



# **JOSIAH H. BEEMAN COMMISSION IMPLEMENTATION PLAN**

**September 2009**



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# **JOSIAH H. BEEMAN COMMISSION IMPLEMENTATION PLAN**

## **Introduction**

The Josiah H. Beeman Commission was established by the Fairfax County Board of Supervisors to develop a vision and blueprint for the direction of the public mental health service delivery system. The expected outcome is a broad roadmap for transforming the system with the following deliverables:

- (1) Recommendations on the Appropriate Role of Public Mental Health Services in the Fairfax County Service Delivery System.
- (2) Recommendations on Service Populations.
- (3) Recommendations on Service Delivery Design.
- (4) Recommend Strategies for Funding and Resource Development to Support the Service Delivery Design.
- (5) Recommend Outcomes and a System of Measures to Gauge Performance.
- (6) Assessment of the Current System of Mental Health Services Delivery.
- (7) Transformation Roadmap and Strategies.

The resulting Commission membership reflected local, statewide and national expertise in the mental health field, as well as consumer involvement. The Commission members met over an 18-month period analyzing both written materials and hearing testimony from both those involved in the current system and national experts.

The resulting Commission Report was published and presented to the Human Services Committee of the Board of Supervisors in late October, 2008. The report contained the following recommendations for a Transformed System with a series of strategies connected to each:

- (1) Promote effective leadership and governance to attain and sustain the vision for the mental health system.
- (2) Maximize and leverage all potential sources of funding for the system and for individuals with psychiatric disabilities.
- (3) Increase prevention and early intervention efforts for children, youth, and adults in order to decrease the need for mental health services.
- (4) Build a service delivery system that in its entirety supports recovery and resilience.
- (5) Assure safe, affordable, and stable housing for person with psychiatric disabilities.
- (6) Expand employment and education support for persons with psychiatric disabilities.
- (7) Facilitate connection with primary health care for person with psychiatric disabilities.

- (8) Assure a workforce that possesses skills, values, and attributes consistent with the vision of a recovery-and resilience-oriented system.
- (9) Ensure cross-system accountability with performance and outcome measures and use the data to improve the system.
- (10) Utilize technology to support providers in delivering quality care, individuals in participating in their care, and the system in collecting data for effective management.

A series of specific strategies related to each of these recommendations was placed in the Report. The Board of Supervisors accepted the Report and requested the County Executive and Deputy County Executive for Human Services to develop an implementation plan. This request, in turn, was delegated to the Fairfax-Falls Church Community Services Board (CSB) Executive Director.

### **Implementation Planning Process**

This Implementation Plan outlined below is a management implementation of a structure that will provide for a service environment at the Fairfax-Falls Church CSB which will integrate recovery and self-determination in all aspects of the system. The success of this plan will be measured by, in addition to the traditional management tools for efficiency and satisfaction, the number of people whose quality of life is improved because of the support our system provides.

The Implementation Planning Process was developed with the idea of generating implementation ideas from the broadest number of stakeholders in a relatively short period of time. The group that coordinated the process, the Implementation Steering Committee, had no intent to create an extensive study of the Commission results, but instead to solicit the ideas of the variety of content experts and community partners who would be able to identify how to realistically implement the strategies identified by the Commission.

Over the course of a 30-day period, 12 distinct workgroups, staffed by over 100 key stakeholders, met simultaneously to generate the ideas for implementation that will be identified in this report. Each of the workgroups was organized based on the key categories of recommendations from the Beeman Commission. Each workgroup met several times during that 30-day period and developed an extensive number of action steps to implement each of the recommendations and related strategies *(A full copy of each workgroup recommendations as well as a chart with implementation timelines are in the attached appendix. Each workgroup input will be integrated into either an implementation project team or part of a specific directors' implementation plan).*

This report is structured to provide an overview of the key elements and strategies that will be implemented, using timelines, key business processes and key elements of the Board's original requests, as the organizing framework. The specific implementation action items will be imbedded into that framework during the actual implementation process.

## **Implementation Items to be Completed by the End of FY 2010**

The most important organizing item among the many strategies recommended by the Beeman Commission is a set of measurable goals and objectives that would enable everyone involved with the CSB to identify the direction of the organization and their progress. To that end, the following items will be implemented during FY 2010:

- (1) *Implement a strategic business planning process that is performance focused.*  
This effort, while initiated by the CSB Board and the CSB Senior Leadership, will eventually reach out to all levels of the organization and stakeholders in the community for both input and monitoring. The CSB Board will focus on the overall agency performance and their governance duties and the CSB staff will be working on an organizational plan where decisions will be increasingly made at the point of impact rather than the top of the organization with accountability focused on measurable outcomes.
- (2) *Link key goals with the above plan to quarterly measures of success using a continuous quality improvement model that includes data on utilization management, risk management and service outcomes.* While there are many challenges and demands placed on a system of this complexity, by using traditional healthcare success elements, as well as a no-fault approach to solving problems or eliminating barriers, the CSB will be able to successfully monitor such key indicators of success as:
  - Budget management.
  - Access to services.
  - Staff productivity.
  - Ensuring appropriate levels of service for the need.
  - Satisfaction of those using services.
  - Key outcomes such as increased independent behaviors associated with consumers maintaining stable housing and employment/day services.
- (3) *Continue the process of establishing the CSB Board role as using the two items above to govern the overall performance of the CSB.* While the senior leadership of the CSB is essential with the implementation of the above plan and measures, the role of the Board cannot be overstated. Their commitment to govern the CSB as a system of interdependent parts is essential. The Board has already made a commitment to implementing these top three items and will continue to work with CSB leaders as well as county leadership and the Board of Supervisors to further establish this role.

Once the above goals are in process, there are key elements of the Beeman Commission recommendations that will be priorities to implement. These elements are a product of both the concerns expressed by many stakeholders and the priorities for services established by CSB and county initiatives. The following items are not listed in priority order but will all be completed in FY 2010:

- (4) *Implement the Consumer/Family Affairs role with all human rights regulatory requirements and recovery activities coordinated out of one office.* This role will ensure that the voice of those who use and need our services is heard during all decision-making deliberations and that there is a balance between regulatory demands and human aspirations.
- (5) *Establish and implement an internal project prioritization process and project management process to ensure full implementation of priority goals established within the Strategic Business Plan.* The CSB staff is very responsive to consumer and community needs, establishing projects and initiatives in response to their needs and concerns. However, sometimes the number and scope of the projects become overwhelming, especially with the demands of day-to-day operations. This will ensure that any established project will be well defined and completed within a set of timeframes.
- (6) *Create a coordinated marketing/communications plan that will emphasize business partnership development and a process to review all funding stream opportunities to implement the mission.* The CSB leadership and staff are and have been very creative in their efforts to respond to opportunities to work with community partners and expand funding sources. However, the efforts are sometimes narrowly focused, such as a single disability group and more often unknown to others in the CSB and the County. This newly coordinated effort will be one of the key linkages to developing services linked to funding sources based on pre-determined priorities that have been clearly articulated.
- (7) *Implement at least three population-based projects that are internally coordinated among Programs and externally coordinated with key county and community partners (such as child services, people with mental illness who are homeless and primary care integration).* Essential to effectively meeting the needs of some of the most vulnerable populations in the county is the ability to structure the service system so that it is as seamless as possible. This will include the internal structure of the CSB which will break-down any disability-oriented barriers and the departmental structure of the county where the CSB will blend service providers into teams with other department providers. The CSB already has shown the ability to do this and will increase that effort as these needs become manifest.
- (8) *Work with the CSB Residential Development office to develop a business plan linked to the above strategic business plan that coordinates with county and community agencies to develop housing stock based on annual targets.* The CSB Residential Development office has been very successful over the years in developing a variety of housing opportunities for consumers. This action will build on that legacy and further establish the role as part of the above marketing/communications team.
- (9) *Work with key community agencies to establish a planning process that emphasizes employment and educational opportunities for all consumers.* This effort will build on the successful partnerships already established by the CSB staff with agencies that provide training and work opportunities. The goals will be

to emphasize this effort and eventually engage as many consumers as possible who need or want this type of service.

While these nine items above are significant, in most instances, CSB staff has already begun working toward achieving them. The key to successful implementation of these FY 2010 initiatives will be the establishment of sustainable processes that will be built upon in the following two years.

### **Implementation Items that will be Completed by the End of FY 2011-2012**

The key to implementing the Beeman Commission strategies in a manner that they will work to the scale of Fairfax County and Fairfax-Falls Church CSB is to create flexible structures that are adaptive to the changing environment, but maintain a structure and discipline for all involved. The initial items above will be implemented within an environment of tight budget management and maintaining key programming amid funding reductions. The following items are established to focus on higher performance in a variety of environments:

- (1) *Complete the implementation of those items from FY 2010 that carried over.* It is not likely that there will be any items that will require much, if any, time or resources to complete. However, there will always be some allowance for delays and barriers that delay items.
- (2) *Establish a five-year strategic business plan that will identify those service lines that will be primarily provided by the CSB staff and those items that will be based on a partnership with community agencies, and those items that will be fully developed in community settings.* As the reader will note, the items implemented in FY 2010 around marketing/communication and service elements will now be the foundation for creating a key roadmap to establish more clearly defined “markets” for Fairfax County-owned services and those in private settings. A key element in the successful development of this plan is the CSB Board’s role in assessing community needs and establishing priorities for each population.
- (3) *The above plan will emphasize standards for accessibility and availability of services which include timeliness of service, responsiveness of service to needs, effectiveness of the service, and the ability of the service to respond to diversity needs.* The use of the terminology of “market” will actually mean that there will be a planning and implementation of service models that respond to the above access elements.
- (4) *Integrate consumer-run services into the above plan with an emphasis on sustainability.* In addition to building relationships with key private service systems that already provide services to CSB consumers, the CSB will develop increasing options for consumer-run services and support the development of business plans that enhance the long-term viability of that service.

In addition to the above planning effort, the CSB leadership will also work on developing key business management processes that enhance the system's ability to further develop the above planning:

- (5) *The CSB Board and leadership will establish a business review process that will ensure effective use of business models internally and externally, including using blended and braided funding streams.* The development of models for how the CSB sets up businesses and partnership, as well as the effort to find new funding sources or the further development of existing ones, requires a proactive planning approach that is integrated into the overall strategic business planning process. This coordinated effort will also make the best use of outside consultants, when needed, to assist with these efforts.
- (6) *Purchase the necessary software to ensure that the entire CSB system has an electronic health record (EHR) and it is sufficiently robust and flexible to be used by a private partner or linked to by community agencies.* In addition to being an eventual required standard for medical records, the newer, robust software increases the likelihood of standardizing unnecessarily inefficient documentation, improving billing and collections, coordinating services with partner agencies, and connecting with personal health records used by individuals receiving services. The EHR should be supported by hardware to improve business practices and functionality.
- (7) *Create a project management process within the CSB that implements three or four major business initiatives at any one time.* This effort would build on the initial steps taken in FY 2010 to increase the likelihood that all major implementation efforts will reach a successful conclusion and that projects do not expand beyond their intent.

The final element of this Implementation Plan is development of both management and staff:

- (8) *The CSB Board and leadership will collaborate with private sector leadership to establish a management training program that will ensure that all middle management and upper level management in the CSB, as well as willing private partners organizations, are operated based on sound business principles.* This Management Training Institute will ensure that leadership follows best practices whenever possible and role models for the entire organization.
- (9) *Establish a robust workforce development plan that ensures sufficient recruitment and retention strategies are used throughout the CSB, including incorporating consumer employees and workforce diversity issues.* This item will be part of the ongoing key indicators as part of the strategic business plan.

### **Implementation Items for FY 2013-2014**

- (1) *Ensure all effective processes developed above are consistent and applied effectively.* This will enforce a culture that does not continue with procedures and

processes that no longer work and can change things more quickly without extensive study unless indicated.

- (2) *Adjust business plans based on changes in demand, payers and the provider system.* This is the application of continuous improvement within business processes and will be taught as part of the Management Institute. By this time, the strategic business planning will lead to the identification of CSB business units which will be operating with a full expectation of accountable, measurable performance based on agency and population priorities.

## **Conclusion**

This document concludes the planning effort to meet the expectations established by the Fairfax County Board of Supervisors to transform the service and management thereof of the CSB Mental Health system. The above Implementation Plan links directly to the strategies outlined by the Beeman Commission and addresses the deliverables identified in the Commission Charter.

The leadership of the CSB had already recognized the need for this transformation prior to the establishment of the commission and had already begun a process to restructure services, realign management positions and increase access to other revenue streams. In many ways, this document will formalize and accelerate the process of change at the CSB.

As the above plan articulates, the CSB will be using some key elements of high performance planning and implementation to ensure that the outcomes are fully transparent to all stakeholders and increase the likelihood of success through a wider ownership. The effort will always focus on consumers, in specific, and county residents, overall, as the primary focus with an emphasis on measurable quality, access to needed services in a timely manner, and ongoing focused feedback.

In addition to this customer-first emphasis, the CSB Board will be developing clear and measurable business processes to ensure that resources are efficiently used and that funding sources are diverse and maximized. This will include the effective development of recovery initiatives which benefit the consumer and create efficiencies for the entire system as more people have greater independence. The above Implementation Plan will also implement an effective technology system that generates decision-making data in a timely manner and supports the needed system efficiencies.

The effective development of staff resources is also directly addressed in the Implementation Plan through the use of training to a higher level of performance as well as tracking our ability to keep good employees, including strategies that need to be developed to accomplish that goal.

Following the approval of this Implementation Plan by the Board of Supervisors, the CSB staff will begin implementation with the following next steps:

- (1) Establish specific timelines for the implementation of the FY 2010 items.
- (2) Work with the Board of Supervisors to establish regular reports on our progress and overall performance.
- (3) Build the FY 2011 implementation items into the upcoming budget planning process.

In conclusion, this effort has involved the input of hundreds of citizens, consumers, staff, CSB Board members, experts in the field, and county leaders. This short summary document synthesizes all of their work and the resulting implementation process will reflect many of the ideas and strategies that were shared.

# **Josiah H. Beeman Commission Implementation Plan**

## **Appendix of the Workgroup Recommendations**

Appendix of the Workgroup Recommendations

*\*The Executive Director is Responsible for Implementing all Plans*

<b>WORKGROUP</b>	<b>IMPLEMENTATION TARGET</b>	<b>RESPONSIBLE PARTIES</b>	<b>PAGE</b>
Data and Outcomes	FY 2011-2012	CSB Quality Director CSB MIS Director	104
Employment	FY 2010 – Start FY 2011-2012 – Complete	CSB MH, ADS, & MR Directors	72
Fiscal	FY 2010 – Start FY 2011-2012 – Complete	CSB Fiscal Director	17
Housing	FY 2010 – Start FY 2011-2012 – Complete	CSB Housing Director CSB MH and ADS Directors	61
Leadership and Board	FY 2010 – Start FY 2011-2012 – Complete	Board Chair CSB Senior Management	12
Primary Health Care	FY 2010 – Start FY 2011-2012 – Complete	CSB Deputy Director CSB Medical Director	83
Prevention	FY 2011-2012, FY 2013	CSB Prevention Director CSB MH and ADS Director	22
Services and Consumer Focus	FY 2010 – Start FY 2011-2012 – Complete	CSB Consumer/Family Affairs Position	30
Service and Coordination	FY 2011-2012	CSB MH and ADS Directors	47

*Appendix of the Workgroup Recommendations*

<b>WORKGROUP</b>	<b>IMPLEMENTATION TARGET</b>	<b>RESPONSIBLE PARTIES</b>	<b>PAGE</b>
Services and Models	FY 2011-2012	CSB Deputy Director CSB MH and ADS Directors	56
Technology	FY 2011-2012	CSB MIS Director CSB Quality Director	113
Workforce and Training	FY 2011-2012	CSB HR Manager CSB Quality Director	91

## **Leadership and Board**

**Board and Staff Leadership Workgroup Recommendations**

Strategy	Current Status	Recommended Action
<b>Strategy 1.1</b>		
Review, and as needed, restructure the CSB board to promote service integration and system effectiveness.	Following a retreat with the new Executive Director, the Board voted unanimously to move toward a “big picture” Governance role and use a Strategic Business Plan to guide priorities.	<ul style="list-style-type: none"> <li>(1) Ensure that the Strategic Business Plan is implemented with ongoing performance measures starting with FY2010</li> <li>(2) Board policies changed over the next two years to reflect a governance approach and eliminate any direct operational oversight.</li> </ul>
<b>Strategy 1.2</b>		
Document the skill set needed for overall CSB Board member composition and advise the Board of Supervisors accordingly (with advance notice as vacancies on the Board are known or as soon as an opportunity for a new appointment emerges).	No current activity.	<ul style="list-style-type: none"> <li>(1) Emphasize the skills and experience needed to have a Governance approach as the primarily initial emphasis of the board member’s role and contribution</li> <li>(2) Develop and implement Board Governance training for all current board members within the next 12-18 months.</li> </ul>
<b>Strategy 1.3</b>		
Strengthen partnerships within the public and private sector.	In addition to ongoing contractual relationships with over 70 private sector providers in all disability areas, there are special capacity building projects. A significant example of one is the partnership comprised of the CSB, Health Department, Northern Virginia	<ul style="list-style-type: none"> <li>(1) Use actionable, measurable strategic business goals to create priority targets for public/private efforts</li> <li>(2) Ensure that board committee work as well as CSB planning incorporate ongoing assessments of community needs and resources available.</li> </ul>

Strategy	Current Status	Recommended Action
	<p>Family Services and the Women's Center focuses on the development a network of integrated behavioral and health services. The CSB is a full partner in Fairfax County's 10-year plan to end homelessness which will result in deeper partnerships with private sector shelters and other providers. The CSB Prevention Services is actively promoting the transfer of evidenced based practices such as Girl Power to partner organizations, reaching a much larger segment of the community's youth.</p>	
<b>Strategy 1.4</b>		
<p>Encourage and recognize creativity and innovation while balancing risk with results.</p>	<p>The top leadership already uses a project management methodology that targets key areas for improvement and once staff is assigned, they are encouraged to create solutions within project parameters. Middle managers need to develop project management and facilitation skills.</p>	<ol style="list-style-type: none"> <li>(1) Implement both training and work process that encourage utilization of HPO models that emphasize ownership and accountability at the point of impact</li> <li>(2) Implement, as part of the strategic business planning implementation, a project management methodology that helps staff structure their efforts to find creative, implementable solutions</li> <li>(3) Facilitating staff participation at all levels through flexible scheduling and other supports.</li> </ol>
<b>Strategy 1.5</b>		
<p>Recruit or promote leaders who possess competencies required to manage evolving</p>	<p>The county leadership and CSB board hired a new Executive Director that meets the strategy standard. He has found</p>	<ol style="list-style-type: none"> <li>(1) Develop and implement a mandatory middle management training curriculum that uses HPO principles</li> <li>(2) Develop and use a rigorous model for mentoring and coaching as a follow-up to the training</li> </ol>

Strategy	Current Status	Recommended Action
service and business practices.	significant skill and experience among all of the Senior Leaders in the CSB. Within the system, the top leaders have already begun restructuring and identifying capable and future leaders before the new Executive Director arrived. The CSB participates in Phase 1 of the County's Succession Planning Project and senior leader competencies have been updated and staff throughout the agency has been given the opportunity to participate in this development opportunity.	(3) Reward and recognize effective leadership behaviors.
<b>Strategy 1.6</b>		
Provide ongoing leadership development.	There has been ongoing access and support for leadership training including LEAD and Leadership Fairfax. However, that has not always been followed up with mentoring our emerging leaders and assuring their potential to use these skills and principles in their job roles.	(1) Implement middle management training and mentoring as noted above (2) Use restructuring opportunities to implement principles of HPO as part of responding to the changing environment.
<b>Strategy 1.7</b>		
Assure a mechanism for accountability of leaders.	This area has been inconsistent, but improving as the CSB board and agency leadership work on tying key	(1) Implement an ongoing process of Strategic Business Planning which will establish specific measurable goals (2) Establish a scorecard that is directly linked to goal achievement and business plan performance.

Strategy	Current Status	Recommended Action
	goals to balanced scorecard reports.	
<b>Strategy 1.8</b>		
Require and model respect in all interactions throughout the system.	There is a concerted effort on the part of the Senior Leadership to role model respect and encourage their staff to act accordingly. However there is no specific initiative beyond this, other than the system-wide Cultural Diversity work that does promote respect for all employees, consumers and their families.	<ul style="list-style-type: none"> <li>(1) The combination of all of the above actions and actions in the other workgroups should lead to this cultural focus</li> <li>(2) Develop mechanisms so that top management role models effective, accountable and respectful leadership.</li> </ul>

## **Fiscal**

**Fiscal Recommendations**

Strategy	Current Status	Recommended Action
<b>Strategy 2.1</b>		
<p>Maximize revenue and reimbursements from Medicaid and other entitlements for individuals receiving mental health services, including Medicare, State Children's Health Insurance Plans (S-CHIP), Comprehensive Services Act (CSA), Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) to complement local, state, and federal grant/tax dollars</p>	<p>There are opportunities to maximize revenue and reimbursement at both the site level and the CSB level. At the site level, there is a fragmented process to ensure eligibility for individuals receiving mental health benefits and limited availability/ training of administrative staff around these processes. Clinic front desk staff may not inquire about benefits or check if the patient is enrolled in public programs and each site only has one financial intake staff member. Consumers who are identified as eligible for Medicaid or other services may not flow through the appropriate verification and billing process. For example, as of January 2009, over 1600 consumers were identified as potentially insured through Medicaid; however, only 900 consumers received a Medicaid case management service, and that service was billed for only 750 consumers. There is a policy on discharge from services due to nonpayment but its enforcement is challenging. At the organization level, the system has just one central account manager to handle</p>	<ol style="list-style-type: none"> <li>(1) Concentrate efforts to build, implement and evaluate a new Medicaid prior authorization component in the CSB management information system by July 1, 2009 in order to avoid loss of fee revenues for services which previously did not require a prior authorization (e.g., case management, day treatment, targeted support services, and psychosocial rehabilitation).</li> <li>(2) Evaluate resource requirements needed to move forward the development of a new financial counselor role at each mental health clinic, which will be trained intensively in Medicaid and will have broad knowledge of other public programs. Expectations of the role include gathering documentation, screening for eligibility for Medicaid and other programs, completing applications for Medicaid and other programs as appropriate, making referrals as necessary, and frequent monitoring of pended applications for lack of complete documentation. This person will submit completed applications to the DFS HAAT specialist to be filed.</li> <li>(3) Redefine roles, responsibilities, and expectations for personnel including (a.) front desk personnel who should engage the consumer to provide a copy of his/her insurance or Medicaid card and inquire online as to the active/inactive status in the health benefit plan (b.) the administrative staff conducting the financial intake (see point 2. above).</li> <li>(4) Develop a front office business process that has appropriate workflows and staffing levels to allow the front desk staff to coordinate collection of documentation, completion of applications, etc. for clients at each entry point for the system.</li> <li>(5) Direct the central account manager to focus proportionately more time on payment of open cases rather than focusing on</li> </ol>

Appendix of the Workgroup Recommendations

Strategy	Current Status	Recommended Action
	<p>delinquent accounts. The focus of this individual has been to pursue debt set-off (tax returns) of closed cases, yet the self-pay aged accounts receivable is more than \$600,000 for accounts over 120 days in AR. In addition changes to Medicaid will require pre-authorizations for some services.</p>	<p>closed cases, thereby reducing the growing self-pay aged accounts receivable. As of mid-March 2009, the self-pay aged accounts greater than 120 days total more than \$600,000.</p> <ul style="list-style-type: none"> <li>(6) Instruct clinical supervisors to review cases identified as Medicaid eligible but that were not billed as such (700 cases identified as of January 2009). A determination of whether the service should have been performed and billed must be addressed in treatment plans.</li> <li>(7) Instruct financial counselors at each site to review the status of Medicaid-funded consumer's benefit plans (150 cases that received the service but were not billed to Medicaid as of January 2009) to see if the benefit expired and a recertification is required. If determined the service is appropriate, 150 new targeted case management cases will yield \$587,700 annually.</li> <li>(8) Explore the Fee Policy regulation about discharging patients from services for non-payment.</li> <li>(9) Infuse accountability and metrics for financial management to all staff involved in the process, the clinic as a whole, and through the leadership.</li> </ul>
<b>Strategy 2.2</b>		
<p>Deploy Benefits Coordinator positions to mental health service sites in order to assist and advocate for individuals seeking benefits.</p>	<p>Models exist for targeted benefits coordinator type roles in various areas. The first example of a model is the Partnership for Healthy Kids (PHK) where the Inova Health System funded staff that gather documentation and prepare Medicaid applications to submit to DFS for processing. A second example is the creation of the CSB's Office of Family and Consumer Affairs where the office determines the need, resources,</p>	<ul style="list-style-type: none"> <li>(1) Coordinate a targeted enrollment group process with the Department of Family Services (DFS) Self-Sufficiency Program benefits staff to ensure that those identified as potentially enrollable in Medicaid complete the process.</li> <li>(2) Develop the Healthcare/Financial Counselor staff at the mental health clinics to conduct comprehensive interviews, determine if they have private health insurance coverage, and if they do not, gather sufficient screening information and documentation to take Medicaid and other federal/state assistance programs, e.g., Subsidized Nutrition Assistance Program (food stamps), State-Local Hospitalization, General Relief, Refugee Assistance, Temporary Assistance to Needy Families, Supplemental Security Income (SSI), Supplemental</li> </ul>

Strategy	Current Status	Recommended Action
	<p>contracts, training, etc. for peer advocate parents. The SOAR (SSI/SSDI Outreach, Access, and Recovery) model reaches out to homeless individuals in the completion of their applications for SSI and SSDI. The Medicare Part D program advocates also complete applications for that program and assist eligible individuals in determining which of the available plans would be best for covering an individual's medications.</p>	<p>Security Disability Income (SSDI), and other public assistance applications, as appropriate and submit completed applications to DFS for processing. The counselor will screen, enroll and complete applications for other federal/state programs, e.g., Medicare, Medicare Part D and Patient Assistance Program. Once the applications are in the system, track the progress of applications submitted until a determination is made. Make other referrals as necessary. Develop metrics for these positions to ensure that 100% of those eligible are enrolled.</p> <p>(3) Establish peer advocate partners at each mental health clinic to help consumers and the Healthcare/Financial Counselor with the identification of documentation and the need for resources. Again, develop performance metrics for these roles.</p> <p>(4) Establish a Health Access Assistance Team (HAAT) specialist in the DFS Self-Sufficiency Program to process and track applications for Medicaid and other federal/state assistance programs, e.g., Subsidized Nutrition Assistance Program (food stamps), State-Local Hospitalization, General Relief, Refugee Assistance, Temporary Assistance to Needy Families, Supplemental Security Income (SSI), Supplemental Security Disability Income (SSDI), and others. Develop performance metrics for staff.</p> <p>(5) Develop a front office business process at intake and ongoing that has appropriate workflows and staffing levels to allow the front desk staff to coordinate collection of documentation, completion of applications, etc. for clients at each entry point for the system.</p> <p>(6) Measure the effectiveness of an FTE Healthcare/Financial Counselor against the revenue generated.</p> <p>(7) Create a system of accountability and metrics for the staff. Additional Healthcare/Financial Counselor staff hired should be expected to cover their cost by an increase in reimbursement for services provided and / or avoidance of</p>

Appendix of the Workgroup Recommendations

Strategy	Current Status	Recommended Action
		unreimbursed care.
<b>Strategy 2.3</b>		
Seek opportunities for grant funding and assure that the CSB is prepared to sustain initiatives originally financed by grants after the grant money is depleted	Currently, many governmental organizations in the area of mental health are not actively seeking grants. Grant seeking is a time consuming process that is most successful when carried out by a dedicated staff. Past efforts for grants have been largely unsuccessful. The public schools, however, have an active and very successful grant seeking arm.	<ol style="list-style-type: none"> <li>(1) Engage in strategic planning to a. establish the high priority needs related to the CSB's core mission and b. discern which opportunities are likely to self-sustain through revenue generation or cost avoidance.</li> <li>(2) Forge a business relationship with the proven Fairfax County Public Schools grants office, as part of County-School collaboration initiative.</li> <li>(3) Move toward a model with dedicated grant seeking staff/time to ensure that grants are appropriately selected and written.</li> <li>(4) Train all staff to look for grants that may shape the system, test new technologies, and implement new protocols or processes. These grants, which are generally time-limited will provide ongoing value.</li> </ol>
<b>Strategy 2.4</b>		
Explore the establishment of a foundation whose purpose would be to assure an accessible, affordable, and integrated mental health system.	The Northern Virginia community has existing foundations which fundraise for mental health causes. Some of those organizations, like the Northern Virginia Mental Health Foundation, have a broad foundation mission and others, like Fairfax Futures, have a targeted mission. The CSBs and other government organizations work with these groups and may on occasion provide support to them.	<ol style="list-style-type: none"> <li>(1) Establish the core purpose of a new foundation, its mission, and an easily and broadly understood message to use in fundraising or support.</li> <li>(2) Conduct roundtable discussions with existing advisory board foundations. Many have narrow geographic or consumer population bases (some operate more as alumni groups and some do limited fundraising) and they may be interested in forming an umbrella foundation.</li> <li>(3) Explore seed money from a private source to obtain the professional and/or legal services necessary to establish a foundation and a governing body.</li> </ol>



# Prevention

**Prevention Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 3.1</b>					
<p>Organize and deliver education and public awareness activities and campaigns about mental health and wellness. Actively publicize information about the public mental health services and supports to the community.</p>	<p>CSB Speakers Bureau coordinated by CSB Communications Director.</p> <p>SAP and Prevention receive requests for speaking engagements and health fairs, provide 1x presentations and educational events.</p> <p>Prevention- Planning environmental campaign in October and some involvement in past.</p> <p>MHS- a variety of service provider training/ed, Fairfax Fair, CSA Symposium, linkages to Network of Care Site, Access has resources/info sheets available, helping to focus Advisory Board efforts, Vocational Fair for people receiving MHS.</p>	<p>Develop approach for response to requests and proactive, strategic awareness activities and delineate roles/ responsibilities for evidence-based prevention and public relations.</p> <p>Develop priority targets for public awareness to incl. all groups at left.</p> <p>Develop messaging with focus on stigma and other priority targets (incl. youth survey).</p> <p>Develop materials for dissemination.</p> <p>Connect with NAMI and SAARA about involvement, their initiatives, and collaboration.</p> <p>Involve parents, family members, and individuals impacted by mental illness and substance use disorders.</p>	<p>CSB Communications Team + collaborators from across CSB and other stakeholders/ consumers</p> <p>CSB Communications team as lead</p> <p>CSB Communications as lead with OPA and CSB staff</p> <p>CSB Communications team</p> <p>CSB MH, ADS, and other staff</p> <p>CSB Communications Team Denise Raybon with support from Laura Yager and PST/ PCT</p>	<p>Within 12 months for all</p>	<p>Time prioritized by Communications Team to coordinate project.</p> <p>Some possible print shop costs depending on materials and/or media messaging approaches used.</p> <p>Prioritization by the PST and commitment of staff resources</p>

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		<p>Involve Prevention Coordinating Team, tying efforts developed to goal areas and for help in getting out message</p> <p>Create more formal involvement with Advisory Committees for community awareness. Review information sheets and community resource materials developed and disseminate more widely.</p>	<p>Jenkins or designee and Communications team</p>		
<b>Strategy 3.2</b>					
<p>Assure that prevention is a fundamental responsibility of every provider in the system.</p>	<p>At present, limited knowledge among staff and limited connection across CSB services.</p>	<p>Develop cross system workshop with youth survey and other communitywide data as framework, with connection to the Recovery Model, to educate about protective and risk factors with identification by participants of 5-6 prevention strategies for inclusion across treatment system.</p> <p>Adopt the 5-6 prevention strategies as a policy, congruent with recovery principles, and begin to embed them across treatment system.</p>	<p>Denise Raybon with support from Laura Yager, David Sherman (or designee) and PST/ PCT</p> <p>CSB workforce</p>	<p>By end of Calendar year 2010 for all</p>	<p>Prioritization by the PST and commitment of staff resources</p>

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		<p>Develop measurement approaches to track progress/system change.</p> <p>Consider formal recommendations for adoption across human services system.</p> <p>Link with County Competencies effort and consider tie-in to performance reviews.</p> <p>Develop strategy and implementation plan with contractors and other mental health service providers. Consider inclusion of prevention as a fundamental responsibility in future contracts across CSB system.</p>	<p>Pumphrey, MacDonald</p> <p>CSB Mgrs, Yager, Raybon</p> <p>Potter, Friedman</p> <p>Contracts, MHS Mgrs, Yager, Raybon</p>		
<b>Strategy 3.3</b>					
<p>Integrate more fully with Fairfax County Public Schools to support the mental health of children and youth.</p>	<p>Some role confusion with school psychology/ SW and CSB roles.</p> <p>LRP and SAP well-integrated but with serious communication/confidentiality issues.</p> <p>Many relationship-based collaborations as opposed to formal</p>	<p>Review current status of FCPS/CSB MOU and fix information-sharing problems. Expand MOU to include all CSB services.</p> <p>Involve highest level decision-makers in information-sharing resolution.</p> <p>Develop policy for regular,</p>	<p>Ed Rose, FCPS legal, FCPS Office of Student Services, McConnell, Lennon, Yager, MacDonald, Berenson, Jones, Kudless, Williams, Braunstein</p>	<p>September 2009</p>	

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	<p>integration agreements.</p> <p>Integration of residential programs and ADT with Alternative Schools.</p> <p>Regularly scheduled meetings with mid mgrs in MHS and FCPS.</p> <p>Ongoing FAPT and CSTs.</p> <p>7 year contract with FCPS for Assessment, treatment, and consultation for noncategorical preschools.</p> <p>Joint grant applications between MHS and FCPS</p>	<p>school-based multiagency team meetings to discuss high and at-risk youth.</p>	<p>Braunstein, Teresa Zutter, possibly Tony Griffin and Jack Dale</p> <p>Bermingham, Raybon, Yager, Lennon, MacDonald, Berenson, Pallas Washington, Bruce</p>		
<b>Strategy 3.4</b>					
<p>Expand early intervention practices to prevent the need for crisis and emergency care, and to mitigate further progression of illness</p>	<p>CSB worked with groups of consumers across three locations in the county to develop and open the drop-in centers.</p> <p>CSB continues to provide coaching and mentoring for 2 of the</p>	<p>Establish a holistic response and transition supports for people with changing service needs including:</p> <p>Educate service providers about current practices in MHS related to transition planning/ crisis, safety, and</p>	<p>Case Managers</p>		

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	<p>locations on a weekly basis. No systematic referral process although CM can encourage consumers to attend. No formal “handoff” to help people access Wellness Centers.</p> <p>Discharge planners attend transition meetings for complex cases coming out of residential placements.</p> <p>WRAP plans are standard practice as part of community readiness adult day support program, encouraged with Intensive Case Mgmt, CTR case managers.</p> <p>Referral and linkages to alternative services are offered</p> <p>Linkages to natural supports such as leisure programs, self-help groups, community-based tx, and family</p>	<p>support plans.</p> <p>Develop best practice standards, aligned with Systems of Care approaches, related to transition planning throughout MHS and assure staff have knowledge and skills through information dissemination, training, and coaching.</p> <p>Family outreach, helping families learn early intervention approaches and about psychiatric advance directives.</p> <p>Develop and implement policies/best practices for involving families on an ongoing basis when children are receiving MH. Adult and Children components of MHS codifying their practice for working together when the adults with serious mental health issues are also parents of children--that they work holistically with the family to develop recovery and stabilization plans. Best</p>	<p>MHS Mgmt Team</p> <p>MHS Adult Services</p> <p>Managers of the Adult and Children Mental Health Services</p>		

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		<p>practice would include teaming with other HS professionals involved with any family member.</p> <p>Provide training in family involvement/ engagement throughout the system.</p> <p>Strong linkages with peer support services.</p> <p>Establish transition plan as “formal” services change focusing on establishing natural support handoffs, check-in points, and crisis plans in case help is needed.</p> <p>Promote use of the Network of Care website at wellness centers, esp training modules on wellness and recovery.</p> <p>Promote internet accessibility for people exiting services by providing community access information.</p> <p>Encourage libraries to obtain WRAP for Computers for use on all library public access</p>	<p>Mgmt Team</p> <p>Training Coordinators</p> <p>Wellness Center staff and designated MHS staff</p> <p>CSB Mgrs Pumphrey and CSB Communications Team</p> <p>CSB Communications Team</p> <p>CSB Communications Team</p>		

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		computers and consider purchase of additional copies for dissemination in key community locations.  Promote use of Safety and Support Plans throughout MHS.	CSB Mgmt Team		

## **Service and Consumer Focus**

**Service and Consumer Focus Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 4.1</b>					
Assure that all who seek access to the mental health system secure either access to public mental health services and supports or linkage to private or non-profit mental health services and supports. Build a robust network of care with practices that ensure cross-system accountability for referral connections.	<p>Implementation of the Access system within Mental Health has made substantial progress on issues of timely availability. Access is currently seeing and assessing 95% of people who seek system services within 10 business days, the industry standard cited in the Beeman report.</p> <p>The Commission also recommended “regular monitoring of the metrics associated with access.” For at least the past year, MH and CSB senior management have received detailed monthly reports of these metrics and use them for decision making.</p>	Continue process of actively monitoring and managing access response time, with a long term goal – as recommended by the Commission - of exceeding the industry standard when budgetary constraints ease and permit fuller staffing.	MH and CSB senior management, MH UMQA Director, Access/Entry units.	Ongoing	Gradual relief from current budgetary restraints that impact service delivery availability.
	Entry/Access has always had referral lists for community	While considerable progress is being made in finding willing community	MH and CSB senior management,	As above, this is an ongoing	Time, networking skills, willing community providers.

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	<p>services and informal arrangements with other providers, but this is currently being pursued in an even more systematic and measurable way. For example, the CSB Medical Director has worked out a networked arrangement with CHCN – the Community Health Care Network – to connect consumers with primary health care; the CSB, in return, deploys psychiatric hours to CHCN. Referral arrangements exist with Inova Outpatient, Northern Virginia Family Services, Catholic Charities, the Women’s Center, and others.</p> <p>Callers who are looking for connections to private or community providers are assisted through the use of an outside provider list; the list is</p>	<p>partners in the non-profit arena and some within private provider circles, the system is still some way from what the Commission calls a “robust network.” One especially important element as the network grows will be a feedback accountability loop to ensure that not just referrals, but connections to other providers have been made.</p> <ul style="list-style-type: none"> <li>• Recommend that the CSB continue its analysis of care network potentials and ways of formalizing and monitoring such arrangements. The ultimate goal is a network of care that goes beyond the walls of the CSB and creates a mental health system in the broadest meaning of that phrase.</li> <li>• As a part of establishing and growing network partners, the CSB/MH must also educate partners on what services it uniquely provides, permitting</li> </ul>	<p>MH UMQA Director, Access/Entry units.</p>	<p>process that is well underway. So as not to leave this loose, progress reports should be made to the CSB Board and stakeholders annually.</p>	

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	<p>kept current by an intern who has responsibility for that task. Further, there has been increased and organized collaboration with HS Systems Management's Coordinated Service Planners team, an important font of resource information. So is the Network of Care website, which has a growing list of local and national resources.</p> <p>Meantime, the CSB's Deputy Executive Director, Mary Kudless, applied for and received a Hoffman-Campbell planning grant aimed at looking at ways to create community based mental health services and dental services. Ms. Kudless is also involved in working to develop a small network of private MH providers who guarantee they will accept specific</p>	<p>appropriate referrals from community providers to the CSB/MH system.</p> <ul style="list-style-type: none"> <li>• Getting feedback on referrals to ensure that a connection to service was actually made is crucial. This is somewhat limited by the referral receiver's willingness to communicate a connection and by confidentiality limits and caller anonymity preferences.</li> <li>• Some possible mechanisms include designing Network of Care website pop-up feedback loops (resource and referral information from Access/Entry, including willing private practitioners, should be duplicated on the NOC site whenever possible); negotiating formal feedback mechanisms with outside providers in advance; and having Access/Entry ask individuals to let us</li> </ul>			

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	third-party payment arrangements.	know when a referral connection has been made. In the case of anonymous callers seeking referrals, a number could be assigned and used by the individual when he or she called back.			
<b>Strategy 4.2</b>					
Ensure integration of person-centered practices and processes in working with individuals with psychiatric disabilities.	The Beeman Commission noted CSB efforts at ensuring that individuals who receive services are involved in the development, monitoring and changing of treatment plans. A Commission survey of stakeholders found that about 70% affirmed an item that said “Staff see me as an equal partner in my treatment program.” Almost 60% responded positively to the statement “My treatment plan goals are stated in my own words.”	Continue current systemic efforts aimed at transforming the integrated service delivery system both in MH and ADS into an even greater person centered enterprise, with a goal of improving the 60-70% positive response rate percentage to 90%.  Please see recommendations under 4.8 and 1.9 below on system integration and hiring of persons with lived experience at all levels of the organization and the establishment of an Office of Consumer and Family Affairs.	Senior CSB, MH and ADS Managers, Stakeholders.	Repeat system survey elements probing person centered practices 12 months from now.	Time, commitment and collaboration.

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	<p>While this is progress, it is notable that 30-40% of service recipients did not feel that their services were sufficiently person centered.</p> <p>This has been taken seriously by the CSB and is being addressed in a number of ways.</p> <ul style="list-style-type: none"> <li>• Not only in Mental Health, but also in Alcohol and Drug Services there are joint initiatives at the very highest management levels to ensure a Recovery focus, person centered practices and, within the limits of existing resources, treatment choice. A "Change Agent" process has been established to permeate the system at all levels around Recovery principles, a No Wrong Door policy, Integrated</li> </ul>				

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	<p>MH/ADS assessments and service provision, keyed to personalized goals and employing a range of evidence based treatment collaboration options.</p> <ul style="list-style-type: none"> <li>• New staff trainings are to be keyed to these principles.</li> <li>• A Recovery Work Group has access to senior management, provides regular input on practices and has been involved in designing system enhancements. It includes consumers, family members and providers and also features regular report-outs by MH providers on new and enhanced Recovery initiatives underway within their divisions. This group also</li> </ul>				

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	<p>conducted its own detailed survey of stakeholder perceptions of care and systems needs.</p> <ul style="list-style-type: none"> <li>As noted under another strategy below, the system is committed to increasingly integrate consumers into system roles as peer specialists, merit clinicians and volunteers</li> </ul>				
<b>Strategy 4.6</b>					
<p>Enable persons to be served in their natural communities by assisting staff in transportation needs.</p>	<p>It is hard to underestimate the importance of increased community work and service delivery by clinician case managers and mental health counselors. Some county vehicles are currently assigned to specific programs, such as residential programs, Mobile Crisis, day treatment, jail diversion and a few others. However, field outreach in</p>	<p>Conduct a detailed analysis of vehicle demand and need for expanded community outreach activities by clinical case managers and counselors, including an examination of cost/benefit ratio of personal vehicle to fleet use, finding a mix that is most likely to support staff outreach at the most economical cost. There must be recognition, however, that substantially increasing community outreach will come at an unavoidable increased cost.</p>	<p>Mental Health Director and senior clinical staff in conjunction with CSB CFO.</p> <p>County Attorney and Risk Management offices will need to weigh in.</p> <p>Process should include input and guidance from experts at Vehicle Services</p>	<p>No later than December 31, 2009.</p>	<p>To be determined by analysis.</p>

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	<p>programs like outpatient services is substantially underutilized and there is no vehicle fleet assigned to adult outpatient services. Therefore, any community outreach within this program occurs with staff members using personal cars.</p> <p>Such use of personal vehicles was not a condition of employment and, while the county provides reimbursement for mileage, many staff members are reluctant to use their own cars because of the county policy which, in the case of an accident, requires staff members to use their own auto insurance first, with the county only stepping in to assist when the employee's insurance doesn't cover costs. Staff note that this has the</p>	<p>The current county insurance policy places an unfair burden on staff. If an analysis determines that it is ultimately more economical for the county to encourage staff to use personal vehicles, then consideration must be given to lifting this barrier.</p> <p>While additional fleet cars will likely be necessary acquisitions to increase community work, possible economies must be examined, such as:</p> <ul style="list-style-type: none"> <li>• Maximizing use of current fleet cars assigned to other programs during utilization lulls.</li> <li>• Examining acquisition of used county cars for some functions. For example, the mental health system jail diversion program has, in the past, acquired selected used public safety sedans when such vehicles no longer met the rigorous requirements of police use but were still shown to be safe and</li> </ul>	<p>and from DFS (which successfully manages a large social worker outreach effort, a fleet of 53 cars and a mileage reimbursement budget of \$240,000 to support it).</p>		

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	<p>effect of making staff vulnerable to personal policy rate increases after an accident, whether they were at fault or not.</p> <p>To the extent that staff get involved in transporting individuals to appointments for medical care, vocational assistance, food shopping and other mental health support services, fleet cars designated for client transportation, rather than personal cars, are necessary for outpatient staff clinicians and are currently largely unavailable.</p>	<p>economical – when compared to rentals vehicles - for less rigorous social services duty.</p> <ul style="list-style-type: none"> <li>• Making effective use of Logisticare for transportation of individuals whenever possible.</li> <li>• When examining possible fleet expansion, analyze parking and placement issues which, at some sites, are critically limited.</li> </ul>			
<b>Strategy 4.8</b>					
Assure that peer services and supports permeate the mental health system.	Nine Peer Specialist positions currently exist in some critical segments of the Mental Health system, such as Emergency Services, Crisis Care, PACT	<u>Promote merit position opportunities at all levels.</u> When candidates for merit positions meet minimum advertised requirements, having lived experience of mental illness should be counted among preferred	For changes in Merit Hiring and addition of Peer Specialists and Counselors: Senior MH and CSB staff, CSB Human	Changes in Merit Hiring: 90 days.  Addition of Peer Specialists and	Minimal to none for changes in Merit Hiring policies.  Dollars for addition of peer specialists in additional mental health programs, but amount can be mitigated by ability to restructure

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	<p>and with one contract provider. Additionally, Mental Health Services was just awarded a grant that will permit hiring two peer specialists to work with the Jail Diversion program.</p> <p>A formalized mechanism for expansion is also well underway. Back in October 2008, a plan to develop an array of job specifications was agreed to at Workforce Planning with Human Resources. A high level work group within Mental Health completed and submitted Class Specifications to HR for three levels of Peer positions (Specialist, Counselor and Supervisor – please see appendices for the draft position descriptions). HR is reviewing the specifications and a Market Place</p>	<p>qualifications.</p> <ul style="list-style-type: none"> <li>Go beyond traditional bulk newspaper advertising; periodically post CSB job opportunities at consumer-operated drop-in centers, with consumer and family organizations, with the Virginia Peer Support Coalition, with MH vendors and in MH facility lobbies. Attend job fairs to added recruitment.</li> <li>Job application processes sometimes favor internal candidates because of familiarity with the hiring process. Designate a contact person to assist potential applicants with any confusion about application requirements.</li> <li>Review vacancy announcements to differentiate between fundamental and marginal job functions. For example, the routine requirement of having a driver’s license might be a barrier to some</li> </ul>	<p>Resources lead and Workforce Planning lead, DMB.</p> <p>For Volunteer expansion and enhancement: MH Volunteer Coordinator.</p>	<p>Counselors to additional programs: As soon as possible given budget restraints and DMB permission for CSB to restructure positions and allocate savings to added peer slots.</p> <p>Volunteer enhancement and expansion: Underway no later than December 31, 2009.</p>	<p>workforce and apply savings to created peer positions.</p> <p>Volunteer enhancement and expansion: Likely need for admin support to operate efficiently and effectively.</p>

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	<p>Comparison will soon occur. The challenge will come in having the flexibility to create new positions from others.</p> <p>This work group believes, too, that people with lived experience should be sought for a wide variety of merit positions and not be solely employed in Peer roles.</p> <p>Finally, for those individuals who wish to be involved in helping others but who are not interested or able to engage in employment, meaningful volunteer opportunities should be available.</p>	<p>applicants with disabilities and, in fact, may not really be a requirement for the job.</p> <ul style="list-style-type: none"> <li>• Job postings should state that “Persons with disabilities are encouraged to apply.”</li> </ul> <p><u>Place More Peer Specialists throughout the system.</u></p> <ul style="list-style-type: none"> <li>• Provide a peer specialist presence at portals. Consider placing a peer greeter/aide in the lobby of each outpatient site, especially in the role of being able to offer welcoming assistance to individuals entering the MH system for the first time.</li> <li>• Examine what specialized clinical teams might benefit from adding a peer specialist.</li> <li>• Clinicians should be aware of openings for Peer Specialists and communicate opportunities to consumers they work with.</li> <li>• A Peer Mentor program should be established, using seasoned system</li> </ul>			

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		<p>peers as resources to new ones and each other.</p> <ul style="list-style-type: none"> <li>• Educate clinical, administrative and facilities staff on the value of peers within the system.</li> <li>• This work group strongly supports the Beeman Commission’s recommendation that MH be given flexibility to downgrade some clinical positions in an eventual right-size restructuring and use the savings to create additional peer specialist positions.</li> <li>• The CSB should consider financially supporting periodic peer specialist training for interested individuals to grow a pool of trained candidates. It is often difficult for consumers to afford the training that would make them able to qualify for these positions.</li> <li>• Make entitlements counseling available to peer specialists. Some individuals who apply for jobs receive entitlements</li> </ul>			

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		<p>and will be concerned that coming to work, even at the modest pay levels involved, may cost them more in benefits loss than they will gain in salary.</p> <p><u>Expand Volunteer Opportunities and Regrow the Volunteer Cadre.</u></p> <ul style="list-style-type: none"> <li>• Not all individuals who wish to contribute are interested in or able to engage in the work through paid positions. Volunteer opportunities would benefit the system and the individual.</li> <li>• MH Volunteer Coordinator should attempt to enlist some volunteers to act as regional volunteer leads at outpatient sites, with the intent of enlisting neighborhood assistance with transportation of consumers, etc.</li> </ul>			
<b>Strategy 4.9</b>					
Invest in and enhance peer-run drop-in centers	Mental Health Services currently provides \$214,926 annually to help support three consumer operated drop-in centers in	Offers of specific training and consultation should be enhanced an expanded to include: <ul style="list-style-type: none"> <li>• Financial and office management practices.</li> <li>• Finding and pursuing</li> </ul>	MH Contracts Manager and designated clinical staff.	As soon as possible, employing available partnerships with other agencies as	Interagency and non-profit partnership facilitation and, in some cases, targeted training dollars from CSB and other sources.

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	<p>Fairfax County. That money is allocated with \$54,366 going to a center in Reston, \$80,280 going to one at Seven Corners and \$80,280 going to a drop-in center in south county. The MH Contracts Manager is also available as an ongoing contact and consultant, offering technical assistance on the contract, management consultation around business and financial practices and clinical consultation. Additionally, clinical staff has offered to provide training and consultation around clinical issues such as managing aggressive behavior and other clinical safety issues. Having said all this, more support is needed to ensure the viability and growth of these three important resources.</p>	<p>grant opportunities and other funding sources – growth and autonomy can not rely solely on county dollars. On Our Own in south county has already had some success in this arena, but further resource development assistance should be made available to all.</p> <ul style="list-style-type: none"> <li>• Conflict resolution skills and, perhaps, MANDT training.</li> <li>• Facilitating establishment of vocational resources at drop-in sites, including partnerships with DRS and other agencies. Some of this is currently underway.</li> <li>• Training center staff in helping center participants secure benefits and entitlements.</li> <li>• Work with center staffs to establish training for participants in WRAP, Peer-to-Peer, etc.</li> </ul> <p>While additional funds from the CSB are not available in the current financial situation, and should, in</p>		<p>a first approach and helping facilitate those steps that involve financial and personnel resources as they become available.</p>	

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		<p>principle, only be a portion of blended funding to operate drop-ins, it should be noted that some CSB add-on funding, when possible, is a worthwhile investment. It is an investment both in the overarching principle of Recovery, as well as a specific life-line for many individuals – especially those living in settings like woods and streets – who do not trust a government-based treatment delivery system, but who will find opportunities for haven and growth within a consumer operated drop-in center. Furthermore, drop-in centers, while reliant on some volunteer efforts, must be able to hire a core staff and pay those staff members a reasonable wage. For example, the current Reston drop-in site has been forced to rely heavily on volunteers and is only able to reimburse paid staff at a rate of \$10 per hour.</p> <ul style="list-style-type: none"> <li>Recommend that the CSB look for opportunities to increase funding amounts as</li> </ul>	<p>CSB and MH senior staff</p>	<p>Dependent upon financial situation.</p>	<p>Capital</p>

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		soon as financial circumstances permit and to set this as a priority.			
<b>Strategy 1.9</b>					
Establish an Office of Consumer and Family Affairs with well defined responsibilities and a leader who reports to the CSB Executive Director	Per the CSB Executive Director, this position has been approved by DMB and will be going to recruitment soon (please see appendix for position posting). It will be a high-level position with responsibility for developing consumer-run services with consumer groups, applying for grants and generally ensuring that all disability programs within the CSB – not just Mental Health - have Recovery and Self Determination efforts as vital elements of treatment partnerships. In hiring for this position, lived experience will be a preferred qualification.	Support this welcome initiative	Executive Director and assigned staff.	Final hire within 3-4 months	Being addressed

## **Service and Coordination**

**Service and Coordination Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 4.3</b>					
	<p>CSB uses Language MHT/Case Manager to describe case management services. This lends to confusion for staff providing case management services and consumers receiving the service. CSB has moved to using term Clinical case management with outline of services and functions provided. This approach can be expanded to include MR Case Management and ADS Case Management CSB currently advertises in the recruitment process for MHT/Case Manager, Senior Clinician with the expectation that both positions provide case management.</p>	<ol style="list-style-type: none"> <li>(1) Address Language confusion in CSB use of Case Management/Therapist.</li> <li>(2) Define both case management and therapy clearly to include core functions roles to assist staff, consumers, and consumer support network to understand service design.</li> <li>(3) Consider CSB recruitment and advertisement for case managers and therapist.</li> <li>(4) Terms should be defined and consistently used for all disability areas of the CSB.</li> </ol>	<p>Senior Management HR Specialist Program staff from each disability area</p>	<p>30 days from review</p>	<p>Time limited workgroup with representation from all disability areas of the CSB. Consultation with HR Services. Review of Case Management Study completed by the CSB with Community Partners in early 2000 (Peggy Kane and Tom Schuplin may be a resource for this document).</p>
<b>Strategy 4.3</b>	<p>Case Manager provides care coordination and linking as a core part of case management function. The 90-day Service Plan Review process should</p>	<ol style="list-style-type: none"> <li>(1) CSB needs to incorporate face-to face team meetings or telephone conference to allow for ongoing</li> </ol>	<p>Program Managers Supervisors Case Management Staff</p>	<p>Immediate</p>	<p>Written Program Procedure Audit of 90 day review plan to ensure collaboration Review of process in supervision.</p>

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	include the consumer, case manager, treating psychiatrist, consumer support network and community treatment providers as the approach to developing and reviewing the individualized consumer recovery plan. Team approach should be strength based and not crisis driven. CSB utilizes a team approach concept but needs to move toward implementation of the process.	participation of case management team (2) Case manager should take primary responsibility for team meeting coordination with consumer support			
<b>Strategy 4.3</b>	CSB utilizes a Single Accountable Individual (SAI) concept. This allows for the consumer to have an identified case manager to provide and assist with service needs. "MHT/Case Managers", Senior Clinician/Case Managers provide both case management and therapy within mental health services.	(1) A separate cadre of staff that provides case management services should be in place. (2) Provide therapy as a separate targeted service and refer consumer for therapy to community resources. This is currently facilitated by the ACCESS unit, case manager/therapist and Adult Partial Hospitalization. (3) Leadership needs to clarify core work of the CSB Mental Health Service	Executive Management provides direction  Division Managers provide strategies guidance for implementation and monitoring  Program Manager provide supervision and training for implementation, guidance and monitoring  Program Staff implements and provides feedback on the process	90 days to develop strategic implementation plan	Human Resource Consultation CSB training Committee Consultation on training resources Time limited workgroup with representation for all disability areas.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		<p>delivery system across disability areas.</p> <p>(4) Leadership needs to provide a mission and vision statement as it relates to the core work of the CSB system across disability areas with guidance for implementation and accountability.</p> <p>(5) CSB to define job title, core job function and method of implementation for case manager and therapist across disability areas.</p> <p>(6) CSB to provide training in case management to assist in addressing staff attitude/culture that views case management as "lesser service".</p> <p>(7) CSB to develop and implement policy and procedure to review documentation tools to ensure current assessment tools are reflective of strength based approach to</p>			

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		services and quality assurance utilization review to ensure consistent implementation.			
<b>Strategy 4.4</b>					
	<p>The CSB has the framework for providing continuity of care. Efforts at transitioning through the CSB system have been "clumsy" for consumers and family members. Not having a clear understanding of who is available to assist them in navigating the CSB system has been a problem. Case management as a centerpiece for mental health offers the opportunity for support and improved access to service with minimal confusion. Consumer and family member of the workgroup highlight model of a single contact person to coordinate services as a major improvement in the CSB system.</p>	<p>(1) Case manager to follow the consumer and family throughout the service delivery processes excluding consumers who initially access the system through special programs.</p> <p>(2) Transfer process to program services should be seamless. Transfer process should include face-to-face meeting with the consumer, consumer support network, case manager and key treatment providers. Transfer process should include case review, progress report, updated treatment plan and service needs. Transfer process should be interactive. Consumer satisfaction should be</p>	<p>Division Directors Program Managers Program Staff Community Partners</p>	<p>90 days to develop implementation plan</p>	<p>Time limited workgroup with representation from all disability areas and community partners as needed.</p> <p>Written Procedure Supervision Training</p> <p>Consumer survey and consumer statement as ongoing part of treatment process.</p> <p>Community Partner Survey, Staff feedback</p>

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		<p>reviewed ongoing during the treatment process.</p> <p>(3) Accountability mechanism for providers to ensure that evidence based, best practice services are provided with a strength based recovery focus is in place to review service provision within the CSB.</p> <p>(4) 4) Mechanism for communication with community partners involved in the service delivery process needs to be developed and consistently utilized. Case review process should include consumer, consumer support network, community service providers and CSB staff as the norm and not just as a result of crisis situations.</p>			
<b>Strategy 4.5</b>					
	CSB has implemented programs that provide community based services and crisis intervention	(1) Provide skill training for staff to address safety issues outreach, crisis	CSB Training Committee CSB County Attorney CSB IT Staff	90 days to develop strategic implement-	Utilize internal staff resources for training PACT team, Mobile Crisis Intensive Case Managers

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	<p>services with limited resources. The CSB programs that currently provide community based treatment are the PACT Team, Intensive Case Management, Jail Diversion, Older Adult Services and some site based CTR case managers.</p>	<p>intervention and service engagement with consumers in the community.</p> <p>(2) Leadership statement supporting community based services with guidance on CSB support resources to ensure staff and consumer safety.</p> <p>(3) CSB to review vehicle insurance policy to support staff utilization of own vehicle in the transportation of consumers to increase transportation options to support community based work.</p> <p>(4) CSB to provide technical resources to facilitate community based work, laptops, wireless cards, cell phones, remote access cards.</p> <p>(5) Develop strategy to maximize mental health support services to supplement CSB community-based</p>	<p>Executive Leadership Senior Leadership</p>	<p>ation plan</p>	<p>Consultation with training Committee Consultation with County Attorney</p>

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
services.					
<b>Strategy 4.7</b>					
	<p>Families that are exhausted with the task of supporting a family member with mental health issues find it difficult to engage in community based family support resources. Family members that have consumers in residential placement or living situations outside of the home are more likely to utilize community based family support resources. The CSB provides limited respite services through MR services and Crisis Care program. The focus of family support needs to expand to include resources that offer stressed families relief focused interventions. The CS currently provides site based family support groups, individual family support/therapy services</p>	<ol style="list-style-type: none"> <li>(1) Increase planned respite options to assist families to have "normalized" quality of life activity periodically will increase family's willingness to maintain the consumer in the family home.</li> <li>(2) Development of respite subsidy program that assist families with payment for private respite in the home to allow for community outings.</li> <li>(3) Provide resource education and training on family interventions for case managers providing community based treatment.</li> <li>(4) Incorporate family education as a core component of CSB residential programs. Include site-based respite as a component of family support service design.</li> </ol>	<p>Program Managers Supervisors Program Staff NAMI Recovery Workgroup</p>	<p>120 days to develop a strategic plan</p>	<p>NAMI Family-to-Family Training. Development of a Cadre of Family volunteers. CSB Training Committee. Limited workgroup with representation from all disability areas.</p>

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		<p>(5) Explore open access to existing residential programs family groups. Family member of workgroup conveyed the value of family support at the Corner Stones Program. A family education and support group to provide support in assisting family members in encouraging treatment participation for family member with co-occurring issues.</p> <p>(6) CSB support in establishing a family leadership role in the CSB to provide outreach, education and support to families in the community, building on the peer specialist concept to include a family support focus.</p>			

## **Services and Models**

**Services and Models Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 4.10</b>					
Overarching strategy is to develop co-Occurring capability in all MH and ADS programs and to create specialized co-occurring enhanced assessment and treatment programs.					
1. Develop structure for VASIP.	Completed	N/A	N/A	N/A	N/A
2. Complete COMPASS.	Completed	N/A	AIC with input from Transformation. Steering Committee	1 May 09	N/A
3. Develop structure for change agents.	Completed, but can be modified as needed	Change on call for specific projects	Deputy Director	N/A	N/A
4. Formation of MH/ of MH/ADS Senior Leadership Team & Transformation Strng Comm. Str Comm.	Completed	N/A	Supervisors	Ongoing	N/A
5. Integrated CSB Adult Assessment.	Completed and Implemented	Continued training and modify as needed	CSB Director of QA	1 May 09	N/A
6. Drug and Alcohol Screening Procedure.	Procedure and initial training completed	-Need integrated CSB Consent for Services to address screening -Ongoing supervision and support for staff -SYNAPS audit for code 166.	MH Managers SYNAPS Team	Ongoing 30 Dec 09	

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
7. Consumer/Client Transfer Process.	OIS Written	Create a transfer oversight team that can handle complex or difficult to place transfers.	Manager of Entry and Referral (MH) and Director of	1 Sep 09	N/A
8. Integrated CSB Youth Assessment.	Piloted	Complete Pilot and fully implement.	Assessment and Referral Center (ADS).	Not Known	N/A
9. Diagnosis Workgroup to determine guidelines for diagnosing.	Draft due at end of March	Diagnosis formulations staff responsible	CSB MH and ADS Managers Medical Director	1 Jul 09	N/A
10. Affirm Definitions for Co-Occurring Capable & Enhanced Programs and Staff.	Completed but not widely distributed	Disseminate definitions	Transformation Steering Committee	15 May 09	N/A
11. Enhance collaboration and cross-training between MH and ADS staff.	Ongoing	Continue and expand	Managers provide oversight and support; supervisors implement	N/A	N/A
12. Concept paper on client choice should be utilized in staffing venues.	Paper is complete but has not been widely distributed	Disseminate	Transformation Steering Committee	15 May 09	N/A
13. Determine which programs will be co-occurring enhanced.	Draft was done by AIC and given to MH/ADS Senior Leadership Team	Finalize and Disseminate	Transformation Steering Committee	15 May 09	N/A
14. Fully develop and formalize co-occurring enhanced Continuum of Care.	Enhanced programs are programs exist but do not function as an integrated continuum	-Identify existing enhanced programs -Identify gaps -Create integrated	Transformation Steering Committee	15 May 09	N/A

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
15. Create fully integrated MH/ADS Entry and Assessment Unit.	Collaboration currently exists between two separate units. Preliminary talks have been held about integration.	<p>programs/teams (e.g. integrated MH/ADS case mgmt/treatment teams in each part of the county) -Co-locate agencies at main sites.</p> <p>Full integration via consolidation of teams and reworking of business practices.</p>	Transformation Steering Committee and Senior Management	Jan 11	COE Staff
16. Develop and implementing/peer supervision curriculum focused on enhanced core competencies for all clinical managers.	Under development	Get input from stakeholder. Utilize AIC and Change Agents to establish process.	Director of ADS	30 Feb 2010	N/A
17. Provide a variety of training and supervision opportunities focused on developing the core competencies for co-occurring capability.	<p>MH and ADS training committees are currently separate.</p> <p>A variety of trainings are offered through the CSB and in the community (NVMHI).</p> <p>VASIP monies fund specific co-occurring trainings.</p>	<p>-Merging of MH/ADS Training Committees</p> <p>-Disseminate info about trainings in the community and encourage attendance</p> <p>-Encourage staff to attend VASIP trainings</p> <p>-Supervisors provide feedback to training committee regarding needs for specific trainings.</p>	<p>Deputy Director</p> <p>Training Committee(s)</p> <p>Supervisors</p> <p>Supervisors</p>	30 Feb 2010	<p>Dependent upon training budget and community</p> <p>VASIP Monies</p>

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 4.11</b>					
1. Jail Diversion Housing Grant.	Sequential Intercept Model II in development	-Work with Sheriff's Dep't to develop and finalize processes -Hire 1/2 time case manager -Establish and hire two peer support specialists	MH Manager for Jail Diversion Program	1 Jul 09	NA- Positions already funded
2. Roll Call Trainings with Police.	Has been done in the past; due to hiring of new officers, need to do more trainings	Contact all police stations and set up training dates	MH Manager for Jail Diversion Program	31 Oct 09	N/A
3. Jail Diversion Regional Housing Grant.	Initial Discussion Phase	Collaborate with Region HPR2 to finalize proposal for state	MH Clinical Director	Unknown	Unknown
4. Community Restoration for Competency to Stand Trial.	In early phases	Train more clinicians to do community restoration (preferably group trainings)	MH Manager for Jail Diversion Program	Unknown	N/A
5. Development of joint CSB MH/ADS discharge planning team modeled on state hospital discharge planners.	One discharge planner from jail diversion currently responsible for only those clients returning from WHS and CSH to the ADC and the community (under ETO or Restoration orders).	Create team with MH and ADS discharge planners to work under ACS/ADS out-patient (matrix managed) OR Entry/ARC; team would also link clients to other services in community.	Transformation Steering Committee	Jan 11	\$150K(2FTE)

# Housing

**Housing Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 5.1</b>					
Support the Housing First model and efforts to maximize housing as outlined in the County's Ten-Year Plan to End Homelessness	New Office to End Homelessness is being established. Director appointed. BOS Housing Committee has CSB recommendation to include 2400 additional homeless persons with disabilities among those to be served. Current Ten Year Plan counts only approximately 600 individuals with mental disabilities living on the streets. The CSB has also converted approximately 10 units from CSB leases to individual leases with support.	<ol style="list-style-type: none"> <li>1. Secure Board of Supervisors revision of Ten Year Plan to include 2400 additional low-income persons with mental and physical disabilities among homeless to be served under the Plan and a ten-year goal of housing those individuals.</li> <li>2. Immediately expand housing for low-income persons with mental and physical disabilities by making available approximately 155 consumer-leased housing opportunities that become available during FY 2009 and again in FY 2010 through DHCD voucher, public housing, and rental assistance programs.</li> </ol>	Deputy County Executive for Human Services, CSB Director, Office to End Homelessness Director, Director of the Department of Family Services, Director of the Department of Housing and Community Development	September 2009	Approximately \$1 million annually for increased subsidies and structural modifications -- costs offset by savings resulting from decreased utilization of expensive emergency services, hospitalizations and incarcerations.
<b>Reference 5.1</b>	CSB currently operates four Housing First Programs and most all of Pathway Homes programs have been Housing First model for many years.	<ol style="list-style-type: none"> <li>3. Increase number and availability of Housing First units. CSB to provide support to homeless people residing in units</li> </ol>	Office to Prevent and End Homelessness. CSB staff	ongoing	Staff time, political will.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Reference 5.1</b>	CSB partners with Pathway Homes in the provision of units utilizing Housing First concepts.	4. In conjunction with 10 Year Plan, explore options to increase number/ availability of Housing First Programs utilizing grant funding, Medicaid, private funds	Office to End Homelessness, ADS/MH Director of Residential Services, DHCD, Housing Nonprofits.	ongoing	Staff time, Grant writer
<b>Reference 5.1</b>	CSB Homeless Services Manager key participant in Ten Year Plan workgroup relating to HOST and Housing First.	5. Continue to participate in the Ten Year Plan to Prevent and End Homelessness	CSB Homeless Services Staff	ongoing	Staff time
<b>Reference 5.1</b>	The CSB has identified barriers to utilizing Housing First principles and has worked with partners to amend agreements to increase flexibility needed in Housing First model.	6. Request that the Housing Resources Committee of the Ten Year Plan to End Homelessness include a mechanism to regularly collect information from housing and support providers regarding barriers and potential solutions to utilizing Housing First principles. Specifically request the Housing Resource committee address potential solutions to issues regarding poor credit and criminal backgrounds.	CSB Executive Director to make request to Housing Resource committee of the Ten Year Plan to End Homelessness for inclusion in group charter	June 1, 2009	Staff/committee time

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Reference 5.1</b>	Key CSB staff participate in committees, workgroups and forums of the Ten Year Plan to End Homelessness	7. Continue CSB representation on existing committees	CSB Homeless Services Staff	ongoing	Staff time
<b>Strategy 5.2</b>					
Engage individuals receiving services, families of individuals receiving services, and national and local nonprofit organizations in expanding housing options with accompanying support services	Ten Year Plan to End Homelessness calls for establishment of a Foundation to encourage public-private partnerships to increase supportive housing opportunities.	1. A. Set as a priority for the new foundation the creation of public-private partnerships to provide supportive housing to low-income persons with mental and physical disabilities. B. Develop pro bono partnerships with local attorneys and bankers to create opportunities to acquire foreclosure properties at depressed prices. Secure stimulated government funding opportunities for acquisition. Fannie/ Freddie consultation, family bequests.	Office to End Homelessness, CSB Executive Director, Director of DHCD, Director of DFS, CSB Director of Consumer and Family Affairs, Consumer Advisory Group of 10-Year plan, CSB Site Development Team, Private Housing Developers.	February 2010	Access to legal, banking and family prospects.
<b>Reference 5.2</b>	Limited options for consumers receiving intensive residential services to step down to more independent housing and services	2. Create additional capacity for step-down options for individuals residing in existing higher-intensity programs and develop a continuum of housing and flexible services that enable consumers to be served at the appropriate	Existing providers of intensive residential services throughout the county, CSB, DHCD, DFS, OPEH	TBD	Staff time for better coordination. Also, the various levels exist but there aren't enough of them. Add new resources (see 5.1)

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		level based upon their changing needs.			
<b>Reference 5.2</b>	Inconsistency between level of support service needed and Medicaid or other reimbursable options to provide these services and be compensated.	3. Maximize use of entitlements and develop resources to fund support services for those who do not qualify for entitlements.	County, CSB, DFS, OPEH, DMAS, DBHID	TBD	Collective advocacy, staff time, fundraising experience
<b>Reference 5.2</b>	Third party payee/mentor payee functions essentially not being used or severely underutilized.	4. Explore development of a "clinical concierge" service to address third party payee/mentor payee responsibilities for identified consumers Explore provision of triaged support to include payee, and support service needs targeted to families and supports/consumers capable of providing payment for care coordination, and other brokerage options. Many elderly parents have indicated a willingness and need for secured services for loved ones to be built into trusts, wills, etc.	Director of Consumer and Family Affairs.	TBD	Research, staff time
<b>Reference 5.2</b>	Creative supportive housing partnerships such as with the Brain Foundation/Pathway Homes exist in	5. Specifically target funding through resources such as CCFP to fund support services and secure more private non-profit	Private/non profit housing developers and service providers.	Ongoing	Resources to fund support services such as CCFP grants

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	moderation.	partnerships to advance similar models.			
<b>Reference 5.2</b>	Utilization of family members as partners in the provision of supportive housing options is limited or non-existent.	<p>6.A. Identify potential candidates and recruitment of identified parents/family members that will purchase or bequeath real estate for targeted non-time-limited services.</p> <p>B. Develop long term, in home housing and support services for consumers in their own "private homes."</p> <p>C. Match trained/ qualified citizens to provide housing and supports for homeless/ disabled consumers in their homes (similar concept to adult foster care). Stipends would be secured through consumer contributions, philanthropic, ecumenical, and government funding</p>	Director of Consumer and Family Affairs, CSB, DFS, private providers.	Ongoing	Time allocation, staff time to develop and coordinate
	Limited or non-existent use of private practitioners to assist with needed services for consumers.	7. Identify and recruit local private practices and licensed clinicians to pledge to commit to providing a designated number of pro bono services each year.	TBD	TBD	Committee designated, staff time for outreach and development.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Reference 5.2</b>	Underutilization of the Faith Community as partners in the creation of supportive housing options.	8.A. Engage ecumenical/ faith community of over 2,000 existing congregations in Fairfax County to each sponsor one individual in an apartment with a rent subsidy. B. Engage congregations to utilize their land and property to develop and build a housing unit(s) for persons with disabilities.	Faith Communities in Action, Interfaith Liaison, Hypothermia Network, Nonprofit Housing Developers, CSB, DFS, DHCD	TBD	Committee designated, staff time to develop and coordinate.
<b>Strategy 5.3</b>					
Create a housing development fund to support housing for persons with disabilities	New Office to End Homelessness will establish a Foundation. Under the auspices of the Foundation, such a fund could be created.	9.A. Conduct outreach to non-profit community and faith-based organizations to expand housing opportunities (i.e. construction by faith based organizations, business-CSB partnerships, etc) B. Use Consultant to Identify resources in public and private sector. C. Review related work of the Technical Assistance Collaborative. D. Review Successful Models from Fairfax and other communities such as Options Program, Housing Trust Funds. Describe current known	A. Office to End Homelessness CSB Executive Director, Director of DHCD, Director of DFS B. CSB site development and DBHID. D. CSB MH and CSB MH Vendors	February, 2010  FY 2010  FY 2010	Potential seed funds from the County  Consultation Budget  Survey current partners on federal, state and local level

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	Annual Application to county from CSB	<p>sources of funds for MH housing and assistance.</p> <p>E. Partner with Disability Associations. Contact NAMI, Urban Institute, etc. for shared research on funding for Mental Health.</p> <p>F. Explore use of Proffers such as Loudon County's for group home development.</p> <p>G. Review FFX Co Capital Improvement Program (CIP) priorities and plan with County Leadership Team to include more housing higher in the priority list.</p> <p>H. Consult with Universities and other Philanthropic organizations to research the use of Endowments.</p> <p>I. Centralize tracking of grant applications and submissions occurring across the county.</p>	<p>E. CSB Mental Health Advisory Committees, MH Committee, NAMI</p> <p>F. CSB Mental Health and Site Development Staff and Dept of Planning and Zoning.</p> <p>G. Deputy County Executive for Human Svcs and agency specific/DHCD and CSB</p> <p>H. Human Services Staff who have worked with fundraising through Endowments</p> <p>I. Dept of Management and Budget</p>	<p>FY 2010</p> <p>FY 2010</p> <p>October, 2009</p> <p>FY 2010</p> <p>FY 2010</p>	<p>Staff to coordinate some community dialogues and agendas with other partners in the field</p> <p>Review and Analyze with Fairfax Land Use Staff</p> <p>Capital Construction Funds from Fairfax County Bond Program</p> <p>Development and fundraising staff</p> <p>Tracking then Staff hours for applications</p>
<b>Strategy 5.4</b>					
Explore existing systemic challenges between housing and	Some coordination between CSB and DHCD but no	1. Under auspices of Office to End Homelessness, establish a Disability	Office to End Homelessness, CSB Executive	April 2010	Staff time

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
mental health services in order to optimize collaboration for the benefit of persons with psychiatric disabilities	systematic, broadly-constituted or on-going strategic coordination of policies, programs or services. Currently, separate wait lists exist without full integration resulting in duplication. Initial effort to establish CSB/FRHA/DSB policy coordination group and staff-level working group on hold pending BOS action on CSB policy recommendations	<p>Housing Clearinghouse that will coordinate matching of persons/families in need with available housing opportunities.</p> <p>2. Establish County-wide informed consent process and documentation, which included DHCD, in order to facilitate sharing of client information across public and private agencies to increase housing and supportive services coordination.</p> <p>3. Amend FCRHA Bylaws to include specified representatives from DSB, CSB, DFS, and OPEH on the commission.</p>	Director, Director of DFS, Director of HCD, Office of the County Attorney (informed consent)		
<b>Reference 5.4</b>	The CSB collaborates with DHCD to perform reasonable accommodation requests. There is no standard timeline or consistent process on how decisions are made with these requests	Have a standard process and a point person in DHCD that can make decisions and communicate those decisions to the CSB in a timely manner.	DHCD and CSB	September 1, 2009	DHCD staff and CSB staff
<b>Reference 5.4</b>	The CSB collaborates with DHCD on several different housing projects. Different staff in both agencies have	Create a standard process and a point person in DHCD and the CSB that will have the knowledge and ability to make decisions on the	DHCH and CSB	September 1, 2009	

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	to communicate with various staff in the other agency. There is no point person in DHCD or the CSB to pull information and process together on the various programs. The special needs of persons with disabilities often get ignored in the standards bureaucratic processes, often resulting in consumers inappropriately getting dropped of wait lists.	varying programs that the CSB and DHCD have collaboration, and work with CSB and DFS to develop more effective ways to take into consideration the special needs of and interact more effectively with persons with severe disabilities.			
<b>Reference 5.4</b>	There is no regular stream of housing for individuals served by the CSB that is provided by DHCD	Create a process that will have DHCD provide the CSB with a consistent housing stream to meet housing needs of the individuals we serve. Establishing a disability Housing policy that includes a significant increase in the number of housing opportunities available to the individuals we serve.	DHCD	December 31, 2009	DHCD policy change and Housing
<b>Reference 5.4</b>	CSB Consumers get dropped of the housing wait list because a letter is sent requiring them to respond before a certain date, which they often don't succeed at for a variety of reasons	DHCD provide a blanket reasonable accommodation that any such consumer with a disability who has been dropped off the list be placed back on as of the date they first applied.	DHCD	September 1, 2009	DHCD Policy change and Housing

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	(hospitalizations, etc.) and they get dropped of the list.				
<b>Reference 5.4</b>	The CSB collaborates with DHCD on several different housing projects. Different staff in both agencies have to communicate with various staff in the other agency. The CSB collaborates with DHCD on several different housing projects. Different staff in both agencies have to communicate with various staff in the other agency. There is no point person in DHCD or the CSB to pull information and process together on the various programs.	Create a point person in DHCD and the CSB who will have the knowledge and ability to make decisions on the varying programs that the CSB and DHCD need to collaborate and coordinate closely on.	DHCD, CSB	September 1, 2009	DHCD Policy Change and Housing

# Employment

## **Employment**

**Still to do: Staff Responsible/Target Date/Resources Needed for Completion needs input from CSB senior managers.** The Workgroup did not feel it was in a position to know where existing positions could be re-aligned, who the appropriate CSB staff would be, what competing priorities are. **In most cases, it was our belief that no new resources were needed but rather that a realignment and systems change could lead to the desired results.**

**Overall priorities** follow below, with more detail within each strategy:

1. Establish staff with vocational responsibilities, starting with a high management level position and then insuring there are vocational liaisons established throughout the system to champion/educate/mentor on an ongoing basis.
2. Change CSB position descriptions/performance evaluations to include some expectation that employment related services are part and parcel of the therapeutic process. Individual performance objectives should reflect organizational objectives; if it is not spelled out staff person by staff person, there's no reason to believe it will happen.
3. Create a one stop/no wrong door system. Co-locate vocational providers - public and private - just a cubicle away to insure staff and consumers have regular access to information and services. The hallway conversations, staffings, etc. provide far greater training than any formal training.

**Measures for all strategies: The workgroup felt strongly that in the absence of clear measures and rigorous evaluation of those measures, systems change will not occur in a meaningful, lasting way. You cannot improve what you cannot measure. People do what you inspect, not what you expect. A possible starting point regarding measurement of employment rates could be the statistics compiled from the vendors who are currently providing direct services to CSB or from DRS where a consumer is referred for employment services with the assumption that once exposure and education is provided with all the recommended actions, then their statistics would indicate improvement or not.**

Therefore, for all strategies, create, implement and share a dashboard of key indicators/outcomes for individual staff and organizations as a whole, including the CSB and its vendors. Individual staff measures would be tracked and evaluated by supervisors. CSB organizational measures would be tracked and evaluated by the CSB Board of Directors. Vendor organizational measures would be tracked by the CSB Contract Manager. The major measure for each SAI would be the rate of change (“delta”) for each client, and for the CSB and its vendors the rate of change on a macro level. Possible measures include: (measure baseline for each of these) 1) number clients expressing an interest in working or school; 2) number who become employed; job placement; job retention; wages; benefits on the job; hours worked; number successful linkages to a benefits counselor. Number in school; number volunteering. Pay for performance must be tied to the measures – the data – that are fair and rigorously evaluated. HR would need to be included.

Train supervisors and team leaders regarding expectations, measures, outcomes and evaluations. Train and provide oversight to ensure outcomes are directly tied to merit increases (once we have them again....). “Break the mold.” Concern expressed that any workplace can create inertia. However, we hope that with all of these resources put in place, there would be changes. To avoid this, individual, organizational and

contract merit increases must be tied to meeting realistic outcomes/targets such as: “x” linkages/connections made; “y” % of clients who state they wish to work become employed. Dai Nguyen has experience developing employment measures and can be helpful to the CSB. It is important to provide support and training to the CSB and its vendors, as well as holding the CSB and its vendors accountable to outcomes.

Strategy	Current Status	Recommended Actions	Measures
<b>Strategy 6.1</b>			
<p>Implement employment services, consistent with the principles of evidence-based supported or individualized employment.</p>	<p>Buy-in by SAIs is not consistent. Employment as a routine goal for all clients is not in place.</p>	<ul style="list-style-type: none"> <li>• Consumers initiate self-referral to employment services through their SAI and/or IRTT.</li> <li>• Create a vocational assessment tool that includes interest in paid employment, volunteer work and/or education. Expect that SAIs will routinely use this tool with their consumers to insure ongoing vocational needs assessment occurs. Tool includes follow up linkages with names and numbers of contacts and when/if those contacts were made. Build into the system a mechanism to insure that the referral/linkage occurred. Includes current benefit status and link to benefits counseling that will clarify the impact of employment on current benefits/incentives. Implement WorkWorld in CSB computer system agency-wide such as what Jean Hartman is in the process of installing in PACT computers.</li> <li>• Add vocational component to the ISP.</li> </ul>	<p>Measure baseline and then measure change (increase) in the % of consumers on a caseload who are actively working on an employment goal; measure baseline and then measure change (increase) in the % of consumers on a caseload who are working.</p>

Strategy	Current Status	Recommended Actions	Measures
		<ul style="list-style-type: none"> <li>• Market employment/education/volunteerism to clients via PSAs in the lobbies, etc. TVs with continuously running looped tape with information about clients working, etc. Sell them on the idea of becoming employed. Create a “yellow pages” for vocational.</li> <li>• Hold seminars/panels/resource days for clients.</li> <li>• Train and educate family members.</li> <li>• Create more flexibility with job descriptions for CSB staff based on need to focus on vocational/education. Redefine the role of the case manager/SAI. Add expectations/ clear measures and evaluation mechanism to all performance appraisals. Involve HR at the county level to review job descriptions.</li> <li>• Providers, consumers and family members have to see results to embrace the reality that persons with psychiatric disabilities do work successfully.</li> </ul>	
<p>Employment supports are integrated with mental health treatment.</p>	<p>System integration is poor. IRTT attempts to provide an arena for such integration but needs to happen on the SAI level. Staff expectations have tremendous impact on results; there is</p>	<ul style="list-style-type: none"> <li>• Expand referral avenues beyond IRTT and its requirement of SAI to complete referral form; encourage, support and permit direct referral for consumers.</li> <li>• Explore shared</li> </ul>	<p>Measure baseline and then measure change (increase) in % of clients on caseload who are part of ID team meetings regarding supported employment.</p>

Strategy	Current Status	Recommended Actions	Measures
	<p>inconsistent awareness and belief that persons with psychiatric disabilities can work, as well as inconsistent case management activity to lead to a successful employment outcome.</p>	<p>assessments/information/updates across network of providers such that there is electronic integration rather than silos. Integrate the data bases of all vocational organizations with the CSB. Integrate forms that are currently being used by PACT to the rest of the CSB.</p> <ul style="list-style-type: none"> <li>• Create and provide interagency trainings regarding resources. Change the entire focus of the ISP from problem-focused to person-centered/solution focused (Grieder and Adams). Always ask at intake “What are your hopes and dreams? What have you accomplished?”</li> <li>• Educate staff about meeting clients where they are at. Train staff to proactively engage every client to facilitate their movement towards education/employment. Train staff on motivational interviewing, on customer service focus. Hire staff based on such skills and passion. Training staff re: how the many aspects of working can be integrated into case management conversations with clients – such as how to ride the bus, how to shop, what to wear, etc.</li> <li>• Determine provider roles and required KSAs (knowledge, skill</li> </ul>	

Strategy	Current Status	Recommended Actions	Measures
		<p>and abilities) to provide consumers with the skills they need to be competitive. KSAs include demonstrated ability to proactively engage and facilitate movement.</p> <ul style="list-style-type: none"> <li>• Place vocational resources in the same buildings where SAI offices are located. No wrong door – one stop approach within CSBs or other provider settings such that all resources are available in one place. The role of the provider/SAI is to assist client with stabilization and help set goals in other areas of life. It is important that the SAI and the consumer have access to all resources on site.</li> <li>• Survey clients at each site to learn what would help them, what supports they have received, etc.</li> </ul>	
<p>Services are focused on competitive employment as the goal.</p>	<p>This depends on the vendor and the consumer's needs. There are many individualized jobs, job carving opportunities and Ability One jobs in the community. Generally, services are focused on competitive employment.</p>	<ul style="list-style-type: none"> <li>• Employment vendors in the lobbies of all CSB sites to provide materials and resources. A resource guide created and given to every client.</li> <li>• A peer navigator is offered to every client to guide and support, and to orient clients to expectations and roles as an employee.</li> <li>• Pictures on the walls throughout the facility of people “who look</li> </ul>	<p>Measure baseline and then measure change (increase) in % of clients on caseload who are working.</p>

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Strategy	Current Status	Recommended Actions	Measures
		like me” working. Inspirational visuals - show employment success and possibility in every way. “Treat me as a person not as a disease” on the walls.	
A rapid job search approach is used.	DRS and its vendors support this model. It is getting more difficult to place clients in jobs of their choosing and preference given the current economy.	CSB staff needs training on the research that supports this approach.	For contract agencies: length of time from referral to placement; tenure within jobs once placed.
Job finding is individualized with attention to consumer preferences.	This depends on the specific vendor and the specific consumer’s needs and preferences. There are many individualized jobs, job carving and Ability One jobs in the community.	<ul style="list-style-type: none"> <li>• Training and education system/provider-wide about the research base of the use of individualized job choosing. Analyze employer needs and emerging trends for the future labor market. Then determine training needs for clients to fit those jobs. Booz Allen Hamilton has done such a study for SOC.</li> <li>• Push Fairfax County as an employer to hire persons with psychiatric disabilities in all departments, not just the CSB.</li> <li>• Explore Projects with Industry whereby ServiceSource is partnering with INVOA to determine their employment needs.</li> <li>• CSB establish a Business Advisory Council.</li> </ul>	Client surveys demonstrate 80% satisfaction with their jobs, with the number of hours they are working, with their pay, etc.
Supports are ongoing.	Mixed. There is not enough resource to meet all the long term needs.	<ul style="list-style-type: none"> <li>• Create a peer navigator role within the system to facilitate ongoing individualized support from intake onward.</li> </ul>	Measure baseline and then measure change (increase) in % of employed clients who are receiving long term supports.

Strategy	Current Status	Recommended Actions	Measures
		<ul style="list-style-type: none"> <li>Strengthen the ID team that includes: client, vendors, DRS, facility based CSB vocational liaisons, SAI. Require regular meetings between the client and the ID team.</li> <li>Tap Ticket to Work (see Strategy 6.3) to build capacity by increasing dollars available for long-term supports.</li> </ul>	
Benefits counseling is used to educate consumers on the effect of earnings on benefits	Benefits counseling: resources exist somewhat but not being adequately tapped or linked up with. This is probably the single MOST important action that must take place early on.	<ul style="list-style-type: none"> <li>Determine benefits resources that currently exist. Create more technical resources (i.e incorporate WorkWorld into SAIs' computers for easy access).</li> <li>Train and educate CSB/providers why it is so critical that benefits counseling must be one of the first topics assessed and the implications of benefits.</li> <li>Have a benefits specialist on site.</li> <li>Have a peer office on site.</li> <li>Train and educate family members.</li> </ul>	Measure baseline and then measure change (increase) in % of clients on caseload who receive benefits counseling. Measure baseline and then measure (decrease) in length of time between intake and benefits counseling.
<b>Strategy 6.2</b>			
Identify an employment liaison to facilitate collaboration at the system level in order to reduce barriers that hinder employment and expand opportunities that promote employment.	There isn't such a function. Interestingly, there used to be vocational liaison staff housed within the CSB.	Create "employment czars" or vocational liaison whose role is to be at the table with senior CSB managers/leaders, and well as have a presence at each CSB facility. Could be done by redesigning/realignment of current	Employment liaisons identified and in place at every CSB site. CSB staff and clients report through surveys that they have access as needed.

Strategy	Current Status	Recommended Actions	Measures
		<p>roles/CSB resources for existing positions OR create new positions if resources permit. First choice of workgroup is realignment of current CSB resources to make this happen. Vocational liaison is the hub of the wheel of the ID team. Day to day operations, linkages, education and training of CSB staff a part of the role. Another approach is to partner differently to get to this same strategy; invite DRS staff to be deployed to each CSB facility. Other measures must include SAI customer service actions (measured by client surveys like a 180 degree evaluation for individual staff by the persons they serve).</p>	
<b>Strategy 6.2</b>			
<p>Access the federal funding for Ticket to Work by creating an employment network.</p>	<p>There are a number of local Employment Networks (EN) who provide services to adults recovering from mental illness. The new federal regulations adopted last July 2008 make it more attractive for organizations to take tickets. DRS is also an EN and can receive cost reimbursement for any ticket holder. It is our understanding that at the current time, The CSB cannot become an EN.</p>	<ul style="list-style-type: none"> <li>• CSB staff awareness and education about how to facilitate client access to their tickets. Ask at intake if the client has a ticket. If the answer is “no,” develop decision tree of questions to drill down because sometimes clients do have tickets but are not aware that they do. A decision-tree will help frame the training and procedural process for SAIs to work from.</li> <li>• CSB staff be provided training on Social Security work incentives and the updated regulations regarding Ticket to Work to insure maximum use of benefits planning for all</li> </ul>	<p>Measure baseline and then measure change (increase) in number of clients who have been determined to have tickets, and whose tickets are “in use” somewhere within our system of care.</p>

Strategy	Current Status	Recommended Actions	Measures
		<p>consumers.</p> <ul style="list-style-type: none"> <li>• Any consumer who is receiving Social Security benefits and has a Ticket to Work should be identified routinely via the IRTT referral process and/or referral to DRS or any other vocational provider to insure maximum utilization of the Ticket to Work benefits.</li> <li>• SAs and vocational liaisons help clients and staff learn about the ticket.</li> <li>• Support ENs/DRS moving forward with their MOAs that will strengthen the ability of the network of providers to access tickets, maximize their use and build additional capacity in the system such as increased dollars for long term supports.</li> <li>• Tap Maximus/CESSI to provide training.</li> </ul>	
<b>Strategy 6.4</b>			
<p>Strengthen connections with local educational institutions in order to support adults wishing to further their education.</p>	<p>This is an area that has not been addressed at all. LMEC offers computer training. PRS offers Adult Education. There is much to learn and put in place.</p>	<ul style="list-style-type: none"> <li>• Educate entire system including clients and providers about what supported education is. Identify existing resources such as tutors or services that may already exist within the community college or university system.</li> <li>• Explore disability services within the schools for 18 – 22 year olds.</li> <li>• Train and educate staff about how to access existing</li> </ul>	<p>Measure baseline and then measure change (increase) in % of clients on caseloads who are involved in educational activities.</p>

Strategy	Current Status	Recommended Actions	Measures
		<p>resources.</p> <ul style="list-style-type: none"> <li>• Explore legal requirements for schools and systems to provide such support/accommodations to persons with disabilities if the supports are not in place. Involve VOPA.</li> <li>• Replicate LMEC model of getting college credit for their courses through NVCC. Analyze what LMEC does that leads to success in their computer training programs and replicate across the system.</li> <li>• Research/benchmark other jurisdictions nationally. Do a literature search. Study Boston University which has a robust supported education program in place for its students.</li> </ul>	

## **Primary Health Care**

**Primary Health Care Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 7.1</b>					
Better assess and share health care needs by meeting and looking at the same (uniform) health history tool.	Individual programs use their own checklists, self-assessment medical history tools.	Include SYNAPS checklist/ medical history form (share widely) with referral to other non-CSB agencies.	Dr. Hand, Dr. Glossa (CHCN Medical Director, Molina)	Fall 2009	Staff
Better assess behavioral health (BH) by using a uniform assessment tool (e.g., PHQ questionnaire).	CHCN is in the process of implementing the brief PHQ (BH assessment tool) at the CHCN health centers.	Establish protocols and implement uniform assessment tool throughout the CHCN sites and other primary health care sites.	Dr. Glossa, Chris Stevens	Summer 2009	Staff, Staff education
Establish point of contact person/liaison – have an established mechanism to obtain information for both enrollment and treatment from primary and behavioral health programs.	There is an established liaison between the CHCN and the CSB (Judy Cornecelli).	Identify and educate staff about their program liaison, established points of contact and protocols.	Key member(s) of each organization	Summer 2009	Staff
Establish a mechanism to exchange patient information.	Lots of barriers (with some exception for those who use the “multi-agency authorizations to exchange information”) among programs that are serving the same consumers.	a) Request a legal opinion – what ideas does HIPPA actually allow? b) Once “a” (above) is determined, educate staff on HIPAA.	Dr. Hand will take the lead in consulting with the County Attorney and HIPAA Coordinator for the County.	Fall 2009	County Attorney, HIPAA Coordinator (Sharon Arndt), Staff, Staff education
Implement a shared EMR (electronic medical record).	SYNAPS is the CSB’s ECR (electronic clinical	Explore implementation of a shared EMR among key primary health and	Program staff (program and IT representatives	Complete within two years (Spring	DIT, IT staff for each program, County Leadership, Staff

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	record). Currently, there is no shared record by providers. Information, such as medication updates, would be beneficial to better care for consumers.	behavioral health providers.	from each agency) and DIT	2011)	
Explore the possibility of the CSB and other behavioral health providers utilizing the streamline eligibility system (SES).	Primary health care "safety net" providers use the SES currently. SES shows if a consumer already is enrolled in one of the local safety net medical homes.	Utilize the SES by behavioral health care. Begin with the CSB, PRS, and Pathway Homes.	Dr. Hand, Chris Stevens, SES Steering Committee	Fall 2009	Staff
Establish a Medicaid (DMAS) interface with the Streamlined Eligibility System (SES).	During the needs assessment and implementation of the SES, Medicaid (DFS) staff participated with the goal of integrating/interfacing the two systems. Contact was made with DMAS leadership to explore interface possibilities by executive committee members, such as JoAnne Jorgenson.	Explore with DMAS an interface between SES and DMAS (Medicaid).	Sandy Ovuka with County Leadership,	Spring 2011	SES Steering Committee representatives, substantial program and IT staff resources
Use skill building to hire consumers to be "health promoters." Charge	PRS has "Leisure Coaches" Recovery Group	Coordinate efforts between the two groups and peer specialist or	PRS	Winter 2009	Staff (program and fiscal/reimbursement)

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
Medicaid for mental health support services.	qualified para-professionals (QPP).	peer support specialists.			
DFS staff to provide information about other health resources to applicants anytime there is a Medicaid denial. DFS staff should facilitate CHCN enrollment as appropriate.	Many DFS staff members routinely provide a list of health resources when there is a Medicaid denial.	(a) Build on the current practice to ensure that all denials are followed up with health resources. (b) Explore ways to actively facilitate enrollment into CHCN.	Sandy Ovuka, Cheryl Jones	Summer 2009	Staff
DFS – prevention – medical card/ Medicaid card should come with clearer instructions. One-to-one advocacy is ideal or a “one-to-one” orientation group.	DFS staffs Health Access Assistance Teams (HAAT) at each CHCN site. HAAT members explore health resources and educate consumers about using health resources.	Build on the goals/ success of HAAT by educating consumers on how to use health resources; explore with DMAS additional educational tools for new Medicaid recipients.	Sandy Ovuka, Cheryl Jones	Fall 2009	Staff, IT - SES infrastructure/ programming costs
Implement the HAAT model at Woodburn.	DFS staff members are currently at Woodburn two times per month, IMP weekly and Cameron Glen monthly. They determine eligibility for Medicaid only.	Expand the current model by increasing hours, increasing sites and explore all health resources (not just Medicaid).	Sandy Ovuka, Cheryl Jones, DFS Leadership, Dr. Hand	?	\$\$\$ Additional staff resources to explore 50/50 Medicaid match
Expand primary health care to other sites (beyond CSB).	Nursing students from GMU currently rotate to PRS.	Use CHCN and other resources (private).	Inova, Tax credit	?	Money

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
Recruit psychiatrists to provider pro-bono services (organized charity care model).	There are localities within the US that have an organized charity care model to provide behavioral health/ psychiatric services. CHCN has an organized charity care model for specialty care.	Explore models and methods to establish a volunteer network of psychiatrists.	Dr. Hand	Begin effort (meeting) Fall 2009	Purchasing, program staff, legal, IT
Provide education to CHCN staff to provide a better environment for patients SMI and improve the environment of the health centers so they are more "SMI-friendly."	CHCN has in-services to increase staff awareness of needs of patients with SMI.	Provide an in-service periodically for all CHCN staff so they have a better understanding of the needs of patients with SMI.	Dr. Hand, Chris Stevens	Summer 2009	Staff
Increase Medicaid providers locally <u>and</u> improve the "consumer to doctor" match.	Currently, the match of a consumer to a Medicaid doctor is less than desirable, e.g., an adult is sent to a pediatrician, someone who lives in Alexandria is assigned a doctor in Reston. DFS staff has shared concerns with DMAS.	"Lobby" DMAS to recruit more providers. Share information with DMAS about the poor "consumer to doctor" match process.	County and DFS leadership	Initiate meeting with DMAS Spring 2009	Staff
Further integrate CHCN and CSB by increasing psychiatric hours at CHCN and increasing primary care doctor hours at the CSB.	CSB provides a psychiatric to each of the three CHCN health centers one full day every month. CHCN sends a doctor	Increase medical doctor hours to Woodburn, increase sites, such as Northwest and Mt. Vernon.	CSB and Health Department leadership.	2011	Funding

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	to Woodburn to serve consumers one morning per month.				
<b>Strategy 7.2</b>					
Establish a larger group to explore modification of the primary health care system.	The County has an established Health Care Advisory Board.  Many discussions within various groups have taken place about FQHCs. The FQHC model has limitations and benefits. One key benefit discussed was the federal requirement for expanded services, such as behavioral health, dental and specialty care.	Study work that has already been done with the County and Inova.	Health Care Advisory Board (HCAB) - take the lead.	Fall 2009	Staff
<b>Strategy 7.3</b>					
Monitor federal and state progress regarding initiatives related to expanded coverage, including universal health care coverage.	County staffs from various agencies monitor progress related to state and federal initiatives.	Identify staff to actively monitor federal and state initiatives.	County legislative staff.	Ongoing	County legislative staff
Establish a task group to explore the feasibility of a locally developed group health insurance plan.	In the past State legislative session, there was a proposal for a shared state, employee, employer health plan. It did not pass.	Request the HCAB to establish a task group to explore the feasibility of a locally developed group health insurance plan.	Health Care Advisory Board (HCAB)	Make the request of the HCAB to take the lead/ coordinate with CSB in Spring 2009	Staff

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<b>STRATEGY</b>	<b>CURRENT STATUS</b>	<b>RECOMMENDED ACTIONS</b>	<b>STAFF RESPONSIBLE</b>	<b>TARGET DATE FOR COMPLETION</b>	<b>RESOURCES NEEDED</b>
Increase enrollment into CHCN (primary health care) for eligible enrollees, including consumers with SMI.	Currently the CHCN limits gross family income of enrollees to 200% FPL or below. Other local safety net providers have increased their income eligibility to 250 or 300% FPL.	Increase income eligibility in CHCN from 200% of the Federal Poverty Level (FPL) to 250% FPL.	CHCN's Community Advisory Committee	Summer 2009	Staff

## **Workforce and Training**

**Workforce and Training Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 8.1</b>					
<p>Define the needs of recipients by conducting a comprehensive needs assessment.</p>	<p>Although we have participated in various types of assessments (ROSI, Beeman focus groups, etc), we have not conducted a thorough needs assessment of current or potential recipients of services. As a result we have too often responded to funding streams or perceived needs, rather than strategically planning programs and types of staffing to target the verified unmet needs of the community and corresponding specific levels of service.</p>	<p>Core competencies of staff, their roles and responsibilities will be clarified during this process and may very well result in new programs, new positions descriptions and new qualifications for various positions in class series to better align services with need.</p>	<ul style="list-style-type: none"> <li>• Executive Director</li> <li>• Leadership Team</li> </ul>		

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
Develop a strategic projection of staffing needs by type and number for 3 and 5 year periods based upon needs assessment and overall strategic plan of the agency.		Strategic projects based on unmet community need increases the strength of our argument with the BOS to seek increased flexibility as it will be easier to demonstrate economies.	<ul style="list-style-type: none"> <li>• Executive Director</li> <li>• Leadership Team</li> </ul>		
Gain BOS support to remove current restrictions on numbers of positions when there is no adverse budgetary effect.	Much improvement has been made in flexibility through the Workforce Planning process in recent years, however a major hurdle remains with the BOS prohibition against establishing new positions even if there is no adverse impact on the budget or even if there is a positive gain. The only way around this prohibition is via designated non-County funding streams to create merited grant positions, but this is insufficient.	Preparation of a presentation to the BOS with a specific request for new procedures allowing the CSB more span of control than current limitation of abolish-establish or designated funding streams for new positions. Presentation would demonstrate: <ul style="list-style-type: none"> <li>• economies achieved by aligning positions and programming directly to need and mission</li> <li>• linkage to CSB strategic plan to implement Beeman recommendations and transition to a new service model</li> <li>• efficiency of addressing needs not met in the private sector</li> <li>• benefit to the BOS in planned position projections.</li> </ul>	<ul style="list-style-type: none"> <li>• Deputy County Executive for Human Services</li> <li>• CSB Board</li> <li>• Executive Director</li> </ul>		

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 8.2</b>					
Define staff technical competencies based on comprehensive needs survey described above.	Competencies at the Division Director level are in draft. None have yet been developed for lower echelons. In practice we have emphasized professional licensing and advanced degrees with less emphasis on competencies to address continuity of care, outreach, active case management, vocational assistance, benefits planning, co-morbid challenges, & direct assistance skills.	Complete the process of defining technical competencies for all positions. Provide feedback from needs assessment to the workgroup. Ensure that new emphasis on systems transformation to recovery and resiliency-oriented system is captured. Plan for how competencies will be communicated to staff and workgroup on re-writing position descriptions (see below). Also consider how competencies can be used for recruitment and in the interview process to develop behaviorally oriented questions.	Current succession planning/career development project group with follow up on interview plan via agency HR manager working with hiring managers.		
Adopt the Individual Development Plan model to encourage and support professional development in these new areas of competencies.	The IDP is used sparingly in Mental Health, though it has been introduced via the Beacon. Use of the IDP separate from the Pay for Performance process gives the message that management is interested in staff's professional development. Pairing with identified competency areas	Supervisory staff should complete training and introduce to subordinate staff so that it becomes more unusual to not have a plan than to have one. MH leadership should consider use of job shadowing, mentors, cross-training, etc to explore creative opportunities for staff development which will enhance agency capacity. The younger workforce is likely to make more job	HR staff to provide training on IDP for supervisors and managers.		

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	demonstrates our value of these new competencies as "professional".	changes, so we should look for less siloed development opportunities (e.g., inter program, inter disability area, or even inter-agency). MRS/IDS are making some progress in this area.			
Gear all future trainings to align with staff competencies, skills and knowledge areas identified by the needs assessment, evidence-based and best practices.	trainings are not consistently strategically aligned to mission	Since we are anticipating the need for a skill set that has not been emphasized before there will be a need for re-training. Therefore we should align training with competency areas as much as possible similarly to the County's model.	MH Leadership to communicate training priorities to the training committee.		
Improve efficiency in training by utilizing available technology.	Most training is provided via a group seminar format which involves many staff hours in travel, time away from primary assignment and results in outcomes of varying value. Potentially we could save staff time and improve the value of some trainings if we considered alternate formats.	Automate routine repeated training such as OSHA, universal precautions and communicable disease training (e.g., via Risk Management's online courses for OSHA training or DMHMRSAS' online training on HR regulations paired with application Q&A training with local expert). These and potentially trainings that would be conducive to a computer-based training format can be packaged as required modules to complete with pre and post tests during staff's routine schedule. This could also be used for	Task training committee or a project group to identify trainings which could be more effectively and efficiently provided in a different format.		

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		special training such as online training in Person Centered Planning via Cornell University's School of Industrial and Labor Relations Employment and Disability Institute.			
Utilize peers or family members in interview panels for MH leadership and provider positions.	Occasionally but rarely used.	Although this may not be practical for every position, we should see as routine for any high level positions, residential settings, and perhaps second interviews whenever practical elsewhere in the system.	Hiring Managers		
<b>Strategy 8.3</b>					
Adopt a policy statement from the Board of the CSB defining this ethos.		Executive Director to work with the Board to adopt such a position/policy statement and define implications.	<ul style="list-style-type: none"> <li>CSB Board</li> <li>Executive Director</li> </ul>		
Define a career ladder establishing a Peer Classification Series that includes a "minimum experience qualification" vetted by HR & HIPAA Compliance.	This is in process with an active work group comprised of CSB staff, peer employee, and HR Compensation and Workforce analysts. Job class specs are in draft form. HIPAA Compliance Officer (HCO) has been approached.	The County's HCO already has concerns about this series. We recommend these objections be handled at the higher echelons using the experience of the Georgia Project and perhaps NY State where such positions have been established successfully.	Workgroup to complete classification series with addition of Will Williams to workgroup. Executive Director help vet through HCO and County Attorney's office.		Utilize experience, reference materials, and contacts available through the Georgia Certified Peer Specialist Project <a href="http://www.gacps.org/Home.html">http://www.gacps.org/Home.html</a>
Include formatted "preferred qualification" or	We do not actively and consistently seek applicants with lived	One of our concerns is that if we only establish specific peer positions, but do not	<ul style="list-style-type: none"> <li>Executive</li> <li>HR Manager</li> <li>HCO</li> </ul>		

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
"encouraged to apply" stmt on advertising of all MH and admin support positions that is vetted by HR and HIPAA Compliance.	experience (sans ADS) and there is still internal stigma so that overall providers are generally not yet encouraged or comfortable disclosing.	honor recovery from mental illness as an enhanced KSA for all positions we will not have fully participated in system transformation.			
Train hiring managers and supervisors re ADA, accommodations, HIPAA with employees, use of EAP, etc.	Training is available through the County but not specific to psychiatric disability.	Enlist Human Resources to customize their training of both those conducting interviews/supervisors and job seekers to cover issues related to psychiatric disability.	<ul style="list-style-type: none"> <li>• CSB HR Manager-Chris Miracle</li> <li>• HR Employment Division-Sherry Rowe</li> </ul>		
Link successfully employed peers and their managers/supervisors to help train managers/supervisors who will be supervising peers for the first time.	There is no formally coordinated effort although some of this has occurred by virtue of current peers being employed in the same division.	This is a means of using natural influencers to set a positive tone on the value of employees in recovery to co-workers, team-effort, and individuals served. It can lower anxiety and raise support as clichés and theoretical constructs about recovery are replaced with practical applicable testimonies. It is a format to help new supervisors of peers witness the value of peer-to-peer services; understand its place in comprehensive treatment and communicate that to other staff; and troubleshoot supervisory issues and share guidance (e.g.,			Use of some resource such as National Association of Peer Specialists Training Manual may also be helpful.

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		on supervising peers re self-disclosure and negotiating contextual boundaries, etc).			
<b>Strategy 8.4</b>					
Increase the availability of WRAP groups throughout the County.	There are at least 16 Certified Wrap Facilitators (CWF) in NOVA, but we are not running many groups. CWF need to run groups to stay current and be eligible for train-the-trainer certification (see below).	<ul style="list-style-type: none"> <li>• Establish a pool of CWFs to provide 2 WRAP classes in each of the three areas of the County (i.e., North, middle, and South) for a total of 6 continuously running classes. The second class in each area would begin concurrent with the halfway session of the first class so that there would be no more than a 4-week wait for individuals before they could enroll in a class.</li> <li>• Deploy CWF from their “home” programs to provide these classes to the community.</li> <li>• WRAP classes could be held at the MH Centers, but may better lend themselves to meeting sites more reflective of community integration such as library meeting room or other community-based setting.</li> </ul>	<ul style="list-style-type: none"> <li>• Director of MH and Division Directors to redeploy CWFs.</li> <li>• Managers/ Supervisors to educate staff re schedule of availability of new classes.</li> <li>• CWFs to publicize among community of potentially participants.</li> </ul>		WRAP Books and training materials, meeting places, AV equipment, stipends for CWF who are not providing as part of their employment with CSB or its contractors. ~\$450 per class.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
Sponsor regional peer specialist certification training.	There are currently 6 peers directly employed by the CSB or its contract agencies who have completed Peer Specialist. Certification training. The excellent training was provided a contractor selected by the State and funded through a technical asst grant which has expired. There are no timely plans for future training at this point. We propose to contract with the same proven provider to ensure consistency of quality.	<ul style="list-style-type: none"> <li>Contract with the Mental Health Association of Southeast Pennsylvania to run a certification class for up to 20 participants. Training to be sponsored and funded Regionally.</li> <li>Prioritize participants: 1st CSB employees; 2nd Contract Agencies; 3rd Other interested individuals</li> </ul>	<ul style="list-style-type: none"> <li>Regional CSB Execs</li> <li>Regional DAD \$ decision-makers (what is the official name of Cindy's group?)</li> <li>Contract-sponsor (Prince William CSB?) for sole-source contract</li> <li>Regional MH Directors to identify participants</li> </ul>		<ul style="list-style-type: none"> <li><input type="checkbox"/> Contract with MHA of Southeast Pennsylvania</li> <li><input type="checkbox"/> Maximum of 20 participants</li> <li><input type="checkbox"/> ~\$30,000 in costs</li> </ul>
Sponsor Consumer Empowerment and Leadership Training (CELT) for individuals interested in advocacy and leadership.	CELT is provided throughout the year now but usually not locally. Peers often find the distance and cost prohibitive. Next training is 5/19-22. Chris Owens is the contact through the MHA of Virginia	<ul style="list-style-type: none"> <li>Establish as standard training for peer employees and peers serving on the CSB</li> <li>Encourage for individuals interested in volunteer advocacy, participating in a speakers bureau, or serving on advisory boards</li> <li>Look for grant money to fund and possibly channel through MH</li> </ul>	Utilize CSB Public Information Officer to establish related speakers bureau and Contracts staff to establish training contract. CBO development officer to seek funding grants?		CELT cost \$425 per person (not including expenses) or can be accomplished in a retreat format for \$1300 per person inclusive of lodging and food. A minimum of 10 participants are required to hold a training.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		Foundation <ul style="list-style-type: none"> <li>Use to establish a speakers' bureau and strengthen a network of peer advocates for anti-stigma efforts, board participation, and public hearing testimonies.</li> </ul>			
Sponsor at least 2 peers to complete the Advance Level WRAP Facilitator training (i.e., train-the-trainer) through the Copeland Center.	There are no CWFs in FFCCSB who are certified at the advanced level to train other WRAP facilitators. Therefore everyone who wants to become a CWF has to go away for the training. Minimum of one week and most are out of the NOVA area.	Sponsor two CWFs to complete the training and employ them to train future Wrap facilitators. Requires acceptance into the program with selection made by Copeland staff on stringent standards. It would require us to identify viable candidates to make application and have a plan to utilize their services (i.e. fund future trainings) upon their graduation in order to gain an efficient return on the training investment.			Training is provided through the Copeland Center. Contact is Nancy Haleman at <a href="mailto:nancy@copelandcenter.com">nancy@copelandcenter.com</a> or 1-866-436-9727. Cost is approximately ~\$2500 per person. Minimum of two persons must be trained by there requirements. Admission is competitive. Applicants must first be active experienced CWFs.
<b>Strategy 8.5</b>					
Develop accountability standards for all echelons.	We have not had clearly articulated performance and productivity standards. We have started to standardize some productivity standards (see below), but do not have consistently articulated	In order to demonstrate high expectation we need to communicate defined roles for each echelon and the shared responsibility for all echelons, i.e. higher echelons will be evaluated on the performance of lower echelons. For example: Division Directors will design programs which	Supervisory chain and assigned workgroups.		

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	performance standards (varies from supervisor to supervisor).	address client need and maximize Medicaid revenues; Managers will refine programs and allocate staff based on SYNAPS reports and transformation to recovery goals; Supervisors will monitor and evaluate subordinates performance in relation to productivity goals; Clinician will partner with clients to develop and implement behaviorally-oriented treatment plans based on functional assessments and individual recovery goals.			
Complete work begun by MH Leadership to set productivity standards.	MH Leadership has begun to set standards (current proposal for 24 hours/wk for line staff and 12 hours per week for supervisors)	Base standards on client needs, acuity level, intensity of service, setting of service, etc; rather than on caseload size. Once standards are set and approved, develop a communication plan to affected staff and identify how the standards will be monitored.	MH Leadership, Division Directors, Managers and Supervisors		
Provide reliable, relevant, and regular utilization reports.	There are inconsistencies in what data is tracked and how it is communicated	Determine which reports will be monitored. Communicate both individual and aggregate team results through supervisory chain so that progress can be celebrated			

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		and the need for improvement can be highlighted and a corrective plan implemented. This should be done on a set schedule such as monthly or quarterly so that feedback is relatively current. Consider whether the Quality Improvement Plan process would be a helpful tool here if communicated to frontline staff.			
Build in a feedback loop to gather ideas from staff on how to improve efficiencies.		The magnet hospital standards and SAMHSA report on workforce development cited in the Beeman report, both list involvement in data collection and input into service delivery decisions as preferred criteria in organizations that retain strong staff. Frontline staff may miss the forest but they have a good view of trees and management will need to partner with strong frontline staff to make progress.	Supervisory chain		
Limit the development of new programs or initiatives to those which are indicated in a needs assessment,	New initiatives (i.e., groups or elements of programs to whole new programs) are sometimes birthed	Managers and supervisors should review what activities (groups, etc) are being offered through their programs and evaluate in	Executive Director through supervisory chain		

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
preferably an evidence based or best practice, and not otherwise available in the community.	from the interest of staff but without demonstrated need or consideration of availability in the community. In a new world of shrinking resources and higher demand for accountability and a value of facilitating community integration; new initiatives need to be evaluated for alignment with our mission before they are implemented.	light of new productivity and performance standards, comprehensive assessment, and vision statement and make changes accordingly. Similarly they need to communicate with staff these same criteria when considering new avenues.			
<b>Strategy 8.6</b>					
Make this principle explicit from the leadership via example, training, and stated expectation.	There is no clear standard and we are inconsistent in the degree of practice and understanding of Person First language. We need to address at all levels in internal and external communications.	<b>W Set Expectation</b> W Review W Correct W Train W Monitor  See below	CSB/MH Leadership send directive explaining principle and reasoning, steps to be taken to actualize Agency's commitment.		W APA Guidelines for Non-Handicapping Language in APA Journals W DMHMRSAS Guidance bulletin No. 2007-01 W Examples of People First Language <a href="http://www.disabilityisnatural.com">www.disabilityisnatural.com</a>
Review all language in class specifications, position descriptions, electronic health record, & CSB web site and public information for	We are aware of inconsistencies in our communications. The Anasazi workgroup has begun to look at the language of the PGOs and other	<b>W Review</b> W Correct W Train W Monitor	W HR Manager or Competency Workgroup looks for Person First Language in class specs and PDs.		W APA Guidelines for Non-Handicapping Language in APA Journals W DMHMRSAS Guidance bulletin No. 2007-01 W Examples of People First Language

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
adherence to the principles.	areas. No thorough review has been undertaken.		W PIO review website and PR materials. W EHR staff review language of the electronic forms.		<a href="http://www.disabilityisnatural.com">www.disabilityisnatural.com</a>
Initiate anti-stigma campaign in conjunction with MIAW which addresses language as a carrier or barrier to stigma.	We have helped sponsor a conference as but not strategically educated about stigma.	<b>W Correct</b> W Train W Monitor	PIO in conjunction with community groups and community based organizations		W APA Guidelines for Non-Handicapping Language in APA Journals W DMHMRSAS Guidance bulletin No. 2007-01 W Examples of People First Language <a href="http://www.disabilityisnatural.com">www.disabilityisnatural.com</a>
Train the Board Members of the CSB.	No specific training in person first	<b>W Train</b> W Monitor	Executive Director and designees who provide Board training and development. Include in orientation of new members.		W APA Guidelines for Non-Handicapping Language in APA Journals. W DMHMRSAS Guidance bulletin No. 2007-01 W Examples of People First Language <a href="http://www.disabilityisnatural.com">www.disabilityisnatural.com</a>
Train staff how to document to adhere simultaneously to utilization review requirements and person first principles.	no specific training in person first	<b>W Train</b> <b>W Monitor</b>	Include this training in all new employee training and monitor through supervisory review of assessments, treatment plans, and treatment plan reviews. Medical Director should also orient psychiatrists re this standard for documentation.		W APA Guidelines for Non-Handicapping Language in APA Journals W DMHMRSAS Guidance bulletin No. 2007-01 W Examples of People First Language <a href="http://www.disabilityisnatural.com">www.disabilityisnatural.com</a>

## **Data and Outcomes**

**Data and Outcomes Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 9.1</b>					
<b>Measure 1.</b> Percentage of adults admitted to a program indicating they are participating in the design and implementation of their service plan: Target 100% by June 2009.	Recorded manually. Consumer's signature on the plan in consumer's paper medical record.	<b>Step One:</b> Sample medical records for presence of participation in design and implementation of their service plan.	QA staff, supervisors and service providers	6/30/2009	QA Team to design and implement sampling procedures, write reports and follow up as necessary
		<b>Step Two:</b> Provide feedback to staff on status and monitor for any needed performance improvement.	QA staff	6/30/2009	
		<b>Step Three:</b> Recommend purchasing of signature pads for electronic health record.	QA & PIM Staff	TBD	Funds to purchase signature pads.
		<b>Step Four:</b> Identify and automate dash board measures in CSB's MIS, includes design, testing, implementing and monitoring MIS performance.	QA, PIM, work with Anasazi and DIT	TBD	A design team, take measures, map needed data elements to store and retrieve from MIS. Funds for MIS enhancements.
<b>Measure 2.</b> Percentage of adults actively participating in the annual review of their service plan: Target 100% by June 30.	Recorded manually. Consumer's signature on the annual review form in consumer's paper medical record	<b>Step One:</b> Sample medical records for presence of participation in annual review of their service plan.	QA staff, supervisors and service providers	6/30/2009	QA Team to design and implement sampling procedures, write report and follow up as necessary.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		<b>Step Two:</b> Provide feedback to staff on status and monitor for any needed performance improvement.	QA staff, supervisors and service providers	6/30/2009	
		<b>Step Three:</b> Recommend purchasing of signature pads for electronic health record.	QA & PIM Staff	TBD	Funds to purchase signature pads.
		<b>Step Four:</b> Identify and automate dash board measures in CSB's MIS, includes design, testing, implementing and monitoring MIS performance.	QA, PIM, work with Anasazi and DIT	TBD	A design team, take measures, map needed data elements to store and retrieve from MIS. Funds for MIS enhancements.
<b>Measure 3.</b> Percentage of adults reporting positively about social connectedness at admission to a program and at discharge from a program: Target TBD	Recorded manually in narrative format in consumers' electronic medical record. Elements of social connectedness are captured manually in text boxes in the Adult Assessment Form section on Recovery Environment.	<b>Step One:</b> Define the measure. This measure is equal to number of consumers who are involved in education, have housing, have health insurance, can access primary health care, employment status, leisure/recreation, social roles, peer support groups, self-determination, and religion/spirituality.	QA staff, supervisors and service providers	6/30/2009	QA Team to design and implement sampling procedures, write report and follow up as necessary
		<b>Step Two:</b> Determine which measures of social connectedness are currently available in the medical record.	QA & PIM Staff	6/30/2009	
		<b>Step Three:</b> In the adult assessment form add elements of social	QA & PIM Staff	9/30/2009	QA Team to design and implement sampling procedures, write report and

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		connectedness defined above by state and federal reporting requirements and benchmarks being studied by the University of Pennsylvania's Federally Funded Collaborative on Community Integration.			follow up as necessary
		<b>Step Four:</b> Identify and automate dash board measures in CSB's MIS, includes design, testing, implementing and monitoring MIS performance.	QA, PIM, work with Anasazi and DIT	TBD	A design team, take measures, map needed data elements to store and retrieve from MIS. Funds for MIS enhancements.
<b>Measure 4.</b> Percentage of individuals receiving services who are involved (incarcerated) with the criminal justice system at admission and at discharge.	Recorded in consumer's medical record assessment section on legal/ court status. Some elements are yes/no and others are captured manually in a text box.	<b>Step One:</b> Sample medical records for presence of completed section on legal status at admission, annually, and at discharge from CSB programs.	QA staff, supervisors and service providers	6/30/2009	QA Team to design and implement sampling procedures, write report and follow up as necessary.
		<b>Step Two:</b> Benchmark what should be added to the section on legal status/court status. Review elements collected in legal status section, modify as needed to capture not just incarceration. Need to include involvement with probation and parole, NGRI, violent offender, and sex offender status.	QA staff, supervisors and service providers, PIM staff	6/30/2009	QA Team to design and implement sampling procedures, write report and follow up as necessary.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
		<b>Step Three:</b> Identify and automate dash board measures in CSB's MIS, includes design, testing, implementing and monitoring MIS performance.	QA, PIM, work with Anasazi and DIT	TBD	A design team, take measures, map needed data elements to store and retrieve from MIS. Funds for MIS enhancements.
<b>Measure 5.</b> Percentage of individuals with a medical home (consistent provider of health care): Target 100% of individuals served have a medical home, including access to general medical, vision and dental services.	Limited information is captured manually in the consumer's medical record on status of having a medical home. Information is collected on medical history.	<b>Step One:</b> Sample electronic medical records for presence of completed session on medical admission, annually, and at discharge from CSB programs.	QA staff, supervisors and service providers	6/30/2009	QA Team to design and implement sampling procedures, write report and follow up as necessary.
		<b>Step Two:</b> Add elements to medical history section in the medical record to capture consumer's access to vision and dental care.	QA & PIM Staff	9/30/2009	Funds to purchase upgrades to MIS
		<b>Step Three:</b> Identify and automate dash board measures in CSB's MIS, includes design, testing, implementing and monitoring MIS performance.	QA, PIM, work with Anasazi and DIT	TBD	A design team, take measures. map needed data elements to store and retrieve from MIS. Funds for MIS enhancements.
<b>Measure 6.</b> Number of individuals served moving from housing waitlists to housing.	Adult residential waitlist data is captured manually. Monthly reports are generated by the	<b>Step One:</b> Explore ways to show how many consumers move off the various wait lists into housing.	QA staff, supervisors and service providers	6/30/2009	QA Team to design and implement sampling procedures, write report and follow up as necessary.

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	various adult residential program managers. This data is not available in the CSB's management information system.				
		<b>Step Two:</b> Explore ways to integrate these monthly reports into the CSB's manual reports on wait lists	QA & PIM Staff	9/30/2009	Funds to purchase upgrades to MIS.
		<b>Step Three:</b> Develop a data report matching current wait list to people admitted and discharged from adult residential units.	QA & PIM Staff	9/30/2009	QA Team to design and implement sampling procedures, write report and follow up as necessary.
		<b>Step Four:</b> Identify and automate dash board measures in CSB's MIS, includes design, testing, implementing and monitoring MIS performance.	QA, PIM, work with Anasazi and DIT	TBD	A design team, take measures, map needed data elements to store and retrieve from MIS. Funds for MIS enhancements.
<b>Measure 7.</b> Percentage of adults employed at admission and discharge: Target by June 30, 2009: 22%	Employment history is captured in the electronic medical record section on employment.	This is a National Outcome Measure (NOMs), reports can be generated from the MIS.	QA & PIM Staff	6/30/2009	As is
<b>Measure 8.</b> Percentage of adults receiving mental health services who receive an assessment appointment within ten business days of their first call for service: Target 100%	This data currently captured in the MIS in a monthly report titled "Entry to Access"	Continue running monthly reports.	QA staff	Monthly	As is

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
by June 30, 2009 (last quarter of FY 2008: 91%)					
<b>Measure 9.</b> Percentage of youth who receive an assessment appointment within five business days of their first call for service. Target: 100% by June 30, 2009 (last quarter of FY 2008: 17%).	This data is currently captured in the MIS in a monthly report titled "Youth Entry to Intake".	<b>Step 1:</b> Continue running monthly reports.	QA staff	Monthly	As is
		<b>Step2:</b> Establish an Access Unit for Youth and Family Services.	MH Director of Youth & Family and MH Management Team	TBD	Staffing and funding
<b>Strategy 9.2</b>					
Seek information from other organizations about successful approaches to serving the mental health needs of children, youth and adults.	MH Senior Management & CSB Deputy Director have researched and developed Access Team in Adult Services, based on Los Angeles CA model.	Continue Access Team efforts to design, implement, monitor and improve services.	MH Management Team - QA	Ongoing	As is
	Implemented monitoring units in Y&F and Adult Services to help track people waiting for services.	Continue utilizing monitoring units.	QA	Ongoing	As is
	CSB Y&F staff are participating in	Utilize resources available to the CSB from the	Director of MH Youth and	Ongoing	As is

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	County-wide service system initiative.	National Technical Assistance Center for Children's Mental Health at Georgetown University.	Family and MH Management Team		
	Y&F Director meets regularly with counterparts from other CSB's to gather information about successful approaches.	Continue to meet with others from HPR II to assess current and promising practices to serving those youth and family members with mental health needs.	Director of MH Youth and Family	Ongoing	As is
	Y&F Director attends quarterly VACSB statewide Youth & Family Council meetings to gain information about successful approaches to MH service delivery.	Continue to meet with others from HPR II to assess current and promising practices to serving those youth and family members with mental health needs.	Director of MH Youth and Family	Ongoing	As is
<b>Strategy 9.3</b>					
Conduct periodic analyses of system functioning to identify points for improvement.	Monitor initial Dashboard measures.	Continue	QA, PIM, Executive Staff	Ongoing	As is
	Run periodic utilization management and performance reports for various parts of MH system.	Continue	QA, PIM, Executive Staff	Ongoing	As is
	Analyze and monitor Adverse Incident Reports individually and review trend data.	Continue	QA, PIM, Executive Staff	Ongoing	As is

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<b>STRATEGY</b>	<b>CURRENT STATUS</b>	<b>RECOMMENDED ACTIONS</b>	<b>STAFF RESPONSIBLE</b>	<b>TARGET DATE FOR COMPLETION</b>	<b>RESOURCES NEEDED</b>
	Conduct periodic satisfaction surveys and review results.	Continue	QA, PIM, Executive Staff	Ongoing	As is
	Prepare risk management and corporate compliance plans and review activity regularly.	Continue	QA, PIM, Executive Staff	Ongoing	As is

# Technology

**Technology Recommendations**

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 10.1</b>					
<p><b>10.1-</b> Support improvements in efficiency and recovery through the purchase and support of a new electronic health record/personal health record (EHR/PHR) following county funding and procurement procedures. Funding for this recommendation would be considered through the county's IT Enhancement Fund.</p>	<p>DIT and CSB in agreement to move ahead with RFP; funding pending County decision.</p>	<p>1. Agreement within agency and County to move ahead; funding support to make purchase.</p>	<p>George Braunstein Cathy Pumphrey</p>	<p>TBD</p>	<p>Money identified in FY to be able to issue RFP. Anticipate one year to complete RFP process.</p>
	<p>RFI issued and returned on 2/17/09, 37 respondents; evaluation pending.</p>	<p>2. Issue an RFI to determine interest and available software; evaluate proposals; incorporate information into RFP.</p>	<p>Cathy Pumphrey</p>	<p>Review Completed by End of September</p>	
	<p>Reviewing set up in current product; purchase upgrade.</p>	<p>3. Assess current product and use of funds.</p>	<p>Cathy Pumphrey</p>	<p>Ongoing</p>	
	<p>Software is currently supported by DIT, servers in the Gov Center; previous review of ASP options with current vendor.</p>	<p>4. Review costs and options available for ASP site, or SAAS (software as a service).</p>	<p>Rick Dumas</p>	<p>Pending RFP</p>	

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	Ongoing discussion with DIT with identified sites.	5. Identify hardware and connectivity requirements, provide adequate support.	Rick Dumas/DIT	Ongoing	Funds, opportunities
	Application to stimulus package with Health Department for EHR solution.	6. Explore alternative funding sources and approaches. Review option of delayed payment, stretching payment out over time period.	Cathy Pumphrey	Awaiting Stimulus Package Decision; Alternative Payments Pending RFP	Grant possibilities
<b>Strategy 10.2</b>					
<b>10.2-</b> Purchase hardware (laptops and similar portable devices) that supports changes in business process.	Part of County 4 year PC replacement program; follow county standards for equipment.	1. Identify appropriate life cycle of equipment to make the most use of state of the art technology.	Rick Dumas	Ongoing	Flexibility in standards; funding to pilot equipment alternatives
	Buying increased number of laptops as part of PC replacement program as need is identified in the field.	2. Assess laptop/desk top ratio and need.	Rick Dumas	Ongoing, New Assessment to be Completed by Dec 2009	Funds to convert desktops to laptops; DMB option to increase # of PCs in replacement program
	CSB EHR staff regularly review new technologies.	3. Identify potential emerging technologies- set up CSB.org site to get ideas from staff, using a template for responses; work with EHR vendor to utilize state of the art mobile technologies.	Cathy Pumphrey/DIT	Sept 2009; Pending RFP with Vendor	
	Currently use DIT training rooms- not adequate supply. CSB training room at	4. Establish adequate training facilities for CSB. Consider using portable laptops on a	Rick Dumas	Re-establish Mt. Vernon Room by Sept 2009	Funds to purchase furniture and update computers

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STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
	Mt. Vernon taken down with renovation of that site.	cart as an option of being tied to a site.			
	Distribution of peripherals follows CSB IT Distribution Principles.	5. Include needed peripherals in assessment of needs (printers, etc).	Rick Dumas	Ongoing	
<b>Strategy 10.3</b>					
<b>10.3-</b> Establish, through a collaborative effort with the county Department of Information Technology, CSB-specific guidelines and procedures that provide CSB greater flexibility to grant authorized staff certain system administrative rights when using desktops, laptops, and related peripherals.	In initial Mt. Vernon relocation CSB staff was granted permission to move computers.	1. Identify opportunities for change- for example, relocation of staff with budget situation and Mt. Vernon renovation; review projects, apply changes to ongoing operations.	Cathy Pumphrey/ Rick Dumas	Project Specific and Ongoing	
		2. Review list of CSB Super Users and discuss administrative rights that would improve service delivery with DIT.	Rick Dumas /DIT	Fall 2009	Time allocated from superusers
<b>10.3-</b> Administrative rights for authorized CSB staff (continued)		3. Complete a gap analysis to determine which might be done by remote access to a desktop to increase efficiency.	Dick Jensen/DIT	TBD	

Appendix of the Workgroup Recommendations

STRATEGY	CURRENT STATUS	RECOMMENDED ACTIONS	STAFF RESPONSIBLE	TARGET DATE FOR COMPLETION	RESOURCES NEEDED
<b>Strategy 10.4</b>					
10.4- Facilitate access to information for individuals receiving services by extending public access to CSB sites and purchasing computer "kiosks" for key CSB service sites.	Sites not wired for public network access; proposed plan for 3-stage implementation of public access (large main sites, residential treatment, majority of staff computers).	1. Identify proposed points of access	Cathy Pumphrey	TBD	Coordination with DIT, Computers, printers, furniture, dedicated space at sites
	3-phase plan submitted with estimates of computers needed to DIT, asking for PC replacement computers.	2. Identify equipment needs and strategies to meet these (including software).	Cathy Pumphrey	1st Phase Completed	Equipment
		3. Pilot access	Cathy Pumphrey	TBD	
		4. Assess and Refine approach	Cathy Pumphrey	TBD	
		5. Develop a simple portal approach for both staff and individuals receiving services to access information that includes links to sites	CSB Communication Staff	TBD	Staff time to develop
		6. Assess ability for individuals receiving CSB services to utilize currently existing public access sites- Pennino, So County, Falls Church, Reston.	Cathy Pumphrey	July 2009	
		7. Review possibility of using donated equipment for public use	Cathy Pumphrey	July 2009	

Strategy 10.1 EHR/PHR

1. Include cost for support and maintenance of 2 systems.
2. Review possibilities of Software as a Service (SAAS) in addition to ASP model.
3. Consider I-net as an option at CSB sites:
  - a. Cost effectiveness for small locations
  - b. Study model of hot site at the Chantilly library
  - c. Look at ROI
4. Consider wireless network at group homes.
5. Review remote access to desk tops given space difficulties.
6. Explore video conferencing options at the desk top level (Jean to follow up).
7. Review levels of access needed by staff at particular sites.
8. Include interoperability.
9. Review of current product:
  - a. Cost of retraining staff
  - b. Potential for adjusts with current vendor- improve the product, redo current structure, etc.
10. Include electronic release.
11. Review the number of staff to support getting information out of the system and also number of staff to support the product.
12. Review the interface with the schools for children 0 to 3 and the transition time at age 22; also include the health department. Key would be to enter data once.
13. The application should support business model, IT is the vehicle for transformation.
14. Identify the role and importance of decision support and business intelligence in the purchase of the product.
15. Review possibilities for integration of PHR information (e.g. from Network of Care, etc), both with current product and for the future.

Strategy 10.2 Purchase hardware that supports business practices

1. Rotate stock of current computers – move newer equipment to hi end users, not everyone needs the same equipment.
2. Review the potential effect on changes on staff, training is only the tip of the iceberg.
3. Going to a web based system, and considering the size of the CSB, might drive product choice.
4. Upgrade memory of current stock.
5. Review options for shared use.
6. Review hardware options such as netbooks, handhelds; include discussion of WiFi, Wi Max

Strategy 10.3 CSB Administrative rights

1. Administrative rights vary by users.
2. Staff might install things like VPE files, Adding/removing Printers, Windows settings, software add/delete, registry updates/repair, Run LIVE update for antivirus, Defrag, Delete temp file and internet cookies, Install Thick Client
3. Update training of CSB Superusers.
4. Have super users identify for staff “things you can easily do” to make working on line easier such as changing font size setting, refresh rate, and ADA related issues.

Strategy 10.3 Public Access

1. Portal approach – include links to jobs, housing, Network of Care; application forms for programs.
2. Explore intranet (secure communication) options for communication back and forth between staff and individuals receiving services and their families; also email encryption.

Parking Lot of additional ideas:

1. Look at the state-wide standardization of forms, such as done in Ohio.
2. Make the County Web site easier to navigate- should be easier to reach the CSB main page. Consider a redesign using a focus group.
3. Review use of flash drives and CD's, including considering not having this option of computers with CD's to improve security.
4. Consider synching personal phones with outlook; also seamless integration of outlook and Electronic Health Record.
5. Consider stipend for staff using their own blackberries and phones so more staff can have these.

