support. We cannot control salary or benefit levels, but we can look for tangible ways for the CSB Board and CSB leadership to reflect this value.

## Completing the Transformation

### *Services*

A more fully transformed CSB system will have a seamless array of services, primarily integrated into community settings, supporting the following expected **outcomes**:

1) **Adequate housing** that enables an individual to live in an integrated community setting
2) **Meaningful daily activities** that contribute to positive self-worth and integration into a chosen community
3) Adequate **health** as measured by not only an absence of symptoms, but also by the participation in early intervention/preventative health activities that produce results (one area the CSB has focused upon in the past is decreasing tobacco use)

All services in this system will be based on a national benchmark for service quality and will use those standards and measures to compare service outcomes. Examples of those models already exist in our system, such as co-occurring service models based on the Learning Collaborative established in partnership with Dartmouth University and the Pathways model for Housing First linked to the Intensive Community Treatment Teams.

The service system will be designed to focus on the individuals who are **significantly disabled** by mental illness, substance dependence and intellectual disability. The skills and focus of the service providers emphasize responsiveness to people with highly complex needs who will not be able to achieve the

above outcomes without a coordinated set of services and supports. The CSB service system will be a seamless, well-coordinated group of providers who either work as CSB employees or who partner with us as contractors. Most of the services will be provided in community settings.

The following services that will support the achievement and maintenance of the desired outcomes:

1) Crisis entry into the CSB system must be managed in a timely, effective manner. Therefore the system must build up to stronger mobile emergency response capacity so that issues can be resolved in the community whenever possible. The CSB emergency services site needs to be a fully staffed, 24/7 drop off center that provides interventions such as 23-hour beds, availability for medical detox either at the site or through a no refusal center, partial hospital programs that resolve acute care problems while the individuals remain living in the community, and residential crisis stabilization.
2) Entry into the system through a routine request for services must be made in adherence with a system-wide policy of access to CSB services due to a disabling condition related to mental illness, substance use disorder or intellectual disability. Services must combine a robust assessment of need with a referral directly to the program that provides that service. If an individual must wait for a service, this must be assisted by a combination of group supports, access to other services from that service area, if available, and urgent responsiveness whenever needed. Those with service needs but who do not meet the criteria for admission to the CSB, will be assisted to find community resources.
3) The overall treatment and community support system must move ever closer to a model whose overall goals, starting with admission, are community integration, recovery, and self-determination. The success of this system is measured by outcomes such as housing, meaningful daily activities and health indicators. Treatment is necessary as a means to that end.
4) With all of the above services, individuals who have received services need to be involved in service planning and provision. This can be through peer-operated organizations or through employment with the CSB. Models for peer driven services for every aspect of the CSB system, exist somewhere in the United States. When one of those models would more effectively meet the needs of the people we serve, it must be part of the implementation planning.

Prior to the Beeman Commission report the CSB had already been moving toward the above models for service. As a result of the report, despite the budget shortfalls, the pace has increased. The key challenge to full implementation is the ability to fully implement admission criteria and find the right balance of treatment-only oriented services (residential treatment, office-based treatment), which are necessary for some of those we serve, but cannot be the core of the system if desired outcomes are to be achieved.

## *Funding*

Acquiring the needed funding for any service system will depend on three fundamental factors:

1) Developing **new revenue sources** and expanding existing ones.
2) Determining the most **cost effective service delivery** system to achieve the desired outcomes.
3) Finding options to **reinvest** existing funding to the CSB core service areas.

This section expands upon those three factors:

1) Revenue Sources
    a. Assuming it moves forward, the full implementation of federal health reform involves both an expansion of coverage and a cost management strategy. Opportunities for additional revenues will be available but they are not as expansive as predicted.
    b. A stated goal of the CSB and our fiscal manager the Department of Administration for Human Services (DAHS) will be to Increase third-party payments such as private insurance, Medicaid and Medicare. Key to the success of this strategy is the continued development of a robust CSB support team providing financial assistance, screening and coordination to ensure that everyone who qualifies for such assistance is enrolled and that invoices are generated with consistent, adequate information to be able to bill these revenue sources.
    c. As the system evolves into desired and well benchmarked programs, major grants will be more available. However, sustainability will be a challenge in the long run for more than a few select areas where there are no significant potential long term funding supports at this time.
    d. Increased access to local funding has been the major source of support. However, experience over the last ten years, especially the last four years, leads to caution about any significant new investments.

2) Cost/Benefit Analysis
    The Beeman Commission strongly recommended this type of analysis to determine the most efficient manner to deliver needed services. This has been accomplished on a small scale in some areas. Creating an analysis model and applying it to all areas with a balance of cost and desired service outcomes would, at minimum, validate current service structures and possibly lead to improved use of limited resources.

3) Reinvestment
    Identify those service and management areas which are not part of a core service system (e.g. residential treatment beds, office-based services) and reduce those areas even further than current budget reductions require. The resulting funds could then be reinvested in those services identified as core to the mission and direction of the CSB such as intensive community treatment and housing.

### *Role of the CSB Board*

The CSB Board has two fundamental roles with which to lead and provide ongoing oversight for any implementation process.

The first primary role is that of governance. Their recent increased oversight role with the CSB budget is fundamental. As their governance role further evolves, the Board needs to actually review and approve annual budgets as well as any addendum items that significantly impact either services or the budget. Their leadership in establishing a balanced approach between service needs and quality with fiscal accountability is essential.

The second primary role is that of the local authority that links the local government and the needs of the community with state policies. Essential to this role is the Board's ability not only to advocate for adequate funding for those on CSB waiting lists, but also to identify all the major service needs for all key population groups.

This plan envisions the CSB Board assuming an increasing role in leading community discussions regarding the needs of local residents who do not meet CSB admission eligibility but who need services for mental health and/or substance use services. Other populations that do not receive adequate funding and support include people with developmental disabilities, especially autism, individuals with brain injuries and those with dementia. Working with local and state leaders through education and policy development is an important role for the CSB Board.

## Next Steps

The CSB staff has been working in project groups to find available savings, efficiencies and further improvements in various parts of the service delivery system. Work plans have been developed and are being implemented. These activities will continue as part of the CSB's overall operations. Secondly, the CSB staff will provide a framework to future analysis on the cost and benefit of various methods to structure services. Thirdly, CSB staff will analyze the key growth recommendations and determine the actual cost of growing these service areas. Some of this work has already been done.

The most important next steps will be led by the CSB Board. Upon review and discussion, these recommendations reflect key policy changes that will require the Board's full support and advocacy. The CSB Board must engage county and city leaders in ongoing discussions so that they can fully understand and support the **specific actions** required to move the CSB in the direction they endorsed when they approved the Beeman Commission report and subsequent implementation plan.

The above recommendations, or some alternative approved by the CSB Board are much more specific in defining **who is eligible** for CSB services and what **core services** will be available directly from this publicly funded system.

# Beeman - Transformation Progress Report

| Category-Defined | Indicators | Status | Key Outcomes |
|---|---|---|---|
| **1. Leadership and Governance** Sufficient to attain and sustain the system vision | **1.1** Promote service integration and system effectiveness | → | • Service system restructured<br>• Working toward full standardized integrated services<br>• Centralized any administrative or management function that did not directly supervise services |
| | **1.2** Board members skill set communicated to Board of Supervisors | → | • Description developed and forwarded to the Board of Supervisors Chair<br>• Recent budget crisis increasing the variety and skills of appointees |
| | **1.3** Strengthen partnership in public and private sector | → | • Regular dialogue in all sectors including healthcare<br>• Increased housing partnerships |
| | **1.4** Encourage and recognize creativity and innovation while balancing risk with results | → | • Gradually flattening decision making to the point of impact which also creates greater shared accountability<br>• Supporting new service developments and improvements in current system<br>• The current county environment is highly risk averse |
| | **1.5** Recruit/promote leaders who possess competencies to manage evolving service and businesses practices | → | • Changing assignment to leadership roles for current staff based on strengths<br>• Promotions to promising staff whenever opportunities are available<br>• Limited ability to recruit externally due to budget restrictions on hiring |
| | **1.6** Provide ongoing leadership development | → | • Established a training coordinator role integrated in county Organizational Development and Training<br>• Established a performance oriented management leadership curriculum using county resources which will be implemented by the end of calendar year 2012<br>• Succession planning implementation not fully planned or implemented because the organization continues to be in transition |

→ Significant progress in achieving the goal
→ Some progress, substantially more to do
→ Unable to further pursue at this time

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|---|---|---|---|
| | **1.7** Assure a mechanism for leader accountability | → | • Beyond performance evaluation, accountability tools still need to be developed and linked to the management leadership curriculum<br>• 360 tool has limited value but has been used in the most positive way |
| | **1.8** Require and model respect in all interactions throughout system. | → | • This has been increased both through agency leadership and Office of Consumer and Family Affairs as measured through satisfaction and ROSI surveys |
| | **1.9** Establish an Office of Consumer and Family Affairs with well-defined responsibilities and leader reporting directly to the CSB Executive Director | → | • Fully implemented with a designated peer provider position by county Human Resources and increased number of peer employees |
| **2. Fiscal Management**<br>Maximize and leverage all potential funding sources for system and individuals served | **2.1** Maximize revenue and reimbursements for individuals served from Medicaid and other entitlements including Medicare, State Children's Health Insurance Plans (S-CHIP), Comprehensive Services Act (CSA), Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) to complement local, state and federal grant/tax dollars | → | • The total amount of Medicaid revenues has increased, but the overall percentage has not<br>• The establishment of Financial Assessment and Screening Team (FAST) has increased the number of new cases screened immediately for eligibility<br>• Medicare and Medicaid billings still can be improved |
| | **2.2** Deploy Benefits Coordinator positions to service sites to assist and advocate for individuals seeking benefits | → | • FAST established at all major sites<br>• FAST has lost a few positions due to budget reductions |
| | **2.3** Seek opportunities for grant funding and assure CSB is prepared to sustain initiatives originally financed by grants after money is depleted | → | • Established an Office of Resource and Partnership Development to take the lead on grant and other new revenue development<br>• Coordinated human services-wide contractor process for grant proposal writers and evaluators<br>• A sophisticated grant seeking system that includes sustainability planning still needs to be completed |

→ Significant progress in achieving the goal
→ Some progress, substantially more to do
→ Unable to further pursue at this time

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| | **2.4** Explore establishment of a foundation whose purpose is to assure an accessible, affordable and integrated system | → | • As part of the Office noted in 2.3, established a private, not-for-profit Fairfax REACH to accomplish this goal<br>• Still developing REACH's role to maximize the impact |
| **3. Prevention and Early Intervention**<br>Increase prevention and early intervention efforts for children, youth and adults to decrease the need for services | **3.1** Organize and deliver education, public awareness activities and campaigns about behavioral health and wellness as well as publicize information about the public services and community supports | → | • Established Mental Health First Aid training which has been implemented widely<br>• Loss of resources and positions due to budget reductions<br>• Planning and implementing a plan to integrate Prevention into a human services system-wide effort to maximize the impact of limited resources |
| | **3.2** Assure prevention is a fundamental responsibility of every system provider | → | • Limited formal programming due to decreased funding<br>• Some effective community early intervention efforts have been established and expanded such as training Police in CIT skills |
| | **3.3** Integrate more fully with Fairfax County Public Schools to support children and youth behavioral health | → | • Developing more service oriented programs within the schools to address both mental health and substance use disorders<br>• Both county and schools budget reductions limit growth |
| | **3.4** Expand early intervention practices to prevent the need for crisis and emergency care and mitigate further progression of illness | → | • Wellness Recovery Action Plan (WRAP) training has exponentially expanded both in Fairfax and regionally<br>• Use of gradually expanding urgent care services to address needs before they are an emergency |
| **4. Services and Supports**<br>Build a service delivery system that supports recovery and resilience in its entirety | **4.1** Assure all who seek access to the system secure either access to public services and support or linkage to private or nonprofit services and supports. Build a robust network of care with practices to ensure cross-system accountability for referral connections | → | • Established a single entry and assessment system<br>• Established an increased collaborative relationship with the private sector with increasing referral capacity including Inova Behavioral Health outpatient clinics |

→ Significant progress in achieving the goal
→ Some progress, substantially more to do
→ Unable to further pursue at this time

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|---|---|---|---|
| | **4.2** Ensure integration of person-centered practices and processes in working with individuals served | → | • Established as service expectation in all areas at all levels<br>• All internal CSB decisions focus on this as the top priority |
| | **4.3** Make care coordination/case management a centerpiece of service delivery design utilizing a strength-based model | → | • Increased emphasis on targeted case management including separating that role from therapy<br>• Created child Intensive Care Coordination and increased case management available<br>• Created adult Intensive Community Treatment services |
| | **4.4** Build continuity of care into the model for delivering care coordination | → | • As part of the transformation restructure and organization flattening, encouraged eliminating service silos and internal barriers to access.<br>• Continuity and integration projects developing in child services and adult mental health/substance use services |
| | **4.5** Implement a policy that completes the shift from office to community-based provision of care that includes, but not limited to, case management and emergency services. | → | • As part of transformation, established Community Living Services – to increase the overall emphasis on community-based services<br>• Planned second mobile crisis team to respond to issues in the community on hold because of budget reductions<br>• Increased housing and employment opportunities are available and continue to be a planning priority |
| | **4.6** Enable persons to be served in their natural communities by assisting staff in transportation needs | → | • Established four peer run service centers spread across the county<br>• Transport for staff to go into the community to provide services available, but limited |
| | **4.7** Increase support to families of children, youth and adults with disabilities as part of shift to care in community | → | • Limited direct family support programs<br>• Support No. Virginia NAMI and other family programs |
| | **4.8** Assure peer services and supports permeate the system | → | • Four peer run centers established and a mobile peer service for substance use disorders<br>• Increased peer positions in all parts of the service system |

→ Significant progress in achieving the goal
→ Some progress, substantially more to do
→ Unable to further pursue at this time

| Category-Defined | Indicators | Status | Key Outcomes |
|---|---|---|---|
| | **4.9** Invest in and enhance peer run drop in centers | → | • See 4.6 and 4.8<br>• Exploring two other peer run services--crisis and a warm line, pending funding availability |
| | **4.10** Continue integration efforts of mental health and substance abuse assessment and treatment for individuals with co-occurring disorders | → | • Gradually implementing the Dartmouth University integrated model for benchmarking and quality improvement throughout the system<br>• A Learning Collaborative has been launched to continue the above initiative |
| | **4.11** Support and expand existing examples of cross-system collaboration emphasizing treatment in lieu of or in addition to incarceration | → | • Expanded Jail Diversion program into a full ICTT program<br>• Expanding medical detox availability<br>• Engaged local Community Criminal Justice Board in sequential intercept planning with very limited outcomes at this time<br>• Expanded CIT training for Police with about 40% of the force fully trained at this time |
| **5. Housing**<br>Assure safe, affordable, and stable housing for persons with disabilities | **5.1** Support Housing First model and effort to maximize housing outlined in county's Ten-Year Plan to End Homelessness | → | • Implemented Housing First through ICTT and county Housing Blueprint access to housing resources<br>• Increased housing access at least five fold annually |
| | **5.2** Engage individuals being served, families and national/local nonprofit organizations in expanding housing options with accompanying support services | → | • Established an ongoing set of partnerships with public and private housing agencies as part of the planning for use of Housing Blueprint |
| | **5.3** Create housing development fund to support housing for persons with disabilities | → | • Attempted to do so unsuccessfully in the first two years following the release of this report<br>• In lieu of a separate CSB fund, established a more robust role in housing planning and access to resources through Housing Blueprint |
| | **5.4** Explore existing systemic challenges between housing and behavioral health services to optimize collaboration for the benefit of persons served | → | • Housing Blueprint efforts have greatly increased ongoing collaboration with both county agencies and private providers |

→ Significant progress in achieving the goal
→ Some progress, substantially more to do
→ Unable to further pursue at this time

| Category-Defined | Indicators | Status | Key Outcomes |
|---|---|---|---|
| **6. Employment**<br>Expand employment and education support for persons with disabilities | **6.1** Implement employment services, consistent with principles of evidence-based supported or individualized employment | → | • Integrated all employment services into a single program to create greater opportunities<br>• Changing PRS psychosocial philosophy to employment centered Recovery Academy<br>• Increased individualized mental health employment placements |
| | **6.2** Identify an employment liaison to facilitate collaboration at system level to reduce barriers that hinder employment and expand opportunities that promote employment | → | • See 6.1 |
| | **6.3** Access federal funding for Ticket to Work by creating an employment network | ➡ | • Explored without success at this time |
| | **6.4** Strengthen connections with local educational institutions to support adults wishing to further their education | → | • Limited but increasing discussion with the community college around educational and vocational opportunities |
| **7. Primary Health Care**<br>Facilitate connection with primary health care for all persons with disabilities | **7.1** Support and expand existing examples of cross-system collaboration between primary and behavioral health care providers | → | • Increased Community Health Care Network (CHCN) access at two sites<br>• Implementing partnerships with two Federally Qualified Health Centers (FQHC) to integrate services in Mt. Vernon and Herndon |
| | **7.2** Explore modification of affordable healthcare system to a FQHC Look-Alike to strengthen the interface between primary and behavioral health care | → | • Now have a Medically Underserved Population (MUP) designation in Mt. Vernon<br>• See 7.1 |
| | **7.3** Explore the possibility of a locally developed group health insurance plan | ➡ | • Not being considered at this time |

➡ Significant progress in achieving the goal
→ Some progress, substantially more to do
➡ Unable to further pursue at this time

| Category-Defined | Indicators | Status | Key Outcomes |
|---|---|---|---|
| **8. Workforce and Training** Assure a workforce that possesses skills, values and attributes consistent with the vision of a recovery- and resilience-oriented system | **8.1** Create, within defined budget, flexibility to authorize and relocate positions to respond to needs of individuals receiving services | → | • Limited capability, but being done within policy limits such as increased youth mental health access with substance use providers because their volume of referrals decreased |
| | **8.2** Recruit and develop a workforce that possesses competencies that support and sustain the system vision | → | • Recruiting as budget allows while also maintaining or increasing quality of service expectations of current staff |
| | **8.3** View personal experience with mental illness as a preferred qualification in recruiting applicants for positions | → | • Established a defined Peer Counselor position within county Human Resources |
| | **8.4** Assure training opportunities for persons interested in offering peer support | → | • Vastly improved access through E-Learning system with over 600 courses<br>• Increasing access to quality speakers and bringing them to the county |
| | **8.5** Demonstrate high expectations for efficiency and accountability through clear performance and productivity standards | → | • Continuing to develop, but not fully operational-availability of usable date limited but growing |
| | **8.6** Promote person-first language that is consistent with a recovery- and resilience-oriented system of care | → | • Information office and other leaders consistently monitor official communication for person-first language |
| **9. Data and Outcomes** Ensure cross-system accountability with performance and outcome measures, and use the data to improve system. | **9.1** Adopt robust system of performance measures and ensure performance data is used to improve system effectiveness | → | • Moved from dashboard not related to goals to scorecard related to goals and results-based accountability and return on investment. Still in process<br>• Consolidated disability-based quality to system quality in a single office<br>• Data to information soon to be developed |
| | **9.2** Seek information from other organizations about successful approaches to serving the behavioral health needs of children, youth and adults | → | • Increased use of benchmarking and use of outside experts--Dartmouth-adults, Virginia Commonwealth University-youth.<br>• Still limited consistent benchmarking |

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|---|---|---|---|
| | **9.3** Conduct periodic analyses of system functioning to identify points for improvement | → | • Process still in development based on results measures process |
| **10. Technology and Information Sharing** Utilize technology to support providers in delivering quality care, individuals in participating in their care, and the system in collecting data for effective management | **10.1** Support efficiency and recovery improvements through the purchase and support of a new electronic health record (EHR) following county funding and procurement procedures. Funding to be considered through the county's IT Enhancement fund. | → | • New EHR purchased and implemented<br>• Still developing the data capacity |
| | **10.2** Purchase hardware (laptops and similar portable devices) that supports changes in business practice | → | • Mobile hardware in planning, but limited by budget |
| | **10.3** With Department of Information Technology collaboration, establish CSB-specific security guidelines/ procedures for greater flexibility to grant authorized staff system administrative rights when using desktops, laptops, etc. | → | • Flexibility limited by county policies |
| | **10.4** Facilitate access to information for individuals receiving services by extending public access to CSB sites and purchasing computer "kiosks" at key CSB sites. | → | • Peer access to EHR in planning process<br>• Kiosks available at major sites |

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→ Some progress, substantially more to do
→ Unable to further pursue at this time