FAIRFAX - FALLS CHURCH
Community Services Board

FAIRFAX-FALLS CHURCH CSB BOARD MEETING

Garrett McGuire, Chair
Merrifield Center
8221 Willow Oaks Corporate Drive, Level 1, Room 3-314, West
Fairfax, VA 22031
Wednesday, March 23, 2022, 5:00 p.m.
This meeting can also be attended via electronic access through Zoom

Dial by your location to access live audio of the meeting:

+1 301 715 8592 US (Washington DC)	+1 669 900 9128 US (San Jose)	+1 646 558 8656 US (New York)
+1 253 215 8782 US (Tacoma)	+1 312 626 6799 US (Chicago)	+1 346 248 7799 US (Houston)

Meeting ID: 835 8296 8288 • Passcode: 005767

MEETING AGENDA

1. **Meeting Called to Order** — Garrett McGuire
2. **Matters of the Public** — Garrett McGuire
3. **Amendments to the Meeting Agenda** — Garrett McGuire
4. **Approval of the February 23, 2022, Meeting Minutes** — Garrett McGuire
5. **Staff Presentation**
   - A. Department of Management & Budget - County Budget — Dana Thompson
6. **Director's Report** — Daryl Washington
   - A. Services Update
   - B. Staffing Update
   - C. Electronic Health Record Update
7. **Matters of the Board** — Garrett McGuire
8. **Committee Reports**
   - A. Service Delivery Oversight Committee — Anne Whipple
   - B. Compliance Committee — Garrett McGuire
   - C. Fiscal Oversight Committee — Jennifer Adeli
   - D. Other Reports
9. **Action Item:**
   - A. Proposed Changes to FY 2023 CSB Fee Schedule — Sebastian Tezna

Closed Session: Discussion of a personnel matter as permitted by Virginia Code Section 2.2-3711(A)(1) and consultation with legal counsel employed by a public body regarding specific legal matters requiring the provision of legal advice by such counsel, as permitted by Virginia Code Section 2.2-3711(A)(8).

10. **Adjournment**

Meeting materials are posted online at www.fairfaxcounty/community-services-board/board/archives or may be requested by contacting Joseline Cadima at 703-324-7827 or at Joseline Cadima

FAIRFAX-FALLS CHURCH COMMUNITY SERVICES BOARD
VIRTUAL MEETING MINUTES
FEBRUARY 23, 2022

The Fairfax-Falls Church Community Services Board met electronically due to the COVID-19 pandemic that has made it unsafe to physically assemble a quorum in one location or to have the public present. Access was made available via video and web conferencing platform to CSB Board members, CSB staff, and members of the public. The meeting notice, including participation instructions, was posted electronically and on the building in which the meeting is typically held. Additionally, attendees were offered an opportunity to register for public comment during the 30 minutes prior to the meeting being called to order.

1. **Meeting Called to Order**

Board Chair Garrett McGuire called the meeting to order at 5:01 p.m.

Roll Call, Audibility, and Preliminary Motions

PRESENT: **BOARD MEMBERS:** GARRETT MCGUIRE (ALEXANDRIA, VA), BOARD CHAIR; KAREN ABRAHAM (FAIRFAX, VA); JENNIFER ADELI (GREAT FALLS, VA); ROBERT BARTOLOTTA (FALLS CHURCH, VA); SHEILA COPLAN JONES (ALEXANDRIA, VA); CAPTAIN DEREK DEGEARE (LOUDOUN COUNTY, VA); LARYSA KAUTZ (FAIRFAX, VA); BETTINA LAWTON (VIENNA, VA); SRILEKHA PALLE (FAIRFAX, VA); DIANA RODRIGUEZ (MCCLEAN, VA); EDWARD ROSE (FALLS CHURCH, VA); ANDREW SCALISE (FAIRFAX, VA); DAN SHERRANGE (CHANTILLY, VA); ANNE WHIPPLE (GREAT FALLS, VA)

ABSENT: **BOARD MEMBERS:** DARIA AKERS; SANDRA SLAPPEY BROWN

Also present: Executive Director Daryl Washington, Deputy Director of Clinical Operations Lyn Tomlinson, Deputy Director of Administrative Operations Daniel Herr, Deputy County Attorney Cynthia Tianti, Service Director Marissa Farina-Morse, Deputy Director Barbara Wadley-Young, Healthcare Systems Director Jennifer Aloi, Director of Behavioral Health Operations Sebastian Tezna and Board Clerk Joseline Cadima

Board Chair Garrett McGuire conducted a roll call with each CSB Board Member present, as identified above, to confirm that a quorum of CSB Board members was present and audible. Board Chair Garrett McGuire passed the virtual gavel to Board Vice Chair Dan Sherrange to make several motions required to begin the meeting. A motion was offered confirming that each member's voice was audible to each other member of the CSB Board present; this motion was seconded by Board Member Robert Bartolotta and passed unanimously.

Preliminary Motions

Board Chair Garrett McGuire made a motion that the State of Emergency caused by the COVID-19 pandemic makes it unsafe for the CSB Board to physically assemble and unsafe for the public to physically attend any such meeting, and that as such, FOIA's usual procedures, which require the physical assembly of this CSB Board and the physical presence of the public, cannot be implemented safely or practically. A further motion was made that this Board may conduct this meeting

electronically through a video and web conferencing platform, that may be accessed via Meeting ID: 895 0671 7992 and Passcode: 664302. Motions were seconded by Board Member Captain Derek DeGeare and unanimously approved. Board Chair Garrett McGuire made a final motion that that all the matters addressed on today's agenda are statutorily required or necessary to continue operations and the discharge of the CSB Board's lawful purposes, duties, and responsibilities. The motion was seconded Board Member Captain Derek DeGeare and unanimously passed.

2. Matters of the Public

Kimi Fergus, member of the public, thanked the Board for hearing and addressing her concerns over the temporary closing of the "New Generations" program, which is the only program in Fairfax County that allows a mother to enter treatment with her child. She looks forward to hearing updates regarding metrics being used to explain the closure of the program.

3. Amendments to the Meeting Agenda

The meeting agenda was provided for review, no amendments were made.

BOARD MEMBER CONSENSUS TO APPROVE AGENDA ITEM NO. 3

AYES: BOARD MEMBERS: GARRETT MCGUIRE (ALEXANDRIA, VA), BOARD CHAIR; KAREN ABRAHAM (FAIRFAX, VA); JENNIFER ADELI (GREAT FALLS, VA); ROBERT BARTOLOTTA (FALLS CHURCH, VA); SHEILA COPLAN JONES (ALEXANDRIA, VA); CAPTAIN DEREK DEGEARE (LOUDOUN COUNTY, VA); LARYSA KAUTZ (FAIRFAX, VA); BETTINA LAWTON (VIENNA, VA); SRILEKHA PALLE (FAIRFAX, VA); DIANA RODRIGUEZ (MCCLEAN, VA); EDWARD ROSE (FALLS CHURCH, VA); ANDREW SCALISE (FAIRFAX, VA); DAN SHERRANGE (CHANTILLY, VA); ANNE WHIPPLE (GREAT FALLS, VA)
NOES: BOARD MEMBERS: NONE
ABSTAIN: **BOARD MEMBERS:** NONE
ABSENT: BOARD MEMBERS: DARIA AKERS; SANDRA SLAPPEY BROWN

4. Approval of the Minutes

The January 26, 2022, CSB Board Meeting Minutes were provided for review, no amendments were made.

MOVED BY BOARD MEMBER EDWARD ROSE, SECONDED BY BOARD MEMBER BETTINA LAWTON TO APPROVE AGENDA ITEM NO.4.

AYES: BOARD MEMBERS: GARRETT MCGUIRE (ALEXANDRIA, VA), BOARD CHAIR; KAREN ABRAHAM (FAIRFAX, VA); JENNIFER ADELI (GREAT FALLS, VA); ROBERT BARTOLOTTA (FALLS CHURCH, VA); SHEILA COPLAN JONES (ALEXANDRIA, VA); CAPTAIN DEREK DEGEARE (LOUDOUN COUNTY, VA); LARYSA KAUTZ (FAIRFAX, VA); BETTINA LAWTON (VIENNA, VA); SRILEKHA PALLE (FAIRFAX, VA); DIANA RODRIGUEZ (MCCLEAN, VA); EDWARD ROSE (FALLS CHURCH, VA); ANDREW SCALISE (FAIRFAX, VA); DAN SHERRANGE (CHANTILLY, VA); ANNE WHIPPLE (GREAT FALLS, VA)

NOES: BOARD MEMBERS: NONE
ABSTAIN: **BOARD MEMBERS:** NONE
ABSENT: BOARD MEMBERS: DARIA AKERS; SANDRA SLAPPEY BROWN

5. Staff Presentation

A. Jail-Based & Diversion Program

Service Director Marissa Farina-Morse provided a brief overview of the program which included information on staff, budget, adult detention center, jail diversion, and court-based programs.

6. Director's Report

A. Services Update

Deputy Director of Clinical Operations Lyn Tomlinson noted the current vacancy count of 193 and provided an update on the two programs that are temporarily offline. Partial Hospitalization has been offline since mid-December 2021 (staff has been assigned to Outpatient Adult Case Management and Front Door Programs) and New Generations has been offline since mid-January 2022 (staff has been assigned to Residential Substance Abuse Co-Occurring Programs). More orientations were offered to youth and adults during the month of January than all last year, this is due in large part to the number of staff that have been re-assigned from the programs that are temporarily offline, such as the PATH program and the Wellness Health Promotion & Prevention Services. The former Nursing Home, known as Cameron Glen, located in Reston had homeless individuals living in the building, in a collaborative effort with Reston Strong, Office of Code Compliance, and INOVA the individuals were safely removed. INOVA plans to tear down the building and construct something else.

Deputy Director Barbara Wadley-Young mentioned that due to the increasing of staff vacancy, specifically in the behavioral health outpatient services, this has led to the recent tracking of staffing vacancies and time to treatment data. The data capacity reporting is specifically looking at six primary areas: full-service capacity, current service capacity, service capacity shortfall & vacancies, current number served (point-in-time), over-subscribed service capacity, and monitor individuals waiting for services (monitoring list and waiver wait list).

Executive Director Daryl Washington reported an update on the data platform (state-wide Crisis Services Platform), the Fairfax County's Information Technology office provided approval to move forward with using this platform. Services continue to be provided for the Call Center Services, Emergency Services, and Contract Provider Services; however, the data/information is not being entered into the state data platform at this time.

B. COVID-19 Update

Deputy Director of Administrative Operations Daniel Herr noted that after the large increase in positive infections following the holiday season, the numbers have dramatically decreased.

C. Other Updates

Executive Director Daryl Washington mentioned the upcoming VACSB Training Conference held in Reston, Virginia on May 4-6, 2022. The Fairfax County Budget was presented to the Board of Supervisors on Tuesday, February 22, 2022, briefly discussed the impact to the Fairfax/Falls Church CSB which was sent as an email to the Board. The main highlights include employee compensation of $13.4 million in funding for a 4.01% market rate adjustment for all employees, performance and longevity increases averaging 2.15%, Diversion First $695,364 for 4 new positions and $212,800 in operating expenses. Detoxification and Residential Treatment Services will receive $612,310 for 4.5 new positions, Emergency Services $150,364 for 1 new position, Co-Responder and Behavioral Health Crisis Calls $2.1 million in ongoing funding to pay for the 17 positions that were added at the FY 2022 budget mid-year review. And lastly, the transfer of $375,950 for 2 positions which facilitate countywide Diversion First and response to the opioid epidemic. Important dates include March 8 advertisement of the tax rate, April 12-14 public hearings on the budget, April 22 Budget Committee meeting for pre-markup, April 26 Board of Supervisors marks up FY 2023 Budget, and May 10 will be the adoption of the FY 2023 Budget. Also mentioned changes to staff compensation which occurred this past week, this mid-year adjustment includes the following: Developmental Disability Specialists and Behavioral Specialists were given a two S-Level increase (which is a 10% increase), Nurses and Business Analyst positions were given a one S-level increase (which is a 5% increase). The number of CSB staff impacted by this change in compensation is 756. The Chairman and other localities will be visiting Merrifield Center on Friday, February 25, 2022, to go over the Diversion First Program and tour the Emergency Services.

Healthcare Systems Director Jennifer Aloi provided a summary on the recent changes to the Electronic Health Record, which caused the cancellation of the contract with Welligent at the end of January 2022. It was also noted that they are working to modify the current contract with Credible (recently bought out by Qualfex), along with putting out market research for several different Electronic Health Record's out of the market, with the possibility of placing a Request for Information. After diligently conducting research and based on the needs of the CSB the list of possible vendors went from 30 to 12.

Deputy Director of Administrative Operations Daniel Herr highlighted the impact of the national and state work shortage on administrative services: Human Resources is experiencing a 30-50% vacancy rate, the Finance Department has the Chief Finance Officer, Budget Manager as well as four supervisory vacant positions, the Business Operations (Client Access Services Team) has decreased a vacancy rate to 7% which was at a high of 30% at one point in time.

7. Matters of the Board

Board Chair Garrett McGuire noted March as Developmental Disability Inclusion Month, and a collaborative proclamation will be presented in the Board of Supervisors Meeting. Reminded the Board of the Fairfax County Budget Hearings will occur in April of 2022, and an email will be sent out requesting volunteers to provide public testimony at the hearings. Updated the Board on re-visiting

the topic of the Board Retreat and narrowing down on dates, also mentioned having in-person meetings soon following guidance from the Executive County's Office.

8. Committee Reports

A. **Service Delivery Oversight Committee**
Committee Chair Anne Whipple mentioned their February meeting had two breakout sessions (Developmental Disability Session and Behavioral Health Session) in which each group discussed legislation related to their field. **The next meeting is Wednesday, April 13, 2022, at 5:00 p.m.**

B. **Compliance Committee**
Committee Chair Garrett McGuire reported that Quality and Improvement Director Joan Rodgers provided information on the building of a report that would allow tracking of training completion by staff. The Department of Behavioral Health and Developmental Services has begun their in-person audits again, and the committee reviewed the Serious Incidents in our community. **The next meeting is Wednesday, March 16, 2022, at 5:00 p.m.**

C. **Fiscal Oversight Committee**
Committee Chair Jennifer Adeli noted covering time to treatment and other key metrics reports along with receiving an administrative update on the electronic health record. **The next meeting is Thursday, March 17, 2022, at 4:00 p.m.**

D. **Other Reports**
None were raised.

9. Information Item:

A. Proposed Changes to the FY 2023 Fee Schedule

Director of Behavioral Health Operations Sebastian Tezna provided the staff report which included information on the process for the annual rate setting for the CSB fee schedule, approval of the fee schedule by the CSB Board on March 23, 2022, approval by the Board of Supervisors on the April or May 2022 meeting, and new fees going into effect on July 1, 2022.

Closed Session:

Board Chair Garrett McGuire inquired whether there were any matters that required discussion in closed session, none were raised.

10. Adjournment

Board Chair Garrett McGuire adjourned the meeting at 6:19 p.m.

AYES: BOARD MEMBERS: GARRETT MCGUIRE (ALEXANDRIA, VA), BOARD CHAIR; KAREN ABRAHAM (FAIRFAX, VA); JENNIFER ADELI (GREAT FALLS, VA); ROBERT BARTOLOTTA

(FALLS CHURCH, VA); SHEILA COPLAN JONES (ALEXANDRIA, VA); CAPTAIN DEREK DEGEARE (LOUDOUN COUNTY, VA); LARYSA KAUTZ (FAIRFAX, VA); BETTINA LAWTON (VIENNA, VA); SRILEKHA PALLE (FAIRFAX, VA); DIANA RODRIGUEZ (MCCLEAN, VA); EDWARD ROSE (FALLS CHURCH, VA); ANDREW SCALISE (FAIRFAX, VA); DAN SHERRANGE (CHANTILLY, VA); ANNE WHIPPLE (GREAT FALLS, VA)

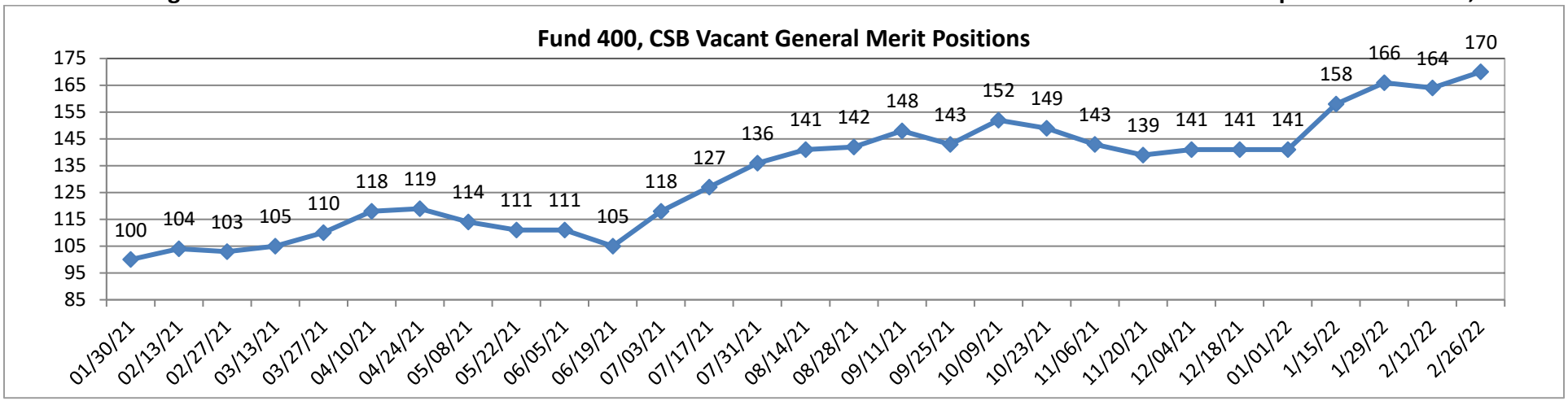
NOES: BOARD MEMBERS: NONE

ABSTAIN: **BOARD MEMBERS:** NONE

ABSENT: BOARD MEMBERS: DARIA AKERS; SANDRA SLAPPEY-BROWN

Date Approved

CSB Board Clerk



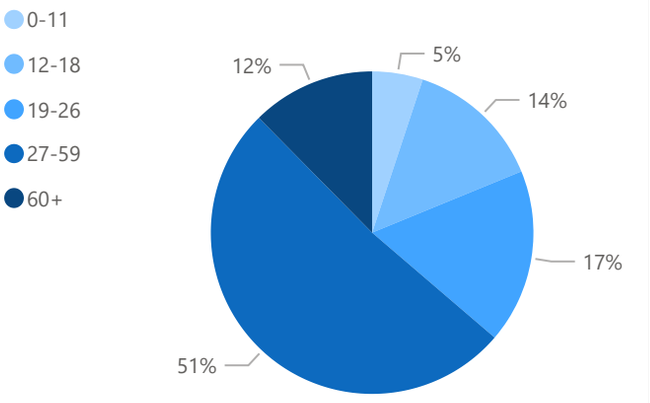
Vacancies in critical areas* *includes all merit positions (all funds - regular and grant)

Service area /Program	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	January		February	
Emergency Svcs/MCU	4.5	3.5	3.5	1	1	0	0	6	9	4	12	11	8 CIS	12	9 CIS
													1 Mobile Crisis Supv		2 Mobile Crisis Supv
													2 Peer Supp Spec		1 Peer Supp Spec
Behavioral Health – Outpatient Svcs	10	11	11	12	8	11	12	16	14	16	19	21	11 BHS II	22	13 BHS II
													7 BH Sr. Clin		6 BH Sr. Clin
													2 BHN Clin/Case Mgr		2 BHN Clin/Case Mgr
													1 BHN Supv		1 BH Supv
Youth & Family – Outpatient Svcs	8	9	9	9	6	5	5	5	8	6	6	8	8 BH Sr. Clin	11	9 BH Sr. Clin
															2 BHS II
Support Coordination	8	10	12	12	10	15	24	29	32	27	28	26	25 DDS II	27	25 DDS II
													1 DDS I		1 DDS I
															1 DDS III
ADC/ Jail Diversion	7	7	9	10	10	9	10	9	6	13	12	13	5 BHS II	12	6 BHS II
													2 BH Supv		2 BH Supv
													2 BH Sr. Clin		1 BH Sr. Clin
													1 BHS I		
													2 Peer Supp Spec		2 Peer Supp Spec
													1 BHN Clin/Case Mgr		1 BHN Clin/Case Mgr
EAR									8	8	8	6	1 BHS I	5	1 BHS I
													1 BH Supv		2 BH Supv
													4 BH Sr. Clin		2 BH Sr. Clin.

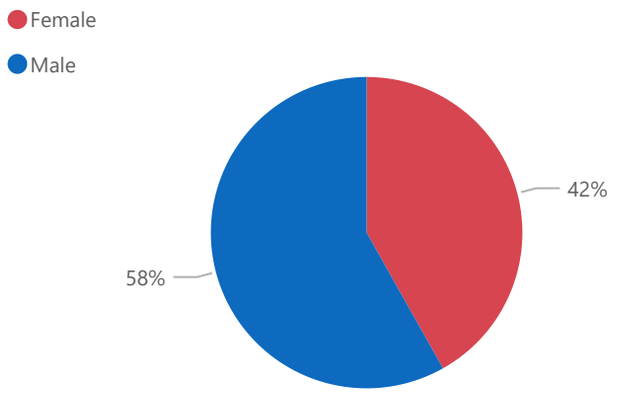
FAIRFAX - FALLS CHURCH
Community Services Board

CSB Status Report - January 2022

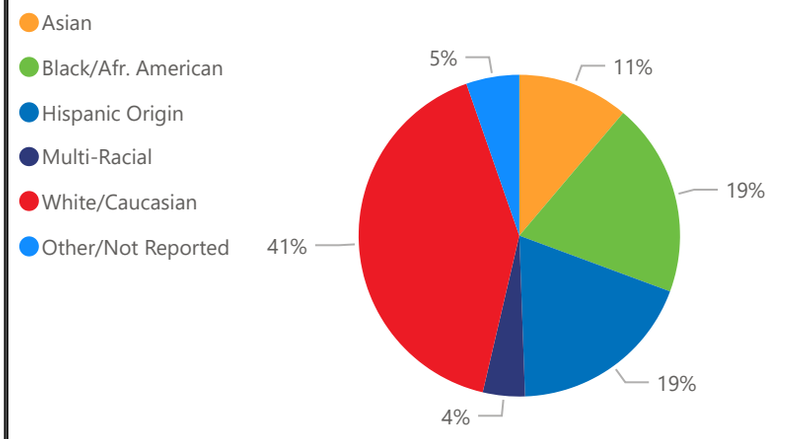
Age



Gender

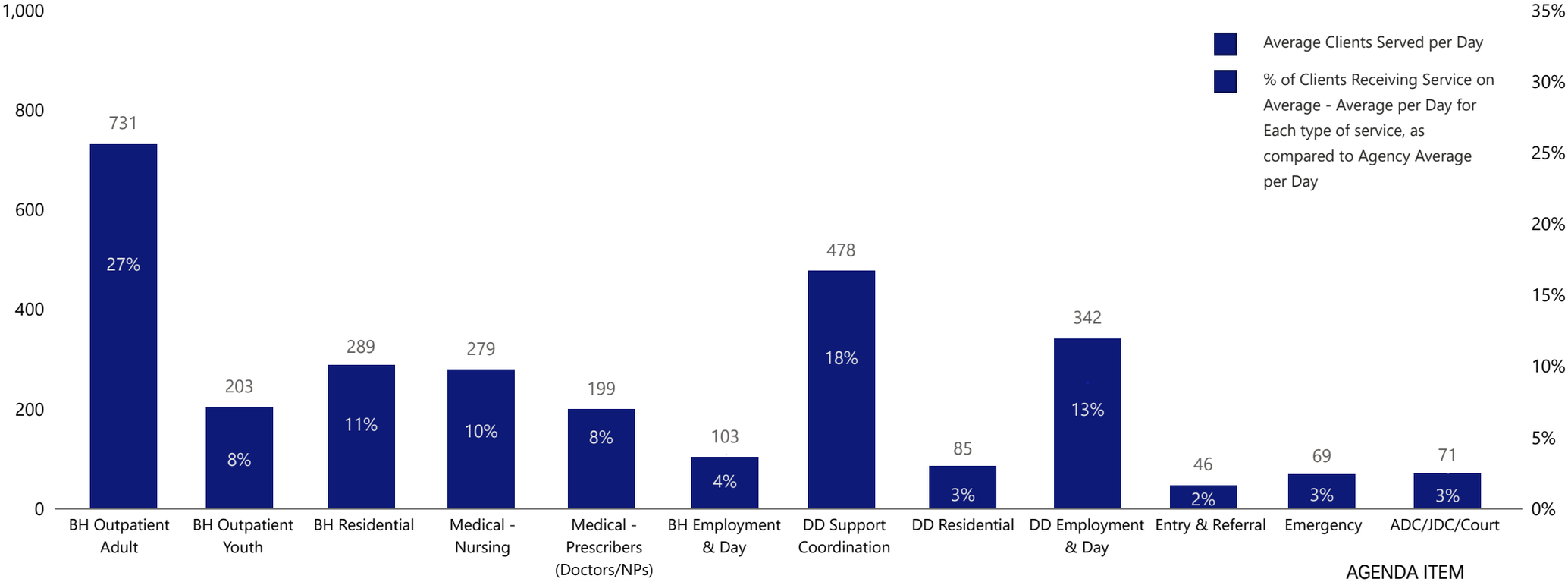


Race/Ethnicity



Average Clients Served per Day by Type of Service - January 2022

Agency Average Served per Day in January 2022 = 2,641



AGENDA ITEM #6.2

FAIRFAX - FALLS CHURCH Community Services Board

Individuals Served by Month by Type of Service Jan'21 - Jan'22

Service Area	Jan'21	Feb'21	Mar'21	Apr'21	May'21	Jun'21	Jul'21	Aug'21	Sep'21	Oct'21	Nov'21	Dec'21	Jan'22	Monthly Variance	Yearly Variance	# Served Past 12 Months
All Individuals Served	9,099	9,448	9,553	9,314	9,293	9,407	9,459	9,215	9,126	9,380	8,903	9,023	9,072	▲ 0.5%	▼ -0.3%	22,142
BH Outpatient Adult	3,446	3,441	3,642	3,507	3,383	3,374	3,359	3,383	3,382	3,264	3,177	3,146	3,174	▲ 0.9%	▼ -7.9%	5,470
BH Outpatient Youth	851	863	903	894	903	932	889	831	801	813	805	864	856	▼ -0.9%	▲ 0.6%	1,772
BH Residential	459	482	483	476	481	474	482	502	494	491	481	472	458	▼ -3.0%	▼ -0.2%	1,524
Medical - Nursing	1,180	1,615	1,523	1,484	1,284	1,278	1,330	1,281	1,236	1,387	1,215	1,206	1,275	▲ 5.7%	▲ 8.1%	3,680
Medical - Prescribers	2,939	3,018	3,159	3,088	2,910	3,076	2,816	2,787	2,734	2,778	2,578	2,600	2,633	▲ 1.3%	▼ -10.4%	6,768
BH Employment & Day	427	431	417	429	421	420	414	390	374	377	396	371	363	▼ -2.2%	▼ -15.0%	729
DD Support Coordination	2,420	2,508	2,507	2,453	2,365	2,395	2,755	2,576	2,503	2,775	2,454	2,559	2,744	▲ 7.2%	▲ 13.4%	5,244
DD Residential	98	97	95	92	90	88	88	88	87	87	85	86	85	▼ -1.2%	▼ -13.3%	98
DD Employment & Day	370	338	369	366	473	591	675	782	837	903	951	926	910	▼ -1.7%	▲ 145.9%	1,154
Entry & Referral (EAR)	470	607	720	689	714	697	547	429	440	533	476	486	499	▲ 2.7%	▲ 6.2%	4,432
EAR Screenings	164	218	250	216	228	264	211	212	198	271	375	335	294	▼ -12.2%	▲ 79.3%	2,947
EAR Assessments	104	115	156	117	128	140	110	136	121	134	125	142	156	▲ 9.9%	▲ 50.0%	1,610
Emergency	881	810	950	886	1,005	899	907	891	926	938	845	864	792	▼ -8.3%	▼ -10.1%	7,099
ADC/JDC/ Court	392	431	492	468	440	469	441	432	455	483	447	455	461	▲ 1.3%	▲ 17.6%	2,125

* Monthly variance compares current month to previous month; Yearly variance compares current month to the same month in previous calendar year (Ex: May 2021 compared to May 2020). Number Served Past 12 Months is an unduplicated count of clients served in each area in the 12 months prior to end of the reporting period (ex: June 2021 - May 2021).

Service Definitions	
All	Includes all individuals receiving services from the Community Services Board. Includes services for people of all ages who have mental illness, substance use disorders and/or developmental disabilities.
BH Outpatient Adult	Individuals receiving services from adult outpatient behavioral health programs. Includes the following service areas/programs: Behavioral Health Outpatient (BHOP) - MH Outpatient, MH Case Management, SUD Intensive Outpatient, Turning Point, Partial Hospitalization; Intensive Community Treatment - Intensive Case Management, PACT, Discharge Planning, PATH; Jail Diversion; Medication Assisted Treatment. Includes individuals receiving engagement, monitoring and treatment services.
BH Outpatient Youth	Individuals receiving services from youth behavioral health outpatient programs. Includes the following service areas/programs: Youth & Family Outpatient - MH Outpatient, MH Case Management, SUD Outpatient; Youth & Family Intensive - Wraparound Fairfax, Resource Program, Youth Discharge Planning. Includes individuals receiving assessment, monitoring, and treatment services.
BH Residential	Individuals receiving services from behavioral health residential programs. Includes the following service areas/programs: Supportive Community Residential - directly operated and contracted residential services; SUD Residential Treatment - Crossroads, Cornerstones, A New Beginning, New Generations; Youth Residential - Leland House; Wellness Circle Residential Crisis Stabilization, Fairfax Detoxification.
Medical - Nursing	Individuals receiving Nursing services in an outpatient setting.
Medical - Prescribers	Individuals receiving services from a prescriber (psychiatrist or nurse practitioner). Services are provided in a variety of treatment settings, including outpatient, residential, assessment, and emergency services.
BH Employment & Day	Individuals receiving behavioral health individual or group supported employment services.
DD Support Coordination	Individuals receiving developmental support coordination services. Includes individuals receiving targeted case management, monitoring, and assessment services.
DD Residential	Individuals receiving developmental disability residential services. Includes directly operated group homes and apartments, and locally funded contracted residential placements.
DD Employment & Day	Individuals receiving developmental day support services; individual, group, or sheltered employment services; and self-directed services. Includes both waiver and locally-funded services.
Entry & Referral (EAR)	Individuals receiving behavioral health entry and referral services. Includes Adult & Youth walk-in screening and assessment clinical services, case coordination, and call center referrals.
EAR Screenings	Individuals receiving behavioral health screening services at Entry & Referral.
EAR Assessments	Individuals receiving behavioral health assessment services at Entry & Referral.
ADC/JDC/Court	Individuals receiving CSB jail-based or court services. Includes CSB services provided at the Adult Detention Center, Juvenile Detention Center and adult participants in specialty court dockets (Veterans' Docket, Mental Health Docket, Drug Court).

Notes:

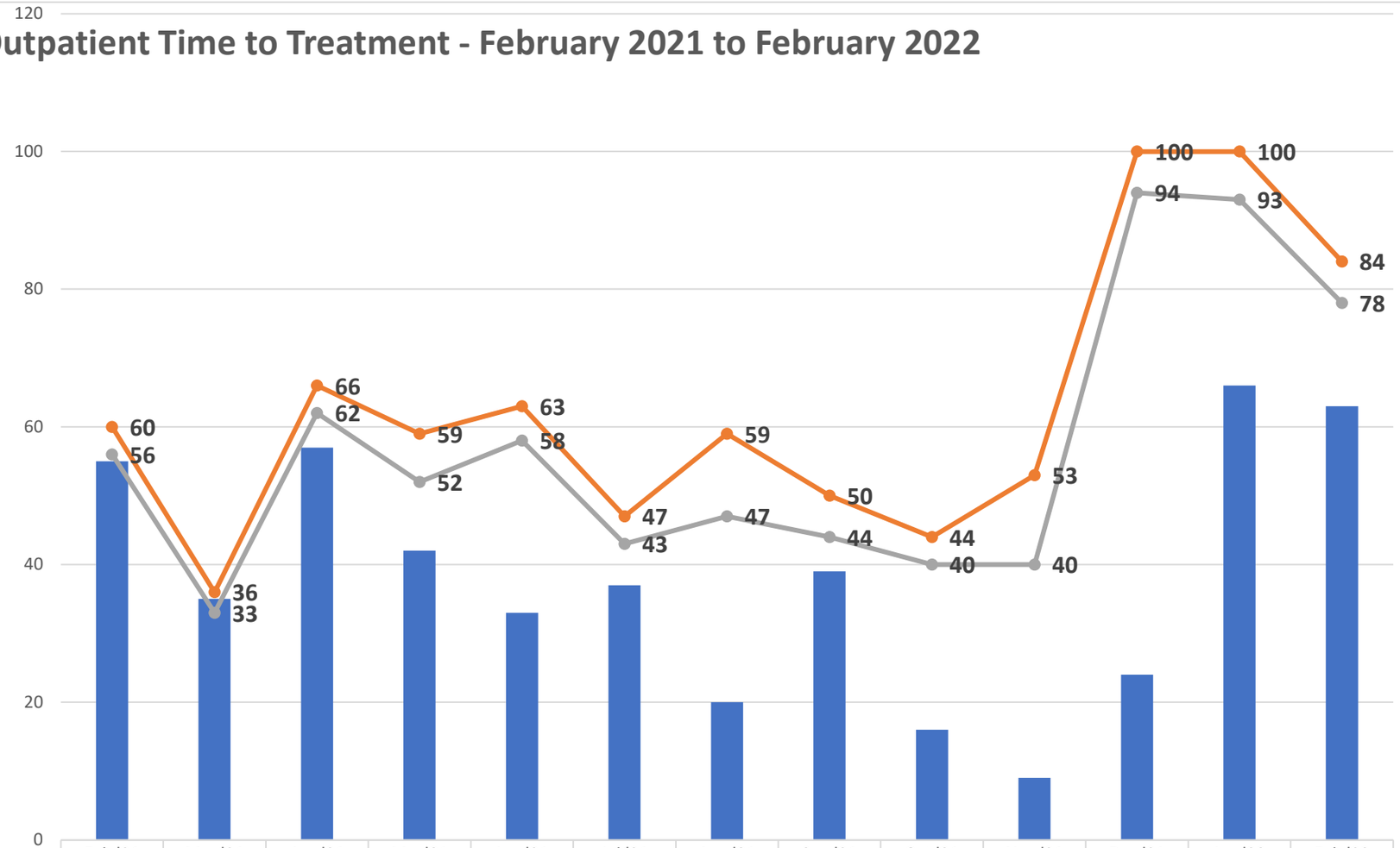
Page 1:

- Demographics – Typically little change in demographics over time. Reflects demographic characteristics of all individuals served in the reporting month.
- Average Clients Served per Day by Type of Service – Compares average served per day in each service area to the agency-wide average number served. Individuals may receive more than one type of service per day and totals may be greater than 100%.

Page 2:

- Numbers reported show the unduplicated number of clients served in each service area. Individuals may receive multiple services each month within a service area and may receive more than one type of service each month.
- The Monthly Variance compares the reporting month to the prior month. The Yearly Variance compares the reporting month to the same month in the previous calendar year.
- BH Outpatient Adult – The number of individuals served is up slightly from December but trending lower overall as compared to last year and appears to be due to the impacts of staff vacancies and the omicron variant.
- BH Outpatient Youth – This service area typically sees an increase in referrals and individuals served in the late fall that continues throughout the school year and drops off over the summer months. Numbers served are on trend as compared to the previous year.
- Medical – Prescribers – Prescribers (Psychiatrists & Nurse Practitioners) serve individuals in a variety of treatment settings. The number served is up slightly from last month but trending lower compared to last year. The reduction is correlated with the lower number of individuals receiving services in the adult behavioral health treatment programs.
- BH Employment & Day – The number of individuals served is lower as compared to the prior year due to staff turnover in the Individual Supported Employment program and a reduction in the number of clients served in the PsychoSocial Day program resulting from client concerns with attending in-person programming due to the omicron variant.
- DD Support Coordination – There is typically monthly variation based on individual quarterly service plan review cycles. In January, client counts were also higher than average due to a new DMAS documentation requirement for all individuals on the waiver waiting list.
- DD Residential – Includes all individuals served in directly operated residential programs and locally-funded contract placements. The number of individuals served each month is trending lower overall due to reductions in the directly operated group home census and locally funded contract placements through natural attrition. New residential placements through community partners are waiver funded.
- DD Employment & Day – There has been an upward trend in this service area as developmental employment & day programs have been able to reopen from closures that were necessary earlier in the pandemic to ensure individual safety.
- Entry & Referral (EAR), EAR Screenings & EAR Assessments – In mid-October, Entry & Referral launched a new streamlined screening and assessment process with changes to the triage, screening, and assessment workflows. Direct comparisons cannot be made to prior months. There was close to a 10% monthly increase in the number of clients receiving assessments in January.
- Emergency – There is some monthly fluctuation in the demand for Emergency services. All clients who present for services are evaluated by Emergency services staff.
- ADC/JDC/Court – The number of individuals served is trending higher as compared to January 2021. The jail census was significantly reduced earlier in the pandemic in response to health and safety issues.

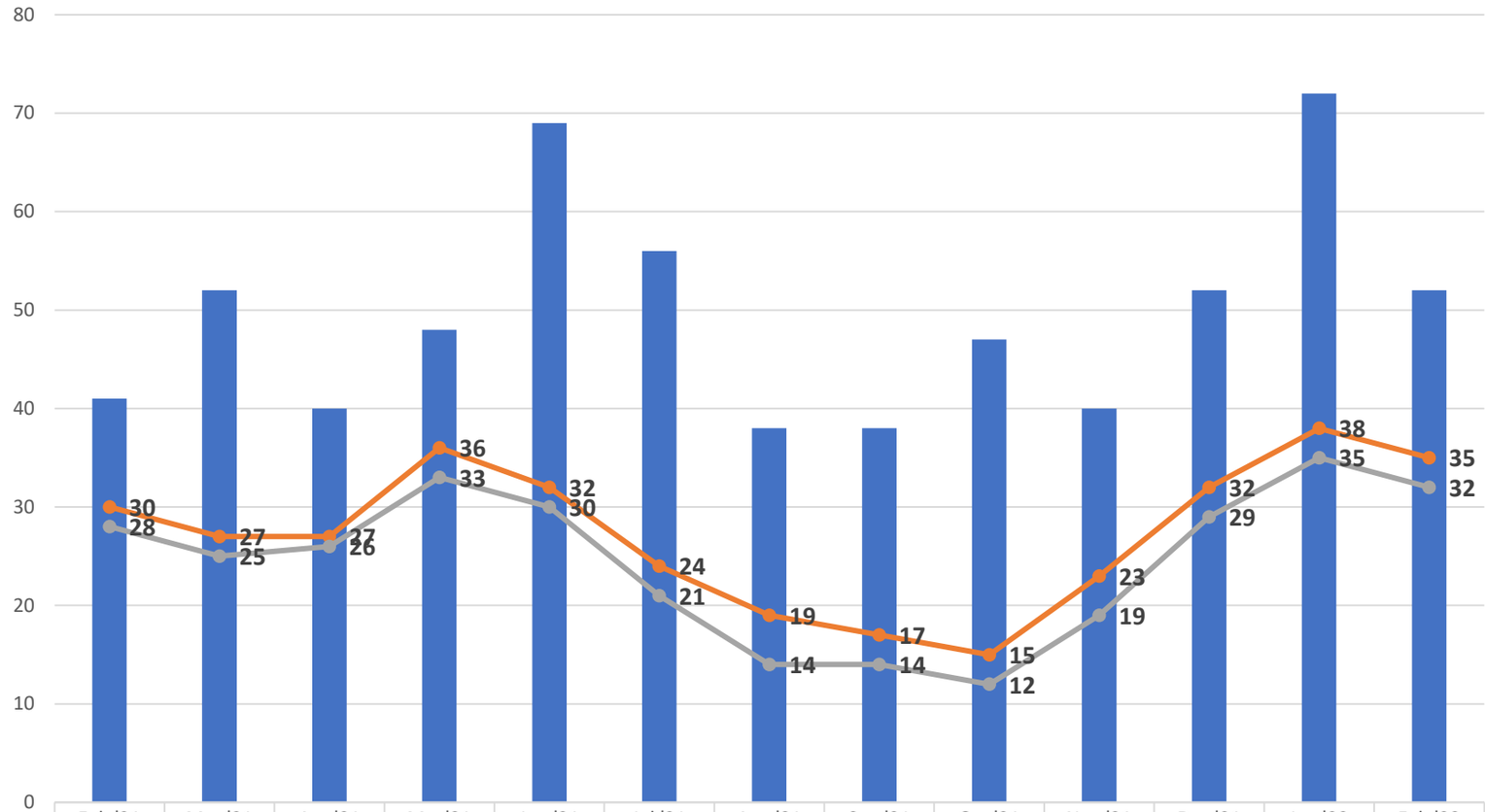
Adult Outpatient Time to Treatment - February 2021 to February 2022



	Feb '21	Mar '21	Apr '21	May'21	Jun '21	Jul '21	Aug '21	Sep '21	Oct '21	Nov '21	Dec '21	Jan '22	Feb '22
# Adults Who Attended 1st Treatment Appt	55	35	57	42	33	37	20	39	16	9	24	66	63
Average # Days from Assessment to Treatment	60	36	66	59	63	47	59	50	44	53	100	100	84
Average # Days from Assessment to 1st Available / Accepted Appt*	56	33	62	52	58	43	47	44	40	40	94	93	78

***Average number of days from Assessment to Date of First Available Appointment (if known) OR from Assessment to Date of First Accepted Appointment**

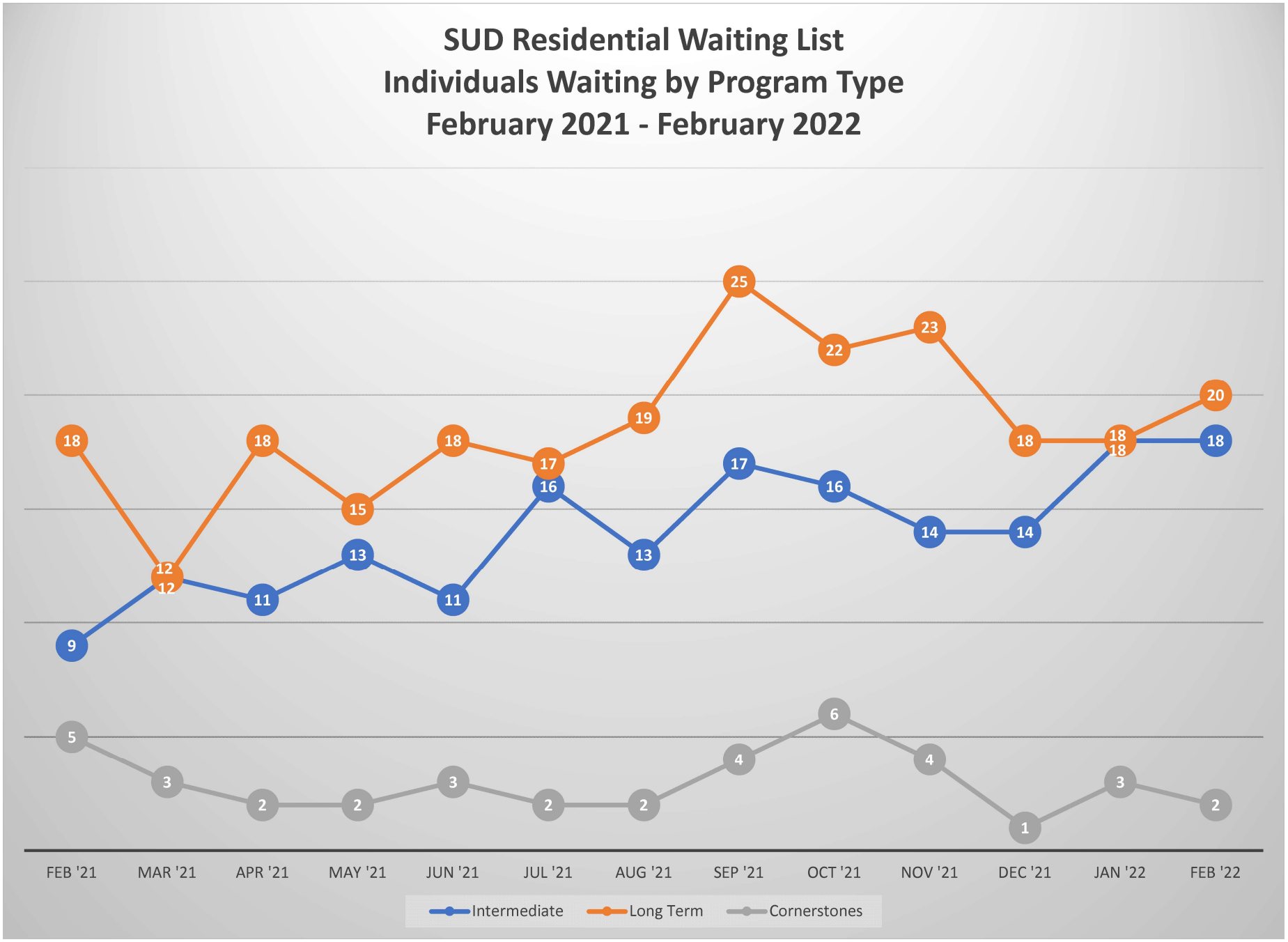
Youth Outpatient Time to Treatment - February 2021 to February 2022



	Feb '21	Mar '21	Apr '21	May'21	Jun '21	Jul '21	Aug '21	Sep '21	Oct '21	Nov '21	Dec '21	Jan '22	Feb '22
# Youth Who Attended 1st Treatment Appt	41	52	40	48	69	56	38	38	47	40	52	72	52
Average # Days from Assessment to Treatment	30	27	27	36	32	24	19	17	15	23	32	38	35
Average # Days from Assessment to 1st Available / Accepted Appt*	28	25	26	33	30	21	14	14	12	19	29	35	32

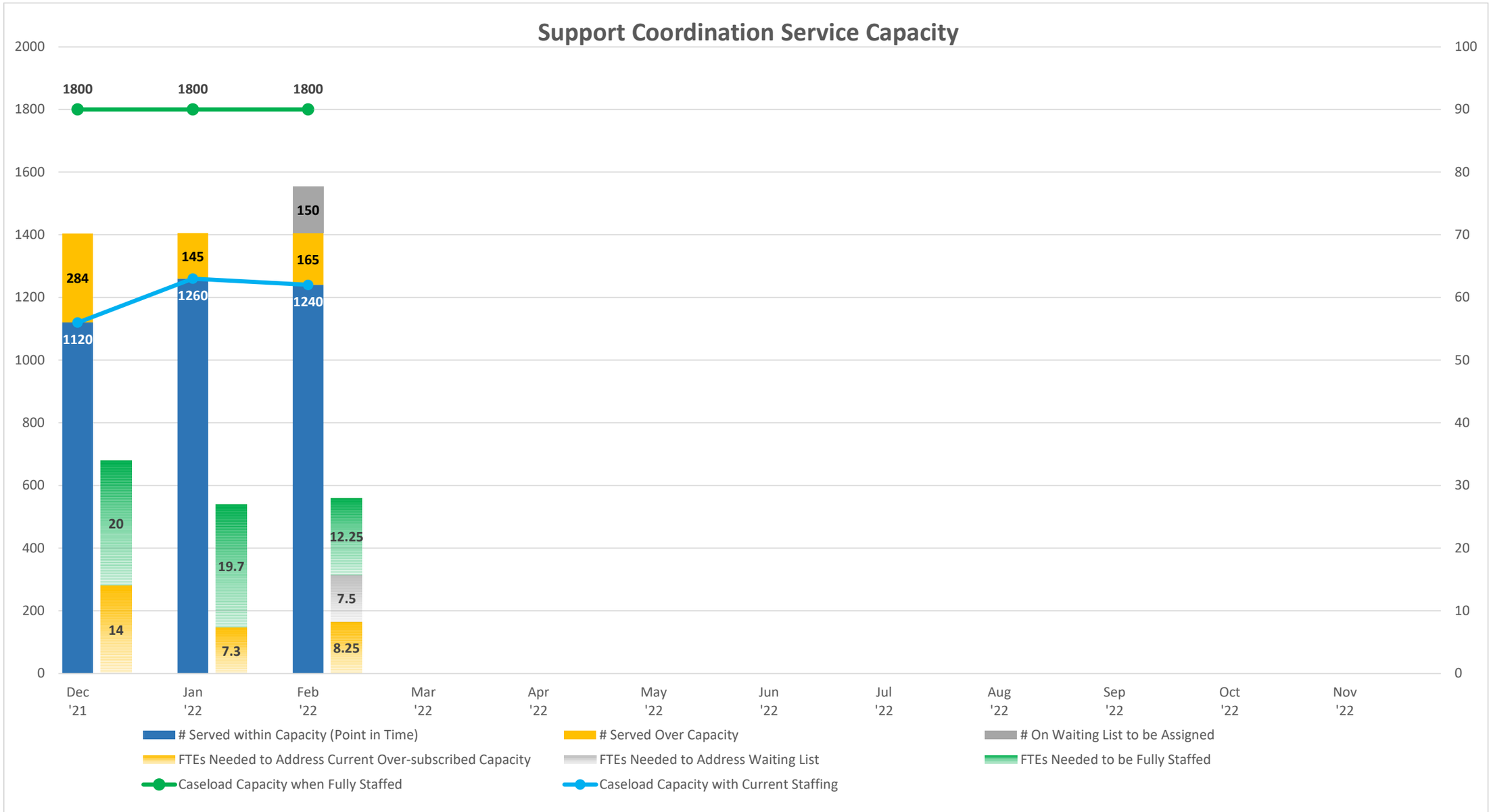
*Average number of days from Assessment to Date of First Available Appointment (if known) OR from Assessment to Date of First Accepted Appointment

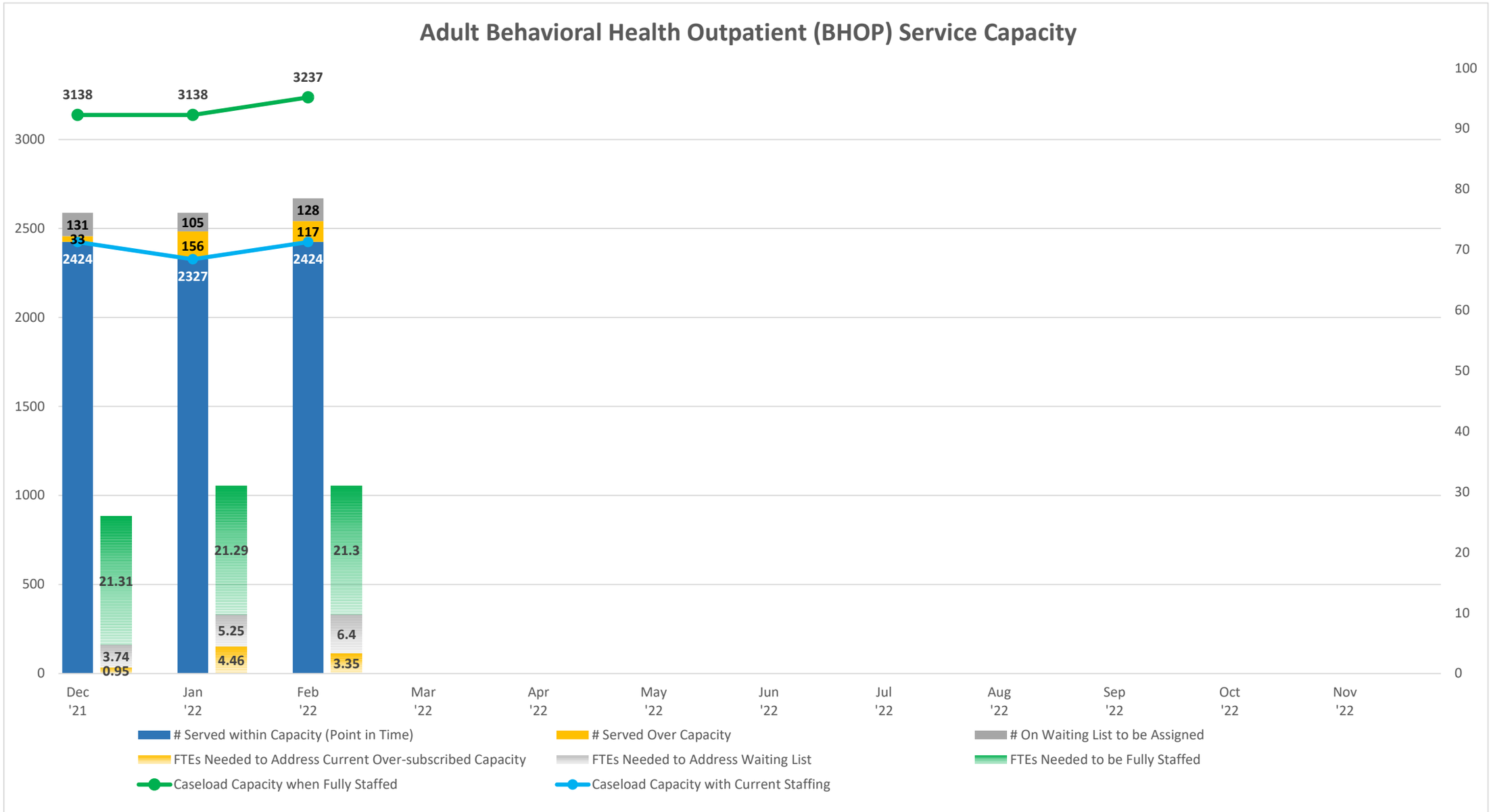
SUD Residential Waiting List
Individuals Waiting by Program Type
February 2021 - February 2022



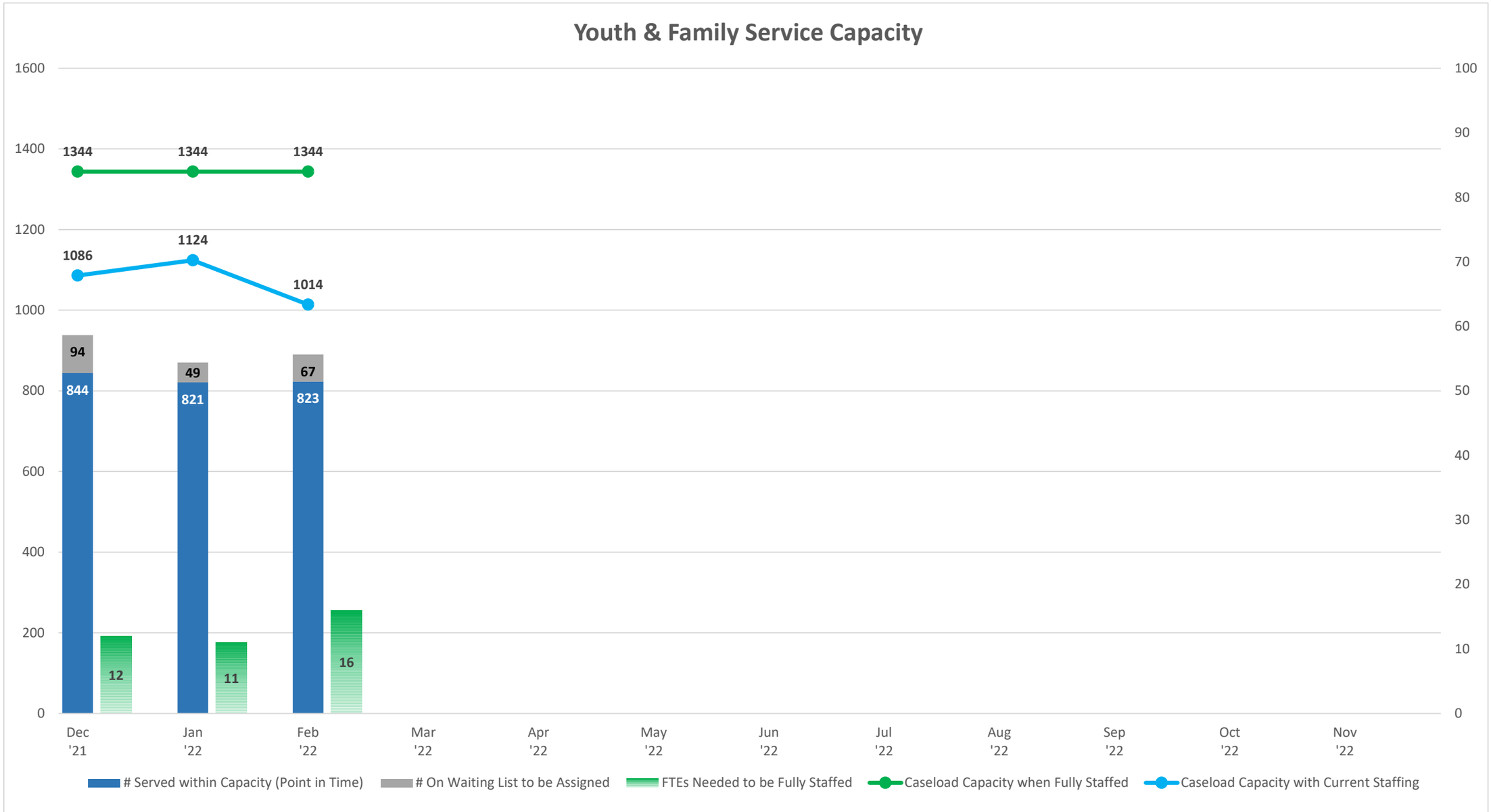
CSB Targeted Service Capacity At-A-Glance: December 2021 to February 2022

	Dec-21						Jan-22						Feb-22					
	SC - Waiver		BHOP		Y&F		SC - Waiver		BHOP		Y&F		SC - Waiver		BHOP		Y&F	
	# svd	ftes	# svd	ftes	# svd	ftes	# svd	ftes	# svd	ftes	# svd	ftes	# svd	ftes	# svd	ftes	# svd	ftes
Full Service Capacity	1800	90	3137.75	155.75	1343.5	73.5	1800	90	3137.75	155.75	1343.5	73.5	1800	90	3236.75	159.25	1343.5	73.5
Current Service Capacity	1120	56	2423.75	129.75	1085.5	61.5	1260	63	2326.75	124.75	1123.5	62.5	1240	62	2423.75	128.25	1013.5	57.5
Service Capacity Shortfall & Vacancies	680	34	714	26	258	12	540	27	811	31	220	11	560	28	813	31	330	16
Current # Served (Point in Time)	1404		2457		844		1405		2483		821		1405		2541		823	
Over-subscribed Service Capacity	-284	-14.2	-33.25	-0.95	241.5	9.66	-145	-7.25	-156.25	-4.46	302.5	8.64	-165	-8.25	-117.25	-3.35	190.5	5.44
Monitoring			-131	-3.74	-94	-3.76			-105	-5.25	-49	-1.96	-150	-7.5	-128	-6.4	-67	-2.68


Support Coordination Service Capacity
2000
1800
1600
1400
1200
1000
800
600
400
200
0
100
90
80
70
60
50
40
30
20
10
0
1800
1800
1800
284
145
150
165
1120
1260
1240
20
14
19.7
7.3
12.25
7.5
8.25
Dec '21
Jan '22
Feb '22
Mar '22
Apr '22
May '22
Jun '22
Jul '22
Aug '22
Sep '22
Oct '22
Nov '22
Served within Capacity (Point in Time)
Served Over Capacity
On Waiting List to be Assigned
FTEs Needed to Address Current Over-subscribed Capacity
FTEs Needed to Address Waiting List
FTEs Needed to be Fully Staffed
Caseload Capacity when Fully Staffed
Caseload Capacity with Current Staffing



AGENDA ITEM
#6.10


Youth & Family Service Capacity
1600
1400
1200
1000
800
600
400
200
0
100
90
80
70
60
50
40
30
20
10
0
1344
1344
1344
1086
1124
1014
94
844
12
49
821
11
67
823
16
Dec '21
Jan '22
Feb '22
Mar '22
Apr '22
May '22
Jun '22
Jul '22
Aug '22
Sep '22
Oct '22
Nov '22
Served within Capacity (Point in Time)
On Waiting List to be Assigned
FTEs Needed to be Fully Staffed
Caseload Capacity when Fully Staffed
Caseload Capacity with Current Staffing

		FY 2022 REVISED Budget[5]	FY 2022 YTD Budget	FY 2022 Actuals February YTD	Variance from YTD Budget	FY 2022 Projection	FY 2022 Projection vs. FY22 REVISED Budget
	Est. Beginning Balance	**38,790,324**	**38,790,324**	**38,790,324**	**-**	**38,790,324**	**-**
F	Fairfax City	2,218,100	554,525	1,171,908	617,383	2,343,816	125,716
F	Falls Church City	1,005,368	251,342	531,174	279,832	1,062,348	56,980
F	State DBHDS	7,839,233	5,226,155	5,843,232	617,077	7,839,233	-
F	Federal Pass Thru SAPT Block Grant	4,053,659	2,702,439	2,841,300	138,861	4,053,659	-
V	Direct Federal Food Stamps	154,982	103,321	63,139	(40,182)	94,708	(60,274)
V	Program/Client Fees	4,296,500	2,864,333	2,980,713	116,380	4,471,070	174,570
V	CSA	890,000	593,333	401,757	(191,577)	602,635	(287,365)
V	Medicaid Option	8,582,708	5,721,805	6,186,462	464,657	9,279,693	696,985
V	Medicaid Waiver	7,000,000	4,666,667	5,558,209	891,542	8,337,313	1,337,313
V	Miscellaneous	124,800	83,200	83,200	-	124,800	-
	Non-County Revenue	36,165,350	22,767,122	25,661,093	2,893,972	38,209,275	2,043,925
	General Fund Transfer	150,158,878	150,158,878	150,158,878	-	150,158,878	-
	Total Available	**225,114,552**	**211,716,324**	**214,610,295**	**2,893,972**	**227,158,477**	**2,043,925**
	Compensation	90,244,263	54,760,426	52,120,139	2,640,287	83,971,335	6,272,928
	Fringe Benefits	38,463,039	23,546,966	21,878,911	1,668,056	35,249,356	3,213,683
	Operating	71,907,646	39,050,696	31,588,473	7,462,223	47,382,709	24,524,937
	Recovered Cost (WPFO)	(1,568,760)	(522,920)	(883,829)	360,909	(1,325,744)	(243,016)
	Capital	898,899	400,000	271,196	128,804	406,793	492,106
	Transfer Out	15,000,000	15,000,000	15,000,000	-	15,000,000	-
	Total Disbursements	**214,945,087**	**132,235,168**	**119,974,888**	**12,260,280**	**180,684,449**	**34,260,638**
	Ending Balance	**10,169,465**	**79,481,156**	**94,635,407**		**46,474,028**	
	DD MW Redesign Reserve[1]	2,500,000	2,500,000			2,500,000	
	Medicaid Replacement Reserve[2]	2,800,000	2,800,000			2,800,000	
	Opioid Epidemic MAT Reserve[3]	50,000	50,000			50,000	
	Diversion First Reserve[4]	4,408,162	4,408,162			4,408,162	
	Unreserved Balance	**411,303**				**36,715,866**	

Key

F Fixed Annual Allocations

V Variable Revenue based on number of services provided and total billing collections

1 The DD Medicaid Waiver Redesign Reserve ensures the County has sufficient funding to provide services to individuals with developmental disabilities in the event of greater than anticipated costs due to the Medicaid Waiver Redesign effective July 1, 2016.

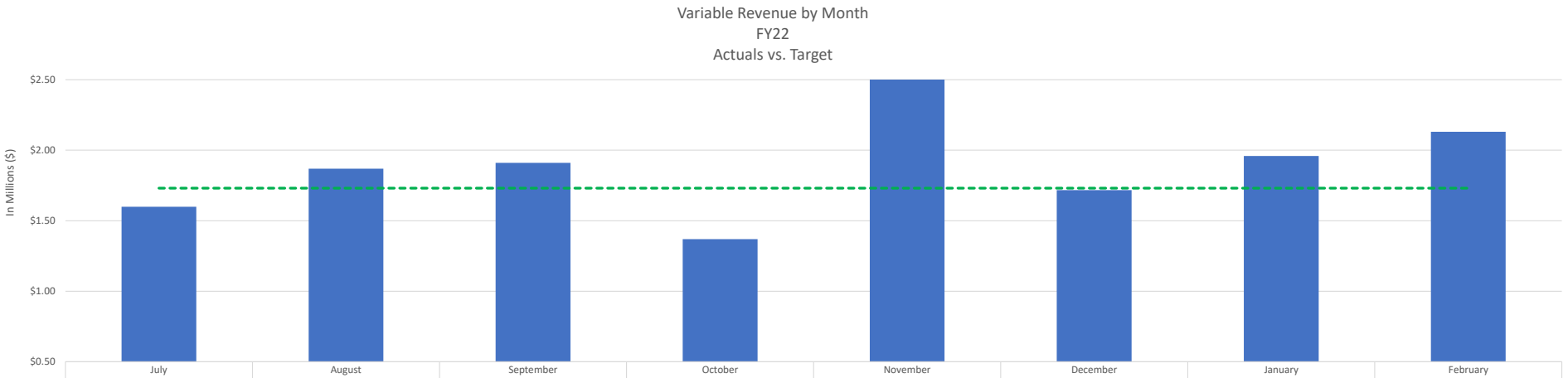
2 The Medicaid Replacement Reserve, for the implementation of Medicaid Expansion to a potential 600 consumers and will provide support with the transition of funding from the State support to Medicaid fees.

3 The Opioid Use Epidemic Reserve provides flexibility, consistent with the Board of Supervisors' FY 2018-FY 2019 Budget Guidance, as the County continues to work with national, state, and regional partners on strategies to combat the opioid epidemic.

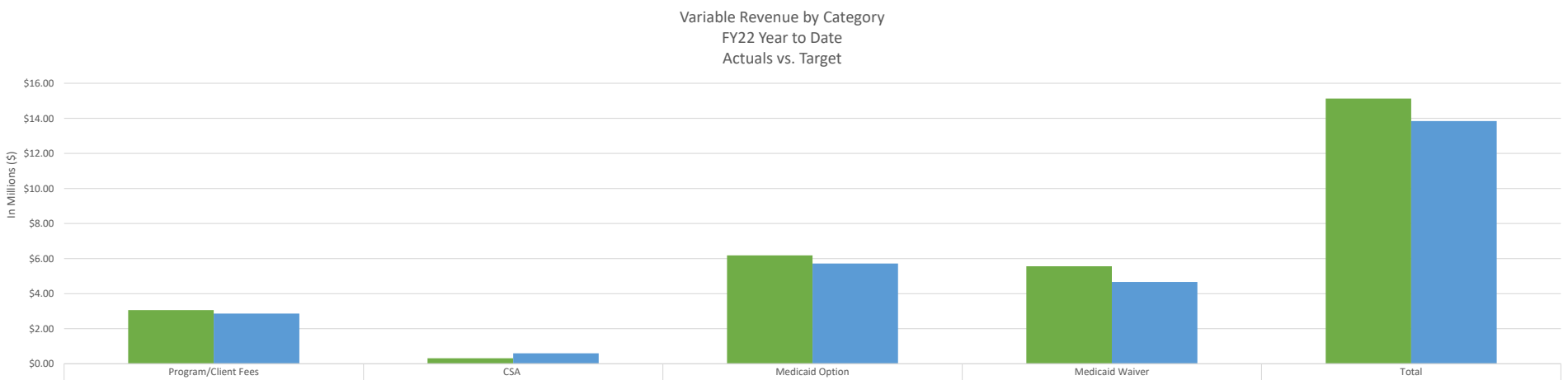
4 The Diversion First Reserve represents one-time savings that were realized in FY 2017 as a result of longer than anticipated recruitment times to fill new positions and savings in operating expenses to pay for medical clearances. This funding will be reallocated as part of a future budget process based on priorities identified by the Board of Supervisors. This reserve has been reduced by $250K at FY20 Carryover for costs associated with medical clearances.

5 FY22 Revised Budget reflects BOS Approved Carryover adjustments. They are:
*$1.5M for 1x bonus for merit and non-merit employees
*$10.1M for FY21 encumbrances to occur in FY22
*$15M transfer to general fund
*$250K appropriation from Opioid Task Force reserve
*$250K for additional capital projects

February FY22 YTD Revenue Analysis



	July	August	September	October	November	December	January	February
Actuals	$1,599,508	$1,869,485	$1,910,596	$1,369,590	$2,571,746	$1,716,423	$1,959,074	$2,130,717
Target	$1,730,767	$1,730,767	$1,730,767	$1,730,767	$1,730,767	$1,730,767	$1,730,767	$1,730,767



	Program/Client Fees	CSA	Medicaid Option	Medicaid Waiver	Total
Actuals	$3,063,714	$318,755	$6,186,462	$5,558,208	$15,127,140
Target	$2,864,333	$593,333	$5,721,805	$4,666,667	$13,846,139

AGENDA ITEM
#6.13

Fairfax-Falls Church Community Services Board
Operating Expenditures
Program Budget vs. Actuals
February FY22 YTD

SERVICE/PROGRAM AREA	FUND 400-C40040 (UNRESTRICTED FEDERAL, LOCAL AND STATE)			FUND 500-C50000 (RESTRICTED FEDERAL, STATE AND OTHER)			TOTAL (UNRESTRICTED, RESTRICTED FEDERAL, STATE AND OTHER)		
	Budget	Actuals	Variance	Budget	Actuals	Variance	Budget	Actuals	Variance
G761501 - CSB Office of the Deputy Director - Clinical									
G761001004 - Consumer & Family Affairs	*$ -*	*$ 110*	*$ (110)*				*$ -*	*$ 110*	*$ (110)*
G761001008 - Medical Services	*$ -*	*$ 15,936*	*$ (15,936)*				*$ -*	*$ 15,936*	*$ (15,936)*
G761501002 - Consumer & Family Affairs	$ 1,884,333	$ 1,173,012	$ 711,321	*$ (5,795)*	*$ (64,565)*	$ 58,770	$ 1,878,537	$ 1,108,447	$ 770,091
G761501003 - Medical Services	$ 14,505,037	$ 7,530,617	$ 6,974,420	*$ 130,000*	*$ -*	$ 130,000	$ 14,635,037	$ 7,530,617	$ 7,104,420
G761501004 - Opioid Task Force	$ 4,225,018	$ 1,625,166	$ 2,599,852				$ 4,225,018	$ 1,625,166	$ 2,599,852
G761501005 - Utilization Management	$ 646,148	$ 368,258	$ 277,890				$ 646,148	$ 368,258	$ 277,890
G761501 - CSB Office of the Deputy Director - Clinical Total	**$ 21,260,536**	**$ 10,713,100**	**$ 10,547,436**	**$ 124,205**	**$ (64,565)**	**$ 188,770**	**$ 21,384,740**	**$ 10,648,534**	**$ 10,736,206**
G762001 - Engagement Asmt & Referral Services									
G761001011 - Wellness Health Promotion Prevention	*$ -*	*$ 7,218*	*$ (7,218)*				*$ -*	*$ 7,218*	*$ (7,218)*
G762001001 - EAR Program Management	$ 405,106	$ 189,333	$ 215,773	$ 0	$ -	$ 0	$ 405,106	$ 189,333	$ 215,773
G762001002 - Entry, Referral, & Assessment	$ 2,831,455	$ 1,287,904	$ 1,543,551	$ 145,706	$ (150,624)	$ 296,330	$ 2,977,161	$ 1,137,280	$ 1,839,881
G762001004 - Wellness Health Promotion Prevention	$ 2,347,862	$ 1,301,417	$ 1,046,444	$ 127,284	$ 119,836	$ 7,447	$ 2,475,145	$ 1,421,253	$ 1,053,892
G762001 - Engagement Asmt & Referral Services Total	**$ 5,584,423**	**$ 2,785,873**	**$ 2,798,549**	**$ 272,990**	**$ (30,788)**	**$ 303,778**	**$ 5,857,412**	**$ 2,755,085**	**$ 3,102,327**
G762002 - Emergency & Crisis Care Services									
G762002001 - Emergency & Crisis Care Svcs Program Mgm	$ 207,047	$ 125,495	$ 81,552				$ 207,047	$ 125,495	$ 81,552
G762002002 - Adult Crisis Stabilization	$ 3,318,732	$ 2,380,774	$ 937,958				$ 3,318,732	$ 2,380,774	$ 937,958
G762002004 - Emergency	$ 6,759,072	$ 4,204,856	$ 2,554,216	$ 209,296	$ 128,590	$ 80,705	$ 6,968,367	$ 4,333,446	$ 2,634,921
G762002 - Emergency & Crisis Care Services Total	**$ 10,284,850**	**$ 6,711,125**	**$ 3,573,726**	**$ 209,296**	**$ 128,590**	**$ 80,705**	**$ 10,494,146**	**$ 6,839,715**	**$ 3,654,431**
G762003 - Residential Treatment & Detoxification Services									
G762002003 - Detoxification & Diversion	$ 176,768	$ 13,596	$ 163,172				$ 176,768	$ 13,596	$ 163,172
G762003001 - Residential Treatment Program Management	$ 213,307	$ 151,429	$ 61,878				$ 213,307	$ 151,429	$ 61,878
G762003002 - Residential Admissions & Support	$ 798,872	$ 506,985	$ 291,887				$ 798,872	$ 506,985	$ 291,887
G762003003 - A New Beginning	$ 3,666,187	$ 2,226,154	$ 1,440,033				$ 3,666,187	$ 2,226,154	$ 1,440,033
G762003004 - Crossroads Adult	$ 3,328,655	$ 1,995,257	$ 1,333,398				$ 3,328,655	$ 1,995,257	$ 1,333,398
G762003005 - New Generations	$ 1,508,442	$ 1,010,055	$ 498,386				$ 1,508,442	$ 1,010,055	$ 498,386
G762003006 - Cornerstones	$ 2,294,210	$ 1,503,812	$ 790,398				$ 2,294,210	$ 1,503,812	$ 790,398
G762003007 - Residential Treatment Contract	$ 1,678,164	$ 219,519	$ 1,458,645				$ 1,678,164	$ 219,519	$ 1,458,645
G762003008 - Detoxification Services	$ 4,420,122	$ 2,770,099	$ 1,650,023				$ 4,420,122	$ 2,770,099	$ 1,650,023
G762003 - Residential Treatment & Detoxification Services Total	**$ 18,084,728**	**$ 10,396,907**	**$ 7,687,821**	**$ -**	**$ -**	**$ -**	**$ 18,084,728**	**$ 10,396,907**	**$ 7,687,821**
G762005 - Youth & Family Services									
G762005001 - Youth & Family Program Management	$ 337,638	$ 131,826	$ 205,812				$ 337,638	$ 131,826	$ 205,812
G762005002 - Youth & Family Outpatient	$ 6,001,124	$ 3,620,662	$ 2,380,462				$ 6,001,124	$ 3,620,662	$ 2,380,462
G762005003 - Youth & Family Day Treatment	*$ -*	*$ -*	*$ -*				*$ -*	*$ -*	*$ -*
G762005004 - Youth Resource Team	$ 1,653,464	$ 802,417	$ 851,047	$ 80,039	$ 54,036	$ 26,003	$ 1,733,503	$ 856,454	$ 877,049
G762005005 - Wraparound Fairfax	$ 833,912	$ 563,120	$ 270,792				$ 833,912	$ 563,120	$ 270,792
G762005006 - Court Involved Youth	$ 456,928	$ 422,188	$ 34,740	$ 1,237	$ 1,185	$ 52	$ 458,165	$ 423,373	$ 34,792
G762005009 - Youth & Family Contract	$ 816,528	$ 301,789	$ 514,739				$ 816,528	$ 301,789	$ 514,739
G762005 - Youth & Family Services Total	**$ 10,099,594**	**$ 5,842,003**	**$ 4,257,591**	**$ 81,276**	**$ 55,221**	**$ 26,054**	**$ 10,180,870**	**$ 5,897,224**	**$ 4,283,646**
G762006 - Diversion & Jail-Based Services									
G763006002 - Forensic Services	*$ 1,782,985*	*$ 121,985*	*$ 1,661,000*	*$ 46,711*	*$ 69,211*	$ (22,500)	*$ 1,829,696*	*$ 191,196*	*$ 1,638,500*
G763006007 - Jail Diversion	*$ 578,014*	*$ (0)*	*$ 578,014*	*$ 149,557*	*$ 206,692*	$ (57,135)	*$ 727,571*	*$ 206,692*	*$ 520,879*
G762006001 - Diversion & Jail-Based Program Mgmt	*$ -*	*$ 1,103*	*$ (1,103)*				*$ -*	*$ 1,103*	*$ (1,103)*
G762006002 - Jail Diversion	$ 2,258,929	$ 1,678,258	$ 580,671						
G762006003 - Forensic Services	$ 2,582,221	$ 874,597	$ 1,707,624				$ 2,582,221	$ 874,597	$ 1,707,624
G762006 - Diversion & Jail-Based Services Total	**$ 7,202,149**	**$ 2,675,944**	**$ 4,526,206**	**$ 196,268**	**$ 275,903**	**$ (79,635)**	**$ 5,139,488**	**$ 1,273,588**	**$ 3,865,900**
G763001 - Behavioral Health Outpatient & Case Mgmt Svcs									
G763001001 - Behavioral Health OP & CM Program Mgmt	$ 201,079	$ 142,107	$ 58,972				$ 201,079	$ 142,107	$ 58,972
G763001002 - Adult Outpatient & Case Management	$ 13,018,325	$ 7,948,338	$ 5,069,987				$ 13,018,325	$ 7,948,338	$ 5,069,987
G763001005 - Adult Partial Hospitalization	$ 1,170,516	$ 639,400	$ 531,116				$ 1,170,516	$ 639,400	$ 531,116
G763001 - Behavioral Health Outpatient & Case Mgmt Svcs Total	**$ 14,389,920**	**$ 8,729,845**	**$ 5,660,075**	**$ -**	**$ -**	**$ -**	**$ 14,389,920**	**$ 8,729,845**	**$ 5,660,075**
G763002 - Support Coordination Services									
G763002001 - Support Coordination Program Management	$ 209,894	$ 78,347	$ 131,547				$ 209,894	$ 78,347	$ 131,547
G763002002 - Support Coordination	$ 11,841,486	$ 6,568,149	$ 5,273,337				$ 11,841,486	$ 6,568,149	$ 5,273,337
G763002003 - Support Coordination Contracts	$ 976,708	$ 215,954	$ 760,753				$ 976,708	$ 215,954	$ 760,753
G763002 - Support Coordination Services Total	**$ 13,028,088**	**$ 6,862,450**	**$ 6,165,637**	**$ -**	**$ -**	**$ -**	**$ 13,028,088**	**$ 6,862,450**	**$ 6,165,637**
G763003 - Employment & Day Services									
G763003001 - Employment & Day Program Management	$ 2,385,553	$ 2,297,267	$ 88,286				$ 2,385,553	$ 2,297,267	$ 88,286
G763003002 - Behavioral Health Emp & Day Direct	$ 785,454	$ 291,842	$ 493,612				$ 785,454	$ 291,842	$ 493,612
G763003003 - Behavioral Health Emp & Day Contract	$ 2,709,328	$ 1,679,389	$ 1,029,938	$ 237,068	$ 84,702	$ 152,366	$ 2,946,396	$ 1,764,091	$ 1,182,305
G763003004 - ID Emp & Day Direct	$ 171,950	$ -	$ 171,950				$ 171,950	$ -	$ 171,950
G763003005 - ID Emp & Day Contract	$ 24,000,766	$ 7,844,181	$ 16,156,584				$ 24,000,766	$ 7,844,181	$ 16,156,584
G763003006 - ID Emp & Day Self-Directed	$ 2,388,136	$ 1,963,050	$ 425,085				$ 2,388,136	$ 1,963,050	$ 425,085
G763003 - Employment & Day Services Total	**$ 32,441,186**	**$ 14,075,730**	**$ 18,365,456**	**$ 237,068**	**$ 84,702**	**$ 152,366**	**$ 32,678,254**	**$ 14,160,432**	**$ 18,517,822**
G763004 - Assisted Community Residential Services									

Fairfax-Falls Church Community Services Board
Operating Expenditures
Program Budget vs. Actuals
February FY22 YTD

SERVICE/PROGRAM AREA	FUND 400-C40040 (UNRESTRICTED FEDERAL, LOCAL AND STATE)			FUND 500-C50000 (RESTRICTED FEDERAL, STATE AND OTHER)			TOTAL (UNRESTRICTED, RESTRICTED FEDERAL, STATE AND OTHER)		
	Budget	Actuals	Variance	Budget	Actuals	Variance	Budget	Actuals	Variance
G763004001 - Assist Community Residential Prog Mgmt	$ 156,977	$ 103,646	$ 53,331				$ 156,977	$ 103,646	$ 53,331
G763004002 - Asst Comm Residential Direct	$ 9,287,597	$ 5,201,499	$ 4,086,097				$ 9,287,597	$ 5,201,499	$ 4,086,097
G763004003 - Asst Comm Residential Contract	$ 5,167,096	$ 2,317,884	$ 2,849,212				$ 5,167,096	$ 2,317,884	$ 2,849,212
G763004004 - Stevenson Place	$ 1,151,316	$ 430,302	$ 721,014				$ 1,151,316	$ 430,302	$ 721,014
G763004 - Assisted Community Residential Services Total	**$ 15,762,986**	**$ 8,053,332**	**$ 7,709,655**	$ -	$ -	$ -	**$ 15,762,986**	**$ 8,053,332**	**$ 7,709,655**
G763005 -Supportive Community Residential Services									
G763005001 - Support Community Residential Prog Mgmt	$ 1,087,457	$ 788,715	$ 298,742				$ 1,087,457	$ 788,715	$ 298,742
G763005002 - Supportive Residential Direct	$ 2,059,608	$ 1,189,042	$ 870,566				$ 2,059,608	$ 1,189,042	$ 870,566
G763005003 - RIC	$ 3,037,833	$ 1,741,603	$ 1,296,230				$ 3,037,833	$ 1,741,603	$ 1,296,230
G763005008 - New Horizons	$ 3,417,715	$ 124,227	$ 3,293,488				$ 3,417,715	$ 124,227	$ 3,293,488
G763005009 - Support Community Residential Contract	$ 157,977	$ 2,051,686	$ (1,893,709)				$ 157,977	$ 2,051,686	$ (1,893,709)
G763005 -Supportive Community Residential Services Total	**$ 11,313,781**	**$ 5,895,196**	**$ 5,418,586**	$ -	$ -	$ -	**$ 11,313,781**	**$ 5,895,196**	**$ 5,418,586**
G763006 - Intensive Community Treatment Svcs									
G762001003 - Outreach	*$ 1,000*	*$ 97,582*	*$ (96,582)*	*$ (0)*	*$ (3,842)*	$ 3,842	*$ 1,000*	*$ 93,740*	*$ (92,740)*
G763006001 - ICT Program Management	$ 30,073	$ 132,704	$ (102,631)				$ 30,073	$ 132,704	$ (102,631)
G763006003 - Assertive Community Treatment	$ 2,627,599	$ 969,597	$ 1,658,002				$ 2,627,599	$ 969,597	$ 1,658,002
G763006004 - Intensive Case Management	$ 1,558,597	$ 1,462,722	$ 95,875				$ 1,558,597	$ 1,462,722	$ 95,875
G763006005 - Discharge Planning	$ 53,122	$ 506,230	$ (453,108)	$ 6,365	$ (8,620)	$ 14,986	$ 59,487	$ 497,610	$ (438,123)
G763006008 - Outreach	$ -	$ 240,600	$ (240,600)				$ -	$ 240,600	$ (240,600)
G763006 - Intensive Community Treatment Svcs Total	**$ 4,270,391**	**$ 3,409,434**	**$ 860,956**	**$ 6,365**	**$ (12,462)**	**$ 18,827**	**$ 4,276,756**	**$ 3,396,972**	**$ 879,784**
Program Budget Total	**$ 163,722,631**	**$ 86,150,937**	**$ 77,571,694**	**$ 1,127,467**	**$ 436,601**	**$ 690,866**	**$ 162,591,169**	**$ 84,909,280**	**$ 77,681,890**
Non-Program Budget Total [1]	***$ 51,172,456***	***$ 33,824,870***	***$ 17,347,586***	***$ 4,840,312***	***$ 360,254***	***$ 4,480,058***	***$ 56,012,768***	***$ 34,185,124***	***$ 21,827,644***
TOTAL FUND	***$ 214,895,087***	***$ 119,975,807***	***$ 94,919,280***	***$ 5,967,779***	***$ 796,855***	***$ 5,170,923***	***$ 220,862,866***	***$ 120,772,662***	***$ 100,090,204***

Comments

[1] Non-Program Budget Total includes all administrative areas (HR, Finance, Informatics, etc) and Regional.

Gray/Italized Font denotes closed cost centers.

Claude Moore
CHARITABLE FOUNDATION

Strategic Investment Initiatives for Virginia's Public and Private Sector Behavioral Health and Developmental Services Workforce

VA DBHDS Strategic Initiatives Report

Virginia Department of Behavioral Health & Developmental Services

Table of Contents

Background

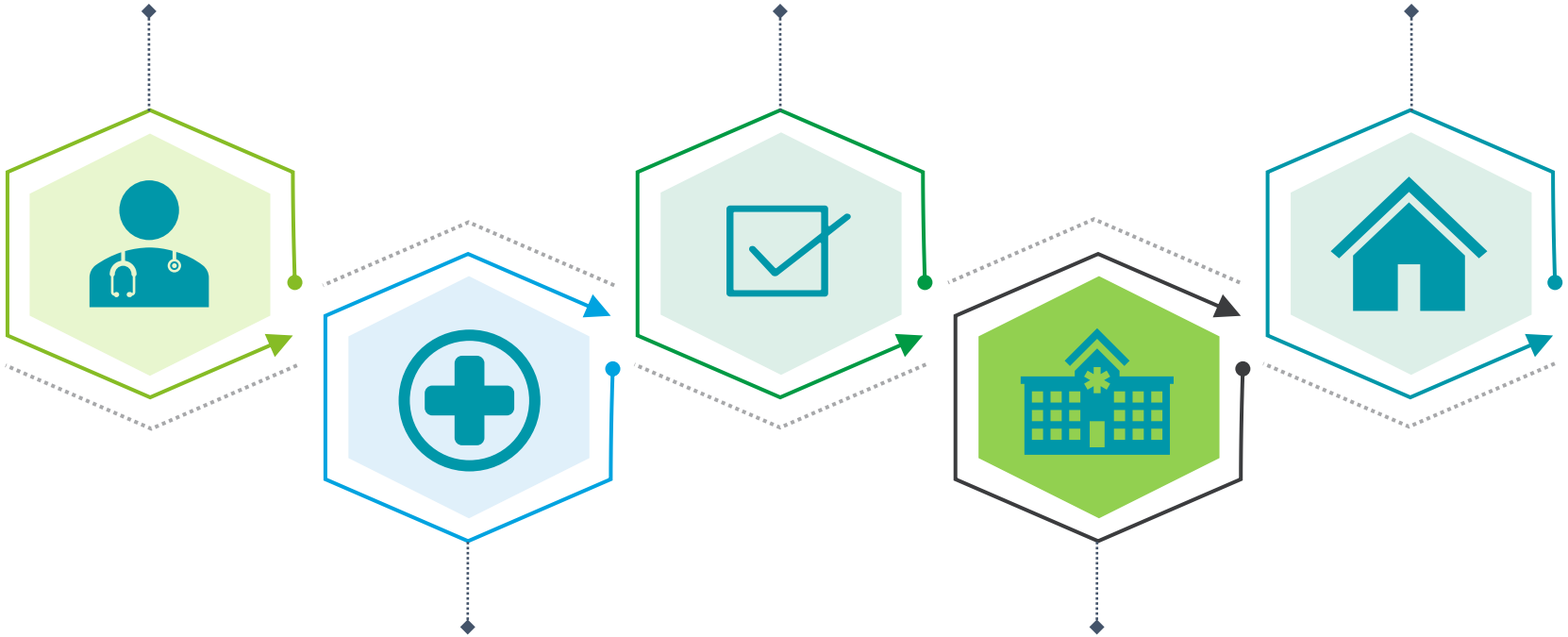
Service Delivery in Virginia

There are multiple avenues for receiving and reimbursing behavioral health and ID/DD services

Private Providers
Fee for service model of care

Managed Care Organizations (MCOs)
Health plan covers Medicaid services including medical, behavioral health, and nursing facility services

Home and Community Based Services (HCBS)
Provides Medicaid beneficiaries with services in their home or community.



Community Service Boards (CSB)
Assures delivery of community-based behavioral health and developmental disability services

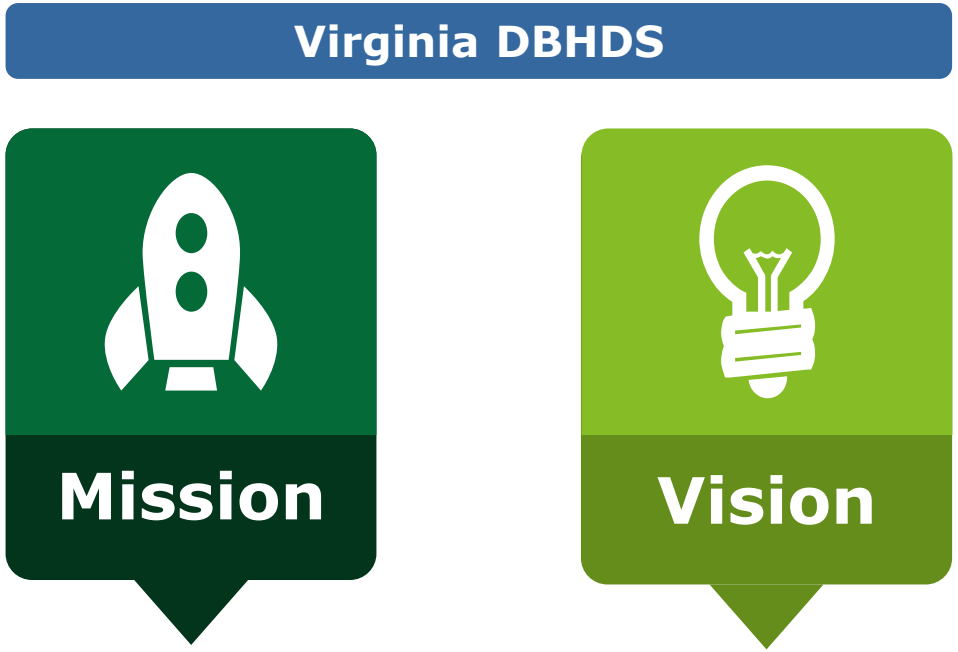
Inpatient Facilities
Treat public and privately insured individuals

Purpose of the Document

This document provides The Claude Moore Charitable Foundation and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) with data and information to support legislative and budget briefings for initiatives to strengthen workforce development across the Commonwealth.

DBHDS seeks to promote dignity, choice, recovery and the highest possible participation in work, relationships, and all aspects of community life for individuals with mental illness, developmental disabilities, or substance-use-disorders. DBHDS operates 13 state facilities and partners with 40 locally run community services boards and hundreds of private providers statewide.

As the need for services and supports continues to rise, it is critical for DBHDS to evaluate Virginia's public and private workforce to ensure that it can continue to serve Virginians now and in the future.



Supporting individuals by promoting recovery, self-determination, and wellness in all aspects of life

A life of possibilities for all Virginians

There are multiple needs across Virginia

Demand is continuing to increase for services and supports

Behavioral Health

- 1,115,000 adults have a mental illness[1]
- 193 BH providers per 100,000 people across VA
- **1,176 licensed providers** across 8,133 facilities across VA
- Virginia operates 9 mental health hospitals that are **nearing or exceeding** patient capacity

ID/DD

- Approximately 80,104 adults in Virginia have ID/DD[2]
- 6,571 individuals **waiting for ID/DD waiver services** in Virginia

Substance Use Disorder (SUD)

- **470,000 adults** in Virginia have a SUD
- **13,390 ED visits** to the ED were SUD-related in 2018 across the state
- 42.1 per 10,000 ED visits in 2018 were SUD-related

Impact of COVID-19 Nationally on BH & ID/DD Services

41% of adults reported symptoms of anxiety and/or depressive disorder, compared to 11% before the pandemic[3]

ID/DD individuals were 2.5x more likely to contract COVID-19, 2.7x more likely to be hospitalized and had 5.9x more fatalities

The number of overdose deaths increased 18.2% nationwide during the COVID-19 pandemic

[1] With any mental illness including mental, behavioral, and emotional disorders, https://mhanational.org/issues/2021/mental-health-america-prevalence-data
[2] Based on the national average of 1.5% of adults diagnosed with ID/DD
[3] 41% reported symptoms in January 2021, compared to 11% between January-June 2019

Despite the increasing need for services, the workforce is waning nationwide

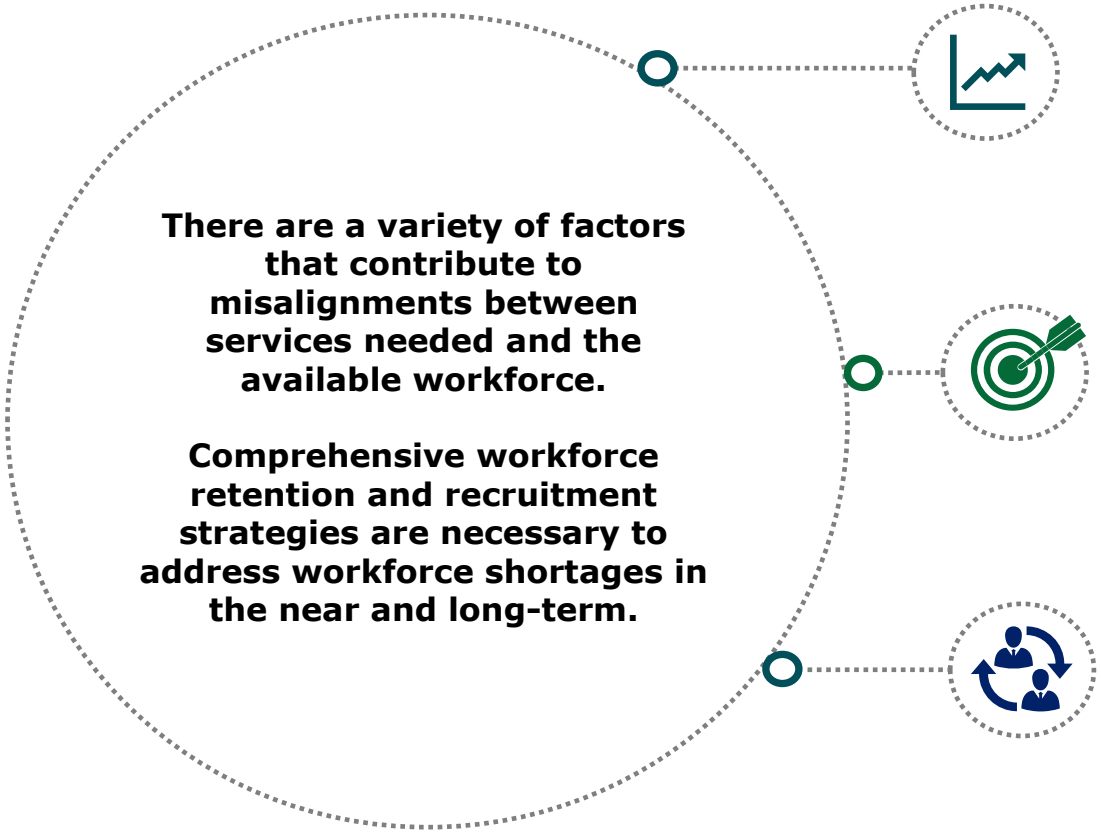
The need for care continues to rise, and as the COVID-19 pandemic pushed an already fragile system into crisis, there continue to be significant challenges to recruit and retain the workforce.

The U.S. Health Resources and Services Administration (HRSA) projects that demand for services will continue to outpace the number of providers by 2030.

Rising Need For Service	The need for services and supports is increasing in the short-term and is projected to continue increasing in the coming decades.
Cost of Quality	Administrative activities that are meant to ensure or improve quality can be burdensome, sometimes disincentivizing the provision of certain services and/or the expansion of services provided.
Compassion Fatigue	Compassion fatigue is a phenomenon that affects healthcare providers across disciplines and is associated with psychological disruptions, emotional exhaustion, impaired interpersonal functioning, and physiological problems and can contribute to turnover. 55% of frontline healthcare workers report burn out nationally.
High Turnover	574,200 new DSPs need to be hired nationwide every year to account for losses in the workforce.

VA DBHDS Goals

While demand for services increases, significant challenges remain in recruiting and retaining members of the workforce. The following principles can inform DBHDS in the development of potential solutions to address the workforce challenges facing the Commonwealth:



Immediate Intervention

There is a rising short-term need for individuals who can provide services due to high levels of staff vacancies, challenges recruiting community services professionals and low retention. Steps to begin addressing Virginia's workforce challenges can be taken immediately.

Long-Term Transformational Change

The issues facing the Commonwealth are systemic and multifaceted, making long-term transformational change critical. Strategically planning and creating a blueprint for addressing workforce development is key to fostering long-term change.

Diversity, Equity, and Inclusion

Increasing diversity through educational pipeline programs and career opportunities is a priority for DBHDS and key to ensuring that the workforce reflects the communities they serve. Ensuring services are delivered equitably throughout the Commonwealth is also a priority.

Key Themes

The strategic initiatives in this report seek to address the following 5 themes identified across stakeholder interviews with public and private providers, provider associations, national experts, and the DBHDS leadership.

Key Themes

Working Conditions

Improving working conditions to support the workforce and recruit new professionals

- Wages and benefits
- Safety of work environments
- Incorporate evidence-based practices while balancing flexibility for professional judgment
- Administrative burden

Role Alignment

Aligning provider roles with expectations and educational experience

- Misalignment in education provided vs. reality
- Differences between what is required for licensing and what is needed in the community
- Scope of practice limits what services certain practitioners can provide patients

Agency Alignment

Promoting agency alignment in workforce efforts

- Alignment within and across agencies on goals, priorities, and responsibilities for workforce efforts
- Need for a coordinating structure or entity on initiatives
- Leverage initiatives as a proof of concept with federal funds in order to secure long-term funding

Career Incentives

Incentives to address labor shortages and retention

- Better pay to attract licensed and non-licensed healthcare workers
- Educational incentive, such as student loan forgiveness
- Career ladders and advancement

Pipeline

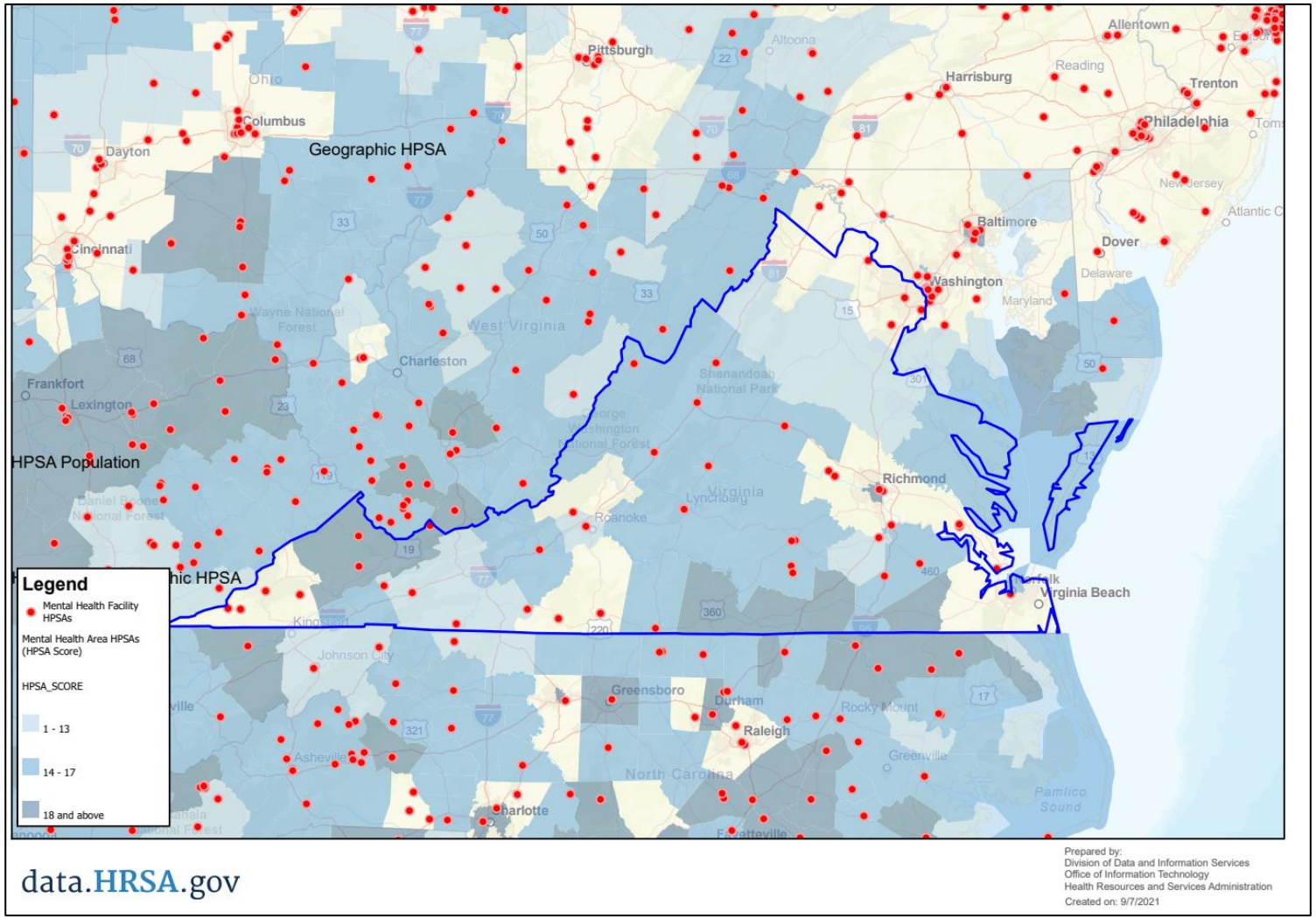
Providing education to build career interest

- The Health Sciences Highway can be a vital resource for improving the workforce pipeline
- Diversity, Equity and Inclusion (DEI)
- Utilize grant and one-time funding opportunities to ensure that there are roles available for the jobs that don't exist yet

Setting the Landscape for BH & ID/DD Workforce Challenges

Behavioral Health Professional Shortages

Most counties in Virginia are designated as Behavioral Health Professional Shortage Areas



- Mental health facility shortages across Virginia

HPSA Score (Higher Scores Indicate Higher Need)

- 1 – 13
- 14 -17
- 18 and above

Expected Workforce Supply Shortfalls

This chart depicts the number of unique job ads posted by employers across Virginia for behavioral health related occupations. It demonstrates a continued need to fill existing vacancies across provider types.

Table 1 Employer Job Ads for Behavioral Health Occupations

		Job Ads (#)		Qualifications [3]		
SOC	Occupation Title	2019	Last 12 months	QMHP	QIDP	QDDP
21-1093.00	social and human service assistants [1]	19,130	17,669	424	57	137
21-1014.00	mental health counselor [1]	4,232	5,222	672		11
21-1094.00	community health workers [1, 2]	4,027	5,170			
21-1023.00	mental health and substance abuse social worker [1]	2,763	3,281	222	5	11
21-1021.00	child, family, and school social workers [1]	2,128	1,939	97		3
29-2053.00	psychiatric technician/specialist [1]	1,316	1,878			
19-3032.00	school psychologist	1,312	1,620			
29.1233.00	psychiatrist [1]	1,205	802			
19-3033.00	clinical and counseling psychologist	497	700			
21-1022.00	healthcare social worker [1]	736	638			
11-9151.00	Social and Community Service Managers	333	357	16		
21-1011.00	substance abuse and behavioral disorder counselor [1]	337	320	3		
21-1015.00	rehabilitation counselor [1]	122	178			
29-1141.02	advanced practice psychiatric nurse [1]	134	139			
19-3039.00	psychologist, all other	44	61			
21-1013.00	marriage and family therapist [1]	39	58			
31-1133.00	psychiatric assistant/aide [1]	1	14			
	Total	**38,356**	**40,046**	**1,434**	**62**	**162**

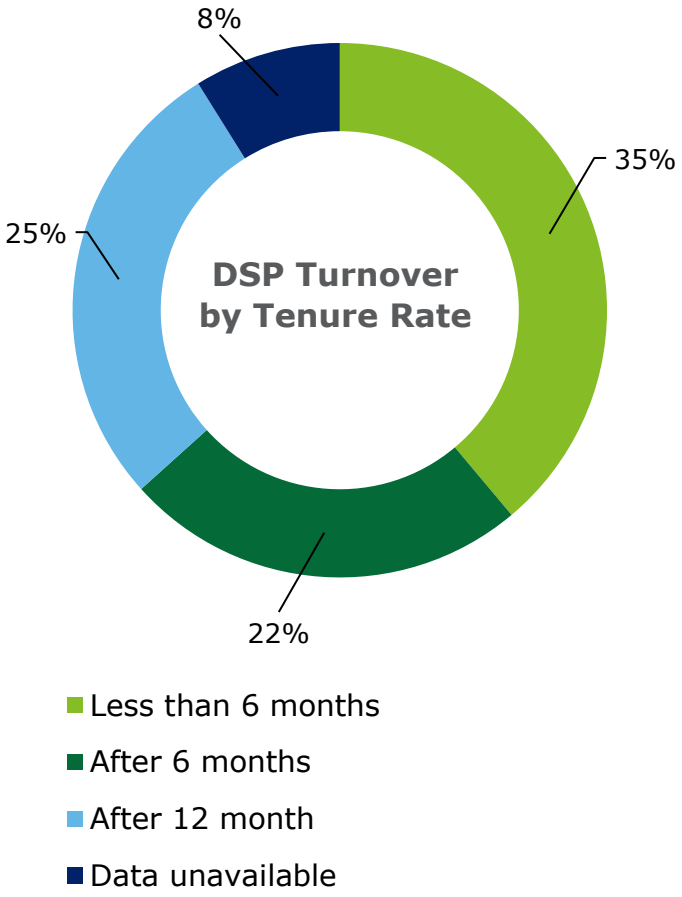
[1] Projected to grow faster than the average growth rate for all occupations (4%) between 2019-2029

[2] The count of community health worker job ads for 2019 and 2020 found by search of SOC 21-1094 and key words. These data are See notes.

[3] Qualifications. This column represents the number of job ads posted online from the last 12 months that include the key words "Qualified Mental Health Professional", "Qualified Intellectual Disability Professional", and "Qualified Developmental Disability Professional"

Direct support professionals (DSPs) are an integral part of the workforce

DSPs operating in public and private provider networks and settings play a critical role in sustaining the independence of individuals with intellectual and developmental disabilities, yet the need for services far outstrips the pool of DSPs



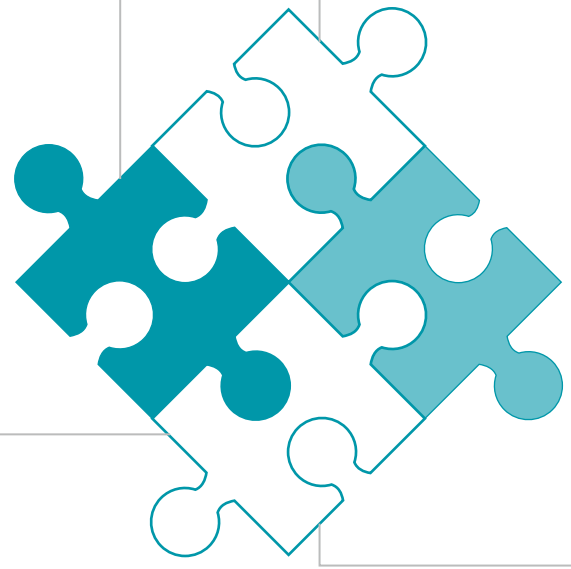
- Average **45% turnover rate**
- **574,200 new DSPs need to be hired every year** to account for this high turnover
- To service the approximately 200,000 people with ID/DD on waiting lists**, an additional 167,001 new DSPs would need to be hired**
- **2.5 part-time workers are needed** to fill one full-time ID/DD needs yet **only 1.3 million DSPs are available to provide support** currently
- There is a significant discrepancy between the job responsibilities and skill expectations as compared to their low wages such that **nearly half of direct support workers in the U.S. rely on public benefits.**

Factors effecting DSP workforce shortage:

- Rising need for services creating competition for workers
- Shifts in the types of services needed
- Low wages
- Lack of benefits
- Lack of training and promotion opportunities

State Examples Addressing Workforce Challenges

Connecticut, Maryland, Massachusetts, and Oregon have taken steps to address their workforce shortages that could be applicable in Virginia. More details on each example can be found in the Appendix.



Oregon

Improved access to behavioral health services and supports by conducting a **needs assessment** of the workforce and creating a **workforce challenges blueprint**

Maryland

Developed a comprehensive plan identifying 5 focus areas, which transformed policies and funding processes to create a **flexible, person-centered, system of supports** to address workforce challenges across all services

Connecticut

Created a pipeline to strengthen future workforce through implementation of the Connecticut Behavioral Health Workforce Collaborative which provides **career pathways** from post-secondary education

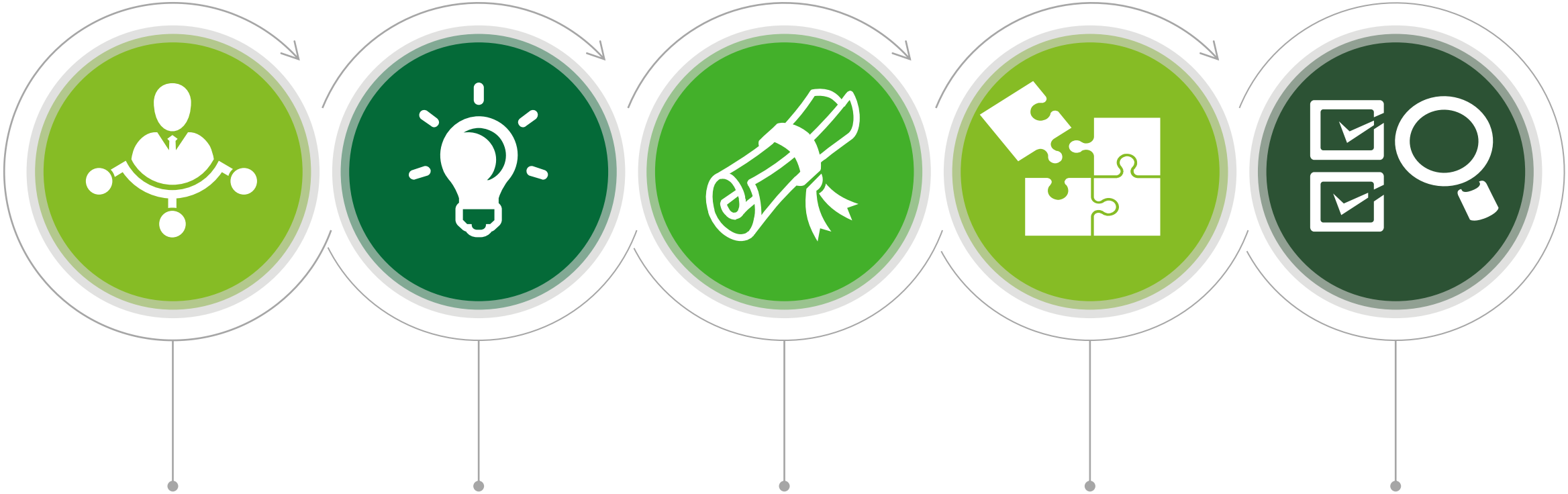
Massachusetts

Addressed the shortage of behavioral health providers practicing in community-based settings by establishing the Behavioral Health Workforce Development Program which offers **partial repayment of student loan obligations** for providers who commit to four years of service at a community health center

Strategic Initiatives for Virginia to Address Workforce Challenges

Areas of Opportunity for Leadership and Investment

We have identified 5 areas of opportunity for Virginia to lead and invest in its behavioral health and developmental services workforce. They include:



Governance, Leadership, Stakeholder Communications & Accountability

Diversity, Equity, & Inclusion (DEI)

Educational Opportunities & Career Pathways

Payment & Working Conditions

Regulatory & Licensing Assessment

DBHDS Can Play Two Key Roles in Addressing Workforce Challenges

We have included initiatives for investment in two categories: one where DBHDS leads and can impact workforce, and the second where DBHDS can play a meaningful role in broader efforts that span across organizations in the Commonwealth for an ecosystem impact beyond that of DBHDS alone. To effect real change, initiatives in both categories need to move forward together.

Charting the Path

These strategic initiatives would require DBHDS to chart the path on planning, implementation and execution. DBHDS may coordinate and collaborate with other state agencies on these efforts, but DBHDS would be the agency responsible for driving the effort and ensuring accountability.

Supporting the Effort

These strategic initiatives may require other (or multiple) state agencies to implement, but long-term success would require support and 'championing' by DBHDS. DBHDS may play a key role in planning, implementation and execution, but may not be the agency responsible for driving the effort.

Different initiatives that fall under each role can occur simultaneously, and DBHDS is not limited to a single role type

Strategic Initiatives Summary

Initiatives	Timing	Impact Of Solution

Develop a Health Workforce Office
• Create a Cross-Agency Entity or Structure that is Accountable for BH & ID/DD Workforce Development
  • Conduct a Cross-Agency Review of Commonwealth Licensing, Administrative Requirements, and Regulations
  • Develop Analytics Capabilities to Monitor Workforce Capacity
  • Undertake a 10-Year Strategic Planning Effort
• Identify and Implement Activities Associated with Strategic Initiatives
	Near Term Impact	Creates stakeholder engagement and provides a holistic workforce perspective
		Alleviate administrative burden and reduce licensing requirements that create barriers to entry for new professionals
		Informs decision making on policy and programmatic efforts
		Enables consistent visions, goals, and priorities for the agency
		Creates a blueprint for how to move forward with next steps

Review Opportunities to Improve Retention of the Workforce • Improve Wages & Benefits of BH & ID/DD Workforce • Modernize Treatment Approaches to Align with Evidence-Based Practices (EBP) • Professionalize the Direct Service Professional (DSP) Workforce	Long Term Impact	Demonstrates the value of the roles Promotes use of learned higher quality service and techniques creating improved retention and recruitment, balanced with flexibility to apply professional judgment Creates career pathways to support growth within the profession

Develop a Health Workforce Office

DBHDS supports the effort

Description: A Health Workforce Office with participants from various stakeholder groups can work to align collaboration efforts across the health workforce ecosystem. It can elevate recommendations to the Governor, and lead coordination activities across government agencies and others who can work together toward a shared vision.

- Body that is specifically focusing on developing the workforce across sectors, provider type, payers, etc.
- Charged with growing pool of workers, defining career pathways, improving work environment
- Directive to the Governor to establish an "Office"
- Provide leadership and advocacy for the provider community in both public and private organizations and facilities

Key Components
- Stakeholder engagement and buy-in
- Adequate staffing and budget
- Prioritization of Council initiatives

Considerations
- Entity responsible for Council creation
- Key participants and desired outcomes
- Measurements of success

Benefits
- ✓ Workforce would have birds eye perspective on workforce initiatives
- ✓ Facilitate alignment across ecosystem
- ✓ Ensure that workforce solutions are prioritized

Primary Stakeholders
- ✓ DBHDS senior leadership
- ✓ DHDS agency leadership
- ✓ Providers (public and private)
- ✓ DHP
- ✓ DMAS

Opportunity Area
- ✓ Governance & Leadership
- ✓ Educational Opportunities
- ✓ Regulatory & Licensing
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

DBHDS supports the effort

Health Workforce Office: Create a Cross-Agency Entity or Structure that is Accountable for BH & ID/DD Workforce Development

Description: Historically, efforts to address workforce challenges have been hindered by a lack of alignment within and across agencies. Ensuring alignment on goals and priorities is critical to addressing workforce shortages in a sustainable way. Creating a coordinating entity or structure that is appropriately resourced and that cuts across different levels of government is key to ensuring that agencies are held accountable for their respective responsibilities.

Activities of this entity or structure may include:
- Prioritization of workforce initiatives
- Convening stakeholders
- Creating goals and setting KPIs for initiatives to measure progress; regularly reporting progress to the public and state leaders
- Determining agency responsibilities and holding agencies accountable to their commitments
- Developing a pipeline across the Commonwealth to recruit new entrants to the workforce in high schools and colleges
- Opening the provider network to increase the number of potential providers

Key Components
- Clearly defined entity or structure that is responsible for workforce initiatives across DBHDS and will help hold agencies accountable
- Reduce administrative burden
- Prioritization of workforce initiatives

Considerations
- Determining the entity or structure is best suited to carry out this work (e.g. task force, Secretariat level entity)
- Methods of accountability
- Staffing and resourcing of the entity
- Appropriate champion for the effort

Benefits
- ✓ Promote agency alignment across and within agencies that play a role in the BH and ID/DD workforce
- ✓ Ensures that each agency fulfills their commitments

Primary Stakeholders
- ✓ DBHDS senior leadership
- ✓ DBHDS agency leadership
- ✓ DHP leadership
- ✓ DBHDS Human Resources
- ✓ DMAS

Opportunity Area
- ✓ Governance & Leadership
- ✓ Educational Opportunities
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

DBHDS supports the effort

Health Workforce Office: Conduct a Cross-Agency Review of Commonwealth Licensing, Administrative Requirements, and Regulations

Description: A significant factor that contributes to administrative burden and staff retention is the variety of paperwork requirements that must be met in order to provide services. The administrative tasks and paperwork can be immensely burdensome, and many of the licensing requirements may create unnecessary barriers to entry into the workforce – it is key to strike a balance between quality and costs of quality.

Potential activities in this review may include:

- Examine and review mandatory and discretionary requirements to determine which regulations provide limited value and can be removed
- Conduct a review of paperwork and documentation requirements and make recommendations to reduce administrative burden
- Conduct a review of licensing requirements to ensure that the requirements are not unnecessarily onerous or otherwise limiting the potential workforce. This includes reciprocity with licensing requirements in bordering states such as NC, TN, WV, KY
- Conduct a review of degree requirements, including evaluation of Sociology and Criminal Justice as eligible degrees
- Evaluation of WaMS and other systems DBHDS requires CSBs to use to eliminate manual data entry and double data entry
- Standardization of authorization, billing and reimbursement practices between MCOs

Key Components

- Stakeholder engagement and buy-in across agencies
- Input and feedback from all providers types

Considerations

- Determine the regulations and requirements that add value to services provided and which ones do not
- Examine how DEI is impacted by licensing requirements
- Evaluate the systems in place that increase administrative burden and ways they can be streamlined

Benefits

- ✓ Reduce administrative burden
- ✓ Remove or reduce current barriers to entry
- ✓ Increase retention and increase the pool of eligible workers

Primary Stakeholders

- ✓ DBHDS senior leadership
- ✓ DBHDS agency leadership
- ✓ DHP leadership
- ✓ DBHDS Human Resources
- ✓ DMAS
- ✓ Providers (public and private)

Opportunity Area

- ✓ Educational Opportunities
- ✓ Regulatory & Licensing
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

Health Workforce Office: Undertake a 10-Year Strategic Planning Effort

Description: Although there is an immediate need to address workforce shortages, it is also important for DBHDS to develop a 10-Year Strategic Plan to think critically and intentionally about how the agency will set a vision to meet the needs of patients and the workforce in the long-term, and what milestones can be created to promote strategic progress toward achieving that vision.

Core activities would include:
- Submit a strategic plan to the General Assembly
- Annual presentation of the plan to the General Assembly to report on progress and milestones
- Distribution of the strategic plan to all DBHDS stakeholders that may be impacted by the strategic priorities, such as CSBs, private providers, DHP, and DMAS
- Publicly available annual progress report that is distributed to all DBHDS stakeholders

Key Components
- Structured so that it spans administrations
- Collaboration and input from all stakeholders and provider types
- KPIs and performance metrics to track progress
- Formalized plan that is presented to the General Assembly

Considerations
- Prioritization of strategic efforts
- Blueprint to implement strategic priorities
- Appropriate and achievable milestones
- Who will spearhead the strategic planning effort

Benefits
- ✓ Create a consistent vision, goals, and priorities for the agency around the BH & ID/DD workforce that can span multiple administrations
- ✓ Enables providers and agencies to plan for the future

Primary Stakeholders
- ✓ DBHDS senior leadership
- ✓ DBHDS agency leadership
- ✓ Providers (public and private)
- ✓ General Assembly
- ✓ DHP

Opportunity Area
- ✓ Governance & Leadership
- ✓ Educational Opportunities
- ✓ Regulatory & Licensing
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

Health Workforce Office: Develop Analytics Capabilities to Monitor Workforce Capacity

Description: The behavioral health and ID/DD workforce encompasses a wide range of provider types and provider settings. In order to understand where the need for providers is most acute and monitor the capacity of the workforce, DBHDS needs to be able to produce reliable data that can drive decision making around how to intervene and focus workforce development efforts.

Having a source of data that the Department owns and can access as needed can increase the efficiency and targeting of efforts geared toward workforce development. This analytics capability purpose would be collecting operational data to help drive decision making on resource allocation and priorities. Examples of operational data may include vacancy rates and turnover, geographic distribution of providers, geographic distribution of provider types, DEI metrics, quality, outcomes, etc.

Key Components
- Stakeholder engagement around which data elements to collect and monitor
- Information technology capabilities to host analytics and data warehouse securely

Considerations
- Data collection methods
- Selecting a platform and process that will not increase administrative burden for providers
- Implementation plan & platform maintenance plan

Benefits
- ✓ Allows access to reliable data to inform decision making and drive policy and programmatic changes

Primary Stakeholders
- ✓ DBHDS senior leadership
- ✓ DBHDS agency leadership
- ✓ DHP
- ✓ Providers (public and private)

Opportunity Area
- ✓ Governance & Leadership
- ✓ Regulatory & Licensing
- ✓ Diversity, Equity, & Inclusion (DEI)

Health Workforce Office: Identify and Implement Activities Associated with Strategic Initiatives

Description: The Commonwealth's current state of crisis in BH and ID/DD workforce requires DBHDS and other state agencies to act without hesitation in implementing these initiatives to provide immediate relief as well as fix systemic issues that were present before COVID-19 created even more fragility.

There are many considerations for the implementation of the strategic initiatives to develop and support the workforce. Engaging in this work will require significant time and resources to plan, coordinate stakeholders, collect feedback and execute strategies to begin to address Virginia's workforce challenges. Specifically, DBHDS could begin a strategic roadmap development process to define discrete initiatives to support initiatives they can lead, prioritize initiatives, develop a strategic roadmap and implementation plan, and begin implementing.

Key Components
- Stakeholder engagement and buy-in
- Adequate resources and budget
- KPIs

Considerations
- Timeline and key milestones
- Prioritization of initiatives
- Strategic Roadmap
- Initiative owners and progress reporting

Benefits
- ✓ Creates a blueprint for next steps
- ✓ Develop a strategic roadmap
- ✓ Facilitates alignment responsibilities and next steps

Primary Stakeholders
- ✓ DBHDS senior leadership
- ✓ DHDS agency leadership
- ✓ Providers (public and private)
- ✓ DHP
- ✓ DMAS

Opportunity Area
- ✓ Governance & Leadership
- ✓ Educational Opportunities
- ✓ Regulatory & Licensing
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

DBHDS supports the effort

Review Opportunities to Improve Retention of the Workforce:
Improve Wages & Benefits of BH & ID/DD Workforce

Description: Low wages are a key contributing factor to recruitment challenges and retention. The wages and benefits in these roles are at a level that requires many BH and ID/DD professionals to work overtime or hold multiple jobs and do not reflect the difficulty of the work. DBHDS can lead an analysis of wages and other benefits to determine how they align with market rates and what non-salary benefits could be offered.

Opportunities to improve benefits may involve:
- Increased wages to promote workplace priority and reduce the need for overtime
- Benefits that align with roles and career aspirations
- Salaries that demonstrate the value of the roles and level of experience
- Living wages that allow staff to complete certifications or other training opportunities outside of their working hours
- Scholarships, loan forgiveness and tuition reduction
- Benefits that recognize and support a primarily female workforce
- Tax incentives to offset increased labor costs

Key Components
- Analysis of potential benefit options and funding mechanism
- Collaboration with colleges on loan forgiveness or tuition reduction
- Extension of 12.5% rate increase beyond 2022
- Decouple funding streams for facilities and CSBs

Considerations
- Determine the most appropriate type(s) of financial incentive
- How DBHDS will administer financial incentive(s)
- Long-term strategic plan so that benefits keep pace with market increases

Benefits
- ✓ Increase job satisfaction
- ✓ Reduce turnover
- ✓ Increase recruitment
- ✓ Allow for individuals to participate in trainings and certification opportunities

Primary Stakeholders
- ✓ DBHDS leadership
- ✓ DMAS leadership
- ✓ Providers (public and private)
- ✓ Workforce
- ✓ DHP

Opportunity Area
- ✓ Educational Opportunities
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

Review Opportunities to Improve Retention of the Workforce: Modernize Treatment Approaches to Align with Evidence-Based Practices (EBP)

Description: Some of the treatment approaches in DBHDS facilities do not align with evidence-based practices, possibly due to inadequate existing staffing levels, facilities, or supporting technology, further exacerbating recruitment challenges and retention of clinical staff. To effectively modernize clinical practices there must be adequate staffing and resources to support facilities and workforce initiatives.

Related activities could include:
- Creating a model for EBP that maintains quality and is flexible to allow for professional judgement
- Pilot of EBP practices and data collection on quality and employee satisfaction
- Develop strategic communication and training for staff who have not practiced EBP
- Identify staffing implications for EBP implementation planning, implementation and maintenance

Key Components
- Identify the EBP practices and processes to be implemented
- Maintaining flexibility in EBP to allow for professional judgement
- Adequate resources and financing

Considerations
- Implementation of EBP without increasing administrative burden
- Prioritization and timeline for which EBPs to implement
- Implementation and maintenance of EBP

Benefits
- ✓ Increase retention of staff
- ✓ Improve recruitment pipeline, especially new entrants to workforce who are seeking facilities that practice EBP
- ✓ Improve quality of care

Primary Stakeholders
- ✓ DBHDS
- ✓ DMAS
- ✓ DHP
- ✓ Providers (public and private)

Opportunity Area
- ✓ Educational Opportunities
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

Review Opportunities to Improve Retention of the Workforce:
Professionalize the Direct Service Professional (DSP) Workforce

Description: There are extremely high turnover rates among DSPs, resulting in staff vacancies, increased organizational costs, and adverse impacts to the quality of care delivered. There is not a path for advancement within direct patient care and it is a career that can be undervalued and is severely underpaid despite the integral role they have in caring for some of the most vulnerable populations.

Professionalizing the DSP workforce via credentialing would create career ladders and pathways that would enable individuals to advance their career within the profession without leaving direct patient care. Standardized DSP credentials could be portable across facilities, reducing training costs for organizations. Moreover, creating salary structures that align with credential levels would not only incentivize professional growth, but also create a sense of feeling valued for the important work that DSPs do.

Key Components
- Career ladders in direct patient care
- Portable credentialing
- Standardized DSP education and credentials across the Commonwealth

Considerations
- Most appropriate type of education and process for credentialing
- Credentialing body, multiple initiatives already exist
- Process and requirements for maintaining DSP credentials
- Salary structures for DSP levels
- Deemed status for licensure

Benefits
- ✓ DSP workforce feeling valued, respected
- ✓ Increase job satisfaction & retention
- ✓ Create and incentivize career growth opportunities in direct patient care

Primary Stakeholders
- ✓ DBHDS leadership
- ✓ DMAS – potential federal matching
- ✓ Dept. of Health Professions (DHP)
- ✓ Providers (public and private)

Opportunity Area
- ✓ Educational Opportunities
- ✓ Regulatory & Licensing
- ✓ Diversity, Equity, & Inclusion (DEI)
- ✓ Payment & Working Conditions

Supporting Strategic Priorities and Effecting Change in the Commonwealth

Leverage Medicaid Administrative Match as a Strategic Funding Stream

Federal dollars are available to support qualifying DBHDS activities and thereby enhance the state funds allocated to support the initiative

State Medicaid programs can claim federal matching dollars for activities that support the effective administration of the State Medicaid Plan

In most instances, the **matching rate is 50%**

If a state contributes $100 for an eligible cost, the federal government will "match" 50% of that amount, resulting in $150 available to the state

There are strict rules governing the availability of federal administrative dollars:

- *The costs must be "proper and efficient" for administering a state Medicaid plan*
- *Costs must be assigned to activities by a methodology that takes into account the relative benefit to the Medicaid program and its members*
- *The costs must be targeted only to **Medicaid eligible individuals***
- *Costs cannot cover facility overhead*

Potential match fund initiatives:

- Programs that support workforce initiatives, such as DSP training and credentialing
- Compensation for staff that lead trainings related to workforce development
- Compensation for training outside of a formal certification process, such as the supervision of interns or trainees doing clinicals
- Technology improvements that can reduce administrative burden, such as EHR upgrades

DBHDS can collaborate with DMAS leadership in identifying potential initiatives that are eligible for federal administrative dollars and deliver necessary details to the federal Centers for Medicare and Medicaid Services (CMS) for approval of the expenditure

Medicaid Administrative Claiming | Medicaid

This is a Historical Moment…

Virginia's Workforce Crisis

Virginia's long-standing workforce shortages have reached crisis levels and must be addressed as soon as possible.

COVID-19 has stressed the provider network in ways that reveal the lack of capacity to meet current staffing and service delivery needs, and to meet the needs of the future.

Federal COVID-19 Funding

As part of the federal response to COVID-19, there are unprecedented funding opportunities available to states, including via the American Rescue Plan Act (ARPA), new HCBS funding, and other provider support dollars through the CARES Act.

Virginia can leverage this opportunity to act and address both immediate and long-term impacts on its BH and ID/DD workforce

Estimated Costs of Strategic Initiatives

Initiatives	Assumptions	Estimated Cost

Develop a Health Workforce Office
• Create a Cross-Agency Entity or Structure that is Accountable for BH & ID/DD Workforce Development
  • Conduct a Cross-Agency Review of Commonwealth Licensing, Administrative Requirements, and Regulations
  • Develop Analytics Capabilities to Monitor Workforce Capacity
  • Undertake a 10-Year Strategic Planning Effort
• Identify and Implement Activities Associated with Strategic Initiatives
	• Assume overlap in individual(s) involved with cross-agency efforts (other entities could include Governor's office, DOE, DMAS, DHP; cost per agency could range from $250,000 -- $400,00, depending on staffing numbers and which agency is leading the effort)
	• 2 FTEs per agency on Commonwealth licensing review
		$400,000* for DBHDS
		$350,000* for DBHDS
		$200,000
		**($1M-$1.6M across agencies*

	Costs for analytics capabilities includes technology and staff to run reports and do analysis	$750,000
	10-year strategic plan includes one time funding for ~4-6 month effort among DBHDS leaders and industry stakeholders (e.g. CSBs, private providers)	$500,000
	Estimated cost for 1 year of consulting services and support for implementation activities, which includes program and project management, along with reporting and communications	$1,500,000
Review Opportunities to Improve Retention of the Workforce • Improve Wages & Benefits of BH & ID/DD Workforce • Modernize Treatment Approaches to Align with Evidence-Based Practices (EBP) • Professionalize the Direct Service Professional (DSP) Workforce	For efforts on improving wages, all agencies involved will contribute equally; 2 FTEs per agency on effort	$200,000
	Medicaid match funds will be leveraged for the modernization of treatment approaches; two trainers & repurposed curriculum from another state	$200,000 (+$100,000 federal)
	For professionalization of DSP workforce, there will be 2 FTEs per agency on the effort	$200,000
Grand Total		***$4,300,000 – $5,500,000***

Appendix:
Stakeholder Interview Insights

Stakeholder Interview Groups

In September 2021, our team spoke with 5 different stakeholder groups across 15 organizations to learn about challenges facing the behavioral health and ID/DD workforce in the Commonwealth from various perspectives and inform our strategic initiatives

Stakeholder Interviewees

In addition to the DBHDS Visioning Session on September 15, 2021, we also spoke with the following individuals and organizations about workforce issues to incorporate their feedback into the Strategic Initiatives Report:

Community Service Board Leaders (CSB)

- Kathleen Wine – HR Manager; Loudoun County CSB
- Cheryl Watson – Assistant Director; Loudoun County CSB
- John Lindstrom – CEO; Richmond Behavioral Health Authority
- Jim LaGraffe – Executive Director; Rappahannock Rapidan CSB
- Sheryl Reinstrom – Associate Executive Director; Rappahannock Rapidan CSB
- Ryan Banks – Division Director; Rappahannock Rapidan CSB
- Henry Eggleston, Sr Director of HR; Rappahannock Rapidan CSB
- Sandy Bryant – CEO; Mount Rogers CSB
- Bob Gordon – Chief HR Officer; Mount Rogers CSB
- Demetrio Peratsakis – Director; Western Tidewater CSB
- Darlene Rawls – Director; Western Tidewater CSB
- Laura Matthews – HR Director; Western Tidewater CSB

Private Providers

- Paul Scardino – Regional Director; National Counseling Group
- Lynda Hyatt – Executive Director; Gateway Homes
- John Weatherspoon – Executive Director; Wall Residences
- Kyle McMahon – Director; Family and Preservation Services
- Sara Viers – Statewide Director; Wall Residences
- Amanda Craig – Regional Director; Wall Residences
- Larry Pope – Executive Director; WHOA Behavioral Health
- Dennis Parker – Vice President; Caliber Virginia

Association Leaders

- Jennifer Faison – Executive Director; Virginia Association of CSBs
- Jennifer Fidura – Executive Director; Virginia Network of Private Providers, Inc.

Department of Medical Assistance Services (DMAS)

- Karen Kimsey – Director; Department of Medical Assistance Services

National Leaders

- Joseph Macbeth – Chief Executive Officer and President; National Alliance of Direct Support Professionals
- Steven Eidelman – Professor of Human Services Policy and Leadership; University of Delaware

Key Themes

Our interviews validated the following key themes as core aspects of the recommended strategic initiatives:

Virginia Stakeholder Insights

Compensation & Benefits

Compensation	- Compensation is a top issue faced across all geographies, provider types, and provider settings - Employers are **competing with industries such as retail and fast food** because working at in fast food or retail is typically much less stressful and physically demanding work - **Loss of employees to other local providers** is a huge issue; some hospitals and private providers can offer signing bonuses or higher salaries that safety net providers can't match
Funding	- Lack of clarity about the **duration of the 12.5% rate increase** magnifies the uncertainty in the market and has significant implications for operational budget planning - **Separation of funding streams** between hospitals and CSBs is another important issue because CSB employees don't receive the same wage increases as hospital employees, even though the budget come from the same bucket
Educational Incentives	- **Loan forgiveness/reduction, tuition reduction, or scholarships** are potential incentives that don't currently exist in a systemic way - One organization negotiated directly with a local college for tuition reductions to help recruitment because no other educational incentives existed - Importance of **compensation for time spent doing continuing education or professional training**

Professionalization of Direct Support Professionals (DSPs)

Career Pathways & Ladders	– **Credentialing DSPs** would create career ladders and incentives to advance professionally – Absence of **career ladders within the profession** results in DSPs leaving direct patient care to grow professionally, further exacerbating workforce needs – Very little **knowledge of different career paths** when individuals enter DSP workforce – Importance of **standardized education** and **portable credentials** which would also reduce organizational onboarding costs – **DSP training should be informed by the skills and interests of DSPs**; for example, most DSPs are women with children who are unlikely to go back to school mid-career to receive a new certification
DSP Credentialing in Practice	– New York: DSP credentialing program pilot – Tennessee: QuILTSS Institute: DSP apprenticeship program – Ohio DSPATHS: DSP certificate program with sub-specialty certificates available – National Alliance of DSPs (NADSP) E-Badge Academy: competency-based skills training and certification

The teaching profession has created entry pathways into the profession by allowing new teachers to teach at the same time they're in training; this could be a model for behavioral health and ID/DD workforce.

Licensing Requirements

Licensing Requirements	- Licensing requirements have continued to increase in a way that has **created barriers to entry** and severely restricts the potential workforce - **Reciprocity for licensing requirements** in neighboring states would help increase the pool of potential workers and help with recruitment efforts – Some **organizations are forced to layoff employees or discontinue services** because of increasing licensing requirements and new regulations, even though they desperately need to fill vacancies and hire more employees – ID/DD professionals have some of the lowest licensing requirements, despite caring for an extremely vulnerable population
Scope of Practice	– **Increasing the scope of practice of certain provider types** would enable facilities to more efficiently use available staff – Many licensed providers spend their time doing screenings instead of providing services such as counseling or therapy
Financing	– **Licensing requirements and the cost of providing care have continued to increase while rates have remained stable**, further shrinking margins and increasing pressure on providers – Increasing provider requirements also increases the costs of providing care, and there is a **lack of financial support to account for the higher costs of service provision**

Recruitment & Educational Preparation

Pipeline Development	– Workforce pipeline needs to be at an **early stage** (e.g. high school and college students) – Learning about the workforce opportunities and career paths could entice individuals who don't plan on **obtaining higher education or going back to school** – Curriculum can be implemented into high school tech programs and focus on developmental disabilities, a similar model to CNA programs – **Expansion of eligible degrees** would create career pathways for a variety of backgrounds

Degree Requirements	– Certain **degree restrictions hinder the ability to hire individuals with a variety of skill sets** (e.g. Sociology and Criminal Justice) and severely restrict potential workforce
	  – Concepts learned in Sociology and Criminal Justice programs are closely related to the work of DSPs and other BH and ID/DD professionals
	– Degree restrictions can also have **negative implications for DEI**
	  – For example, in Virginia criminal justice is a degree that is popular with Black students

Rural CSBs	– Rural CSBs face unique and significant challenges recruiting employees because of their location, and these challenges are exacerbated by the fact that other incentives to attract workers do not currently exist – For rural CSBs located close to bordering states, Virginia's residency requirement for licensing further restricts the pool of people that they can recruit

Administrative Burdens

Administrative Requirements	– **Duplicity and inconsistency in documentation requirements** across facilities and different MCOs – One organization provided a *paperwork bonus* because providers spend so much time on documentation, but don't get reimbursed for it– this incentive came from the organization's bottom line – **CSBs are required to use 8 different systems, in addition to their own EHRs**, to provide the state with documentation; many of the systems are not interoperable, requiring manual and double data entry – Misalignments between mandatory education and actual job responsibilities
Accreditation Requirements	- Requiring accreditation for services is **incredibly costly and time-intensive**, which can disincentivize the expansion of certain services due to the compressed margins organizations already have - No financial support to subsidize or cover the cost of accreditation - Some **organizations are forced to discontinue services or eliminate the expansion of services** when new accreditation requirements are implemented - Instances of **last-minute accreditation requirements** do not account for the time required in the accreditation process

National Leader Insights

National Leader Insights

Joseph Macbeth Chief Executive Officer and President, National Alliance of Direct Support Professionals	Steven Eidelman Professor of Human Services Policy and Leadership, University of Delaware
<u>Perspective</u> - This is a long-standing and critical issue nationwide, with DSPs having +50% turnover rates for decades - Certifying DSPs is a way to increase retention, as certified DSPs stay longer than non-certified DSPs <u>Opportunities</u> - Career ladder vs. Career lattice - COVID tenure bonus - 3 step certification program: NADSP E-badge academy & other state examples	<u>Medicaid</u> - Medicaid waivers serve a wide range of individuals - Costs have increased more than the money allocated to states - Approximately 15 states have implemented a technology-first strategy <u>Strategy</u> - Conduct an analysis on prioritizing retention (maintenance vs. expansion) - Reconsider requirements for credentialing and licensing to reduce barriers to entry - Leverage Medicaid administrative match funds to optimize workforce investments

Appendix:
State Example Highlights

Maryland

Maryland selected five priorities to expand the capacity of its collective service workforce and developed performance measures to monitor the success of each priority.

Priorities				
Improve core competencies of current workforce through training	**Facilitate entry of new professionals** into the field through collaboration with and support to higher education partners	Enhance structures and processes to recruit, promote, and **support a diverse workforce**	Promote the delivery of ongoing **cross-training** of the workforce	Implement **cultural and linguistic competency training** programs that incentivize staff at all levels of the workforce
Performance Measures				
Number of training provided; number of attendees awarded continuing education credit hours	Number of students pursuing service-related degrees that were awarded stipends, scholarships or loan assistance	Number of grants to historically black colleges and universities (HBCUs) to provide financial assistance to students pursuing service-related degrees; Grants to include scholarships, stipends, curriculum infusion activities	Number of trainings provided, number of trainees awarded continuing education credit hours, and survey results on the effectiveness of the training programs	Surveys to measure effectiveness of training programs that track staff performance and the development of cultural competence

Maryland Department of Health, *State of Maryland Behavioral Health Administration,* FY2020-FY2021

Massachusetts

Massachusetts is building Community Behavioral Health worker capacity through its Delivery System Reform Incentive Program (DSRIP) waiver.

Delivery System Reform Incentive Program

Massachusetts DSRIP provides $1.8 billion over five years to support MassHealth (Massachusetts Medicaid) providers as they transition to value-based payment.

Entities that have signed contracts as MassHealth accountable care organizations (ACOs) or Community Partners (behavioral health or long-term support and services) are eligible to participate in DSRIP.

DSRIP supports the **development of infrastructure and the implementation of care coordination activities for ACOs and Community Partners** throughout the state, helps providers transition to new care delivery models, improves enrollees' care and experience, and strengthens provider capacity.

Solution

Broaden access to and build capacity of, the behavioral health workforce through cultural and linguistic competency.

This was driven by evidence that suggests individuals benefit from relationships with people who have similar lived experiences and are members of their community, such as community health workers (CHWs) and peer supports. These professionals include, but are not limited to, promotors, and peer support specialists.

Oregon

The Oregon Health Authority developed the Recruitment and Retention Recommendations for Oregon's Behavioral Health Workforce which identified three priorities; one priority is comprised of two parts:

Priorities			
Part I: Improve equitable geographic distribution of the behavioral health workforce across the state	**Part II:** Improve equitable geographic distribution of the behavioral health workforce across the state	Allocate workforce across different practice settings to meet population needs	Increase number of licensed and unlicensed behavioral health workforce providing direct services
Steps			
Increase the proportion of licensed and unlicensed behavioral health workforce that work in rural and underserved geographic areas: • Develop high-quality education and training programs for advanced practice providers and traditional health workers • Incentivize the redistribution among all provider types to Multnomah County	**Improve access to housing:** • Utilize deed restrictions (restrictive covenants) to ensure that housing remains affordable over time for use and occupancy by local employees. • Develop a state program to incentivize employers to offer commuter or housing benefits such as tax breaks	**Allocate workforce across different practice settings to meet population needs:** • Appropriately allocate workforce to practice setting, i.e., distribute clinicians to match patient need (severity and acuity), including efforts to integrate behavioral health clinicians into school-based and medical settings	**Increase Traditional Health Worker (THW) workforce:** • Create plans for integrating and utilizing THWs as part of integrated healthcare teams, assertive community treatment teams, non-clinical care settings, etc. • Establish alternative payment models with sustainable rates for THW services • Maximize use of peer workers

Connecticut

A review and analysis of the information gathered from Connecticut's Workforce Collaborative on Behavioral Health yielded three key areas of focus:

Using Information From The Connecticut Career Pathways In Behavioral Health Report

Use data from this report to **support the development of workforce strategic planning, policy development, and grant writing** and distribute the data to stakeholders invested in the future of the behavioral health. This report was available on the Connecticut Workforce Collaborative website and disseminated to Collaborative members as stand-alone documents.

Developing Additional Needed Information

Develop workplan to **obtain information on the capacity of the behavioral health workforce**, such as: number of employees; retention and turnover information for Connecticut behavioral health providers and positions; projected position vacancies; comparisons of numbers of graduates completing behavioral health-related programs and anticipated position vacancies; and identification of new programs and curricula needed in addition to with strategies to develop them.

Collaboration With Other Stakeholders

The Connecticut Workforce Collaborative on Behavioral Health should **continue to strengthen its relationships with the Office for Workforce Competitiveness and the Allied Health Workforce Policy Board** in order to incorporate the mental health and addictions field into mainstream health workforce planning in this state.

Appendix:
DSP Credentialing in Practice

NADSP's E-Badge Academy is just one example of how DSP career paths can be professionalized

NADSP created an online "E-Badge Academy" credentialing platform to standardize DSP training and create career ladders in the profession.

Impacts of Credentialing

- Wage stabilization
- Increased tenure
- Improve quality of support
- Potential for credentials to be 'portable' across institutions

How it Works

- DSPs must submit specific examples, experiences and education, which are uploaded for objective review by NADSP
- E-badges are awarded to acknowledge and celebrate progress. DSPs earn badges for:
  - Knowledge
  - Skills
  - Values

Milestones to Stabilization

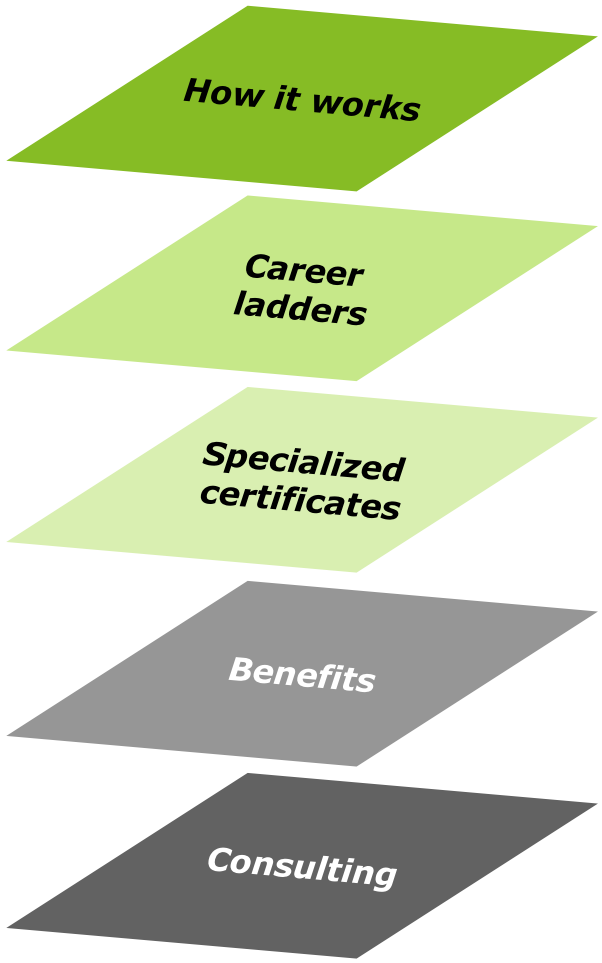
- Competency-based credentials ensure knowledge and enhance quality support
- Pay incentive based on DSP level
- Creates a career ladder

DSP Level Requirements & Competencies

- DSP I
  - Non-Negotiables in Service: Health, Safety and Person-centered support
- DSP II
  - Supporting Community Based Care and Relationships: Community Navigation, Community Networking, Support Choice
- DSP III
  - Supporting Individualized, Values-Based Care: Promoting Rights, Advocating with and Advocating for Individuals Served

Ohio Credentialing Program: DSPaths

DSPaths credentialing program meets the needs of employers and the public, while creating a career ladder and providing incentives to grow professionally



- Credentialing courses are voluntary and available online or at onsite training agencies that are licensed to teach the DSPaths curriculum
- Online courses are **organized into modules** and when DSPs sign up for the online courses they must complete all modules; DSPs are **assigned to an Ohio Alliance of Direct Support Professionals (OADSP) representative** to provide support throughout the process

- Basic certification – 30 hours
- Certificates of Initial Proficiency (CIP) and Certificates of Advanced Proficiency (CAP) – 60 hours
  - Meets the major requirements for a **national credential awarded by NADSP**
  - Credentials are **portable** in the State of Ohio
  - Increased wages incentive (certificates + 2 years of experience)

- Health & Safety management, Assessment tools & Approaches, Incident Report Writing, Communication
- **Specialized Skills in Supporting Individuals with Mental Illness, ID/DD, Autism & Older Adults with ID/DD**
- Crisis Intervention, Effective Support Models, Guidelines Effective Documentation

- Confirms competency, capability and provides recognition
- **Proves dedication and distinguishes a DSPs specialty**
- Certified DSPs have input, influence and has increased organizational participation

Consulting and franchise initiatives to assist statewide entities with building sustainable training and support infrastructure

- Consultations, training and professional development is available to **states and organizations**
- Training, credentialing, and consultations cover both broad based and specific areas
- Evidenced and research-based methods of training for adult learners
- Advanced training ladders and customized curriculum trainings

Appendix:
Additional Resources

Additional Resources

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hh) Thomas S. Bodenheimer, Mark D. Smith,"Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians," 2013, Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians | Health Affairs

ii) United Health Foundation, America's Health Rankings Annual Report, "Prevalence of Mental Illness 2021," 2021, Prevalence Data 2021 | Mental Health America (mhanational.org)

jj) U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, "State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, Rockville, Maryland," September 2018, State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030 (hrsa.gov)

Additional Resources

kk) U.S. HHS, Centers for Medicare & Medicaid, National Plan and Provider Enumeration System," Mental Health Providers in Virginia, United States," 2021, Explore Mental Health Providers in Virginia | 2020 Annual Report | AHR (americashealthrankings.org)

ll) Virginia Association of Community Service Boards, "2020 Overview of Community Services in Virginia", January 2020 Overview of Community Services Delivery in Virginia (vacsb.org)

mm) Virginia Department of Health," Emergency Department Visits," 2021 ED Visits for Drug Overdose – Surveillance and Investigation (virginia.gov)

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Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce

A tool to serve as a baseline to measure progress and to help guide investments intended to increase access to basic mental health services in Virginia.

January 2022

www.vhcf.org

AGENDA ITEM
#6.71

Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce

Executive Summary

The COVID-19 pandemic has brought a tsunami of stressors, resulting in a mental health crisis. Most behavioral health (*BH*) professionals indicate the various related traumas and their after-effects will continue far into the future. BH professionals throughout the Commonwealth are overwhelmed by the demand for services and Virginians are unable to get the help they need. Unfortunately, this demand is expected to continue to outpace the capacity of Virginia's licensed BH workforce.

This assessment provides statewide and locality-specific data on the capacity of each of Virginia's five types of licensed BH professionals; data regarding Virginia's pipeline to produce more licensed BH professionals; the current demand for them; and the consequences of an inadequate supply. It is a tool to help those who want to increase access to basic mental health services prioritize investments of time and resources. It can also serve as a baseline to measure progress.

Key Findings

While Virginia regularly ranks at the top of national scorecards as the best state for business and a top state for public education, when it comes to availability of BH services, that is not the case. The shortage of BH professionals is not a new problem, the severity of the shortage is, however.

- A large and disproportionate number of Virginia's licensed BH professionals are at or nearing retirement age (*61% of Psychiatrists are age 55 or older*).
- Virginia's BH workforce does not reflect the racial and ethnic diversity of the Commonwealth's population.
- 93 of Virginia's 133 localities are federally-designated Mental Health Professional Shortage Areas; 37% of Virginians (*3.2 million*) live in them. Two localities have no licensed BH professionals; 35 have no trained BH prescriber (*Psychiatrist, Psych NP*).
- In many communities with no or a few BH professionals, a large number of households do not have broadband internet access and are unable to access tele-health services. One-in-five Virginians (*20%*) live in these communities.
- Virginia localities with no or a few BH professionals have poorer outcomes on key BH indicators than those with more BH professionals.
- Although Virginia's 40 graduate-level BH programs, combined, graduate nearly 800 individuals annually, the number who ultimately become licensed in Virginia is insufficient to maintain even the current inadequate supply of BH professionals.

The Commonwealth of Virginia is a "can do" state and succeeds when its leaders focus on elevating the state's performance or rankings. It will take a variety of short and long-term strategies over a number of years to address Virginia's significant shortage of licensed BH professionals. As such, time is of the essence. The multi-dimensionality of solutions requires cross-sector engagement, focus, and investments of time, money and attention targeted to strategies which will produce measurable results.

Introduction

The COVID-19 pandemic has brought a tsunami of stressors and challenged the equilibrium of us all. The resulting need for behavioral health (*BH*) services has skyrocketed in Virginia and the nation. Most BH professionals indicate the various traumas and their after-effects will continue far into the future.

This has created a mental health crisis in both the public and private sectors. The workforce shortages that existed in the Commonwealth and in each of the five licensed BH professions before the pandemic have been exacerbated exponentially. The need and demand for behavioral health services far exceeds the available capacity to meet them. BH professionals throughout the Commonwealth are overwhelmed and Virginians are waiting months for help. Demand for services is expected to continue to outpace the workforce in the coming decade.

This assessment of the capacity of Virginia's BH workforce provides statewide demographic data and locality-specific data for each of the five types of licensed BH professionals. It also includes data on Virginia's pipeline for producing more BH professionals; the current demand for them; and the consequences of an inadequate supply. It is hoped this assessment can serve as a tool to help those addressing the shortage of BH providers prioritize and target investments of time and resources. This assessment can also serve as a baseline for measuring progress over the years.

Virginia Ranks Poorly in Availability of Behavioral Health Services

While Virginia regularly ranks at the top of national scorecards as the best state for business and a top state for public education, when it comes to availability of BH services, that is not the case:

- 38 states have more licensed BH professionals/100,000 people than Virginia (*America's Health Rankings, 2021*).
- Virginia ranks 39th in the U.S. for access to mental health care and 41st for availability of its BH workforce (*Mental Health America, 2021*).
- 37% of Virginians live in the 93 localities that are federally-designated Mental Health Professional Shortage Areas (*MHPSAs*), compared to about 30% of all Americans.
- Access to BH services is a top concern in Community Health Needs Assessments conducted by Virginia's nonprofit hospitals every three years.

Demographic Profile of Virginia's Licensed BH Workforce Is Concerning

There are 5 types of licensed BH professionals:

- Psychiatrist (*all types*)
- Psychiatric-Mental Health Nurse Practitioner
- Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Counselor

Many of them are at or nearing retirement age, with a significant portion *age 55 or older*. Data from the Virginia Department of Health Professions (*DHP*) show this is true for each of the five BH professions.

Most alarming is the age of such a large percentage of Psychiatrists and Psychiatric-Mental Health Nurse Practitioners (*Psych NPs*). Virginia is fast approaching a provider cliff with 61% of Psychiatrists *age 55 or older* and 39% of Psych NPs *age 60 or older*. This is particularly distressing, because they are the only types of BH professionals specially trained and licensed to prescribe and manage psychotropic medicines, which are a primary method of treating many mental health conditions.

BH Professional Type	% of Workforce Age 55+
Psychiatrist	61%*
Psychiatric-Mental Health Nurse Practitioner	39%**
Licensed Clinical Psychologist	36%
Licensed Clinical Social Worker	37%
Licensed Professional Counselor	32%

*Psychiatrist Data Source: Association of American Medical Colleges (*AAMC*) (*2019*).
LCP, LCSW and LPC Data Source: Department of Health Professions' Profession reports (*2020*).
**In 2019, 39% of Psych NPs were age 61 or older; 60% were age 51 or older. Data Source: Health Care Workforce Data Center, Virginia Department of Health Professions (*October 2020*).

While the percentage of those nearing retirement in the other three types of BH professional categories is not as startling, it is concerning as well, because it represents one-third or more of those practicing. If these providers' ages were more evenly distributed over the typical four decades of practice, only 25% would be at or nearing retirement age.

More racial and ethnic diversity is needed in Virginia's licensed BH workforce. Currently, it does not reflect the diversity of Virginia's population (*see table below*). Therapy is most effective when the BH professional can personally relate to a client's circumstances. This is especially true when a person's stressors are related to racial and ethnicity-related issues.

Race/ Ethnicity	Virginia	Licensed Clinical Psychologist	Licensed Clinical Social Worker	Licensed Professional Counselor
	2020 Census	*2020 Virginia Department of Health Professions Reports*		
White	**60.3%**	82%	79%	76%
Black	**18.6%**	7%	14%	16%
Hispanic	**10.5%**	4%	3%	4%
Asian	**7.1%**	4%	2%	1%
2+ Races	**8.2%**	2%	2%	2%
Other	**5.8%**	1%	1%	1%

Many Localities Lack the Licensed BH Professionals Needed

Awareness of the number and distribution of Virginia's BH professionals is fundamental to understanding the availability of BH services in the Commonwealth. A vast majority of Virginia's 133 localities are federally-designated Mental Health Professional Shortage Areas; 3.2 million Virginians live in these localities.

A review of the number of each type of BH professional by locality provides an eye-opening perspective. Two localities (*Craig and Surry counties*) have no licensed BH professionals of any kind. Two others (*Mathews and King & Queen counties*) each have ≤ 1 FTE of a BH professional.

The table below shows the number of Virginia localities with **no** BH professionals of a particular type and the number of localities with just 1 FTE or less of a type of BH professional.

Number of BH Professionals/ Locality	# Psychiatrists	# Psych NPs	FTE Clinical Psychologists	FTE LCSWs	FTE LPCs
0	54	51	33	6	3
≤1	25	28	15	5	13
TOTAL	***79***	***79***	***48***	***11***	***16***

Data for Psychiatrists and Psych NPs and LPCs, LCSWs LPCs practicing in Virginia (*in 2021 and 2020, respectively*): Healthcare Workforce Data Center, Virginia Department of Health Professions.

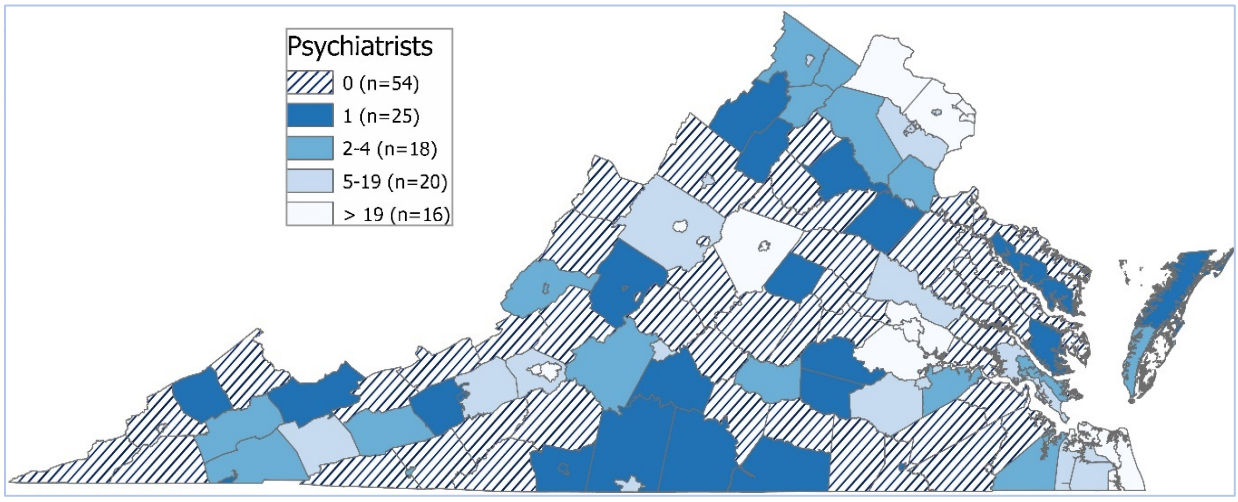
Shockingly, 54 localities have **no** Psychiatrist and 51 have **no** Psych NP. In addition*, 88 localities have no Child/Adolescent Psychiatrist*. Perhaps most significantly, **35 localities are without a prescriber** (*Psychiatrist, Psych NP*) specifically trained in psychotropic medicines and an additional 25 have only 1 prescriber. *Note that these are the same two professions with the highest percentage of those at or near retirement age.*

While primary care providers (*PCPs*) can prescribe behavioral health medicines, most PCPs have little training in psychopharmacology and many feel uncomfortable doing so, as a result. Still, PCPs write many psychiatric prescriptions (*59% of all psychotropic prescriptions in 2006 – 2007, including 62% of antidepressant prescriptions, Reuters Health News, September 2009*). Their lack of training prescribing psychiatric medicines is borne out in the data. More than 50% of PCP-treated patients with depression receive less than the recommended dose of anti-depressants (*Yale Journal of Biology and Medicine, 2013*).

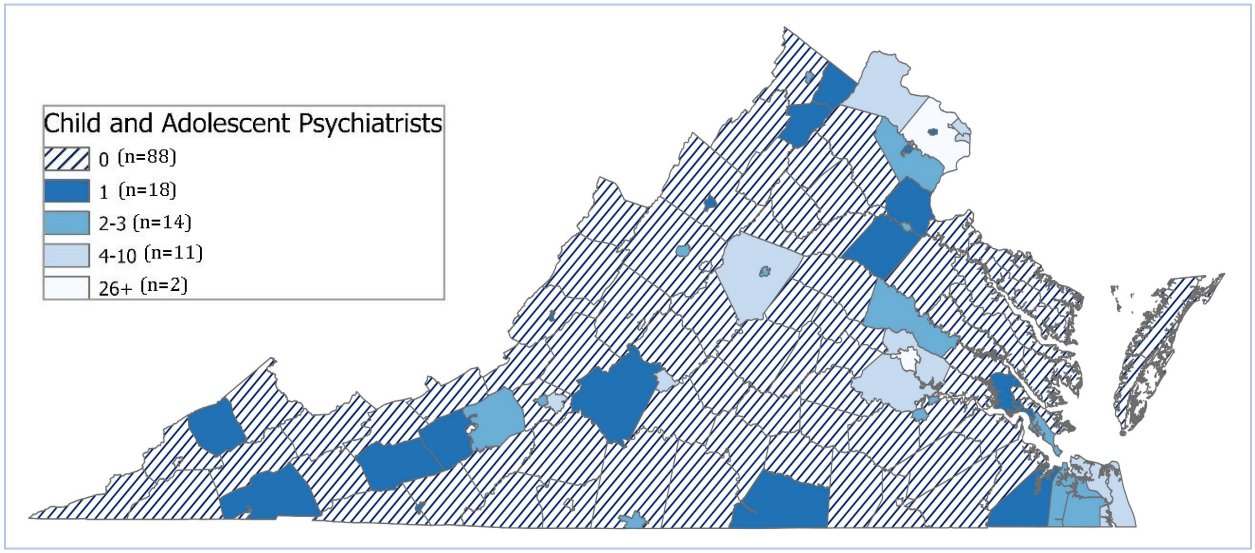
The following maps show the distribution of each of the 5 licensed BH professionals practicing in Virginia by locality.

- Stripes indicate there is none of the type of BH professional in the locality.
- Dark colors are localities with very few of the BH professional type.

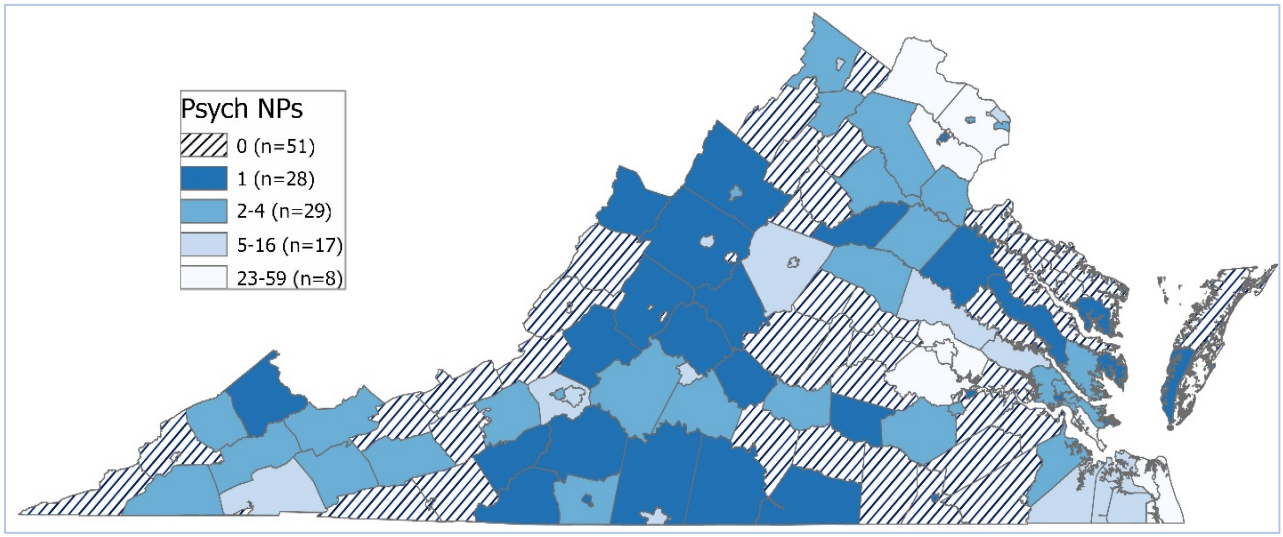
Distribution of Psychiatrists in Virginia



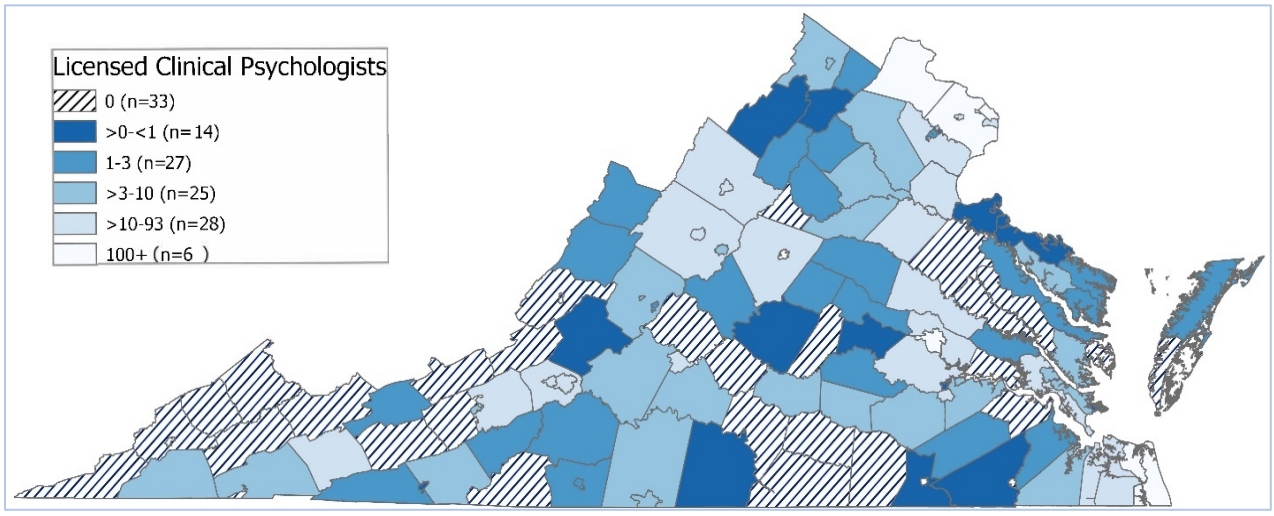
Distribution of Child and Adolescent Psychiatrists



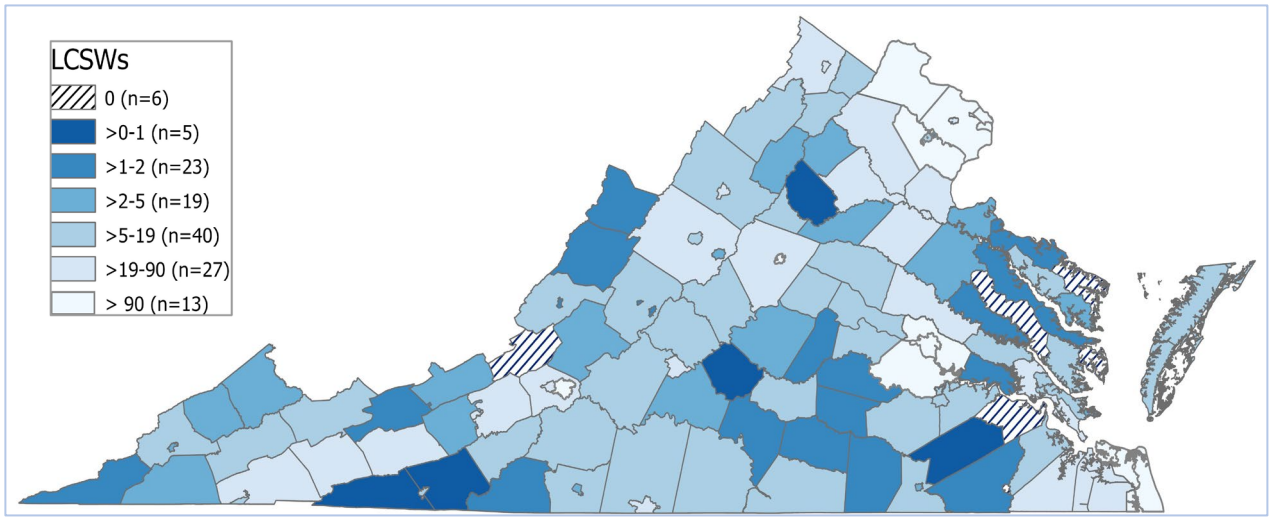
Distribution of Psychiatric-Mental Health Nurse Practitioners



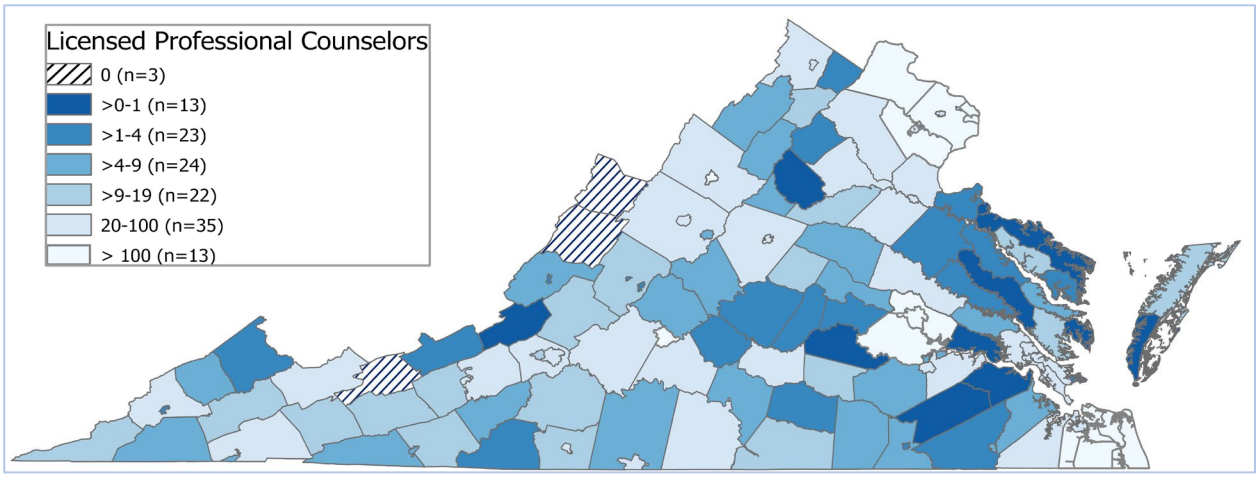
Distribution of Licensed Clinical Psychologists (*LCPs*) in Virginia



Distribution of Licensed Clinical Social Workers (*LCSWs*) in Virginia



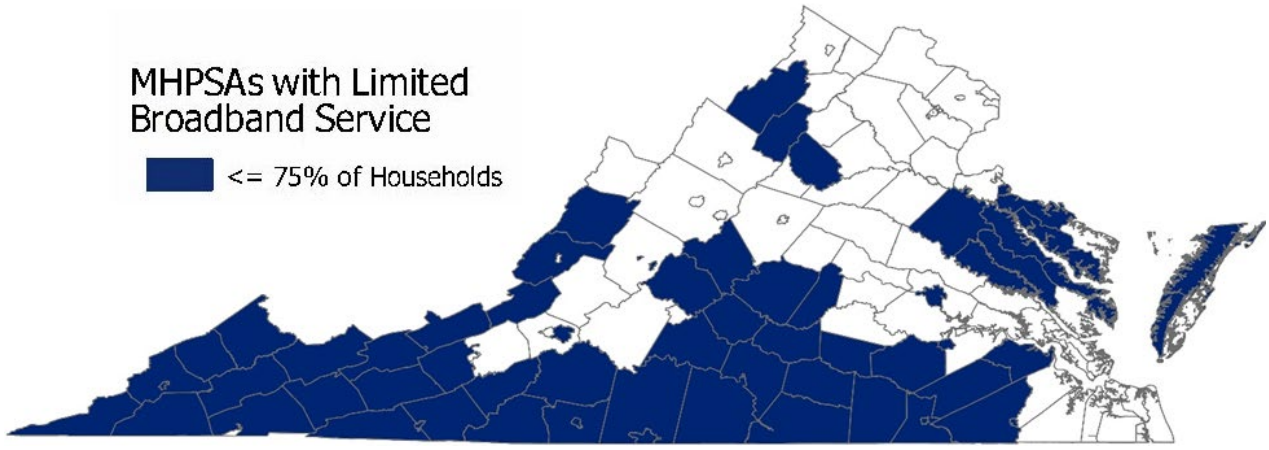
Distribution of Licensed Professional Counselors (*LPCs*) in Virginia



Access to Telehealth Services Can Be Problematic

Often when there are discussions about the shortages of health professionals, many automatically assume that telehealth can address the problem. Telehealth has been a significant help during the pandemic and has enabled many to receive needed care, including BH services. McKinsey and Company reports that telehealth has been used more for behavioral health services than for any other type of outpatient visits during the pandemic (*presented at the Virginia Hospital and Healthcare Association's October 2021 Behavioral Health Summit*). While helpful, telehealth is not a panacea. Many Virginians do not yet have broadband services. This limits their ability to receive BH care via telehealth.

The map below shows the extent to which Virginia's Mental Health Professional Shortage Areas (*MHPSAs*) overlap with localities where 75% or fewer households have broadband internet service. In many communities with no or few BH professionals, a large number of households do not have broadband internet access. One-in-five Virginians (*20%*) live in these communities.



Data Source: Mental Health Professional Shortage Areas, Office of Health Equity, Virginia Department of Health (*August 2021*). Localities where ≤75% of households have broadband internet services needed to assure ready access to BH services via telehealth (*U.S. Census, 2015 - 2019*).

While Virginia is using federal COVID-19 funding and other sources to increase broadband availability to many of these localities, it will take a number of years before the type of last-mile coverage needed to assure ready access to BH services via telehealth is available.

Lack of Local BH Professionals Has Consequences

While some Virginians living in localities with too few licensed BH professionals may be able to travel to other localities for BH services, it is clear there are consequences for individuals and communities without BH professionals. Overall, these localities have much poorer outcomes on key BH indicators than the state as a whole:

- In all of these localities, the percent of adults reporting frequent mental distress (*14+ poor mental health days/month*) exceeds the Virginia rate of 12.5%.
- In all of these localities, the average number of adults reporting mentally unhealthy days in the past 30 days exceeds the number of days reported by Virginia adults, overall (*4 days/month*).
- In 81% of localities with ≤ 1 prescriber **and** ≤ 1 therapist, the suicide rate exceeds the state rate (*13.6/100,000 people*).

Data Sources: The Suicide Death Rate is from the *Office of the Chief Medical Examiner Annual Report, 2019*, Virginia Department of Health (*June 2021*). Data regarding poor mental health days are from the 2018 Behavioral Health Risk Factor Surveillance System (*BRFSS*) conducted by the Centers for Disease Control and Prevention.

High Demand for BH Professionals in Virginia

While the demographic and outcomes data paint a compelling picture of the need for many more licensed BH professionals throughout the Commonwealth, the availability of jobs for these valuable providers reinforces the tremendous demand for them.

BH Professional Type	# Job Postings
Psychiatrist	172
Psychiatric-Mental Health Nurse Practitioner	97
Licensed Clinical Psychologist	148
Licensed Clinical Social Worker	549
Licensed Professional Counselor	412
TOTAL	***1,378***

Data Source: Indeed.com, November 2021

Virginia's Current Pipeline of Virginia BH Professionals Is Inadequate

Given the current and growing demand for BH services and the paucity of licensed BH professionals in the Commonwealth, an examination of Virginia's current capacity to educate and produce these needed providers is important.

Virginia colleges and universities have 40 graduate-level programs to prepare licensed BH professionals. Combined, they graduate nearly 800 BH professionals annually.

Type of BH Professional Program	# Virginia BH Programs	# Graduates from Virginia BH Programs (*2019*)
Psychiatry (*residency*)	5	32
Psychiatric-Mental Health Nurse Practitioner	7	33
Clinical Psychology	10	58
Masters of Social Work	4	351
Masters of Professional Counseling	14	295
TOTAL	***40***	***777***

Unfortunately, Virginia's BH programs **do not produce enough new graduates in the BH professions to maintain even the current inadequate supply**, let alone address the tremendous growth in demand.

BH Professional Type	Current Virginia Workforce	Current Virginia Workforce Age 55+	ESTIMATED # Graduates Becoming Licensed/Yr. in Virginia*
Psychiatrist	1109	677 (*61%)*	26
Psychiatric-Mental Health Nurse Practitioner	544	212 (*39%)*	47
Licensed Clinical Psychologist	2860	1030 (*36%)*	82
Licensed Clinical Social Worker	6304	2333 (*37%*)	194
Licensed Professional Counselor	5812	1860 (*32%*)	224

*Estimates for LCPs, LCSWs, LPCs and Psych NPs use 5-year averages for the number of graduates from Virginia universities *plus* licensure exam pass rates for those schools. There is no data from Old Dominion University, since its first cohort started in 2021 and there are no graduates yet. Estimates for Psychiatrists are based on the average pass rate of 80% for the national psychiatry licensure exam.

One cause of the shortage of LCSWs and LPCs is that graduating with a Masters degree does not immediately result in the ability to take a licensure exam. Master's graduates in counseling and social work must complete a significant number of supervised clinical hours before they are eligible to take their licensure exam (*3400 and 3000 hours, respectively, over a limited time period*).

Many of these pre-licensees must pay for this supervision themselves at an average rate of $100/hour (*$20,000 for counselors and $10,000 for social workers*). As a result, not all who graduate with a Masters degree in these professions become licensed. Given the low salaries available to these pre-licensees (*$42,000 - $47,000/year*) and the high student debt

load they carry, many cannot run the financial gauntlet of paying for the required supervisory hours.

BH Professional Type	% of All Carrying Educational Debt	% ≤ Age 40 Carrying Educational Debt	Median Educational Debt Range for All	Median Salary Range for All
LCSW	39%	65%	$50K - $60K	$60K - $70K
LPC	49%	67%	$80K - $90K	$60K - $70K

Multiple Strategies are Needed to Make Virginia Whole

There are multiple strategies to address Virginia's significant shortage of BH professionals. It will likely require all or most of them to be successful. It will also take a number of years to see the results. As such, time is of the essence.

Several immediate strategies include:

- **Virginia's participation in Interstate Compacts for each licensed BH professional**. This would enable licensed BH professionals from other Compact states to practice in the Commonwealth. The *most productive Compacts provide full reciprocity of licensure*.

  - Legislation authorizing Virginia's participation in a Compact for Licensed Professional Counselors is likely to be considered during the 2022 General Assembly session. It will provide for reciprocity.

  - Legislation approving Virginia's participation in a Compact for Licensed Clinical Psychologists passed in 2020. While it is helpful, it only allows LCPs from other states to provide services in Virginia via telehealth. Given broadband access issues in most of Virginia's mental health professional shortage areas, this approach provides limited relief.

  - A Compact for Licensed Clinical Social Workers, which would include reciprocity, is currently under development at the national level and will likely be ready for the General Assembly's consideration in the next few years.

- **State funding for more psychiatric residencies and Fellowships** for Child and Adolescent Psychiatrists. The data cannot be ignored. Virginia currently has a dearth of Psychiatrists and 677 of them (*61%*) are at or near retirement age (*55 years or older*). Virginia's psychiatric residency programs graduate only about 32 residents a year, combined. The small number of Child and Adolescent Psychiatrists in Virginia is particularly concerning, especially with recent reports of the traumas high numbers of children are experiencing as a result of the pandemic.

- **State payment for the clinical supervision required for licensure of Masters-prepared social workers and counselors.** A pilot program would determine the efficacy of paying these fees for pre-licensees who practice in MHPSAs or of whom there is a disproportionately low number (*e.g., bilingual, people of color*). It would also

have the immediate benefit of immediately adding more therapists in the field to help address the tremendous current demand for services.

Longer term strategies are needed, as well. These include working with the State Council on Higher Education of Virginia and Virginia's BH graduate programs to produce more of each type of licensed BH professional and prioritizing the state's MHPSAs for last-mile broadband development.

The maxim, "That which gets measured gets done" is true, as long as there are leaders paying attention to the data generated, using it to inform or tweak strategies and keeping all key partners focused on the ultimate goal. To that end, a regular assessment of the capacity of the Commonwealth's BH workforce shared with state legislative and executive branch leaders (*possibly every 3 years*) would add value.

Conclusion

The Commonwealth of Virginia is a "can do" state. It has succeeded each time its leaders have focused on elevating the state's performance or rankings. Evidence of this includes, but is not limited to**,** the state's best for business and education rankings, STEM initiatives and development of the Port of Virginia. There has also been progress in addressing some of the challenges in the state's public mental health system via STEP Virginia and Project BRAVO.

While the shortage of BH professionals is not a new problem, the severity of the shortage is. The onslaught of mental health conditions and angst caused by the pandemic and subsequent events have affected a significant percentage of Virginians. They come from all demographics, political affiliations and parts of the Commonwealth.

Many of the conditions for which demand has risen so dramatically are depression, anxiety, panic disorder, and PTSD. There are multiple types of venues where Virginians can seek the mental health services they need. Unfortunately, the shortage of licensed BH professionals exists in all types of practice venues – public and private – and, throughout the state.

No single initiative can address this shortage. The multi-dimensionality of solutions and strategies requires cross-sector engagement, focus, and investments of time, money and attention targeted to solutions which will produce measurable results.

Assessment Sources and Methodology

Data were gathered and analyzed from a variety of state and national sources to provide a comprehensive picture of the capacity of Virginia's licensed BH workforce and related factors. Additional information and insights came from interviews with leaders of the associations of the BH professionals licensed by the state and leaders of Virginia's BH graduate programs.

Key sources and methods used for the data found in the Assessment follow:

- Demographic data (*age, race and ethnicity, educational debt*) about LCPs, LCSWs and LPCs were found in the 2020 Profession reports prepared by the Health Care Workforce Data Center (*HWDC*) at the Virginia Department of Health Professions (*DHP*). These data are gathered from licensees via a survey completed at annual license renewal. Most licensees complete at least part of the survey, with the majority (*70% - 85%*) responding to personal demographic and employment-related questions (*organization type, number of patients per week, FTE*).

- The number of Psychiatrists and Psych NPs by locality were developed by matching license data from Virginia Interactive with individual clinician records from the National Provider Identifier registry, which provides individual practice sites. Data regarding the FTEs of LCPs, LCSWs and LPCs by locality were determined by the HWDC. VHCF hired an expert in geo-spatial analysis and technology to map those data.

- The number of individuals completing BH graduate programs (*psychology, social work, counseling*) from 2015--2019 was provided by the data centers at the Virginia universities that house those programs. Data for Psych NP and Psychiatric residency graduates were obtained from Virginia's schools of nursing and medicine, respectively. Graduation data for 2020 is not yet available from all schools.

- The estimates of the number of new licensed professionals joining Virginia's workforce annually per each BH profession were determined by applying the licensure exam pass rate from each Virginia school to its graduation data, except for Psychiatry, for which the average national pass rate was used.

- Locality-level outcomes data were obtained from the Behavioral Risk Factor Surveillance System, which is sponsored by the Centers for Disease Control, and from the Office of Virginia's Chief Medical Examiner. VHCF compared the outcomes data for localities with ≤ 1 prescriber and/or therapist to data for Virginia, overall, to determine whether BH outcomes were poorer in those communities.

- U.S. Census data (*2015 – 2019*) were consulted to determine the Virginia localities with significant portions of households lacking broadband services. These localities were compared to the MHPSAs to determine how many localities with few or no BH professionals are the same localities where high numbers of households do not have broadband services and likely little, if any, access to tele-mental health services.

VIRGINIA HEALTH CARE FOUNDATION
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About the Virginia Health Care Foundation

VHCF is a public/private partnership initiated in 1992 by Virginia's General Assembly and its Joint Commission on Health Care. Its mission is to increase access to primary health care for uninsured and medically underserved Virginians.

VHCF aligns its work with state priorities, complementing state efforts where appropriate, and identifying and addressing gaps in health access where they exist. The Foundation practices venture philanthropy. It is always looking for opportunities to partner with organizations, companies, individuals, and key funding partners to leverage its limited resources and maximize the availability of services for uninsured and medically underserved Virginians.

VHCF has focused on increasing access to basic mental health services, particularly for uninsured and underserved Virginians, since 2009. It has invested nearly $10 million to make licensed BH professionals, tele-mental health services and BH best practices, such as integrated and trauma-informed care, available to organizations throughout the Commonwealth.

The tremendous need for mental health services caused by the COVID-19 pandemic and its many ripple effects has led the Foundation to make the increased availability of basic mental health services for all Virginians an even greater priority. This assessment is a critical component of the Foundation's enhanced focus on BH and will help guide future VHCF initiatives and investments.

For more information, please contact
Debbie Oswalt, VHCF Executive Director: doswalt@vhcf.org or
Denise Daly Konrad, Director of Strategic Initiatives:
dkonrad@vhcf.org.

Many thanks to the Richmond Memorial Health Foundation for its financial support to help underwrite preparation of the maps included in this Assessment.

CSB Critical Focus Area
3-1-22 Update

1. Improve CSB Staff Recruitment and Retention
    - Improve Salaries
        - Change S-levels
            - Initial round has been completed.
            - Working with HR to determine future classes under review.
        - Address Salary Compression
            - Plan to address during the summer
        - Continue to assess hiring bonus
            - Will be done after salary compression
    - Improve Hiring
        - Blending CM and Licensed Clinician job class
            - Will be on fall workforce planning
        - Implement Generic Job ads
            - Has begun and will expand
        - Examine Continuous Job Openings
            - Recommended not to do after consulting with HR and other agencies
        - Assess benefits of reviewing all job applicants
            - Process underway to expand review of candidates
        - Complete hiring business process mapping and prioritize potential improvements.
            - Mapping of first phase complete: Doing timeline for each step
            - Reviewing for low hanging fruit improvements.
            - Mapping of second phase (job offer to first day of employment) to begin when timeline for each step in first phase is complete
        - Explore retention bonus for hard to fill job classes
            - Will be looked at after salary compression adjustments
        - Reclass PT positions and explore hiring back annuitants for work and interviewing
            - Underway: Need to keep updated on process and success
        - Explore ways to expand Vid cruiter interview efforts.

    - Improve Retention
        - Continue to seek ways to reduce administrative burden
            - Use CSB Staff Suggestion box as one tool to determine changes.
                - ongoing process: Box reviewed by members of ELT and action taken.
            - Continue to advocate for change at regional and state level.
                - ongoing process: Member of DBHDS/VACSB Quality and Outcomes Committee.
                - Requesting advanced copy of regulations.
        - Continue to seek staff feedback through town halls.
            - Spring town halls set up

        - ELT continue to communicate updates to all staff on a consistent basis.
            - Ongoing via regular email updates from Executive Director

    - Examine Ways to expand job pool
        - Review job specifications to determine if minimums can be changed.
            - Underway: Need update on any next steps required; BHS II and DDS I-IV class specs have been revised to allow candidates to be screened in by DHR who may not have a degree in a related field but relevant QMHP or DDP certifications
        - Review and make changes with job classes where we can expand underfills
            - Status update needed: Should we proceed with this? (Underfills permitted for BHSC and BHS IIs when listed in the ad)
        - Use information from Virginia Healthcare Foundation to Develop medium and long-term employment strategies
            - Strengthen relationships with local universities
            - Strengthen internship program
            - Explore ways to increase hiring with undergraduate degree programs.
2. Continue to Implement STEP-VA
    - Next phase involves Case management, care coordination, and psychosocial rehabilitation.
        - Working to establish expectations and outcomes at state level.
        - Requested draft state regs and copies of framework from DBHDS.
    - Implementation of regional crisis hub.
        - Underway but experiencing ongoing difficulties.
        - Appropriate CSB staff on workgroups.
3. Write/Create Marcus Alert Plan
    - Kickoff meeting has occurred
    - Having workgroup meetings to discuss triage protocols.
    - Plan is to have community input sessions in late March or early April.
4. Take Next Steps on Health Record
    - Finalize decision and process with Welligent
        - Contract has been cancelled and Welligent notified.
    - Assess current and future status with Credible.
        - underway
    - Update Health Records requirements and release new RFP.
        - Plan is to perform environmental scan of current health records Scan completed and RFP draft in process.

Other Items

- BOS Audit Corrections
    - Plan is to begin process when new CSB CFO is in place.

County of Fairfax, Virginia

MEMORANDUM

DATE: March 15, 2022

TO: Fairfax County Board of Supervisors
Fairfax County School Board Members

FROM: Bryan J. Hill
County Executive

Scott S. Brabrand, Ed.D
Superintendent, Fairfax County Public Schools

SUBJECT: Youth Nonfatal Overdoses

Local data on fatal and nonfatal opioid overdoses in the Fairfax Health District has been trending higher in 2021, which is consistent with national and state trends.[1] Individuals of all ages are impacted by the opioid epidemic in the Fairfax Health District, with the 18-34 age range having the highest rates of fatal and nonfatal overdoses in the Fairfax Health District in recent years.

Recently we have had a concerning number of nonfatal overdoses involving youth ages 15-17 in the Richmond Highway Corridor that have come to the attention of the Fairfax County Police Department (FCPD). Notably, many of these nonfatal overdoses involve Hispanic youth, some of whom are newcomers to the community. Illicit pills are the primary substance involved, and it is suspected, though not verified by lab tests, that these pills include fentanyl (such pills are commonly known as pressed pills and are prevalent in communities across the country, including Fairfax). While these overdoses have occurred in one part of the County, the opioid epidemic impacts youth and families throughout our County.

For your awareness, this memo provides information on the efforts that multiple County agencies and Fairfax County Public Schools (FCPS) are working on through the Fairfax County Opioid and Substance Use Task Force to connect youth and families with treatment and support services. Because of the Boards' longstanding commitment to addressing the opioid epidemic, the Task Force's multi-pronged strategy involving about 30 programs/activities provides the foundation for a timely, tailored response. One example is the Substance Abuse Prevention Specialists (SAPS) program, a partnership between FCPS, Juvenile and Domestic Relations District Court (JDRDC), and the Community Services Board (CSB) which provides substance use prevention, education, and intervention services to youth and their parents.

[1] Fatal overdose data for October – December 2021 is expected to be released by the Virginia Office of the Chief Medical Examiner in April 2022.

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Specific activities underway to amplify and tailor support services and community engagement/awareness include:

- FCPD's Overdose Investigation Unit (OIU) investigating and apprehending the sources of supply associated with overdoses in the County.
- Exploring expanded Narcan (the medication that reverses opioid overdoses) availability for FCPS staff (currently, FCPD School Resource Officers carry Narcan, but other school personnel do not).
- Working to connect parents with the CSB and FCPS SAPS for treatment services for the youth as appropriate.
- Providing information to the impacted families on family peer support services and Revive! Training (on how to recognize and reverse an overdose), both of which are available in English and Spanish.
- Assessing the continuum of regional substance use treatment options for youth and implementing strategies to fill the identified gaps.
- Seeking feedback from the impacted families to help inform response efforts.
- Engaging local nonprofits to assist in reaching community members.
- Planning for a community event(s) and messaging to raise awareness of the dangers associated with illicit pills and substances and the many early intervention and treatment resources available, both through FCPS and County agencies.
- Providing ongoing targeted substance abuse prevention messaging to youth.

If you have any questions or would like further information, please contact Ellen Volo, Opioid and Substance Use Task Force Coordinator, at 703-324-7073 or Stefan Mascoll, Fairfax County Public Schools, Coordinator of Student Safety and Wellness, at 571-423-4270.

cc:

Tom Arnold, Deputy County Executive
Christopher A. Leonard, Deputy County Executive
Dr. Gloria Addo-Ayensu, Director, Health Department
Michelle Boyd, Assistant Superintendent, FCPS
John S. Butler, Chief, Fire and Rescue Department
Tony Castrilli, Director, Office of Public Affairs
Kevin Davis, Chief, Police Department
Stacey Kincaid, Sheriff, Sheriff's Office
Lisa Potter, Diversion Initiatives Director, Fairfax-Falls Church CSB
Matt Thompson, Director of the Court Service Unit, JDRDC
Daryl Washington, Executive Director, Fairfax-Falls Church CSB

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

March 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16 Compliance Committee Meeting – 4:00 p.m. Access: 852 3980 5304 Passcode: 655026 Executive Committee Meeting – 4:30 p.m. Access: 858 9622 3529 Passcode: 354944	17 Fiscal Oversight Committee Meeting – 4:00p.m. Access: 890 7155 4397 Passcode: 882366	18	19	20
21	22	23 CSB Board Meeting – 5:00 p.m.	24	25	26	27
28	29	30	31			

Board Review, Action, or Information:

- Identify CSB Board Members for Budget Testimony (R)
- Prepare for Budget Testimony & Board of Supervisors Budget Public Hearings in April 2022 (R)
- Development of CSB Input for Human Services Council 2023 Budget Testimony before the Board of Supervisors (R)
- CSB Board Approval of FY 2023 CSB Fee Schedule Submission to Board of Supervisors

Events of Interest:

- Board of Supervisors (BOS) Markup of County FY 2023 Budget
- VACSB Development & Training Conference May 4-6, 2022 (Hyatt Regency – Reston, VA)
- Updated FY 2023 CSB Fee Schedule included in the May 2022 BOS Meeting Agenda
- Board of Supervisors (BOS) FY 2023 Advertised Budget Public Hearings – CSB Testimony

AGENDA ITEM
#7.1

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

April 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
				1	2	3
4	5	6	7	8	9	10
11	12	13 *Service Delivery Oversight Committee Meeting – 5:00 p.m.	14	15	16	17
18	19	20 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	21 Fiscal Oversight Committee Meeting – 4:00 p.m.	22	23	24
25	26	27 CSB Board Meeting – 5:00 p.m.	28	29	30	

Board Review, Action, or Information:

- Appointment of CSB Officer Nominating Committee (A)
- Board of Supervisors FY 2023 Advertised Budget Public Hearings – CSB Testimony (R)

***SDOC meets on the 2nd Wednesday of every even month**

Events of Interest:

- Board of Supervisors (BOS) Markup of County FY 2023 Budget
- VACSB Development & Training Conference May 4-6, 2022 (Hyatt Regency – Reston, VA)
- May 2022 CSB Spirit of Excellence and Honors Awards
- Updated FY 2022 CSB Fee Schedule included in the Board of Supervisors May Meeting Agenda

AGENDA ITEM
#7.2

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

May 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
						1
2	3	4 **VACSB Development & Training Conference ***	5 **VACSB Development & Training Conference ***	6 **VACSB Development & Training Conference ***	7	8
9	10	11	12	13	14	15
16	17	18 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	19 Fiscal Oversight Committee Meeting – 4:00 p.m.	20	21	22
23	24	25 CSB Board Meeting – 5:00 p.m.	26	27	28	29
30	31 Memorial Day					

Board Review, Action, or Information:

- Review of County Legislative Proposals in Preparation for the Human Services Issue Paper (R)
- Revised Fee Policy and Related Materials Presented to the Board of Supervisors for Approval (A) (Effective July 1, 2022)

Events of Interest:

- ***VACSB Development & Training Conference May 4-6, 2022 (Hyatt Regency – Reston, VA)**
- CSB Executive Director Evaluation due in June 2022
- Board of Supervisors Adoption of County FY 2023 Budget

AGENDA ITEM
#7.3

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

June 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		1	2	3	4	5
6	7 BOS Meeting	8 *Service Delivery Oversight Committee Meeting – 5:00 p.m.	9	10	11	12
13	14	15 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	16 Fiscal Oversight Committee Meeting – 4:00p.m.	17	18	19
20 Juneteenth Holiday	21 BOS Meeting	22 CSB Board Meeting – 5:00p.m.	23	24	25	26
27	28	29	30			

Board Review, Action, or Information:

- Election of CSB Board Officers (A)
- SDOC Associate Member Nominations and Appointment (A)
- Community Services Performance Contract Renewal (A)
- CSB Board Review of Human Services Issues Paper (R)

Events of Interest:

- Budget Carryover Due in July 2022
- Board of Supervisors Meetings

***SDOC meets on the 2nd Wednesday of every even month**

AGENDA ITEM
#7.4

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

July 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
				1 FY 2023 BEGINS	2	3
4 Independence Day	5	6	7	8	9	10
11	12 BOS Meeting	13	14	15	16	17
18	19	20 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	21 Fiscal Oversight Committee Meeting – 4:00p.m.	22	23	24
25	26 BOS Meeting *BAC Appts	27 CSB Board Meeting – 5:00 p.m.	28	29	30	31

Board Review, Action, or Information:

- Approval of FY 2023 Budget in Concept (A)
- Match Members with General Assembly Representatives for Outreach (A)
- Schedule Fall Outreach with General Assembly Legislators (A)
- Review of Legislative Talking Points (R)
- Board Carryover Actions (R)
- Approval to Submit Annual FYE 2021 Report (A)

Events of Interest:

- Upcoming: Board of Supervisors (BOS) Carryover Approvals
- Upcoming: VACSB Public Policy Conference 2022

***BAC Appointments: Boards, Authorities, and Commissions**

AGENDA ITEM
#7.5

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

August 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	2	3	4	5	6	7
8	9	10 *Service Delivery Oversight Committee Meeting – 5:00 p.m.	11	12	13	14
15	16	17 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	18 Fiscal Oversight Committee Meeting – 4:00 p.m.	19	20	21
22	23	24 CSB Board Meeting – 5:00 p.m.	25	26	27	28
29	30	31				

Board Review, Action, or Information:

- Draft of Annual FYE Report to CSB Board Chair 08/31/2022 (R)

Events of Interest:

- Upcoming: VACSB Public Policy Conference
- Upcoming: Review of FY 2023 Budget

***SDOC meets on the 2nd Wednesday of every even month**

AGENDA ITEM
#7.6

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

September 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
			1	2	3	4
5 Labor Day	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20 BOS Meeting *BAC Appts	21 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	22 Fiscal Oversight Committee Meeting – 4:00 p.m.	23	24	25
26	27	28 CSB Board Meeting – 5:00 p.m.	29	30		

Board Review, Action, or Information:

- Approval to submit annual FYE 2022 Report (A)
- General Assembly Legislative Session (A)

Events of Interest:

- Board of Supervisors Carryover Approvals
- Upcoming: VACSB Public Policy Conference

*BAC Appointments: Boards, Authorities, and Commissions

AGENDA ITEM
#7.7

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

October 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
					1	2
3	4 BOS Meeting	5	6	7	8	9
10	11	12 **Service Delivery Oversight Committee Meeting – 5:00 p.m.	13	14	15	16
17	18 BOS Meeting *BAC Appts	19 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	20 Fiscal Oversight Committee Meeting – 4:00 p.m.	21	22	23
24	25	26 CSB Board Meeting – 5:00 p.m.	27	28	29	30

Board Review, Action, or Information:

- Begin Preparation for January 2023 CSB Testimony – Local General Assembly Hearings (R)
- Submission of Annual FYE Report to Board of Supervisors, Fairfax City, and Falls Church City

Events of Interest:

- VACSB Public Policy Conference
- Review and Prepare Board of Supervisors Legislative Priority Issues, VACBS, & Region II CSB Priorities

***BAC Appointments: Boards, Authorities, and Commissions**

****SDOC meets on the 2nd Wednesday of every even month**

AGENDA ITEM
#7.8

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

November 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	1	2	3	4	5	6
7	8 Election Day	9 *Compliance Committee Meeting – 4:00 p.m. *Executive Committee Meeting – 4:30 p.m.	10 *Fiscal Oversight Committee Meeting – 4:00 p.m.	11 Veteran's Day	12	13
14	15	16 *CSB Board Meeting – 5:00 p.m.	17	18	19	20
21	22	23	24 Thanksgiving Holiday	25 Thanksgiving Holiday	26	27
28	29	30				

Board Review, Action, or Information:

- CSB Board Meeting Schedule Approval (A)
- Identify CSB speakers, priorities & prepare testimony for January 2023 Hearings (R)
- FY 2023 CIP Budget (I)

Events of Interest:

- Review and Prepare Board of Supervisors (BOS) Legislative Priority Issues, VACSB & Region II CSB Priorities
- Upcoming: VACSB Legislative Conference

***Meeting schedule date change to accommodate holiday schedule**

AGENDA ITEM
#7.9

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

December 2022

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
			1	2	3	4
5	6 BOS Meeting *BAC Appts	7 **Service Delivery Oversight Committee ***Meeting– 5:00 p.m.	8	9	10	11
12	13	14 **Compliance Committee Meeting – 4:00 p.m. **Executive Committee Meeting – 4:30 p.m.	15 **Fiscal Oversight Committee Meeting – 4:00 p.m.	16	17	18
19	20	21 **CSB Board Meeting – 5:00 p.m.	22	23 Christmas Eve (½ Day)	24	25
26	27	28	29	30 New Year's Day Observed	31	

Board Review, Action, or Information:

- Finalize Testimony: January 2023 State Budget Hearings (R)
- FY 2023 CIP Budget (I)

Events of Interest:

- Upcoming: House Appropriations-Senate Finance Committee's Public Hearings on Budget (January 2023)
- Upcoming: Fairfax County Delegation's Pre-General Assembly Public Hearing (January 2023)
- Review Governor's Proposed Budget
- Upcoming: VACSB Legislative Conference January 2023

***BAC Appointments: Boards, Authorities, and Commissions**

****Meeting schedule date change to accommodate holiday schedule**

*****SDOC meets on the 2nd Wednesday of every even month**

AGENDA ITEM
#7.10

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

January 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16 Martin Luther King, Jr Holiday	17	18 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	19 Fiscal Oversight Committee Meeting – 4:00 p.m.	20	21	22
23	24	25 CSB Board Meeting – 5:00 p.m.	26	27	28	29

Board Review, Action, or Information:

- CSB Board Testimony before House Appropriations – Senate Finance Committee - State Budget Hearings (R)
- CSB Board Testimony before Virginia Legislative Delegation (R)

Events of Interest:

- CSB Board Testimony before House Appropriations – Senate Finance Committee's Budget Public Hearings and Fairfax County Delegation's Pre-General Assembly Public Hearing
- VACSB Legislative Conference in January 2023 (Richmond, VA)
- Board of Supervisors (BOS) Budget Committee Meetings

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

February 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15 Compliance Committee Virtual Meeting – 4:00 p.m. Executive Committee Virtual Meeting – 4:30 p.m.	16 Fiscal Oversight Committee Virtual Meeting – 4:00 p.m.	17	18	19
20 President's Day	21	22 CSB Board Meeting – 5:00 p.m.	23	24	25	26
27	28					

Board Review, Action, or Information:

- CSB Board Testimony before House Appropriations – Senate Finance Committee - State Budget Hearings (R)
- CSB Board Testimony before Virginia Legislative Delegation (R)

Events of Interest:

- CSB Board Testimony before House Appropriations – Senate Finance Committee's Budget Public Hearings and Fairfax County Delegation's Pre-General Assembly Public Hearing
- VACSB Legislative Conference
- Board of Supervisors (BOS) Budget Committee Meetings

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

March 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	16 Fiscal Oversight Committee Meeting – 4:00p.m.	17	18	19
20	21	22 CSB Board Meeting – 5:00 p.m.	23	24	25	26
27	28	29	30	31		

Board Review, Action, or Information:

- Identify CSB Board Members for Budget Testimony (R)
- Prepare for Budget Testimony & Board of Supervisors Budget Public Hearings in April 2023 (R)
- Development of CSB Input for Human Services Council 2023 Budget Testimony before the Board of Supervisors (R)
- CSB Board Approval of FY 2024 CSB Fee Schedule Submission to Board of Supervisors

Events of Interest:

- Board of Supervisors (BOS) Markup of County FY 2024 Budget
- VACSB Development & Training Conference May 2023 (Hyatt Regency – Reston, VA)
- Updated FY 2023 CSB Fee Schedule included in the May 2022 BOS Meeting Agenda
- Board of Supervisors (BOS) FY 2023 Advertised Budget Public Hearings – CSB Testimony

AGENDA ITEM
#7.13

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

April 2023

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
					1	2
3	4	5	6	7	8	9
10	11	12 *Service Delivery Oversight Committee Meeting – 5:00 p.m.	13	14	15	16
17	18	19 Compliance Committee Meeting – 4:00 p.m. Executive Committee Meeting – 4:30 p.m.	20 Fiscal Oversight Committee Meeting – 4:00 p.m.	21	22	23
24	25	26 CSB Board Meeting – 5:00 p.m.	27	28	29	30

Board Review, Action, or Information:

- Appointment of CSB Officer Nominating Committee (A)
- Board of Supervisors FY 2024 Advertised Budget Public Hearings – CSB Testimony (R)

Events of Interest:

- Board of Supervisors (BOS) Markup of County FY 2024 Budget
- VACSB Development & Training Conference
- May 2023 CSB Spirit of Excellence and Honors Awards
- Updated FY 2023 CSB Fee Schedule included in the Board of Supervisors May Meeting Agenda

***SDOC meets on the 2nd Wednesday of every even month**

AGENDA ITEM
#7.14

Community Services Board	Item: 9A	Type: Action	Date: 03/23/22

Request for Approval of FY 2023 Fee Schedule

Issue:
Updates to the Fee Schedule

Timing:
If approved by the CSB Board, the Fee Schedule is forwarded to the Board of Supervisors for their review. Following CSB Board approval the changes to the Fee Schedule will not become effective before July 1, 2022.

Recommended Motion:
I move the Board approve the CSB Fee Schedule.

Background:
At the CSB Board meeting on February 23, 2022, the CSB Board discussed the proposed changes.

The recommended changes include:

1. Updated to the fees based on current Medicare, Medicaid, or negotiated rates for CSB services provided and billed to clients

If approved by the CSB Board, the Fee Schedule will be submitted to the Board of Supervisors for review in May 2022. Following Board of Supervisors review, staff will inform clients, conduct staff training, and make adjustments in the Electronic Health Record, resulting in an effective date not sooner than July 1, 2022.

Fiscal Impact:
The fee related documents provide the CSB with uniform mechanisms to maximize revenues from clients, Medicaid, Medicare, and other health insurance plans. The FY 2022 current budget plan for the CSB includes $21M in estimated fee revenues.

Board Members and Staff:
Staff: Sebastian Tezna, Director of Behavioral Health Operations

Enclosed Documents:
CSB Fee Schedule – Eff. 7/1/2022

Service	Service Code	Revenue Code (Facility Billing Only)	Subject to Ability to Pay Scale	Previous Rate	New Rate	Unit	Change
Interactive Complexity* add on to other clinic services when there is a factor that complicates the psychiatric service or increases the work intensity of the psychotherapy service	90785		Yes	$16.47	$16.33	per event	($0.14)
Initial Evaluation/Assessment	90791		Yes	$199.30	$197.19	per event	($2.11)
Psychiatric Evaluation, Medical Services	90792		Yes	$223.16	$221.80	per event	($1.36)
Individual Therapy/Counseling (16 to 37 minutes)	90832		Yes	$85.48	$85.67	per event	$0.19
Psychotherapy w/Pt w/E&M (16 to 37 minutes) - add on	90833		Yes	New	$78.81	per event	New
Individual Therapy/Counseling (38 to 52 minutes)	90834		Yes	$113.62	$113.11	per event	($0.51)
Psychotherapy w/Pt w/E&M (38 to 52 minutes) - add on	90836		Yes	New	$99.40	per event	New
Individual Therapy/Counseling (53 minutes or greater)	90837		Yes	$167.71	$165.87	per event	($1.84)
Psychotherapy w/Pt w/E&M (53 minutes or greater) - add on	90838		Yes	New	$130.74	per event	New
Crisis Intervention - non-Medicaid	90839		Yes	$159.80	$158.89	per hour	($0.91)
Crisis Intervention - Addl 30 Min	90840		Yes	$75.54	$79.74	each add't 30 min	$4.20
Psychoanalysis	90845		Yes	New	$107.15	per event	New
Family Therapy w/out client (50 minutes)	90846		Yes	$107.42	$106.54	per event	($0.88)
Family Therapy w/ client (50 minutes)	90847		Yes	$111.10	$110.19	per event	($0.91)
Multi-Family Group Therapy	90849		Yes	$39.85	$39.95	per event	$0.10
Group Therapy/Counseling (per group, per person)	90853		Yes	$30.37	$30.12	per event	($0.25)
Injection Procedure	96372		Yes	$16.62	$16.91	per event	$0.29
Urine Collection & Drug Screen- Retests Only (Specimen Handling)	99000		Yes	$25.00	$3.68	per event	($21.32)
Office Outpatient New 15-29 Min	99202		Yes	$55.95	$85.86	per event	$29.91
Psychiatric Evaluation & Management Low Complexity - New Patient 30-44 Min	99203		Yes	$130.74	$130.99	per event	$0.25
Psychiatric Evaluation & Management Moderate Complexity - New Patient 45-59 Min	99204		Yes	$193.99	$193.70	per event	($0.29)
Office Outpatient New High 60-74 min	99205		Yes	$255.71	$255.77	per event	$0.06
Nursing Subsequent Care - Established Patient	99211		Yes	$27.34	$27.97	per event	$0.63
Office Outpatient Established 10-19 Min	99212		Yes	$40.51	$66.74	per event	$26.23
Psychiatric Evaluation & Management Low Complexity - Established Patient 20-29 Min	99213		Yes	$106.24	$105.79	per event	($0.45)
Psychiatric Evaluation & Management Moderate Complexity - Established Patient 30-39 Min	99214		Yes	$150.25	$148.55	per event	($1.70)
Office Outpatient Established High 40-54 min	99215		Yes	$209.07	$209.06	per event	($0.01)
Preventative Visit Estimated Age 18-39	99395		Yes	$86.72	$86.23	per event	($0.49)
Preventative Visit Estimated Age 40-64	99396		Yes	$89.89	$79.95	per event	($9.94)
Preventative Visit Estimated Age 65+ (negotiated)	99397		Yes	$95.00	$95.00	per event	$0.00
Prolonged Office Outpatient ea 15 min	99417		Yes	$45.00	$22.34	per 15 min	($22.66)
Complex E/M visit add on	G2211		Yes	$45.00	$45.00	per event	$0.00
Prolonged Outpatient Office Visit	G2212		Yes	$45.00	$37.32	per event	($7.68)
Case Management - SA	H0006		Yes	$243.00	$273.38	per month	$30.38
Residential Treatment	H0010 - HB	Revenue Code(s) 1002, and DRG(s) 894-897	Yes	$393.50	$423.32	per day	$29.82
Intensive Outpatient - SA	H0015	Revenue Code 905 or 906	Yes	$250.00	$281.25	per day	$31.25
Behavioral Health Short Term Residential (TDOs)	H0018 - HK		Yes	$657.96	$657.96	per event	$0.00
Behavioral Health Outreach Service (Case Management - MH)	H0023		Yes	$326.50	$367.31	per month	$40.81
Community Psychiatric Supportive Treatment	H0036		Yes	$30.79	$34.64	per 15 min	$3.85
Intensive Community Treatment	H0039/ H0040		Yes	$153.00	$172.13	per hour	$19.13
Crisis Intervention - Medicaid	H2011		Yes	$30.79	$31.06	per 15 min	$0.27
Therapeutic Behavioral Services	H2019		Yes	$89.00	$100.13	per 15 min	$11.13
Crisis Stabilization - Adult Residential (Therapeutic Behavioral Services)	H2019	Revenue Code(s) 1001, and DRG(s) 876, 880-887	Yes	$583 (Facility only)	$583 (Facility only)	per day	None
Turning Point Program	H2020		Yes	$146.22	$164.50	per day	$18.28
Detoxification, Medical, Residential-setting	H2036 - HB	Revenue Code(s) 1002, and DRG(s) 894-897	Yes	$393.50	$423.32	per day	$29.82
Detoxification, Social, Residential-setting	H2036 - HB	Revenue Code(s) 1002, and DRG(s) 894-897	Yes	$393.50	$423.32	per day	$29.82
Drop-In Support Services, ID	None		Yes	Rate set by vendor(s) but no less than $2 per hour and for those with incomes above 150% of FPL, apply 20% liability (based on ATP Scale) of the CSB contracted negotiated rate. If below 150% of FPL, charge $2 per hour.	Rate set by vendor(s) but no less than $2 per hour and for those with incomes above 150% of FPL, apply 20% liability (based on ATP Scale) of the CSB contracted negotiated rate. If below 150% of FPL, charge $2 per hour.	per hour	None

Late Cancellation or No Show (commercial insurance coverage only)	None		Yes	$25.00	$25.00	per appointment	$0.00
Residential Fee ID Community Living Services	None		No	75%	75%	of monthly gross income	$0.00
Residential Fee MH/SA Community Living Services	None		No	30%	30%	of monthly gross income	$0.00
Returned Check (due to insuffient funds or closed account)	None		No	$50.00	$50.00	per check	$0.00
Transportation	None		No	$100.00	$100.00	per month	$0.00
Partial Hospitalization Psychiatric Patient	S0201	Revenue Code 912	Yes	$500.00	$562.50	per diem	$62.50
Partial Hospitalization Substance Abuse Patient	S0201	Revenue Code 913	Yes	$500.00	$562.50	per diem	$62.50
Release of Information: Research	S9981		No	$10.00	$10.00	per event	$0.00
Release of Information: Per Page	S9982		No	$.37 per pg up to 50 pgs; $.18 per pg > = 51 pgs; $6.00 per CD	$.37 per pg up to 50 pgs; $.18 per pg > = 51 pgs; $6.00 per CD	per pages/CD	Varies