CSB Board Work Session 6:00 p.m.

1. Meeting Called to Order
Ken Garnes, Chair
Ken Garnes, Chair

2. Recognitions
Ken Garnes

3. Matters of the Public
Ken Garnes

4. Amendments to the Meeting Agenda
Ken Garnes

5. Approval of May 28, 2014 CSB Meeting Minutes
Ken Garnes

6. Matters of the Board

7. Directors Report
Len Wales
Ken Garnes

A. CSB Workplan
Daryl Washington

8. Committee Reports

A. Fiscal Oversight Committee
Suzette Kern

1. May Meeting Notes

2. Fund Statement

B. Government and Community Relations Committee
Rob Sweezy

1. Human Services FY2015 Legislative White Paper

C. Intellectual Developmental Disability Committee
Lori Stillman

D. Substance Use Disorders/Mental Health Committee
Susan Beeman

E. Other Reports

9. Action Items
Nominations Committee
Ken Garnes

A. CSB Officer Elections

Suzette Kern/Lisa Potter

B. FY2015-2017 CSB Strategic Plan

10. Information Items

A. Changes in Mental Health Law
Kaye Fair

B. CSB Associate Committee Members
Susan Beeman

C. FY2015-16 State Performance Contract Changes
Jerome Newsome

D. FY2014 State Performance Contract Update
Jerome Newsome

E. Interagency Youth Behavioral Health Project
Daryl Washington

F. DBHDS $100K Allocation to Extend Online Suicide Prevention Programs
Laura Yager

11. Adjournment
Fairfax-Falls Church Community Services Board  
May 28, 2014

The Board met in regular session at the Fairfax County Government Center, 12000 Government Center Parkway, Fairfax, VA.

The following CSB members were present: Ken Garnes, Chair; Gary Ambrose, Pam Barrett, Susan Beeman, Mark Gross, Kate Hanley, Suzette Kern, Paul Luisada, Juan Pablo Segura, Lori Stillman, Diane Tuininga, Jeff Wisoff and Spencer Woods

The following CSB members were absent: Lynn Miller, Dallas “Rob” Sweezy and Jane Woods

The following CSB staff was present: Len Wales, Daryl Washington, Peggy Cook, Ginny Cooper, Jeannie Cummins Eisenhour, Jean Hartman, Evan Jones, Jerome Newsome, Jim Stratoudakis and Lyn Tomlinson

1. Meeting Called to Order
   Ken Garnes called the meeting to order at 7:30 p.m.

2. Approval of the Minutes
   Gary Ambrose offered a motion for approval of the April 23, 2014 Board meeting minutes of the Fairfax-Falls Church Community Services Board which was seconded and passed.

3. Matters of the Board
   - Kate Hanley requested Board members provide comments in consideration of a meals tax.
   - Suzette Kern noted in a recent meeting with Supervisor Jeff McKay, the Health Management Associates (HMA) report was discussed and concerns relayed of a possible fast track that may preclude the appropriate analysis in the decision making process.
   - Jeff Wisoff also indicated that during a conversation at an event, concerns with the implementation track of the HMA report recommendations were also discussed with Supervisor Cathy Hudgins.
   - Lori Stillman noted with the recent findings of a 30% increase in Autism births, 1 in 68, focus is needed on the role of the CSB with this growing population.
   - Susan Beeman shared that planning activities continue for the October 17th Wellness and Recovery Conference and indicated additional information will be provided as it becomes available.
   - Juan Pablo Segura reported a meeting is scheduled next week with CSB staff and a text messaging venture to continue exploring potential services.
   - Ken Garnes reported on the following:
     - Deputy County Executive Pat Harrison has requested further discussion of the HMA report recommendations with the CSB Board, and to accommodate, a
proposal to schedule a work session prior to the June 25th CSB Board meeting was presented. Following agreement, it was indicated the session will be scheduled at 6:00 p.m. and sandwiches will be provided. In addition, Board members requested that any handouts prepared by Ms. Harrison, be provided well in advance to allow time for review.

- The June Board meeting will be the last for Board member Mark Gross in which he will be recognized for his many years of service to the CSB. Also at the June meeting, a family that has established a peer support specialist certification scholarship fund in honor of their son will be recognized.
- A reminder that feedback is still needed from Board members on the draft After Report from the retreat which is an essential document in planning the next steps for several activities.

4. Directors Report

- Len Wales noted the Board planning calendar included in the agenda materials is a living document and updates will be incorporated as needed.
- In addition, the Workplan dashboard that summarizes activities of each project area was presented for review.
- Within the Workplan, clarification was provided on delays encountered within the Youth and Family section.
- In response to the designated funding for about 400 youth identified with emerging, intermediary behavioral health issues and needing individual as well as case coordination services, it was noted these services will be contracted. While it was indicated the CSB is involved in the development, due to the scope of services, the Department of Family Services will be the appointed agency to oversee the contracted services.
- To provide a summary of ongoing activities, some of which are in collaboration with the schools, to address youth behavioral health, a background paper will be prepared and distributed to the Board.
- Daryl Washington highlighted some handouts in the Board member folders which included:
  - The recent CSB Annual Awards and Appreciation Ceremony in which a team of 19 staff from various programs received the award for their partnership in creating an innovative approach to enhance services for individuals waiting for residential treatment services that can alleviate the need for more intensive services.
  - Draft posters of a TipText mechanism that youth, family and community members can access for help will become available on June 1st. It was indicated this was introduced at the May 17th Teen Summit at Hayfield High School in which CSB staff participated providing additional real time coping resources including the recently introduced online Youth Suicide Prevention training.

5. Committee Reports

   A. Fiscal Oversight Committee
   - Ms. Kern highlighted the meeting notes and fund statement provided in the packet.
B. Intellectual Developmental Disability (IDD) Committee
   • Ms. Stillman reported at the May 8th IDD Committee meeting, Mark Gross was honored for his tenure on the CSB Board.
   • In addition, it was noted that a committee charter is currently being developed and recently appointed CSB Assisted Community Residential Services Director Barbara Wadley-Young was introduced. With the aging IDD population requiring hospitalizations and hospice care, this service area will continue to face many challenges.
   • Effective in July, Jane Woods will join the IDD Committee.
   • While attending the recent VACSB conference, Ms. Stillman had the opportunity to meet the new Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) Debra Ferguson who indicated she is looking forward to a collaborative working relationship with the Community Services Boards.

C. Substance Use Disorders/Mental Health (SUDs/MH) Committee
   • Ms. Beeman reported at the May meeting Daryl Washington provided a briefing on the HMA report recommendations. As it was indicated concerns were expressed that Associate Committee members were not aware of the report, moving forward efforts will be made to ensure the members are kept apprised of developments in this area.
   • A reminder was provided of the public comment period on the proposed CSB Strategic Plan that will close May 30, 2014.

6. Action Item
   A. Establish CSB Ad Hoc Fee Committee
      After turning the chair over to Secretary Gary Ambrose, Mr. Garnes provided background on establishing an ad hoc committee to review CSB fees and related policies as provided for in the CSB Bylaws. Following, Mr. Garnes offered a motion to establish an Ad Hoc Fee Policy Committee as recommended and select a minimum of two members to serve on the Committee. The motion was seconded and passed. Any members wishing to participate in the committee were requested to contact CSB staff Jim Stratoudakis.

7. Information Items
   A. June Election of CSB Officers
      Ms. Kern reported that following a meeting of the CSB Officer Nominating Committee, a slate of officer nominations have been identified for presentation at the June Board meeting. The nominees include Ken Garnes as Chair, Gary Ambrose, Vice Chair and Suzette Kern as Secretary. It was indicated that additional nominations may also be offered from the floor during the elections.

   B. Leadership and Resiliency Program RFP
      Noting this award winning program was designed and trademarked by CSB Prevention staff about 15 years ago, Mr. Wales indicated that due to resource reductions in recent years, the program has not been well utilized. As it is being suggested to sell the rights to

May 28, 2014
Page 3 of 5
the program, this proposal is being presented to the Board to ensure there is concurrence before moving forward. There were no objections to the Request for Proposals (RFP).

C. **State Performance Contract Update**

Jerome Newsome provided an update on the current FY2014 Performance Contract activities that included:

- Improvements continue including entry as well as verification of accurate contracted services data.
- Credible Training for support staff is currently being scheduled.
- A mid-year report analysis from DBHDS was received covering July – December 2013 that did not provide any surprises, but in turn, offered opportunities to identify and discuss any issues.

In response to the status of the FY2015-FY2016 Performance Contract, the following was indicated:

- The text version of the proposed contract was received on May 9th along with a memo outlining proposed changes.
- Until the state finalizes a budget, the fiscal portion of the contract as well as the software for entering the data are not available. Without these essential elements, the contract has not been issued for the 30-day public review.
- In the meantime, efforts are underway to gather the projected service data to be entered.
- Looking ahead it was indicated the state code mandates that the contract must be signed by September 30th, which may affect a response timeline once a budget is established.
- An information item will be prepared for the Board that highlights substantive changes proposed in the FY2015-16 language from the current contract.

Clarification was provided that the contract language is the same for all Virginia CSBs.

D. **Day Support Services Funding**

In response to further information requested on funding for individuals leaving the Northern Virginia Training Center (NVTC), Evan Jones provided the following:

- Current Medicaid Waivers cover approximately $85 of the $150 cost of day support services, and although while residing at NVTC the entire $150 is covered, this will not hold true upon their departure.
- Of the individuals leaving all the Training Centers, it is estimated 65-69 individuals will locate in Fairfax needing day support services.
- There is some discussion by the Center for Medicaid and Medicare Services (CMS) of providing a 25% increase in funding to assist with the gap, but this has not been confirmed.
- It was also indicated this funding gap could be addressed as part of the Medicaid Waiver reform currently being considered.
- In addition, it was pointed out that the state has acknowledged inadequate funding by offering bridge funding, even though this is a onetime measure.

Following this overview, there was discussion as to the state’s responsibility in covering these costs. The question was presented whether the U.S. Department of Justice (DOJ)
can intervene through the courts, citing the state’s non-compliance with the settlement agreement by not accommodating the funding needs of individuals being relocated.

To ensure the CSB is kept informed and alerted as to the appropriate time to possibly pursue federal intervention, monthly updates with quantitative data will be provided to the CSB Board.

There being no further business to come before the Board, a motion to adjourn was offered, seconded and carried. The meeting was adjourned at 8:50 p.m.

Action Taken--
- Approval of the April 2014 meeting minutes
- An Ad Hoc Fee Committee was established

Date

Staff to Board
# Section Status Including Tier 2

**POCs:** Len Wales/Daryl Washington

## Section Status:

<table>
<thead>
<tr>
<th>Section</th>
<th>General Summary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>I – Informatics</td>
<td>On Target; key area is to ‘Complete State Performance Contract Data Improvements’</td>
</tr>
<tr>
<td>II – Front Door</td>
<td>On Target</td>
</tr>
<tr>
<td>III – Behavioral Healthcare Outpatient</td>
<td>On Target; four task areas will commence later in 2014.</td>
</tr>
<tr>
<td>IV – Business Process</td>
<td>On Target</td>
</tr>
<tr>
<td>V – Youth and Child Services</td>
<td>On Target; key area is to ‘Review current treatment models’</td>
</tr>
<tr>
<td>VI – Merrifield</td>
<td>On Target</td>
</tr>
<tr>
<td>Tier 2: Future Identified Objectives</td>
<td>Work not started. TBD</td>
</tr>
<tr>
<td>• Re-Engineer Mental Health Emergency Services</td>
<td></td>
</tr>
<tr>
<td>• Develop Cost Benefit Analysis of Medical Detox Unit</td>
<td></td>
</tr>
<tr>
<td>• Consider Co-Locating Medical Detox with Crisis Unit</td>
<td></td>
</tr>
<tr>
<td>• Review Day Program Supplemental Payments and Contracting</td>
<td></td>
</tr>
<tr>
<td>• Move Social Detox Out of Facility Based Program</td>
<td></td>
</tr>
<tr>
<td>• Explore new Models to Leverage More Cases and/or Increase Face-to-Face Visits</td>
<td></td>
</tr>
</tbody>
</table>

## Special Notation:

- None
### Key Activity Status:

<table>
<thead>
<tr>
<th>Task</th>
<th>% Comp</th>
<th>Due Dates</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refine Utilization of Credible: Initial Assessment Summary Report</td>
<td>25%</td>
<td>December 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Complete State Performance Contract data Improvements: Acceptable data reporting by DBHDS</td>
<td>50%</td>
<td>June 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Establish process for responding to future contract changes: Establish more direct onsite contact with Credible staff</td>
<td>50%</td>
<td>September 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Create Credible data reports for CSB staff: Requested reports are being used by clinical staff</td>
<td>25%</td>
<td>December 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Prioritize ongoing Informatics projects and set implementation timelines: Major projects scheduled over realistic period based on current/projected resources.</td>
<td>75%</td>
<td>June 2014</td>
<td>On Target</td>
</tr>
</tbody>
</table>

### Special Notation:

- New SPC delayed because of State Budget approval delays

### Key Risks:

- State budget delays will impact Community Services Performance Contract timeline

### Key Issues:

- Vendor data uploads for FY 2014 contract must be complete before CCS3 Extract run on July 31, 2014

### Planned Activities:

- Bring Credible staff onsite to provide post implementation training support
- Complete and review inventory of current documented business processes for each service area
- Closeout FY 2014 Mid-Year Response and prep for End of Year Report
- Partner with Credible Report Generation training staff to develop reports requested by clinical staff and to support Dashboard
- Complete all major contracted services data entry and complete business process for import process going forward

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6/19/2014
### Key Activity Status:

<table>
<thead>
<tr>
<th>Task: Outcome</th>
<th>% Comp</th>
<th>Due Dates</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design Entry Model: Draft model completed with test satisfaction data available for review</td>
<td>50%</td>
<td>September 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Review Best Practice Models for Behavioral Healthcare Entry Points: Questionnaire outreach, design, analysis and reporting completed</td>
<td>100%</td>
<td>December 2013</td>
<td>Complete</td>
</tr>
<tr>
<td>Use Evidence Based Best Practices in Service Design: 80% of Entry and Referral Services, ACCESS, and ARC new model components will reflect national standards (20% of model may reflect local nuances)</td>
<td>90%</td>
<td>July 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Use Guidelines/Criteria for Access to CSB Services: 98% of individuals referred to community services do not meet standards of defined priority population (2% not meeting the defined priority population meet the exceptions)</td>
<td>100%</td>
<td>April 2014</td>
<td>Completed</td>
</tr>
<tr>
<td>Enhance Revenue Opportunities: 75% of individuals with scheduled appointments to CSB services have participated in initial FAST services</td>
<td>50%</td>
<td>July 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Utilization Management Component: 80% of individuals served are either transferred within CSB services or to community care according to the standard length of service for E&amp;RS, ACCESS, and ARC</td>
<td>50%</td>
<td>December 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Stakeholder Involvement: Incorporate key stakeholder feedback in designs</td>
<td>50%</td>
<td>July 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Project communication: CSB staff informed of project and work plan; provide monthly updates to Senior Management Team</td>
<td>50%</td>
<td>December 2014</td>
<td>On Target</td>
</tr>
</tbody>
</table>

### Key Risks:
- None

### Key Issues:
- Board guidance on priority population provided 4/23/14; related tasks now underway.

### Special Notation:
- None

### Planned Activities:
- Continuing pilot of peer support specialist (contract with LMEC, 10 hours per week) working in the Entry and Referral Office.
- Draft ‘to be’ entry model based on testing; process mapping through 7/31.
- Gather and review sample assessment tools
- Incorporate financial services team into process
- Develop standard for length of service
- Stakeholder assessment
- Continue project communication with staff
## Key Activity Status:

<table>
<thead>
<tr>
<th>Task : Outcome</th>
<th>% Comp</th>
<th>Due Dates</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solidify and document model for service integration (mental health/substance use/primary care) and identify strategy to fully implement at each site : A written plan that outlines the CSB’s model for service integration</td>
<td>80%</td>
<td>July 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Assess site management at each major site and develop a plan to address any leadership/management gaps, including the need for site directors : The creation of a formal document of site-director roles with recommendations for compensation</td>
<td>80%</td>
<td>July 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Identify key service functions at the site (psychotherapy, counseling, case management, etc.) using an established benchmark for service design : Create protocol for consistent models of service across BHOP with appropriate staffing levels for MH/SA programming</td>
<td>80%</td>
<td>July 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>In coordination with the Front Door work, establish Utilization Management standards and implement those protocols for assigning service providers and for length of treatment : Create new and updated written BHOP Level of Care guidelines/protocol across integrated programs that ensure: Individuals are neither underusing or overusing services and receiving optimal level of care; within division standardization of clinical pathways that are helping us determine our treatment approaches; and consistency of application across programs</td>
<td>80%</td>
<td>December 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Establish centralized scheduling wherever possible, sustainable productivity standards, and key service outcome standards</td>
<td>0%</td>
<td>December 2014</td>
<td>On Target – May 2014 start date</td>
</tr>
<tr>
<td>Using processes developed above, establish service capacity and align resources to address priority service needs; include training requirements as necessary</td>
<td>0%</td>
<td>December 2014</td>
<td>On Target – October 2014 start date</td>
</tr>
<tr>
<td>Identify revenue gaps and develop strategies to maximize fee and grant revenues within the service mission</td>
<td>0%</td>
<td>August 2014</td>
<td>On Target – April 2014 start date</td>
</tr>
<tr>
<td>Work with the Medical Director and Services Director for Entry to identify the most effective and efficient services models to address the needs of people with less intensive Medical Service needs and those needing urgent care, establishing consistent protocol for stepping individuals down to lower levels of care</td>
<td>0%</td>
<td>January 2015</td>
<td>On Target – July 2014 start date</td>
</tr>
</tbody>
</table>

## Key Risks:
- None

## Key Issues:
- None

## Special Notation:
- Last four tasks commence during 2014.

## Planned Activities:
- Utilization management workgroup kick off meeting.
- Initial draft of site director position duties reviewed with the Department of Human Resources (DHR).
- Compensation issues for site directors under discussion.
- Continuing work with DHR to address multiple and complex personnel issues to strengthen communication around work performance, work behaviors and work expectations.
**Section 4: Integration of Business Practices**
**POC – Ginny Cooper**

## Key Activity Status:

<table>
<thead>
<tr>
<th>Task : Outcome</th>
<th>% Comp</th>
<th>Due Dates</th>
<th>Status</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial &amp; Human Resource Alignment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review existing business processes related to client registration, data collection, benefits eligibility, and revenue management. Develop standardized, effective and efficient business processes that can be implemented at all CSB service locations and central office.</td>
<td>60%</td>
<td>Nov-14</td>
<td>On Target</td>
<td>90% of individuals are satisfied with service provided by the reconfigured business services</td>
</tr>
<tr>
<td>Align CSB post-transformation with FOCUS and Credible.</td>
<td>80%</td>
<td>Jul-14</td>
<td>On Target</td>
<td></td>
</tr>
<tr>
<td>Develop zero-based budget, including allocation of local funding.</td>
<td></td>
<td>Jan-15</td>
<td>ON HOLD</td>
<td></td>
</tr>
<tr>
<td>Identify resource to manage relationship of specialist billing company and ITC program commercial insurances (non-Medicaid) to assist in sustaining program financial viability.</td>
<td>90%</td>
<td>Apr-14</td>
<td>On Target</td>
<td></td>
</tr>
<tr>
<td>Develop tools and process to evaluate Return-on-Investment and Relative Value of services provided, including residential care (Effort should be coordinated with State Performance Contract planning, monitoring, and reporting).</td>
<td>40%</td>
<td>Oct-14</td>
<td>On Target</td>
<td>90% consistency in methods and measures</td>
</tr>
<tr>
<td><strong>Strategic Planning &amp; Coordination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish agency-wide strategic plan.</td>
<td>90%</td>
<td>Apr-14</td>
<td>On Target</td>
<td></td>
</tr>
<tr>
<td>Create agency-wide performance management system and develop agency performance measures; implement monitoring and reporting process (each service area should have a minimum of one metric; metrics should be used for budgeting and strategic planning)</td>
<td>80%</td>
<td>Jul-14</td>
<td>On Target</td>
<td></td>
</tr>
<tr>
<td>Develop and implement plan for annual operational and programmatic audit.</td>
<td>30%</td>
<td>Jun-14</td>
<td>On Target</td>
<td>Corrections to 1-2 areas of weakness that violate or have the potential to violate the efficient use of resources</td>
</tr>
<tr>
<td>Develop and execute succession plan for key positions.</td>
<td>80%</td>
<td>Jul-14</td>
<td>On Target</td>
<td></td>
</tr>
<tr>
<td>Create and manage a plan to coordinate the entire project portfolio and identify unresolved issues as they present.</td>
<td>25%</td>
<td>Jan-15</td>
<td>On Target</td>
<td></td>
</tr>
<tr>
<td><strong>Change Management/Communications Planning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish a structure and process to address change management needs as part of any major project (e.g., organizational, service, etc.)</td>
<td>100%</td>
<td>Apr-14</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Review and update internal agency communication plan.</td>
<td>100%</td>
<td>Feb-14</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Revise and update external communication plan.</td>
<td>100%</td>
<td>Mar-14</td>
<td>Complete</td>
<td></td>
</tr>
</tbody>
</table>

### Key Risks:
- None

### Key Issues:
- None

### Special Notation:
- Agency Manager requested in May 2014 that the zero-based budget task be put on hold indefinitely.

### Planned Activities:

#### Enhancements to the review of existing business processes task
- Imbedding administrative manager into Entry and Referral Office to observe, participate and simplify procedures in registration process. Trial period – June 2014.
- Conducting across-the-board financial reviews of individuals currently receiving services and have expired financial liability (proof-of-income) dates. Completion date-October 2014.
- Soliciting medical coding specialty firm or individual for short, medium and long term strategies to pursue to increase revenue collection. Completion date-June 2015.
### Section 5: Youth and Child Services
**POC:** Daryl Washington

#### Key Activity Status:

<table>
<thead>
<tr>
<th>Task : Outcome</th>
<th>% Comp</th>
<th>Due Dates</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review current treatment models: Have all services that are provided within the youth and family continuum be provided using evidenced based or best practices.</td>
<td>80%</td>
<td>April 2014 - estimated completion September 2014</td>
<td>On Target for September 2014</td>
</tr>
<tr>
<td>Determine where Youth and Family service models need to change and training needs to occur.: Have resources and services in the youth and family continuum allocated so that at risk youth are receiving the most efficient and effective service available based upon resources.</td>
<td>70%</td>
<td>July 2014</td>
<td>On Target</td>
</tr>
<tr>
<td>Use existing resources to fill gaps in services where identified.: Allocate resources on an ongoing basis so that those programs with the longest wait and greatest need are receiving support quickly and efficiently. Have a process that minimizes gaps whenever possible.</td>
<td>80%</td>
<td>July 2014 and ongoing</td>
<td>On Target</td>
</tr>
</tbody>
</table>

#### Key Risks:
- None.

#### Key Issues:
- Youth Consultant contract was delayed for a few weeks, but now starting to meet again. Project completion by end of summer.
- Finding balance between serving those most in need vs. serving a larger number of “at risk.” kids.

#### Planned Activities:
- Residential programs to receive regional customers.
- Continue work to blend services for opening of Merrifield later in 2014.
- Bring forth recommendations for youth continuum based upon feedback from consultant.

#### Special Notation:
- None
Section 6: Merrifield
POC: Laura Yager

Key Activity Status:

<table>
<thead>
<tr>
<th>Task : Outcome</th>
<th>% Comp</th>
<th>Due Dates</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>Building Operations</td>
<td>75%</td>
<td>August 31 tentative turn over date; move scheduled October-December.</td>
<td>On Target</td>
</tr>
<tr>
<td>Clinical Operations</td>
<td>25%</td>
<td>Ongoing through January 2015</td>
<td>On Target</td>
</tr>
<tr>
<td>Business Process Redesign</td>
<td></td>
<td></td>
<td>On Target</td>
</tr>
<tr>
<td>Admin Coverage Plan</td>
<td>50%</td>
<td>July 31, August 31, September 30</td>
<td>On Target</td>
</tr>
<tr>
<td>System Access Plan</td>
<td>50%</td>
<td></td>
<td>On Target</td>
</tr>
<tr>
<td>Implementation Plan</td>
<td>50%</td>
<td></td>
<td>On Target</td>
</tr>
<tr>
<td>Communications : Provide clear, timely communications in various formats and venues to keep staff, service recipients, other stakeholders, public officials and the general public informed about upcoming move.</td>
<td>25%</td>
<td>June 15 (plan) July-through move completion (implementation) Early 2015-opening event</td>
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</tr>
<tr>
<td>Health Care Center</td>
<td>10%</td>
<td></td>
<td>On Target</td>
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</tbody>
</table>

Planned Activities:

Building Operations:
- Turnover/Progress Meetings with Manhattan Construction Company, Capital Facilities/Building Design & Construction (FMD) every other week.
- Move Coordination Meetings with FMD, CSB, DPWES, Moving Company, and Move Coordinator, every other week.

Clinical Operations:
- Assure that move and site coordination run smoothly (now through December)
- Develop approaches that promote collaboration and integration (now for move and ongoing for culture)
- Engage workforce in the transition to the new site (now through December)

Business Process Redesign:
- Draft Merrifield Center's administrative core coverage plan for client registration practices, by floor, by wing, by shift; develop performance measurement tool.
- Draft a standardized process that includes client registration, service payment setting, and triage/assessment functions for consumer system access (front door) functions at Merrifield to CSB programming.
- Develop an implementation plan, to include staff training and related training materials and staffing plan.

Communications
- Maintain up to date information resource on public website (for all audiences) and on internal FairfaxNet for staff
- Ensure interior building signage reflects CSB’s integrated service structure and makes sense to the general public.

Health Care Center
- Determine needs for a provider (June-July) and develop product describing this
- Prepare health center space as part of the Merrifield move process to the greatest extent possible (now through November)
- Order medical equipment to align with other furnishing procurement and installation.
- Work closely with broader County/HMA planning efforts to assure alignment with overall county planning (ongoing through September)
- Prepare and issue RFP and award contract for provider (ongoing through February)

Special Notation:
- Health Care Center should align with broader county primary and behavioral health care strategies.

Key Risks:
- Building delivery may be delayed.

Key Issues:
- Business Process Redesign is key to successful operations at Merrifield.
CSB Fiscal Committee Meeting Notes

Date: May 16, 2014
Attending: Ken Garnes, Gary Ambrose, Kate Hanley. Jeff Wisoff connected via phone.
Staff: Daryl Washington, Lisa Potter, Ron McDevitt, Jerome Newsome, Sandra Hagan, Ginny Cooper

Summary of Information Shared/Decisions:

Review of Revised Fiscal Committee and Board Calendar
- Committee members reviewed the Fiscal Committee meeting schedule and the annual Board calendar.
- The annual Board calendar will be presented to the Executive Committee and the full CSB Board in May.

April 2014 Fiscal Update
- April 2014 Fiscal information was provided to Committee members: Modified Fund Statement for period ending April, 2014, Projection of Methodology and Explanation of Variance.
- Staff noted that an encumbrance list has been developed to identify priority needs. The Committee requested that staff share the larger items on the list with the CSB Board at the May meeting.
- In regards to shortfall in Medicaid Option revenue, staff noted this is primarily due to vacancies in Intellectual Disability Services (IDS) case management, which affects billing for services. It was noted that IDS is currently in the process of attempting to recruit qualified applicants and fill positions.
- In addition, there has been some lag time in state plan option reimbursements due to a change in the state’s payment contractor (now Magellan). The Virginia Association of Community Services Boards (VACSB) is aware of the statewide reimbursement issues, and CSB staff participates in weekly conference calls to address these issues.

Managed Vacancy Plan/Position Status
- Staff shared information about the Pay Period Metrics, position status and vacancy analysis.
- The Position Vacancy Breakeven Point is 90.
- There was brief discussion about hiring and retention. It was noted that exit interviews will be conducted when staff leave the CSB

FOCUS Realignment
- Staff reported that realignment is complete on the FY 2015 expenditure budget by the final organizational and cost center structure.
- The revenue budget will be realigned prior to July 1, pending additional analysis of structural revenue imbalances.
- This effort will facilitate program and financial management for senior management, fiscal staff, service directors and individual program managers.
- Request was made for an update to be provided to the full Board on the organizational structure.
CSB Fiscal Committee Meeting Notes

State Performance Contract/Credible Review

- Staff provided an update on the CSB State Performance Contract Quality Improvement and Compliance Plan:
  - Accomplishments to date:
    - Contracted Services (Vendor) Data: completed entering 100% of ID data through March into Credible; began entering MH data (July-Dec) (at 25%)
    - Received support staff training proposal from Credible
    - Received FY2014 Mid-Year Analysis Report and submitted response
  - Planned Tasks include:
    - May 20th meeting scheduled with Joel Rothenberg to provide progress update and discuss improvements.
    - Address Credible alignment with FOCUS/HCM prior to July 1.
    - Complete entry of MH vendor data into Credible.
    - Continue development of import process for all vendors.
    - Begin Credible support staff training to expand available internal expertise

CSB Work Plan

- Staff provided a status update and brief summary of the CSB Work Plans to include the new Work Plan format.
  - Informatics: key issue is to complete vendor data entry by the beginning of FY 2015.
  - Front Door: tasks are on target. Highlighted peer support specialist pilot and process mapping activities service access.
  - Behavioral Health Outpatient: key activities are on target, to include a utilization management workgroup kick-off meeting.
  - Integration of Business Practices: developing standardized guidelines for business practices. This will be completed before the Merrifield Center opens but will also apply to all CSB sites. Youth and Child Services: the timeline for review of the youth continuum was delayed while a consultant was hired. This work is currently underway.
  - Merrifield: this is a new work plan and an update will be provided at next Committee meeting
  - Tier 2 Work plans: will include an analysis of the most effective and efficient use of detox services, to include outpatient detox.
- Committee members expressed the importance of ensuring that the Health Management Associates (HMA) consultants and any county groups working on HMA recommendations are aware of these work plans and all of the work staff that has been accomplished or is in process. The Committee suggested that CSB Board members inform their Board Supervisors.
- Committee members recommended that a briefing on the work plans be provided for the full CSB Board at the May meeting.

Potential Impact of Delay in State Budget Approval

- A delay in approving the state budget would not likely impact CSB operations but could affect vendors, who would not be able to provide services without state funding.
The county is closely watching the state budget process.

**Fee Policy Work Plan**
- Staff reported on a preliminary fee policy work plan. The plan will be presented to Executive Committee with a request to bring forward to the full board in May.
- Staff will request the establishment of an Ad Hoc Fee Policy committee and solicitation of at least two Board members.
- Fee Policy meetings will be scheduled in June-July to review topics related to fee schedule and identify decision points.

**Informal Solicitation for Coding, Billing & Revenue Collection**
- Staff reported on the status of the Coding, Billing & Revenue Collection Solicitation. It was noted that no bids were received.
- Committee members made the following recommendations:
  - Explain the discrepancy in the RFP closing date.
  - The revenue maximization outcomes to be realized are important; therefore the RFP should be re-solicited.
  - In the re-solicitation, the scope of work may be best organized into groups of naturally-related tasks and potential bidders encouraged to bid on one or more groupings. Example would be to group tasks and deliverables associated with the coding work separate from the billing business practices and from the audit/compliance plan work. Awards could go to multiple bidders.
  - Set a closing date that provides enough time for potential bidders to respond.
- Staff will follow-up with County Purchasing & Supply Management.

**Open Discussion**
- Commonwealth Coordinated Care project:
  - Staff reported that this is a demonstration project in the State focusing on better care, cost and outcomes by coordinating benefits for individuals who receive both Medicare and Medicaid.
  - DMAS contracted with three Managed Care Organizations (MCOs) to participate in project in Virginia.
  - The Northern Virginia region will be in the next phase of the statewide project, with services beginning in the fall. A potential benefit for the CSB is possibility of an increased rate for enhanced case management services.
- Staff have done an internal analysis and identified that as many as 500 individuals receiving CSB services have both Medicaid and Medicare and could be eligible for this project. Individual participation is voluntary.

**Action Items/Responsible Party Required Prior to Next Meeting:**
- Follow up with County Purchasing & Supply Management- Ginny Cooper

**Issues to Communicate to CSB Board:**
CSB Fiscal Committee Meeting Notes

- Present Fee Policy Work Plan – May Executive Committee meeting

**Agenda Items for Next Meeting on June 20:**

- TBD
### FY 2014 Modified Fund Statement

**Fund 400-C40040, Fairfax-Falls Church CSB**

**CSB Working Document**

**Period Ending May 2014**

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<td>$13,158,280</td>
<td>$11,868,320</td>
<td>93%</td>
<td>$12,045,782</td>
<td>92%</td>
<td>$1,219,820</td>
<td>$13,265,602</td>
<td>$107,322</td>
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<tr>
<td>Subtotal - State</td>
<td>$12,712,937</td>
<td>$13,158,280</td>
<td>$11,868,320</td>
<td>93%</td>
<td>$12,045,782</td>
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<td>$1,219,820</td>
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<td>$43,304</td>
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</table>

/1 $4.8M will be requested as encumbered carryover, including $4.5M in operating and $0.3M in capital
/2 $2.3M will be requested as unencumbered carryover, including $1.0M for Credible, $0.6M for Merrifield startup costs, $0.4M for clients transitioning out of Bridging Affordability, $0.2M for Gartlan renovation and $0.1M for Kognito
/3 $2.5M will be requested as operating reserve
Election of CSB Officers

Issue
Nominations for CSB officers to serve beginning July 2014 will be presented by the CSB Nominating Committee as well as a call for any nominations from the floor. The elections will be conducted by voice vote.

Background
CSB Board Officers are elected each June. As required by Article VI of the CSB Bylaws, in April 2014 three Board members were appointed to serve as the Nominating Committee, Gary Ambrose, Suzette Kern and Lori Stillman, and to submit at least one nominee for each office of Chair, Vice Chair, and Secretary. At the May 2014 CSB meeting, Board members were apprised of the candidates being recommended by the Nominating Committee and informed that nominations may be made from the floor.

The Nominating Committee will present the following names for election:
   Chair: Ken Garnes
   Vice-Chair: Gary Ambrose
   Secretary: Suzette Kern

The term for the newly elected officers begins on July 1, 2014.

Fiscal Impact
None

CSB Officer Nominations Committee--Board Members
Gary Ambrose
Suzette Kern
Lori Stillman
Community Services Board FY2015-2017 Strategic Plan

Issue
The Community Services Board’s (CSB) draft FY 2015-2017 strategic plan and corresponding survey to solicit feedback was distributed on May 1 for a period of 30-days. Survey respondents were asked to respond to data elements including affiliation, 3 Likert scale questions, and comments about the content and format of the plan.

The Strategic Planning Development Team reviewed the feedback received and made revisions to the plan as appropriate. Most revisions were related to language and inclusion of key information, such as an increased emphasis on priority access guidelines. The Development Team is requesting that the CSB Board adopt the FY 2015-2017 Strategic Plan, to be implemented on July 1, 2014.

Background
In August 2013, a Strategic Plan Development Team was convened to review the agency’s strategic planning process and develop a long-term strategic plan. Membership on the team included CSB-wide representation, including two members from the CSB Board. Historically, CSB strategic plans have been disability based and have not reflected agency-wide goals and objectives. While a number of CSB strategic initiatives have been established in recent years, the new strategic plan will align these efforts.

The three-year plan was designed to span from July 1, 2014 to June 30, 2017, with annual review and evaluation. A Strategic Plan Implementation Team will be chartered and convened to oversee the implementation and evaluation of the plan. The team will review progress toward strategic goals, review data and make system recommendations for improvements as needed, and develop an evaluation strategy and annual report. CSB Board members, CSB staff and people receiving services and their families will be invited and encouraged to participate on the team.

Fiscal Impact
N/A

Enclosed Documents
Attachment A- Survey Responses
Attachment B – FY 2015-2017 CSB Strategic Plan

Staff (and or Board Members)
Suzette Kern, CSB Board Member
Lisa Potter, CSB Staff
CSB Strategic Plan Survey Responses
(Survey Administered May 1 – 31, 2014)

Responses for Q1-3

The CSB vision, mission and values statements (above), clearly represent what the CSB does.
(Answered: 120; Skipped: 15)

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<tr>
<th>Strongly Disagree –</th>
<th>Disagree –</th>
<th>Neutral –</th>
<th>Agree –</th>
<th>Strongly Agree –</th>
<th>Total –</th>
<th>Average Rating –</th>
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<td>1.67%</td>
<td>14.17%</td>
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<td>42.50%</td>
<td>33.33%</td>
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**Comments:**
1. While the vision is grand, I don't believe what the CSB actually does includes everyone in our community (at least on a practical, day to day basis). While we value quality, respect and accountability, it seems we should also value recovery, self-determination, and other Beeman principles.

2. The financing provided is insufficient to reach these goals.

3. I believe the CSB Mission Statement should be appended with the phrase, "generally, those individuals and families who are least able to obtain these services due to lack of adequate insurance or inadequate financial resources."

4. Mission statement appears to emphasize outsourcing services and minimize the services that are provided directly by the CSB.

"Other" included: citizen, minister, referral source, CSB Board members, non-profit organizations, City of Fairfax staff, and Gartrial Center Advisory Board.
5. You have left out At-risk and SED youth. Youth are not considered to have a mental illness, and not all youth served have a developmental delay or intellectual disability.

6. I would simply reverse order so respect precedes quality

7. Well said!

8. Very well written, easy to understand and navigate

9. Respect for the people we serve should precede other values

10. Include community-based services to adult with organic/cognitive disabilities

11. Mission mentions supports for individuals and families affected by our primary populations, but doesn't refer to the broader mission to serve the community in general by providing prevention and resiliency supports in addition to our client/family services. Might also be good to mention the agency's role in community capacity building, by supporting networks of providers, etc.

12. Somewhere, we need to state our focus is to be a safety net: serving individuals with the most serious symptoms who have the least resources. We do not have the resources to serve all in the Vision, Mission, Values and it makes promises we can't keep.

13. Everyone in the community does not have the support it needs. Programs are understaffed, and services are not being provided to the best of the abilities.

14. We limit service access based on insurance and we need to further qualify our mission to clarify we address seriously/persistently mentally ill.

15. We need to improve accountability across the board. I do not believe we are quality focused.

16. I agree strongly with CSB values and mission, but as long as the CSB is under-staffed, under-paid, and top heavy with bureaucrats, the vision is a falsehood.

17. For the most part I agree. However, I have seen striking examples of disrespect for the people we serve when employees who clearly should be fired are not, and in some cases are even promoted. Such practices are also not good examples of accountability. 99% of my coworkers are amazing, but the special treatment of the other 1% is very demoralizing to the rest of us. What we say we do and what we do are not always the same.

18. tried for 2 weeks to get help for my sister - they said she was fine - finally, a crises occurred and she was carted by the police to Woodburn for almost a month, she's now out of the hospital but they acknowledge 'she's delusional, but calm' - she's a mess, where do we get her help' - she's crying and crying;

19. Need improvement in Accountability

20. Not enough residential programs available to place clients who need this support especially for 24 hr care. Low cost housing is limited. Housing choice voucher program is always closed to new applications with limited availability.
The CSB goals (stated above) support the vision, mission and values.

(Answered: 110; Skipped: 25)

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Comments:
1. If we start with values of self-determination, recovery, etc., then goals of accountability, quality services, etc. should support these values.

2. The goals are sound but are not sufficiently supported.

3. does not seem fiscally sound, in relation to the budget issues

4. Services should include a focus on outreach/publicity to notify all people, especially ESL populations, of CSB services. Ease of access should be more clearly highlighted as a priority. Coordination within CSB agencies should increased including collaboration for individuals served by multiple "silos," eg ID and MH services. ITC and ID services should increase communication and streamline a process for getting ITC clients on ID Waiver waiting lists. The workforce should have maximum caseloads to meet demands appropriately. Income should be diversified by considering a local/federal match waiver for our grads and other county-funded services. An emphasis should be placed on employment over day services.

5. Goal 2 the workforce is NOT capable, as many are promoted into positions which they are not qualified for. They do not know their business areas. Lack of leadership fundamentals. GOAL 3 NO, work in progress, hoping for improvement.

6. Goals 1 & 2 are accurate but the CSB is not fiscally sound.

7. I do not know if the CSB is fiscally sound. I know that programs are understaffed and we are still being told positions cannot be filled due to budget constraints.

8. The CSB is not fiscally sound.

9. With budget cuts we are not fiscally sound and cannot provide the services that our patients need.

10. I'm not sure we need as many management positions as we have; more line staff would be great.
The strategies included in the plan align with the goals.

<table>
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Comments:

1. What are the strategies?
2. They align with the goals, but do not seem to indicate a strategic direction for improvement or enhancement. In other words, it reads more like a performance measurement plan than a strategic plan.
3. Under the strategy to enhance communications, I hope you envision initiatives to increase public awareness of the CSB as well as public understanding of mental illness.
4. The strategies under Goal 2 are not sufficient. Need to look at the number of offered trainings. Currently, you are only rating the quality of the trainings that are being offered. The number has declined in recent years, and there are not sufficient offerings to carry out Goal 2. Especially need more leadership trainings (there are extensive wait times for current offerings) and clinical trainings on whatever "evidence based" treatment we will be measuring, as well as follow-up and on-going consultation/supervision to support the evidence based practices. Also need to formalize succession planning. Would be good to add a strategy around this.
5. The CSB is too top heavy. Too much money spent on computer systems, upper management and fancy new buildings!
6. Strategies appear to leave out adult OP, adult Day Tx, and residential services as a priority. They’re listed in the description of services, but not listed as a priority. Appears that the plan is still to dump them on the community partners, who don’t have the resources either, and who don’t offer sliding scales. Or is the plan still to send all adults, especially with substance use disorders, to the drop in centers and pretend that that will meet all their needs?
7. What plan? plan isn’t stated, just goals
8. In the measures related to the strategy "to increase accessibility to services so individuals and their families receive services when and where needed:" It would be good to see a measure that separates tracking & monitoring from the planning and service design process. I’d like to see a measure that includes aligning service programming to identified local demand and need for particular services (as tracked in our utilization review, etc. On the professional development strategy, all measures relate to staff assessment of courses. It would be good to include a measure of staff participation in professional development activities (% taking courses, % of allowable training hours used, some measure of rate of promotions among staff at different levels). I’d like to see the measures for the fiscally and operationally sound goal to include creation a cross-agency coordinated planning process that facilitates a) common understanding of regulatory requirements and sound operational practices, and b) a coordinated decision-making on fiscal, technical, management and service delivery to ensure program operations support integrity, coherence, and compliance with regulatory requirements and sound business practices.
9. There seems to be very little effort put into evaluating and promoting a "positive work environment" - other than measuring quality of trainings. This impacts service delivery as well.
(Optional) Please provide any additional comments regarding the format, content and language of the CSB Strategic Plan.

1. The language is satisfactory, but I would like to see better implementation.

2. I think that the plan is well-written, easy to understand and meets the needs and expectations of the community concerning the services provided by the CSB. Thank you for your efforts on this important issue!

3. Specific language outlining how divestiture of direct services to private providers with CSB oversight should be included as the primary means to ensure ongoing service quality and capacity expansion in the most cost efficient manner.

4. Wording used in plan is not consistent with wording currently used. This is of minor concern, however worth pointing out in terms of consistency throughout the agency. Specifically, wording in the document refers to "Adult Behavioral Health Outpatient Case Management..." while currently the term being used is "Adult Behavioral Health Outpatient Program." Thank you for the opportunity to provide feedback.

5. Great format, easy to understand

6. Overall there's quite a bit of jargon and it's not easy on the eye. Perhaps it would be good to add a table outlining goals/strategic plan. This could also prompt others to not be intimidated by a 25 page document, be more user friendly and solicit more excitement and response from staff.

7. Parts sound too idealistic and grandiose. Recommend more realistic language and goals that are concrete and not lofty.

8. If this document is meant for consumers, language such as these quotes must be clarified, using less jargon. "...process improvement is anchored in continuous data review." "...fully integrate the CSB mission, vision and values into staff orientation, onboarding, and ongoing agency activities." (onboarding?) "Administer and act on an organizational culture survey" "internal and external dashboard" "Establish an annual quality improvement plan for service and business areas within the CSB which includes anticipation from individuals and families" (anticipation?) "...process improvement is anchored in continuous data review." ....fully integrate the CSB mission, vision and values into staff orientation, o Administer and act on an organizational culture survey external dashboard Establish an annual quality improvement plan for service and business areas within the CSB which includes anticipation from individuals and families

9. Although you specifically mention populations such as infant/toddler, youth and family and ID, not much mention of older adult specialty. I wonder what are the plans... since it is such a growing population.

10. Change "intravenous drug use" to "injection drug use." Need to add At-Risk Youth and SED Youth to populations served. You get into specifics around Infant Toddler Connection and Women and Girls who are pregnant and injection drug users and developmental delay and intellectual disability but completely exclude youth At-risk for SED or who are considered SED. Youth do not have SMI. Regarding description about emergency services... Not my understanding that ES provides medication evaluations to all. This is done on a very limited basis. Your description is too broad and misleading. Definition for Crossroads... avoid using "anti-social" to describe youth. Case Management does not do justice to the treatment that is done with SMI in adult services (MH). Need to better define what is actually done. To go from CM to Adult-Partial doesn't make sense. There needs to be something in between, which there is, but it's not recognized in your description of services. Need Youth Representation on your CSB Strategic Plan Development Team.
11. Definitely need to proof read your report, many errors from chart error that is missing an amount to words that aren't spelled correctly. It also appears that Intellectual Disabilities are a throw away program in the report and that MH and SA are primary and only relevant services.

12. I don't think that admin/support staff are "behind the scenes" A lot of them are right up front, and doing a fantastic job of being the first face that the public sees. Not sure that it's necessary to call them "behind the scenes"

13. Good plan...Goals are on target, but would like to see some of the strategies reflect a commitment to more integrated management/leadership practices to ensure we can accomplish the goals.

14. Under professional development- include a measure to gauge how many employee can easily access professional development and courses and/or how timely these are offered compared to need

15. I think the publication of an annual progress report is a good idea.

16. The real test of the Strategic Plan is whether or not there will be periodic reviews to determine how well the CSB and county are meeting the goals of the plan. So many of these plans end up on the shelf; I would hope that this could become a "living document" (to use an old cliche).

17. thank you for requesting staff input

18. Only SMI clients can be seen. SMI determined site by site, unequal at this time. No therapy can be offered. CM only which is ridiculous. Staff being micromanaged by ADS staff who are accustomed to dysfunction. Staff morale is lowest it has been in over 10 years. When morale is this low it affects care. Families who 2 yrs ago would get service are not welcome into the CSB at this time

19. CSB services should include a strong focus on outreach/publicity to notify all people, especially ESL populations, of CSB services. Ease of access should be more clearly highlighted as a priority. Coordination within the CSB should be increased including collaboration for individuals served by multiple "silos," i.e., ID and MH services. ITC and ID services should increase communication and streamline a process for getting ITC clients on ID Waiver waiting lists. The workforce should have maximum caseloads to meet demands appropriately. There is a great need to examine and reduce the caseloads of ID Support Coordinators. Income should be diversified by considering and exploring the feasibility of a local/federal match Medicaid Waiver for employment and day support services for the special education graduates and other county-funded services. An emphasis should be placed on Employment First over day support services. There is a great need for increased training of ID staff and Call Center staff about ID resources within the CSB and throughout the community.

20. Please hire the right Executive Director this time! I have been here a while and the last few years have been a mess! Including, Credible, combining all the services, online trainings, budget, etc. There was a very good reason why all the service areas were separate, we are all very different, trying to combine them has been a big mistake.

21. There is still a huge gap between the CSB plans and actual implementation. Despite years of talking about "recovery", clients are still described as "non-compliant" in our EHR because they didn't follow staff recommendations for treatment. We have very limited services for individuals who are using substances and mentally ill. In particular, psychiatrists are often reluctant to treat individuals with active co-occurring disorders and speak of them in disparaging tones. I also feel
that the CSB is stuck in the past with many residential programs when there are newer evidence-based models that provide more successful outcomes.

22. CSB is a leader in which the federal government should look at.

23. IDS need their own therapist and psychiatrist to assist with individual’s needs. If a person with IDS needs MH help within CSB, they are mostly like referred back to their Support Coordinator. SC’s are not licensed therapist and cannot provide MH services, nor prescribe Medication. Very minimal therapy/psychiatrist community resources for people with ID in the community.

24. The Police Dept gave me the number - having only one team for the entire county (lack of resources) for acute problems is not good where mental illness (PTSD, etc.) is concerned. As a veteran, my sister served this country and she is having a hard time. Something traumatic happened. She needs support and cannot get any.

25. CSB needs to emphasize and work on improving clinical development of its providers, to include licensure supervision. The CSB has failed in this area in the past two years.
Strategic Plan
July 1, 2014 to June 30, 2017

Call 703-324-7000, TTY 711 to request this information in an alternate format.
Forward

We are pleased to present the Fairfax-Falls Church Community Services Board’s (CSB) FY 2015 – 2017 Strategic Plan, the roadmap that will effectively guide us towards achieving our mission:

“To provide and coordinate a system of community-based supports for individuals and families of Fairfax County and the cities of Fairfax and Falls Church who are affected by developmental delay, intellectual disability, serious emotional disturbance (youth), mental illness and/or substance use disorders.”

We remain fully committed to our mission but acknowledge there are challenges ahead which are characterized by increasing community needs and diminishing resources. Legislative changes at the national and state levels add to the complexity of the CSB’s challenges. This strategic plan examines these challenges and provides direction for where the CSB is going, the actions needed to get there, and milestones to let us know if we get there successfully.

Our strategic plan was developed using these four principles:

- **Strategic planning is an ongoing process.** This 3 year plan is designed to evolve with the needs of the CSB and those we serve.
- **Strategic planning is future-oriented and proactive.** The plan is flexible and can be adapted as needs change and as new priorities emerge.
- **Evaluation and performance measurement are key to the strategic plan’s success.** The plan will be reviewed and evaluated annually and data will be gathered and shared to demonstrate the achievement of our strategic goals.
- **Strategic planning involves broad participation.** Individuals receiving services, families, community members, partners, stakeholders and staff in the planning, development and implementation of the activities, services and supports outlined in this plan.

We look forward to working with our partners to carry out this plan and celebrate our successes along the way.

Ken Garnes, Chairman
Fairfax-Falls Church CSB Board

Len Wales, Acting Director of Administration/General Manager
Fairfax-Falls Church CSB
Strategic Plan
July 1, 2014 to June 30, 2017

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Comment [PL2]: Added priority access guidelines to appendix
About Us – The Fairfax-Falls Church Community Services Board

Where We Want to Be – CSB Vision
Everyone in our community has the support needed to live a healthy, fulfilling life.

What We Do – CSB Mission
To provide and coordinate a system of community-based supports for individuals and families of Fairfax County and the cities of Fairfax and Falls Church who are affected by developmental delay, intellectual disability, serious emotional disturbance (youth), mental illness and/or substance use disorders.

What We Believe In – CSB Values
In achieving our mission and vision, we value:

- **Respect** for the people we serve.
  Individual dignity and human rights protection are at the center of the CSB service philosophy. Each individual is involved in developing service plans which address his/her needs and preferences. Feedback from service recipients is encouraged to assess program strengths and areas for improvement.

- **Quality** in the services we provide.
  The CSB offers a comprehensive menu of preventative and responsive services that meet the needs of individuals who live in the Fairfax County community. Services are provided by qualified professionals using methods proven to achieve positive, measurable outcomes.

- **Accountability** in all that we do.
  The CSB recognizes its responsibility to the Fairfax County community by striving to provide services to people with limited resources or complex needs in an effective and efficient manner. Policies and procedures are communicated and accessible to all individuals and organizations with whom we work and process improvement is anchored in continuous data review.

Who We Are
The Fairfax-Falls Church Community Services Board (CSB) is the public agency that plans, organizes and provides services for people in our community who have mental illness, substance use disorders, and/or intellectual disability. The CSB also provides early intervention services for infants and toddlers with, or are at risk for, developmental delays.

We are one of 39 Community Services Boards and one Behavioral Health Authority in the Commonwealth of Virginia. State law requires every jurisdiction to have a CSB. We operate as part of Fairfax County government’s human services system.

Our staff and contracted service providers include, but are not limited to, psychiatrists, nurses and medical staff, counselors, therapists, case managers and support coordinators, peer specialists, and support and administrative staff. We partner with community organizations, faith communities, businesses, schools and other local government agencies in many ways to provide the services people need, and to be good neighbors in the community.

1 About the CSB: [http://www.fairfaxcounty.gov/csb/](http://www.fairfaxcounty.gov/csb/)
**Who We Serve**

Our CSB serves residents of Fairfax County and the cities of Fairfax and Falls Church.

*Most CSB services are primarily for people whose conditions seriously impact their daily functioning. However, anyone with a related concern may contact the CSB for help in finding appropriate treatment and resources. (See Appendix B, Guidelines for Assigning Priority Access to CSB Services)*

**What Services We Provide**

There are two main areas of focus for CSB services:

- **Acute & Therapeutic Treatment Services** – Engagement, Assessment & Referral Services; Emergency and Crisis Services, Residential Treatment Services, Detoxification Service, Youth & Family Intensive Treatment Services, Youth & Family Outpatient and Day Treatment Services, and Infant and Toddler Connection.

- **Community Living Treatment & Supports** – Support Coordination Services, Employment & Day Services, Assisted Community Residential Services, Behavioral Health Outpatient & Case Management Services, Supportive Residential Services, Forensic Transition & Intensive Community Treatment Services, and Jail-Based Behavioral Health Services.

Services are provided directly by CSB staff, or provided through contracts with local partner organizations.

**Where We Provide Services**

Services are provided in a variety of settings throughout the county, including offices, residential settings, and in the community.

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2 Who We Serve: [http://www.fairfaxcounty.gov/csb/about/](http://www.fairfaxcounty.gov/csb/about/)


4 CSB Services: [http://www.fairfaxcounty.gov/csb/services/](http://www.fairfaxcounty.gov/csb/services/)

4 Strategic Plan Appendix C

5 CSB Service Locations: [http://www.fairfaxcounty.gov/csb/about/locations.htm](http://www.fairfaxcounty.gov/csb/about/locations.htm)
How We Are Funded

NOTE: This draft plan reflects the FY 2015 advertised budget. The FY 2015 budget will be included when adopted.

CSB FY 2015 Advertised Budget

Total Revenue $153,178,077

CSB FY 2015 Advertised Budget

Total Expense $153,178,077

Getting Where We Want to Go – Goals, Strategies, and Performance Measures

Three goals have been identified:

**Goal 1**: Our SERVICES support individuals and families to live self-determined and healthy lives.

**Goal 2**: The WORKFORCE is capable and dedicated to carry out the CSB mission

**Goal 3**: The CSB is fiscally and operationally sound.

These goals, associated strategies and performance measures described below will help us to meet our vision and mission.

**Goal 1: Our SERVICES support individuals and families to live self-determined and healthy lives.**

- **Strategy**: Provide or coordinate an array of services leading to the attainment of personal goals/objectives as defined by each individual.
  - Establish process to define, record, and report standard outcome measures related to meeting individual goals/objectives.
    - Measure: % of CSB program areas achieving their targets for individuals meeting service plan objectives.

- **Strategy**: Increase accessibility to services so individuals and their families receive services when and where needed.
  - Establish process to track, monitor, and address demand, utilization, and capacity targets.
    - Measure: % of programs meeting standards for access to services.
    - Measure: % of programs operating at capacity.
  - Establish productivity and capacity targets and develop mechanisms to measure progress towards targets.
    - Measure: % of programs meeting identified productivity and capacity.
  - Existence of a process to identify and prioritize service populations, needs, and service gaps to include alignment with County safety net activities.

- **Strategy**: Provide supports and services to promote an individual’s access to primary care, housing, and employment.
  - Establish process to define and measure health care outcomes, stable housing, and employment/day activity.
    - Measure: % of individuals with a primary care provider.
    - Measure: % of individuals who achieve or maintain stable housing.
    - Measure: % of individuals who achieve or maintain employment, school, or meaningful day activity.

- **Strategy**: Implement and evaluate current best and/or evidence-based practices in service delivery.
  - Establish a process to define, prioritize, and measure use of best and/or evidence-based practices.
    - Measure: % of CSB programs employing best and/or evidence-based practices.
Goal 2: The WORKFORCE is capable and dedicated to carry out the CSB mission.

- **Strategy: Promote a positive work culture and environment that supports the CSB mission, vision, and values.**
  - Establish a process to define and measure a “positive work culture and environment” to fully integrate the CSB mission, vision and values into staff orientation, onboarding, and ongoing agency activities.
  - Administer and act on an organizational culture survey.

- **Strategy: Promote and support administrative, clinical, and managerial professional development.**
  - Measure: % of courses for which participants’ overall satisfaction was rated 4 or above on a 5 point scale.
  - Measure: % of courses for which participants rated content as relevant and provided tools or ideas that would help them perform their job better.
  - Measure: % of courses for which participants reported increased knowledge with the training topics after taking classes.
  - Measure: % of courses for which participants indicated an increased/enhanced knowledge and ability to use training concepts.
  - Measure: % courses for which participants indicated that the offering developed their competencies, knowledge, skills, or abilities to achieve current and/or future goals.

Goal 3: The CSB is fiscally and operationally sound.

- **Strategy: Use of accurate, reliable and timely data to inform decision making and system improvement.**
  - Provide a complete and accurate State Performance Contract report, in compliance with all contract elements, to the Department of Behavioral Health and Developmental Services.
  - Develop an internal dashboard for service area directors and managers to use as a program management tool.
  - Develop an external dashboard to display and communicate key data elements and outcomes.

- **Strategy: Allocate and manage resources to maximize service capacity, improve service quality and achieve CSB’s mission.**
  - Align human resources and financial management systems and processes to support the current service delivery system.
  - Develop a zero-based budget based on an analysis of the required resources (positions and expenditures) and non-county and county funding required for each service area, including a review of services provided, population served, and outcomes and an analysis of return on investment.
  - Create easy-to-use financial management tools for service area directors and program managers to improve financial and program management.
  - Update portfolio of financial management policies and procedures to support efficient and effective operations and sound internal controls.
• **Strategy: Cultivate partnerships and supports which build community capacity to provide a continuum of services.**
  - Establish an annual process to identify key partnership areas for development and evaluate outcomes of partnerships developed.
  - Create or expand partnerships that support CSB strategic goals.

• **Strategy: Ensure Regulatory and Corporate Compliance.**
  - Incorporate internal controls into an agency-wide system of regulatory and corporate compliance.
    - Measure: % compliance with internal and external audits (programmatic and finance).

• **Strategy: Integrate performance measurement into quality improvement systems.**
  - Establish an annual quality improvement plan for service and business areas within the CSB which includes participation from individuals and families.
    - Measure: % of programs with at least one outcome/"better off” performance measure and performance target.
    - Measure: % of programs achieving established performance targets.

• **Strategy: Ensure open, timely, and consistent communication.**
  - Develop and enhance strategies to communicate internally and externally, using a variety of media.
  - Use data points from a variety of communication tools to assess effectiveness of communication practices.
    - Measure: % of staff acknowledging satisfaction with the CSB communications content and systems.

• **Strategy: Leverage technology to support the service delivery system.**
  - Refine electronic health record (EHR) implementation and complete business process review to ensure a standardized approach for use of the EHR.
    - Use EHR to establish and retrieve data to support agency strategic goals and activities.

**How We Use the Strategic Plan – The Evaluation Process**

Primary responsibility to facilitate CSB strategic planning activities lies with the Office of Strategy and Performance Management (SPM). This office works closely with members of the CSB Senior Leadership Team to identify strategic planning needs, develop goals/targets, monitor implementation, evaluate results, and recommend performance improvement.

The CSB strategic plan is evaluated on an ongoing basis, as progress toward established goals and strategies are assessed. A comprehensive evaluation of goals, strategies, and performance measures will be completed at the end of each fiscal year with results provided in an annual report. A strategic planning implementation team, facilitated by CSB Office of Strategy and Performance Management, and comprised of a broad representation of CSB staff and stakeholders, is convened to evaluate and recommend revisions to the strategic plan. Recommendations for revisions are brought to the CSB stakeholders for feedback.

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7 Strategic Plan Appendix F - Strategic Plan Development
Appendices
Appendix B – Priority Access Guidelines

Guidelines for Assigning Priority Access to CSB Services

Defining who should have priority access to services of the Fairfax-Falls Church Community Services Board (CSB) is a necessary and critically important process to ensure compliance with state and federal codes and regulations. These priorities guide state contract reporting for the CSB’s allocation of state block grant funding. This process also applies to decisions about how best to use local funding dollars. Guidelines for assigning priority access need to take into consideration and include those individuals whose needs cannot be addressed except through a public system such as the CSB, which provides and coordinates multiple levels and types of services to help individuals gain a level of independence and self-determination. Effective and efficient use of resources is an inherent requirement of all CSB services so that the maximum number of people are served within the limits of federal, state and local funds available.

(1) Exclusionary Criteria
   a. Constituency – Restrict access to residents of Fairfax County and the Cities of Fairfax and Falls Church.
   b. Requests outside of the CSB’s Mission – No service will be provided that is not designed, mandated or funded to be provided by a CSB.

(2) Inclusionary Criteria (in priority order)
   a. Enrolled in Service – Currently enrolled individuals who maintain the need for current services (or the equivalents) being provided.
   b. Need – All people who meet the priority population criteria with serious and imminent needs that cannot be met elsewhere.
   c. Alternative Resources – Individuals with needs for services who do not have alternative resources such as service access, insurance, or family supports.
   d. Effectiveness – Once all those who meet the above criteria have been served, anyone who shows the greatest likelihood of receiving benefit from services can be served.
   e. Comparative Need – If resources are still available, anyone who still has additional needs for service can have those service needs addressed.
   f. Selection Based on Length of Wait – First-come, first-served basis.

NOTE: These criteria do not apply to initial phone screening; acute care services; or wellness, health promotion, and prevention services, all of which are available to all residents of Fairfax County and the Cities of Fairfax and Falls Church.
CSB Priority Populations

Priority Populations
The Fairfax-Falls Church Community Services Board (CSB) has identified the following priority service populations based upon definitions from the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Federal Substance Abuse Prevention and Treatment Block Grant (SAPT), and Part C of Individuals with Disabilities Education Act (IDEA). Individuals must meet the priority service population criteria below to have consistent access to non-emergency/non-acute CSB services.

Note: The following services – initial phone screening; wellness, health promotion and prevention services; and acute care and emergency CSB services – remain available to all residents of Fairfax County and the cities of Fairfax and Falls Church.

Individuals may meet the criteria for more than one priority population and receive services accordingly. Individuals who are only in one priority population receive the CSB services which address the needs of the population area they are in. For example, an individual meeting the substance use priority population criteria only cannot also receive a priority to access services designed for the Intellectual Disability population, unless that individual also meets the criteria for the Intellectual Disability population. People meeting priority population requirements will have access to cross-cutting organizational services such as medical services or housing assistance supports as available to meet service plan goals. People with co-occurring disorders, meeting the priority population criteria, will have access to services as available to address co-occurring needs.

Individuals and families who have private health insurance coverage and are able to access non-emergency/non-acute services privately will be asked to seek those services when they are available in the community. In these instances, the CSB Entry and Referral Services staff will assist in identifying resources, linking with potential non-CSB sources of services, and following up with referrals. If similar resources are not available in the community, individuals with private insurance will be screened for priority using the same criteria as is used for those without insurance.

A. Mental Illness Population
   (1) **Adults with Serious Mental Illnesses** (SMI) assessed along the three dimensions of diagnosis, functional impairment, and duration.
      - **Diagnosis** through the current Diagnostic and Statistical Manual (DSM) of serious mental illness including those along the schizophrenia spectrum, predominantly thought and psychotic disorders, persistent major affective disorders, AND
Impairments due to a serious mental illness that seriously impact, on a recurrent or continuous basis, how the individual functions in the community, including to the following:

- Inability to consistently perform practical daily living tasks required for basic adult functioning in the community (such as keeping a living space clean, shopping for food, hygiene);
- Persistent or recurrent failure to perform daily living tasks except with significant support or assistance by family, friends or relatives;
- Inability to maintain employment at a living wage or to consistently carry out household management roles; or
- Inability to maintain a safe living situation.

The duration of the serious mental illness has been or is anticipated to be of a long duration (at least six months) and is considered chronic. It usually has resulted or, if left untreated, is likely to result in repeated or significant psychiatric hospitalizations.

(2) Children and Adolescents birth through age 17 with Serious Emotional Disability (SED) resulting in a serious mental health problem that can be diagnosed through the DSM, which is used as the professional guidelines for diagnosis by psychiatry and other professionals, plus have at least one of the following:

- Problems in personality development and social functioning which have been exhibited over at least one year.
- Problems that are significantly disabling based upon the social functioning of most children their age.
- Problems that have become more disabling over time and service needs that require significant intervention by more than one agency.
- Children with a co-occurring substance use disorder or intellectual disability diagnosis also meet the criteria for SED.

(3) Children, birth through age 7, who are determined to be at risk of developing Serious Emotional Disability by means of one of the following:

- Child exhibits behavior that is significantly different from or significantly behind most children their age, and which does not result from developmental or intellectual disability.
- Physical or psychological stressors exist that put the child at risk for serious emotional or behavioral problems.

B. Substance Use Disorder Population

(1) Adults with a Substance Dependence Disorder assessed along the three dimensions of diagnosis, functional impairment, and duration.

- Diagnosis: through the current Diagnostic and Statistical Manual (DSM) of Substance Dependence (not including sole diagnosis of nicotine dependence)
• Functional Impairment (any of the following):
  o Continuation or intensification of substance-related symptoms despite previous substance abuse treatment.
  o Inability to be consistently employed at a living wage or consistently carry out household management roles.
  o Inability to fulfill major role obligations at work, school or home.
  o Involvement with legal system as a result of substance use.
  o Involvement with the foster care system or child protective services as a result of substance use.
  o Multiple relapses after periods of abstinence or lack of periods of abstinence.
  o Inability to maintain family/social relationships due to substance use.
  o Inability to maintain stable housing (i.e., on their own or by contributing toward housing costs in shared housing).
  o Continued substance use despite significant consequences in key life areas (i.e., personal, employment, legal, family, etc.).
  o Hospital, psychiatric or other medical intervention as a result of substance use.

• The duration of the Substance Dependence has been or is anticipated to be of a long duration (at least six months) and is considered chronic. It usually has resulted or, if left untreated, is likely to result in repeated or significant impairments in multiple life areas.

(2) Children and adolescents (under 18 years old) with a DSM diagnosis of substance abuse or dependence, who have used substances in the prior 12 months (or who have been in detention or in a therapeutic residential environment and have used substances within the 12 months prior to entry); who present with cognitive, behavioral or physiological symptoms; and present with impairments as a result of substance use in one or more of the following areas:
  • Continuation or intensification of substance-related symptoms despite previous substance abuse treatment interventions.
  • Inability to fulfill major role obligations at work, school or home.
  • Involvement with legal system as a result of substance use.
  • Multiple relapses after periods of abstinence or lack of periods of abstinence.
  • Inability to maintain family/social relationships due to substance use.
  • Continued substance use despite significant consequences in key life areas (i.e., personal, school, legal, family, etc.).
  • Hospital, psychiatric or other medical intervention as a result of substance abuse or dependence.

(3) Special Priority Populations
  • Pregnant women who are intravenous (IV) drug users
  • Pregnant women
  • Intravenous drug users
C. Intellectual Disability and Developmental Disability Populations

(1) Infants and Toddlers: Children from birth to age three with a confirmed eligibility for Part C of the federal Individuals with Disabilities Education Act (IDEA) and their families are eligible for early intervention services through Infant and Toddler Connection (ITC).

(2) Children and Adults: Children no younger than two years old and adults with a diagnosis of Intellectual Disability (ID) with onset prior to the age of 18 who have significant deficits in at least two areas of adaptive living skills (i.e. communication, self-care, home living, social /interpersonal skills, use of community resources, self-direction, functional academic skills, work leisure health and safety).

(3) Diagnosis of Intellectual Disability (ID) must be documented by:

- For children ages 2-6 years of age, a developmental evaluation with a diagnosis of developmental delay or intellectual disability or
- For individuals age 6 and older, a psychological evaluation completed prior to the age of 18 providing a diagnosis of intellectual disability with a full scale IQ of about 70 or below OR other medical, educational, or professional documentation showing that a disability had onset before age 18 coupled with a statement from the family that no formal IQ score had been done or is currently available and a current IQ test showing an Intellectual Disability.
**Engagement, Assessment & Referral Services**

Engagement, Assessment & Referral Services includes the CSB Entry and Referral Call Center that responds to inquiries from people seeking information and services; the Assessment Unit that provides comprehensive screening, assessment, referral and stabilization services for adults; and Outreach Services for people who are homeless or unsheltered and may need CSB services. The goal of all these services is to engage people who need services and/or support, triage people for safety, and help people get appropriate treatment and support to meet their needs. Not everyone with a concern related to mental illness, substance use or intellectual disability is eligible for CSB services, which are primarily for people who are disabled by conditions of mental illness, substance use disorders and/or intellectual disability. However, anyone may call for information and referral to other potential resources in the community. Call center staff can take calls in English and Spanish, and language translation services for other languages are available telephonically when needed.

**Emergency and Crisis Care Services**

Emergency and Crisis Care Services includes two walk-in psychiatric emergency services sites (located in central and southern parts of the County), one Mobile Crisis Unit (MCU) that responds to crises throughout the community, and short-term (7 to 10 days) residential detoxification at the Fairfax Detoxification Center and crisis stabilization services at Woodburn Place Crisis Care.

Anyone in the community who is experiencing a psychiatric crisis can access CSB Emergency Services, which offers recovery-oriented crisis intervention, crisis stabilization, risk assessments, and evaluations for emergency custody orders and admission (voluntary and involuntary) to public and private psychiatric hospitals and three regional crisis stabilization units. The central County site is open 24/7, and can provide psychiatric and medication evaluations as well as prescribe and dispense medications. The MCU includes rapid deployment teams that can respond 24/7 to hostage/barricade incidents with the County’s Special Weapons and Tactics (SWAT) team and police negotiators; a critical incident stress management team that provides assistance during and after traumatic events; and a disaster response team.

Woodburn Place Crisis Care offers individuals experiencing acute psychiatric crisis an alternative to hospitalization. It is an intensive, short-term, community-based residential program for adults with severe and persistent mental illness, including individuals who have co-occurring substance use disorders. Services include comprehensive risk assessment; crisis intervention and crisis stabilization; physical, psychiatric and medication evaluations; substance abuse counseling; psychosocial education; and assistance with daily living skills.

**Detoxification Services**

The Fairfax Detoxification Center provides a safe, temporary, protective environment for individuals experiencing crisis requiring detoxification from use of alcohol, drugs and/or other substances. Individuals receive assessment, care, supervision and medical monitoring necessary to stabilize both physically and emotionally.

**Youth & Family Intensive Treatment Services**

Youth & Family Intensive Treatment Services supports and guides parents, and treats children and youth who are developmentally compromised (may have challenges in development that impact daily functioning), who have or are at risk of developing Serious Emotional Disability, and/or who are involved...
with more than one youth-serving agency. This service area includes Wraparound Fairfax, Resource Team services, two residential programs (Crossroads Youth and Sojourn House), and services for youth involved with the Juvenile and Domestic Relations District Court (JDRDC).

Wraparound Fairfax provides an intensive level of support for youth who are at high risk for residential or out-of-home placement, or who are currently served away from home and transitioning back to their home community. Services are provided for up to 15 months and are designed to enable youth to remain safely in the community with their families. County case managers make the referrals, and approval for services is determined by Comprehensive Services Act (CSA) utilization review staff. Resource Team services include state-mandated discharge planning; behavioral health consultations to CSA related requests; CSA lead case management; case management for youth using State Mental Health Initiative Funding; monitoring of youth under Mandatory Outpatient Treatment commitment; and tracking of regional state hospital funding.

Two residential programs serve adolescent youth. Crossroads Youth is a 10-bed residential program serving adolescent males who have co-occurring mental health and substance use disorders, anti-social behaviors and primary substance abuse. Sojourn House is an eight-bed group home that serves adolescent females who have mental health and/or co-occurring disorders as well as histories of abuse, trauma and mood instability.

Services for youth involved with the JDRDC are provided via court order by a Juvenile Court judge or requested by a Fairfax County probation officer. These services include a variety of evaluations such as alcohol and drug use assessments, psychological evaluations, and Competency to Stand Trial evaluations. Mental health and substance abuse treatment interventions (individual, group and family therapies) are provided to youth and their families in the Juvenile Detention Center, Shelter Care II, Boys Probation House, Foundations, Transitional Living Program, the Post Dispositional Program, and in a community diversion program. In addition, case management services are available, as well as psychiatric medication monitoring.

Youth & Family Outpatient & Day Treatment Services

Youth & Family Outpatient & Day Treatment Services provides assessment, education, therapy and case management services for children and adolescents ages 2 through 18 who have substance use and/or mental health disorders. Case Management services are provided in all services to include medication management, work with the Comprehensive Services Act, and other service coordination.

Infancy, Early Childhood and Pre-Adolescent (IECP) mental health services serve at-risk infants, toddlers, preschoolers and pre-adolescents (children from birth to 12 years of age) and their parents. Services support and guide parents and treat children who are developmentally compromised, seriously emotionally disturbed or at risk of serious emotional disturbance and are involved with multiple youth serving agencies.

Day Treatment Services for youth are provided at two separate programs, one located in Falls Church and the other in Reston. Horizons Adolescent Day Treatment Program in Falls Church serves youth who have primary substance use disorders and secondary mental health disorders. FCPS provides an alternative school at the site, and youth stay from three to six months. The Teen Alternative Program (TAP) in Reston serves youth who have primary mental health disorders and co-occurring disorders.
alternative school is also provided by FCPS at TAP. In both the Horizons and TAP programs, youth attend school in the morning, and treatment occurs in the afternoon and evening.

**Infant and Toddler Connection**

The Infant and Toddler Connection (ITC) of Fairfax-Falls Church is part of a statewide program that provides federally mandated early intervention services to infants and toddlers as outlined in Part C of the Individuals with Disabilities Education Act (IDEA). The CSB serves as the fiscal agent and local lead agency for the program, with advice and assistance from a local interagency coordinating council. ITC provides family-centered intervention to children from birth to age three, who need strategies to assist them in acquiring basic developmental skills such as sitting, crawling, walking and/or talking. Families receive a screening to determine eligibility, service coordination, and development of an Individual Family Service Plan at no cost to them. Through public and private partnerships, ITC provides services including physical, occupational and speech therapy; developmental services; medical, health and nursing services; hearing and vision services; assistive technology (e.g., hearing aids, adapted toys and mobility aids); family training and counseling; service coordination; and transportation.

ITC staff collaborates with the Fairfax County Health Department, Inova Fairfax Hospital, and Fairfax County Public Schools (FCPS) to ensure that infants and toddlers get appropriate services as soon as delays are detected. Given the rising prevalence of autism in Fairfax County, ITC maintains ongoing relationships with the Virginia Autism Research Center and FCPS to address the early identification of children who might need specialized preschool services for this particular disability. ITC contracts with translation services providers to meet the needs of families in the linguistically diverse community. These interpreters are fluent in 10 languages, including Spanish, Urdu, Mandarin Chinese, Korean, Amharic, and others.

**Residential Treatment Services**

Residential Treatment Services (Crossroads Adult, New Generations, A New Beginning, A New Direction, Residential Support Services, and Cornerstones) provides comprehensive services to adults who have substance use disorders and/or co-occurring substance use disorders and mental illness. Individuals served have been unable to maintain stability on an outpatient basis, even with extensive supports, and require a stay in residential treatment to stabilize symptoms, regain functioning and develop recovery skills. At admission, individuals have significant impairments affecting various life domains, which may include criminal justice involvement, homelessness, unemployment, impaired family and social relationships, and health issues. Most individuals are referred by the criminal justice system, are ineligible for insurance or Medicaid, and have few resources. Without this safety net program, most would have no recourse for treatment. People seeking this level of service often need job training, health care access, and help in developing basic life skills for finding and keeping a job, community support and socialization, communication, learning appropriate community (non-criminal) behavior, and regulating emotions.

Services are provided in residential treatment settings that are matched to the level and duration of care needed, and include intermediate and long-term treatment with 24-hour staffing and supervised treatment services with staffing 12-18 hours per day. Services include individual, group and family therapy; psychiatric services; medication management; and case management. In addition, continuing care services are provided to assist with the transition back to the community. Specialized treatment services are provided for clients with co-occurring disorders (substance use and mental illness), for
pregnant and post-partum women, and for people whose primary language is Spanish. Continuing care services offer ongoing structure and support to assist individuals in their continuing recovery from substance use and co-occurring disorders.

**Support Coordination Services**

Support Coordination Services helps individuals who have intellectual disability, and their families, to access essential services and supports so that the individual’s basic needs are met and they can live successfully in a community setting. These include medical, educational, employment, housing, financial, transportation, recreational, legal, life skill, and advocacy services. Service values and approaches include person-centered planning and the principles of community inclusion and participation. Service coordinators help individuals and families identify needed services and resources through an initial and ongoing assessment and planning process, and coordinate with other involved service providers. They also assess progress on an ongoing basis to make sure that services are delivered and are in accordance with regulatory standards for best practice and quality.

**Behavioral Health Outpatient & Case Management Services**

Behavioral Health Outpatient & Case Management Services addresses clinical and case management needs of persons who have mental illness, substance use disorders, and/or co-occurring disorders. This service area includes outpatient programming, case management, day treatment, adult partial hospitalization, and continuing care services.

Outpatient Services provide structured programming, including psychosocial education and counseling (individual, group, and family) for adults whose primary needs involve substance use, but who may also experience mild to moderate mental illness. Services help individuals achieve behavioral changes that promote recovery; encourage the use of problem-solving skills and coping strategies; and help individuals develop a positive support network. Intensive outpatient services focus on similar areas but involve more frequent meetings.

Case Management provides strength-based, person-centered services for adults who have serious and persistent mental or emotional disorders. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or intellectual disability are also eligible for case management services. Services focus on interventions that support recovery and independence and include supportive counseling to improve quality of life; crisis prevention and management; medication management; psychiatric services; and group supports. The goal of case management services is to work in partnership with individuals to stabilize behavioral health crises and symptoms; facilitate optimal community integration; help them learn to manage symptom reoccurrence and build resilience; and promote self-management, self-advocacy, and wellness.

Day Treatment serves adults whose primary needs involve substance use but who may also experience mild to moderate mental illness. In contrast to outpatient programming, day treatment services are for adults who would benefit from a greater level of structure and intensity. Services are provided five days a week and include group and individual counseling as well as case management services.

Adult Partial Hospitalization (APH) programs provide intensive recovery-oriented services to adults with mental illness or co-occurring disorders and complex needs. Services are provided within a day programming framework and are designed to help prevent the need for hospitalization or to help people transition from recent hospitalization to less intensive services. APH focuses on helping individuals
develop coping and life skills, and on supporting vocational, educational, or other goals that are part of
the recovery process. Services provided include service coordination, medication management, psycho-
educational groups, group and family therapy, supportive counseling, relapse prevention and community
integration.

Continuing Care services are available for individuals who have successfully completed more intensive
outpatient services but who would benefit from periodic participation in group therapy, monitoring and
service coordination to connect effectively to community supports. Specialized services, including trauma
work, cognitive behavior therapy and Dialectical Behavior Therapy, are available to individuals served by
Behavioral Health Outpatient Services, as well as to individuals receiving care in other CSB service
areas.

**Employment & Day Services**

Employment & Day Services provides assistance and vocational training to improve individual
independence and self-sufficiency in order to enter and remain in the workforce. Employment and day
services for individuals with serious mental illness and/or intellectual disability are provided primarily
through contracts and partnerships with private, nonprofit and/or public agencies. This service area
includes developmental services; sheltered, group and individualized supported employment; the
Cooperative Employment Program (CEP); psychosocial rehabilitation; and the Community Readiness
and Support Program.

Developmental Services provides self-maintenance training and nursing care for individuals with
intellectual disability who are severely disabled and need various types of services in areas such as
intensive medical care, behavioral interventions, socialization, communication, fine and gross motor
skills, daily and community living skills, and possibly limited remunerative employment. Sheltered
Employment provides remunerative employment in a supervised setting with support services for
habilitative development. Group Supported Employment provides intensive job placement assistance for
off-site supervised contract work and competitive employment in the community, as well as job retention
services. Individualized Supported Employment provides remunerative employment with necessary
support services; this service is primarily for persons with less severe disabilities and stresses how to
integrate socially in the work setting with non-disabled workers. CEP is jointly funded and operated by
the Virginia Department of Aging and Rehabilitative Services and the CSB, and provides supported
competitive employment services to eligible individuals who have developmental disabilities. Using an
individualized approach, program staff assesses skills, analyzes job requirements, and provides on the
job training for individuals and disability awareness training for employers.

Psychosocial Rehabilitation provides an adjustment period and skills development for persons with
serious mental illness and co-occurring disorders transitioning to employment and socialization in a work
setting. Services may include training in areas of self-esteem, self-confidence, and self-awareness. The
Community Readiness and Support Program is a recovery-oriented psychosocial day program for
individuals with serious mental illness and co-occurring disorders who have limited social skills, difficulty
establishing and maintaining relationships, and who need help with activities of daily living. Services
include psycho-educational groups, social skills training, services for individuals with co-occurring
disorders, relapse prevention, training in problem solving and independent living skills, medical
education, pre-vocational services, and community integration.
Supportive Community Residential Services

Supportive Community Residential Services programming is provided through various housing partnerships and is primarily for people with serious mental illness or co-occurring mental illness and substance use disorders.

Residential Intensive Care (RIC) is a community-based, intensive residential program that provides daily (or 5 days/week) onsite monitoring of medication and psychiatric stability. Counseling, supportive and treatment services are provided daily in a therapeutic setting. The Transitional Therapeutic Apartment Program (TTAP) provides residential treatment in a stable, supportive, therapeutic setting. Individuals learn and practice life skills needed for successful community living with the goal of eventually transitioning into the most manageable independent living environment. The Supportive Shared Housing Program (SSHP) provides residential support and case management in a community setting. Fairfax County’s Department of Housing and Community Development (HCD) and the CSB operate these designated long-term permanent subsidized beds, and units are leased either by individuals or the CSB.

The CSB’s moderate income rental program and HCD’s Fairfax County Rental Program provide long-term permanent residential support and case management in a community setting, and individuals must sign a program agreement with the CSB to participate in the programs. Pathway Homes and the CSB jointly operate the Supported Housing Option Program (SHOP), which provides long-term or permanent housing with support services, and focuses on individuals with the greatest needs who are willing to accept needed services. Pathway Homes and the CSB also jointly operate the Shelter Plus Care program, providing long-term or permanent housing with support services to individuals with serious mental illness and co-occurring disorders, including those who are homeless and need housing with supports.

Assisted Community Residential Services

Assisted Community Residential Services provides an array of residential supports for individuals with intellectual disability and individuals with mental illness. Supports are not time-limited, are designed around individual needs and preferences, and emphasize full inclusion in community life. Most residential services are provided through CSB partnerships with approved private providers, with the CSB providing contract management oversight.

This service area includes the following programs: a directly operated Assisted Living Facility (ALF) with 24/7 care for individuals who have serious mental illness and medical needs; directly operated and contracted group homes (small group living arrangements for individuals with intellectual disability, usually four to six residents per home) and Intermediate Care Facilities (ICFs) that provide 24/7 supports; supervised apartments that provide community-based group living arrangements with less than 24-hour care; daily or drop-in supports to maintain individuals in their own homes or in shared living arrangements; short-term, in-home respite services; longer term respite services provided by a licensed 24-hour home; and emergency shelter services.

Other residential supports include programs in which individuals live in their own homes or in shared living arrangements (e.g., apartments and town homes) and receive support services ranging from daily to drop-in, based on individual needs and preferences. Individualized Purchase of Service (IPOS) is
provided for a small number of individuals who receive other specialized long-term community residential services via contracts.

**Forensic Transition & Intensive Community Treatment Services**

Forensic Transition & Intensive Community Treatment Services includes an array of services for adults who have serious mental illness and/or serious substance use disorders and who are involved with the criminal justice system, homeless or unsheltered, or are being discharged from state psychiatric hospitals.

Services for adults who are incarcerated at the Adult Detention Center include assessment, stabilization and referral; facilitation of emergency psychiatric hospitalization for individuals who are a danger to themselves or others; and court assessments, substance abuse education and limited treatment for adults with substance use disorders. More than half of the individuals seen by CSB staff working in the Adult Detention Center are current or former CSB service recipients. Their involvement in the criminal justice system is usually a direct result of mental illness, substance use disorders or co-occurring disorders. Incarceration or other involvement with the criminal justice system can present a unique opportunity for CSB staff to intervene and forge a therapeutic alliance.

Intensive Community Treatment Services includes jail diversion, discharge planning services for individuals in state psychiatric hospitals, Program of Assertive Community Treatment (PACT), as well as intensive, community-based case management and outreach provided by multidisciplinary teams to individuals with acute and complex needs. The Jail Diversion Program provides an intensive level of care to enhance existing resources available to persons with serious mental illness and/or severe substance use disorder and co-occurring disorders who are involved with, or being diverted from, the criminal justice system. Discharge Planning Services are provided to individuals in state psychiatric hospitals to support linkages to community-based services, enhancing successful community-based recovery. The Program of Assertive Community Treatment (PACT) is a multi-disciplinary team and provides enhanced support services for individuals with mental illness, substance use and co-occurring disorders.

Intensive Case Management Teams provide intensive, community-based case management and outreach services to persons who have serious mental illness and/or serious substance use disorders. Teams work with individuals who have acute and complex needs and provide appropriate levels of support and services in the individuals’ natural environment. Services include case management, mental health supports, crisis intervention and medication management.

**Jail-Based Behavioral Health Services**

Services for adults who are incarcerated at the Adult Detention Center include assessment, stabilization and referral; facilitation of emergency psychiatric hospitalization for individuals who are a danger to themselves or others; and court assessments, substance abuse education and limited treatment for adults with substance use disorders. More than half of the individuals seen by CSB staff working in the Adult Detention Center are current or former CSB service recipients. Their involvement in the criminal justice system is usually a direct result of mental illness, substance use disorders or co-occurring disorders. Incarceration or other involvement with the criminal justice system can present a unique opportunity for CSB staff to intervene and forge a therapeutic alliance.
Appendix D – Fairfax County Vision Elements

The CSB’s goals, where applicable, are aligned with the Fairfax County Vision Elements.

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County by:

- **Maintaining Safe and Caring Communities**
  The needs of a diverse and growing community are met through innovative public and private services, community partnerships and volunteer opportunities. As a result, residents feel safe and secure, capable of accessing the range of services and opportunities they need, and are willing and able to give back to their community.

- **Building Livable Spaces**
  Together, we encourage distinctive "built environments" that create a sense of place, reflect the character, history and natural environment of the community, and take a variety of forms -- from identifiable neighborhoods, to main streets, to town centers. As a result, people throughout the community feel they have unique and desirable places to live, work, shop, play and connect with others.

- **Connecting People and Places**
  Transportation, technology and information effectively and efficiently connect people and ideas. As a result, people feel a part of their community and have the ability to access places and resources in a timely, safe and convenient manner.

- **Maintaining Healthy Economies**
  Investments in the workforce, jobs, and community infrastructure and institutions support a diverse and thriving economy. As a result, individuals are able to meet their needs and have the opportunity to grow and develop their talent and income according to their potential.

- **Practicing Environmental Stewardship**
  Local government, industry and residents seek ways to use all resources wisely and to protect and enhance the County’s natural environment and open space. As a result, residents feel good about their quality of life and embrace environmental stewardship as a personal and shared responsibility.

- **Creating a Culture of Engagement**
  Individuals enhance community life by participating in and supporting civic groups, discussion groups, public-private partnerships and other activities that seek to understand and address community needs and opportunities. As a result, residents feel that they can make a difference and work in partnership with others to understand and address pressing public issues.

- **Exercising Corporate Stewardship**
  Fairfax County government is accessible, responsible and accountable. As a result, actions are responsive, providing superior customer service and reflecting sound management of County resources and assets.
Appendix E – Current Issues, Trends, and Challenges

Current Issues and Trends

Many of the more than 20,000 people served by the CSB each year are among our community’s most vulnerable residents. A strategic priority for the CSB is to improve overall health outcomes for the individuals we serve. To further this goal, the CSB partnered with a nonprofit health provider in FY2014 to open a Federally Qualified Health Center (FQHC) at the CSB’s Gartlan Center. In FY 2015, the CSB will open a primary health care clinic, as well as a pharmacy, in the new Merrifield Center.

Another important trend is the increasing need for behavioral health services for children and youth in our community. To help meet these needs, the CSB is working with Fairfax County Public Schools on design recommendations for the development of protocols for intake, assessment, triage, referral, treatment and case management, as well as performance measures for services provided to identified youth who need mental health or substance use treatment and supportive services to prevent the need for higher intensity services. Recommendations will be implemented in FY 2015.

There is growing recognition in the field of behavioral health of the important and uniquely effective leadership role that can be taken by individuals who have experienced mental illness or substance use disorders and who are themselves in recovery. People with serious mental health issues and substance use disorders can and do recover and can help others achieve long-term recovery. In FY 2013, CSB trained 29 certified peer specialists who have subsequently taken paid and volunteer positions at the CSB and throughout the region.

A related issue and strategic priority for the CSB is to confront the stigma associated with mental illness and substance use disorders. Public outreach and education programs are key to this effort. For example, the CSB has implemented a nationally certified Mental Health First Aid program, geared for the general public, that introduces key risk factors and warning signs of mental health and substance use problems, builds understanding of their impact, and describes common treatment and local resources for help and information.

Continuing Challenges

More than 70 percent of the CSB’s budget is supported by the County’s General Fund; however, the department also relies on federal and state revenues as well as third party payments such as Medicare and Medicaid. Current economic projections indicate limited growth in overall County revenues, and there is uncertainty over the level of future federal and state revenues for CSB services. For example, all Medicaid-eligible services, including behavioral health, primary health care and ID/DD Medicaid waivers (for people with intellectual and/or developmental disabilities) will likely need to be restructured as a result of federal health care reform and a new Department of Medical Assistance Services (DMAS) contract for behavioral managed care.

The need for CSB services continues to increase on an annual basis in many areas. For example, service demand for the Infant and Toddler Connection (ITC) program, which is legally mandated to serve all eligible children, increased approximately 29 percent from FY 2010 to FY 2013, and growth between 5 to 6 percent is expected in FY 2014 and FY 2015. The state, not Fairfax County, is legally responsible for providing these services to eligible families, but state funding does not fully cover the cost of services. As another example, the number of special education graduates with intellectual disability needing
employment and day support services after graduation will also continue to place demands on the CSB. Approximately 100 new graduates leave the school system every year, with the largest number ever, 120, expected in June 2014. Services provided to these individuals are largely funded through local dollars.

The CSB prioritizes access to services for those who are most disabled by their mental illness, substance use disorder and/or intellectual disability and who have no access to an alternative service provider. However, even individuals who are eligible for priority access to services may have to wait. In FY 2014, the average wait time for individuals needing medical detoxification services has been two to three weeks. For residential treatment services for substance use disorders, the wait can be even longer, up to three months. In May 2014, there were 138 individuals waiting for these services.

Another significant challenge on the horizon is the need for employment and day services, as well as support coordination services, for individuals with intellectual disabilities who are transitioning out of the state training centers, including the Northern Virginia Training Center in Fairfax as a result of the 2012 settlement agreement between the United States Department of Justice (DOJ) and the Commonwealth of Virginia regarding the rights of Virginians to receive community based services. The implementation of this settlement agreement is increasing the number of individuals seeking intellectual disability services, as well as the level of intensity of services needed. As of January 2014, there were 97 residents of Fairfax County and the cities of Fairfax and Falls Church in state training centers. The settlement requires discharge planning, oversight of transition to community services, ongoing monitoring and enhanced case management for individuals who are being discharged from the training centers. The settlement also requires enhanced case management services for current recipients of intellectual disability (ID) Medicaid waiver recipients, and individuals on the waiting list for ID waivers. This has resulted in a significant increase in workload for CSB support coordinators.

In response to anticipated limited growth in future local, federal and state funding for CSB programs, as well as projected increasing demand for services, the CSB has implemented several cost containment strategies to respond to this challenging environment. For example, the Employment and Day Services program is encouraging the increased use of self-directed services which cost less than the equivalent service in traditional contracts. The CSB is taking a continuous quality improvement approach to improve service planning and financial management and to contain costs. For example, the CSB’s pharmaceutical cost management plan allows the CSB to provide prescription medications worth approximately $17 million a year, with the county paying only 3 percent of that cost. The CSB will continue to implement strategies to improve cost containment, program efficiencies and effectiveness.

Reductions in federal funding due to budget sequestration in FY 2014 reduced available housing supports for people receiving CSB services. Affordable, safe housing coupled with individualized case management and supportive services are needed to increase the likelihood that people receiving CSB services have fewer episodes of crisis, maintain independence and work toward successful recovery. More work is needed to continue expanding public and private options and to address major barriers CSB individuals face, including poor credit, lack of transportation, criminal records and physical disabilities requiring building accessibility accommodations. The CSB is serving an increasing number of individuals who have complex service needs, who are advanced in age, and who have multiple medical problems, as well as individuals who speak languages other than English.
Appendix F – Strategic Planning Development

The FY 2015 to FY 2017 strategic plan was developed by a Strategic Plan Development Team with opportunities for input by CSB staff, members of the CSB Board, individuals receiving services and their families, and other community based partners. Consideration was given, but not limited to:

- CSB System Transformation Principles
- The FY 2013 CSB Strategic Plan Working Document
- Fairfax County Vision and Core Purposes
- Fairfax County Deputy Director for Human Services 2014/2015 Work Priorities
- Fairfax County Human Service System Results Based Accountability Principles/Guidelines
- Fairfax County Department of Management and Budget Direction
- Fairfax County and Commonwealth of Virginia Trends and Mandates
- Beeman Commission Recommendations
- Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Priorities
- Emerging trends and issues
- Best and evidence based practice approaches
- Systematic and programmatic desired outcomes
- Development and implementation of system improvements
- Outreach efforts to diverse communities of interest
- High quality service delivery to maximize customer satisfaction
- Work to assure timely access to all who need services
- A continuing integrated approach to service delivery
- Considerations of positions/issue analyses resulting from federal, state and local policy

CSB Strategic Plan Development Team

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- Lyn Tomlinson, CSB Engagement, Assessment, and Referral Services
- Daryl Washington, CSB Deputy Director
- Lisa Witt, Chief Financial Officer
- Laura Yager, CSB Partnership and Resource Development
CSB Associate Committee Members

Background
As part of the annual appointment of Associate Committee Members as outlined in the CSB Bylaws, the following are being nominated as Associate Members of the Substance Use Disorders/Mental Health Committee. At the July 2014 CSB Board meeting, a motion will be presented for final approval.

a. Advisory Board for the Joe and Fredona Gartlan Center
b. The Alternative House, Inc.
c. The Brain Foundation
d. Concerned Fairfax
e. Inova Health System
f. The Northern Virginia Mental Health Foundation, Inc.
g. Northwest Center Advisory Board: Northwest Center for Community Mental Health
h. Pathway Homes, Inc.
i. PRS, Inc.
j. Northern Virginia Mental Health Consumers Association
k. Consumer Run Programs Representative (Representatives will alternate meeting attendance)
   i. Consumer Wellness Center of Falls Church
   ii. Laurie Mitchell Employment Center
   iii. Reston Drop-In Center, Inc.
   iv. South County Recovery and Drop-In Center

CSB Board Member:
Susan Beeman
FY2015 and FY2016 Community Services Performance Contract Changes

Issue
Board review of current FY2015 and FY2016 Community Services Performance Contract, presented for information purposes at June 25, 2014 Board meeting in preparation for a public hearing and adoption at an upcoming Board meeting, depending on State budget approval.

Considering the timeline impacts presented by a delay in the approval of a State budget to the FY2015 and FY2016 Community Services Performance Contract, the required 30-day public review and comment period and date the executed contract is to be submitted, this information item is being presented to provide background on the major changes to the FY2015 and FY2016 contract to the Board and to acknowledge the intent to disseminate the proposed contract for the 30-day comment period once funding notification is received by the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

Background
On the first year of the biennial State Performance Contract the Board must review, accept public comment, and adopt the contract. The contract delineates the responsibilities between the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the Fairfax-Falls Church Community Services Board (CSB). It specifies the conditions to be met for the CSB to receive State-controlled funds, identifies groups of consumers to be served with State-controlled funds and includes requirements to ensure accountability to the State.

On May 9, 2014 a complete listing of all current changes was provided in a Letter from Paul Gilding, Community Contracting Director, DBHDS, along with copies of the performance contract and partnership agreement. These documents can be accessed through links provided under Enclosed Documents. Attached to this information item is a summary of the major changes to the FY2015 and FY2016 contract based upon the current version provided by the DBHDS. The changes are categorized as either operational, regulatory, or administrative and also reflect any perceived impacts to the Fairfax-Falls Church CSB.

Administrative Requirements
See attachment

Timing
Contingent upon approval of State budget
Enclosed Documents
Attachment: Exposure Draft: FY2015-2016 State Performance Contract
Links to Exposure Draft:
- Transmittal Letter:
- Performance Contract:
- Partnership Agreement:
- CSB Administrative Requirements:

Staff
Jerome Newsome, CSB Informatics Director
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<tr>
<th>Item #</th>
<th>Category</th>
<th>Contract Section</th>
<th>Summary of Contract Change</th>
<th>Impacts</th>
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<tr>
<td>1</td>
<td>Operational</td>
<td>Sec. 4.a, Page 3</td>
<td>CSB must notify the Department when it begins providing a new category or subcategory of core services, stops providing an existing category or subcategory of core services if the service is funded with more than 50 percent of state or federal funds or both. CSB operating a residential crisis stabilization program must notify the Department and receive its approval before the CSB increases or decreases the funded capacity (number of beds) of the program or closes it temporarily or permanently.</td>
<td>Possible operational impacts from delays in obtaining DBHDS approval for funded bed capacity changes</td>
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<td>2</td>
<td>Regulatory</td>
<td>Sec. 4.c.3.), Page 4, Sec 7.b.4.), Page 17</td>
<td>CSBs and state hospitals must follow the <em>Medical Screening and Assessment Guidance</em>, effective April 1, 2014</td>
<td>NONE</td>
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<tr>
<td>3</td>
<td>Operational</td>
<td>Sec. 4.c.6.), Page 5</td>
<td>Acknowledges legitimate reasons for a CSB to deny services to an individual but forbids a CSB from establishing or implementing policies that deny or limit access to services funded in part by state or local matching funds or federal block grant funds only because an individual is not able to pay for services, is not enrolled in Medicaid, or is involved with the criminal justice system.</td>
<td>NONE</td>
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<tr>
<td>4</td>
<td>Regulatory</td>
<td>Sec. 4.c.8.), Page 5 Sec. 7.b.7.), Page 17</td>
<td>CSBs are required to participate in the Virginia Psychiatric Bed Registry as mandated by 37.2—308. 1 enacted by the 2014 General Assembly. If the CSB operates residential crisis stabilization services, it shall provide information about bed availability to the registry.</td>
<td>Increased staff time in data input.</td>
</tr>
<tr>
<td>5</td>
<td>Operational</td>
<td>Sec. 4.c.11.), Page 5</td>
<td>Requires CSBs to provide information to the extent it is available to the CSB about and referral to the full range of available and appropriate services and supports for individuals with developmental disabilities other than intellectual disability and their family members who are seeking services and supports.</td>
<td>NONE</td>
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## FY2015 AND FY2016 STATE PERFORMANCE CONTRACT
### SUMMARY OF MAJOR CHANGES

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<th>Item #</th>
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<th>Summary of Contract Change</th>
<th>Impacts</th>
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<tr>
<td>6</td>
<td>Operational</td>
<td>CSB Section</td>
<td>CSBs are required to monitor its outcome and performance measures on the Department’s CSB Performance Measures Data Dashboard and implement actions to improve its ranking on any measure on which it is below the benchmark.</td>
<td>Some measures used on the Dashboard may not reflective of our service delivery model.</td>
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<tr>
<td>7</td>
<td>Operational</td>
<td>CSB Section</td>
<td>CSBs are required to follow the User Acceptance Testing Process in Appendix D for new releases of the CCS3 Extract.</td>
<td>NONE</td>
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<tr>
<td>8</td>
<td>Operational</td>
<td>Exhibit I</td>
<td>Exhibit I includes a one-time state funding reduction linked to specific non-compliance with requirements in the exhibit</td>
<td>NONE</td>
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<td>9</td>
<td>Sec. 4.e.2, Page 6</td>
<td></td>
<td>Describes some of the responsibilities of CSB case managers under the DOJ Settlement Agreement.</td>
<td>NONE</td>
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<tr>
<td>10</td>
<td>Operational</td>
<td>Sec. 6.b.1), Page 10</td>
<td>Requires the CSB to monitor its outcome and performance measures on the Department’s CSB Performance Measures Data Dashboard, an ongoing Department initiative begun several years ago with CSBs, and identify and implement actions to improve its ranking on any measure on which it is below the benchmark.</td>
<td>NONE</td>
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<tr>
<td>11</td>
<td>Operational</td>
<td>Sec. 6.b.4.) e.) and g), Page 11</td>
<td>Reflect current substance abuse prevention practices. These changes were reviewed and approved by the VACSB Prevention Services Council.</td>
<td>NONE</td>
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<tr>
<td>12</td>
<td>Operational</td>
<td>Sec. 6.b.7, Page 12</td>
<td>Requires CSBs to post complaint procedures in their public spaces and provide copies to the Department upon request, and additional language is added to allow CSBs to provide copies to individuals when they are admitted to services as an alternative to posting them.</td>
<td>NONE</td>
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<tr>
<td>13</td>
<td>Operational</td>
<td>Sec. 6.c.2, Page 14</td>
<td>Revised to require CSBs that report unspent state funds of more than 20 percent in each of the previous two fiscal years in any program area to submit CARS reports quarterly rather than semi-annually. This will enable the Department to monitor</td>
<td>NONE</td>
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## FY2015 AND FY2016 STATE PERFORMANCE CONTRACT
### SUMMARY OF MAJOR CHANGES

<table>
<thead>
<tr>
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<td>expenditures in those CSBs more frequently and closely and work with those CSBs to ensure state funds are used to expand services and avoid such under expenditures in the future.</td>
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<tr>
<td>14</td>
<td>Operational</td>
<td>Sec 7.c.2, Page 18</td>
<td>Requires the Department to develop a CSB Performance Measures Data Dashboard in collaboration with CSBs, post it on the Department’s web site, and work with the CSB to identify and implement actions to improve the CSB’s ranking on any measure on which it is below the benchmark.</td>
<td>NONE</td>
</tr>
<tr>
<td>15</td>
<td>Operational</td>
<td>Exhibit A, Page 28 (AF-3), Page 29 (AF-4)</td>
<td>Revised to a.) change Acute Care (LIPOS) and DAP funds from earmarked to restricted funds, which requires reporting expenditures linked to those funds, b.) allow each of those funds to be spent for the other purpose in certain situations approved by the Department, c.) reflect the merger of individual CSB state DAP funds into regional state DAP allocations, and d.) add lines for the new state FY 2014 DAP funds.</td>
<td>Will have an impact on how present dollars are allocated to individuals receiving services in the community.</td>
</tr>
<tr>
<td>16</td>
<td>Operational</td>
<td>Exhibit A, Page 31 (AF-6)</td>
<td>Revised to delete DV Crisis Stabilization Transfer In/(Out) and DV Trust Fund and is revised to add DV Rental Subsidies and DV Crisis Stabilization for Children.</td>
<td>NONE</td>
</tr>
<tr>
<td>17</td>
<td>Operational</td>
<td>Pages 36 (AP-1) thru 39 (AP-4)</td>
<td>Forms 11, 21, 31, and 01 are revised to reinstitute displaying service capacities in the contract and the capacity and costs columns are labeled as projected capacities and projected costs.</td>
<td>NONE</td>
</tr>
<tr>
<td>18</td>
<td>Regulatory</td>
<td>Sec. IV.A and B, Page 42</td>
<td>Revised to reflect requirements in State Board Policy 1044 on Employment First, including requiring the CSB to ensure its case managers discuss integrated, community-based employment services at least annually with employment age (18-64) adults currently receiving services from the CSB and including employment-related goals in individualized services and supports plans if these adults want to work.</td>
<td>NONE</td>
</tr>
<tr>
<td>Item #</td>
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<td>19</td>
<td>Operational</td>
<td>Sec. V, Page 43</td>
<td>Revised to reinstitute a measure requiring the CSB to collect in a two-week sample each quarter the time within which the preadmission screening evaluator is available when an immediate face-to-face intervention by a certified preadmission screening evaluator is appropriate to determine the need for involuntary hospitalization.</td>
<td>Increase in staff time documenting services.</td>
</tr>
<tr>
<td>20</td>
<td>Operational</td>
<td>Sec. V, Page 43</td>
<td>Revised to add two measures requiring the CSB to monitor and report quarterly on a.) the percentage of employment age adults (18-64) in the DOJ Settlement Agreement target population receiving case management services from the CSB whose case managers discussed integrated, community-based employment with them during their annual individualized services and supports plan reviews and b.) the percentage whose individualized services and supports plans included employment-related goals.</td>
<td>NONE</td>
</tr>
<tr>
<td>21</td>
<td>Operational</td>
<td>Sec. VII, Page 44</td>
<td>Revised to require the CSB to use the CSB Performance Measures Data Dashboard developed by the Department to improve its performance on these measures and to list the measures.</td>
<td>NONE</td>
</tr>
<tr>
<td>22</td>
<td>Operational</td>
<td>Page 45</td>
<td>The FY 2015 Exhibit B Quarterly Performance Measures Report is revised to include the three measures in 21 and 22 above.</td>
<td>NONE</td>
</tr>
<tr>
<td>23</td>
<td>Operational</td>
<td>Exhibit C, Pages 46 and 47</td>
<td>Revised to reflect changes in the DAP program, including the merger of individual CSB state DAP fund allocations into regional state DAP fund allocations.</td>
<td>Will have an impact on how present dollars are allocated to individuals receiving services in the community.</td>
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<tr>
<td>24</td>
<td>Operational</td>
<td>Exhibit E, Pages 40-54</td>
<td>Revised to require submission of quarterly Exhibit B Performance Measure Reports and, if required, 1st and 3rd quarter CARS Reports as conditions of continued semi-monthly disbursements of state and federal funds.</td>
<td>NONE</td>
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<tr>
<td>25</td>
<td>Operational</td>
<td>Exhibit I, Pages 60 and 61</td>
<td>Revised to insert a small one-time state funding reduction linked to specific non-compliance with requirements in the exhibit. Performance contracts contained a similar provision for 10 years (FY 1997 - FY 2007). Then, the Department used it only once to eliminate late submissions of CARS end of the fiscal year reports. This revision addresses perceived needs for increased CSB accountability.</td>
<td>NONE</td>
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<tr>
<td>26</td>
<td>Administrative</td>
<td>Sec. II.A.5, Page 6 and 7</td>
<td>Clarification added about Executive Director position. When Executive Director position becomes vacant, the CSB submits its job description, position advertisement, and salary range to the Department before advertising the vacancy. The CSB submits the candidate’s application and resume and proposed salary to the Department before employing the new Executive Director.</td>
<td>Need to inform all Fairfax County staff involved in the Executive Director search process.</td>
</tr>
<tr>
<td>27</td>
<td>Administrative</td>
<td>Sec. II.A.10. b) 7), Page 13</td>
<td>Clarify emergency services performance expectations.</td>
<td>NONE</td>
</tr>
<tr>
<td>28</td>
<td>Administrative</td>
<td>Sec. II. A.4, Page 20, Appendix A</td>
<td>Continuity of Care Procedures is added to address CSB medical screening and assessment responsibilities as part of the preadmission screening requirements.</td>
<td>NONE</td>
</tr>
<tr>
<td>29</td>
<td>Operational</td>
<td>Appendix D, Page 38</td>
<td>Establishes the User Acceptance Testing Process for software applications. The VACSB Data Management Committee reviewed and approved this process.</td>
<td>NONE</td>
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STATE PERFORMANCE CONTRACT REPORTING IMPROVEMENT STATUS REVIEW

PREPARED FOR:
Fairfax-Falls Church CSB Board

June 25, 2014
Agenda

• Accomplishments
• Vendor Data Entry Status
• Issue Management Status
• Planned Tasks for Next Period
• Questions and Comments?
Accomplishments

• Submitted CCS Monthly Extract for April 2014 data
• Contracted Services (Vendor) Data
  • ID Services Completed through March 2014
  • MH Services Completed through November 2013
• Documented business process for ID Employment Services
• Business Intelligence Tool training for support staff scheduled for 17-19 June 2014 at CSB training site
• Submitted final response on FY2014 Mid-Year Analysis Report to DBHDS
• Resolved majority of service related issues excluding MH Transitional Employment and Supportive Residential
## Vendor Data Entry Status Summary

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## Issue Management Status

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<tr>
<th>Status</th>
<th>Service Area/Program</th>
<th>Action Taken</th>
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<tbody>
<tr>
<td>Y</td>
<td>Youth Resource Team and ICC, JDC, Youth BH Residential</td>
<td>Service Director to provide contract bed days for entry. Follow-up meeting scheduled to discuss Non-Consumer service entry. All other issues resolved.</td>
</tr>
<tr>
<td>G</td>
<td>ID Residential</td>
<td>All issues resolved</td>
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<tr>
<td>G</td>
<td>Medical Services</td>
<td>All issues resolved.</td>
</tr>
<tr>
<td>G</td>
<td>ICM/PACT, Discharge Planning Regional MH Residential</td>
<td>All issues resolved</td>
</tr>
<tr>
<td>G</td>
<td>MH and ID Sheltered Employment</td>
<td>All issues resolved</td>
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<tr>
<td>G</td>
<td>Adult BH OP, Day Treatment, IOP</td>
<td>All issues resolved</td>
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<tr>
<td>G</td>
<td>Detox</td>
<td>All issues resolved</td>
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<tr>
<td>G</td>
<td>PATH and Assessment</td>
<td>All issues resolved</td>
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<tr>
<td>G</td>
<td>BH Youth OP and Day Treatment</td>
<td>All issues resolved</td>
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<tr>
<td>G</td>
<td>Jail Based Services</td>
<td>All issues resolved</td>
</tr>
</tbody>
</table>
Planned Tasks for Next Month

• Address Credible Alignment with Focus/HCM prior to July 1
• Complete input of Vendor data for April and May
• Refine data import process with vendors
• Complete BI Tool training for support staff
• Hold follow-on meeting with Joel
• Began closeout process for FY2014 and preparation for EOY Report
Interagency Youth Behavioral Health

Issue
The Fairfax County Board of Supervisors directed staff to identify requirements to address youth behavioral health service requirements as a part of the FY 2014 budget guidance. One million dollars was appropriated in the FY 2015 baseline budget for youth behavioral health.

Background
The Interagency Behavioral Health Youth Services Work Group was formed to identify the needs and develop a plan on the most appropriate way to address this issue. The Interagency Behavioral Health Youth Services Workgroup was given the following charge:

- Increase the communication and effectiveness of interaction between youth and family serving agencies and services providers;
- Identify gaps in services in behavioral health system (substance abuse and mental health) for youth;
- Recommend possible solutions to address existing gaps in services;
- Prioritize service needs; and
- Improve the mental health delivery system for youth and families identified, but not in intensive case management services already provided via the CSA – Systems of Care.

Recommendations
In September 2013, the work group presented its report that identified existing needs; outlined resources and service capacity available to respond to needs, including those available through county agencies, the school system and providers in the community; identified gaps and strategies to address gaps; prioritized services and associated required resource allocation recommendations to address gaps; and developed recommendations for implementation of an Interagency Youth Services Management and Coordinating Team to manage resource requirements and outcomes.

In May 2014, the work group returned with recommendations on options for a service delivery model using available resources to meet the needs of youth and families. The group also developed service protocols to ensure successful implementation of system-wide goals, outcomes and accountability measures for the following components:

Specifically, the following findings and recommendations were made by the Interagency Behavioral Youth Services Workgroup:

1. Focus efforts on youth with emerging behavioral health concerns. Based on national studies, it is estimated that the number of youth in this category who may require services in the community could range from 500-6000. Of that total, the Work Group recommended that the initial focus to address the gap in
services to youth experiencing anxiety, depression, conduct concerns, trauma, and substance use. The target population was determined on the basis of those youth without insurance or who face barriers in accessing existing services in these five areas and for which an acute care model could be effective. The goal of targeting this core group is to improve individual and family stability, reduce the likelihood of more serious emotional issues, and reduce the risk of using higher intensity services (such as those provided through the Comprehensive Services Act and through the CSB for crisis and emergency services).

2. The Gain Short Screen (SS) was identified as the standardized screening tool to identify individuals who may need behavioral health services. A wide variety of staff working with youth to include, school counselors, social workers, psychologists, DFS workers, community youth providers, Health Department staff, and Juvenile Court staff, will receive an online training on how to administer the Gain SS.

3. Provide services using a combination of evidence-informed individual, family, and system of care service models. These service models are recommended because of their proven successful outcomes with individuals and families experiencing behavioral health issues.

4. Have services provided in a focused time limited approach. In order to best utilize the resources, and serve the maximum number of individual’s utilization management tools will be put in place to measure progress, and identify those who may no longer need this level of care.

5. Hiring county staff to create a youth Systems of Care office. This office will be located in the Department of Family Services (DFS); the System of Care Division Director will report directly to the Deputy County Executive.
   a. System of Care Division Director: This position will oversee the integration of youth and family services across the continuum of prevention, early intervention, treatment and transition services for county and county funded community-based services. This position serves in partnership with community providers and provides liaison services to the Fairfax County Public Schools for public policy development and implementation of agreed upon services and supports.
   b. Service Utilization Specialist: Authorize level of services for family and youth support services for an array of community and county provided services.
   c. Clinician: Coordinates care with school and county staff for the new service array that will be available in FY 2015 for the targeted youth who are not receiving services because they lack insurance or who face barriers to accessing care.

6. Direct services for care coordination and outpatient behavioral health treatment for the target population will be contracted out to vendors, as similar to the existing Comprehensive Services Act program/services. The county will initially seek to utilize existing county vendors where possible to expedite service provision.
Timelines
1. Training of staff on screening tool. (Summer 2014)
2. Hiring staff for Systems of Care office. (end of summer/early fall 2014)

Fiscal Impact
From the FY 2015 Adopted budget Plan for DFS, “An increase of $1,080,571 is associated with expanding behavioral health services for youth and families as a result of the recommendations presented to the Human Services Committee of the Board of Supervisors on October 1, 2013. These recommendations were the direct result of the guidance included by the Board of Supervisors as part of the FY 2014 Adopted Budget Plan directing staff to identify requirements to address youth behavioral human services requirements in schools and the broader community. It is estimated that between 400 and 500 youth and their families are in need of interventions and services. FY 2015 funding creates a new program unit which will implement a Systems of Care model by connecting the continuum of supports and services across County agencies, FCPS and community partners. Additionally, the new unit will also be responsible for implementing contractual services for individuals with emerging mental health and substance use issues. Funding includes $283,006 in Personnel Services, including 3/3.0 FTE positions (1/1.0 FTE Division Director, 1/1.0 FTE Program Manager and 1/1.0 FTE MH/ID/ADS Senior Clinician) and $797,565 in Operating Expenses. The amount noted above includes $200,000 funded as part of the FY 2014 Adopted Budget Plan for behavioral health services for youth in Agency 87, Unclassified Administrative Expenses.”

The impact to CSB operations is expected to include continued participation in inter-agency planning and monitoring of the needs of youth in the community, developing recommendations on the progress of the service approach and continued improvements to assure the needs of served families are addressed.

The full Youth Behavioral Health Reports can be accessed at the following links:
http://www.fairfaxcounty.gov/living/healthhuman/scypt/5-14-agenda-package.pdf

CSB Staff
Daryl Washington, Deputy Director
Patrick McConnell, Director, Youth & Family Outpatient & Day Treatment Services
Allen Berenson, Director, Youth & Family Intensive Treatment Services
DBHDS allocates $100,000 to the CSB to continue its contract with Kognito Solutions, LLC, for online suicide prevention programming for an additional year, allowing the service to extend into FY2016.

The CSB launched an online suicide prevention trip of programs in May 2014, with a license to offer the programming for one year, through June 2015. These evidence-based programs are nationally recognized and are the first to launch in the state. The programs can be accessed through a simple registration process here: http://kognito.com/fairfax. Additional details about each of the programs can be found here: http://www.fairfaxcounty.gov/csb/at-risk/at-risk-flyer.pdf.

DBHDS has prioritized suicide prevention initiatives across the state. This allocation is to extend the local programming contract for an additional 12 months.

Fiscal Impact
This will add $100,000 to the budget, allocated specifically to extend the Kognito contract.

Staff
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